This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0158 Worksheet S Period: From 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/25/2023 2:35 pm] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WEST HOSPITAL (15-0158) for the cost reporting period beginning 01/01/2022 and ending 12/31/2022 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Cara	a Breidster	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Cara Breidster			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	199, 085	-47, 130	0	0	1.00
2.00	SUBPROVIDER - 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	199, 085	-47, 130	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 2:35 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1111 N. RONALD REAGAN PARKWAY 1.00 PO Box: 1.00 State: IN Zip Code: 46123-7085 County: HENDRICKS 2.00 City: AVON 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH WEST HOSPITAL 150158 26900 12/01/2004 Ν 3.00 Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospital -Based OLTC 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From To: 1.00 2.00 01/01/2022 12/31/2022 20.00 Cost Reporting Period (mm/dd/yyyy) 20 00 21.00 Type of Control (see instructions) 21.00 2 1.00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν N 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Does this hospital contain at least 100 but not more than 499 beds (as

"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4.

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 2: 35 pm | XVIII | XIX 1. 00 2.00 3.00 58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 Pt. I Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qualification Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see 60 00 N 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 adjustment? Enter "Y" for yes or "N" for no in column 2. IME Direct GME IME Direct GME 1. 00 2.00 3. 00 4. 00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 0.00 61.00 Ν 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) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 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) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 0.00 61.10 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 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 Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter 63.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

Health Financial Systems	IU HEA	LTH WEST HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMF	PLEX IDENTIFICATION DA	ATA Provider CC		eriod: rom 01/01/2022 o 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/25/2023 2:3	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea	ar FTE Residents in N	onprovider Settings				
period that begins on or after. 64.00 Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in yof (column 1 divided by (column 1 divided by (column 1 divided by (column 2 that trained in your formulation).	s yes, or your facili nber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. 00
or (cordillir r drvrded by (cordillir	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col.	
	11 ogi dili Ndilic	11 ogi dili code	FTEs Nonprovider Site	FTES in Hospital	3/ (col. 3 + col. 4))	
	1. 00	2. 00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00		65. 00
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovi der	Hospi tal	col . 2))	
			Si te	'	, ,	
			1. 00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	ysEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column	unweighted non-prima occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000 Ratio (col.	66. 00
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
(7.00 5.1)	1. 00	2. 00	3.00	4. 00	5. 00	(7.55
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

	Financial Systems IU HEALTH WEST HOSPITAL	W 45 0450 T		eu of Form CMS-			
HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CC	F	Period: From 01/01/202 To 12/31/202		epared:		
				1.00			
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-490 For a cost reporting period beginning prior to October 1, 2022, did you ob MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	otain permissi	ion from your	N	68. 00		
			1.	00 2.00 3.00			
	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta	ain an IPF sul	oprovi der?	N	70.00		
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teachir recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye (column 3: If column 2 is Y, indicate which program year began during this (see instructions) Inpatient Rehabilitation Facility PPS	es or "N" for in a new tead es or "N" for	no. (see chi ng no.	0	71.00		
	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it co subprovider? Enter "Y" for yes and "N" for no.	ontain an IRF		N	75.00		
76. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teachir recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If indicate which program year began during this cost reporting period. (see	"Y" for yes of in accordance column 2 is '	or "N" for e with 42 Y,	0	76.00		
				1. 00			
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for r Is this a LTCH co-located within another hospital for part or all of the c "Y" for yes and "N" for no.		g period? Ente	er N	80. 00 81. 00		
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter Did this facility establish a new Other subprovider (excluded unit) under			D. N	85. 00 86. 00		
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified u 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section		N	87. 00		
	Tood(d)(T)(b)(VT): Litter T TOT Yes OF N TOT TIO.		Approved fo Permanent Adjustment (Y/N) 1.00	Approved			
	Column 1: Is this hospital approved for a permanent adjustment to the TEFF amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co 89. (see instructions)		е		88.00		
	Column 2: Enter the number of approved permanent adjustments.	Wkst. A Line	Effective	Approved			
		No.	Date	Permanent Adjustment Amount Per Discharge			
89. 00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1. 00	2. 00	3.00	0 89.00		
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge.	0.0			3, 07. 00		
	Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.						
			V 1. 00	XI X 2. 00			
	<u>Title V and XIX Services</u> Does this facility have title V and/or XIX inpatient hospital services? Er	nter "Y" for	N	Y	90.00		
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report		N	N	91.00		
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certificati			N	92.00		
00.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and	d XIX? Enter	N	N	93.00		
93.00	"Y" for yes or "N" for no in the applicable column.						
	applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00						
94. 00 95. 00	applicable column.	٦.		0. 00 N	94. 00 95. 00 96. 00		

ealth Financial Systems IU HEALTH WEST				u of Form CMS	-2552-
OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC		Period: From 01/01/2022 To 12/31/2022	Date/Time Pr	epare
			V	5/25/2023 2: XI X	35 pm
			1.00	2.00	
3.00 Does title V or XIX follow Medicare (title XVIII) for the in	terns and resi	idents post	N	Y	98.
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo	or yes or "N"	for no in			
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the report of the column 1 for title XIX. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98.
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on			N	Y	98.
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a criti- reimbursed 101% of inpatient services cost? Enter "Y" for yes		N	98.		
for title V, and in column 2 for title XIX. Boes title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in			N N	N	98
3.05 Does title V or XIX follow Medicare (title XVIII) and add bad	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in				
8.06 Does title V or XIX follow Medicare (title XVIII) when cost in Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	N	Y	98.		
Rural Providers					
05.00 Does this hospital qualify as a CAH?			N		105
06.00 If this facility qualifies as a CAH, has it elected the all-i	inclusive met	hod of paymer	nt N		106
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cos	ct roimburcom	ont for LOD	N		107
training programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF 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			
08.00 s this a rural hospital qualifying for an exception to the (dul e? See 42	2 N		108
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
_	Physi cal	Occupati ona		Respiratory	_
09.00 f this hospital qualifies as a CAH or a cost provider, are	1. 00	2. 00	3. 00	4.00	-
		l NI	N	N	1100
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109
	IN	N	N		109
for yes or "N" for no for each therapy.	I Demonstration	on project (§ "N" for no.	6410A If yes,	1. 00 N	
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Complete Worksheet E, Part A, Lines 200 through 218, and Worksheet E.	I Demonstration	on project (§ "N" for no.	6410A If yes, ough 215, as	1. 00 N	
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Workapplicable.	I Demonstratio Y" for yes or ksheet E-2, li	on project (§ "N" for no. ines 200 thro	6410A If yes, bugh 215, as	1.00	110
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Workapplicable.	I Demonstration Y" for yes or ksheet E-2, line he Frontier Construction of the strength of the	on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2.	3410A If yes, bugh 215, as 1.00 N	1. 00 N	110
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Complete Worksheet E, Part A, Lines 200 through 218, and Workapplicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cose "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for additional contents the services of the services	I Demonstration Y" for yes or ksheet E-2, line he Frontier Construction of the strength of the	on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C"	\$410A If yes, bugh 215, as 1.00 N	1. 00 N	110
for yes or "N" for no for each therapy. 0.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Complete Worksheet E, Part A, lines 200 through 218, and Workapplicable. 1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cosmy. "Y" for yes or "N" for no in column 1. If the response to collintegration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	I Demonstration Y" for yes or the ksheet E-2, line I be Frontier Constreporting plumn 1 is Y, or the constraint of the c	on project (§ "N" for no. i nes 200 thro ommunity period? Enter enter the column 2. ; and/or "C"	3410A If yes, bugh 215, as 1.00 N	1. 00 N	1110
for yes or "N" for no for each therapy. 10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "'complete Worksheet E, Part A, lines 200 through 218, and Workapplicable. 11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for addition for tele-health services. 12.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost reperiod? Enter "Y" for yes or "N" for no in column 1. If column "Y", enter in column 2, the date the hospital began participate demonstration. In column 3, enter the date the hospital cease.	I Demonstration Y" for yes or ksheet E-2, Iii he Frontier Construction of the Frontier Construction of	on project (§ "N" for no. ines 200 thro ommunity period? Enter enter the column 2. ; and/or "C"	\$410A If yes, bugh 215, as 1.00 N	1. 00 N	110
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Health Financial Systems	IU HEALTH WEST	HOSPI TAL		In Lieu	ı of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN		Provi der CCN		Peri od: From 01/01/2022 To 12/31/2022	Worksheet S Part I Date/Time P	6-2 Prepared:
			Premi ums	Losses	5/25/2023 2 Insurance	
440 0411 1 1 1 1 1			1.00	2.00	3. 00	0110.01
118.01 List amounts of malpractice premiums and	a para rosses:		250, 63	30 0		0118.01
110 00 4				1.00	2. 00	110.00
118.02 Are mal practice premiums and paid losse Administrative and General? If yes, su and amounts contained therein.				N		118. 02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies fo §3121 and applicable amendments? (see i "N" for no. Is this a rural hospital wi Hold Harmless provision in ACA §3121 and Enter in column 2, "Y" for yes or "N" for	nstructions) Enter in th < 100 beds that qua d applicable amendment	column 1, "Y" lifies for th	for yes or e Outpatient		N	119. 00 120. 00
121.00 Did this facility incur and report cost	s for high cost implan	table devices	charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for 122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in	related taxes as defi column 1. If column 1				5. 04	122. 00
the Worksheet A line number where these 123.00 Did the facility and/or its subprovider services, e.g., legal, accounting, tax management/consulting services, from an for yes or "N" for no.	s (if applicable) purc preparation, bookkeepi unrelated organizatio	ng, payroll, n? In column	and/or 1, enter "Y'			123.00
If column 1 is "Y", were the majority o professional services expenses, for ser located in a CBSA outside of the main h "N" for no. Certified Transplant Center Information	vices purchased from u ospital CBSA? In colum	nrelated orga	ni zati ons			
125.00 Does this facility operate a Medicare-c	ertified transplant ce		Y" for yes	N		125. 00
and "N" for no. If yes, enter certifica 126.00 If this is a Medicare-certified kidney			fication dat	te		126. 00
in column 1 and termination date, if ap 127.00 f this is a Medicare-certified heart t	•	or the cortif	ication data			127. 00
in column 1 and termination date, if ap	plicable, in column 2.	er the certif	ication date			127.00
128.00 f this is a Medicare-certified liver t in column 1 and termination date, if ap		er the certif	ication date	Э		128. 00
129.00 If this is a Medicare-certified lung tr	ansplant program, ente	r the certifi	cation date			129. 00
in column 1 and termination date, if ap 130.00 f this is a Medicare-certified pancrea	•	enter the cer	tification			130. 00
date in column 1 and termination date,	if applicable, in colu	mn 2.				
131.00 If this is a Medicare-certified intestidate in column 1 and termination date,			erti fi cati or	ו		131. 00
132.00 If this is a Medicare-certified islet t in column 1 and termination date, if ap	ransplant program, ent		ication date	е		132. 00
133.00 Removed and reserved	•	50)	000			133.00
134.00 If this is a hospital-based organ procu		PO), enter th	e OPO number			134. 00
All Providers		fired in CMC	D. L 15 1		1511050	140.00
140.00 Are there any related organization or hechapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	r no in column 1. If y office chain number.	es, and home	office costs		15H059	140. 00
1.00 If this facility is part of a chain org	2.00 anization, enter on li	nes 141 throu		3.00 name and address	of the home)
office and enter the home office contra	ctor name and contract			or's Number: 0810		141. 00
	PO Box:		Contracti	or s Number. 0610	Į.	142.00
143. 00 Ci ty: I NDI ANAPOLI S	State: IN		Zi p Code:	: 4620	2	143. 00
144.00 Are provider based physicians' costs in	cluded in Worksheet A?				1. 00 Y	144. 00
				1.00	2. 00	
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in c Medicare utilization f	olumn 1. If c	olumn 1 is	Y	2.00	145.00
period? Enter "Y" for yes or "N" for no 146.00Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu yes, enter the approval date (mm/dd/yyy	nged from the previous mn 1. (See CMS Pub. 15			N		146. 00

Health Financial Systems	IU HEALTH W	EST HOSPITAL		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLI	X IDENTIFICATION DATA	Provi der CC	CN: 15-0158	Period: From 01/01/2022 To 12/31/2022		epared:
					1.00	-
147.00 Was there a change in the statist	ical basis? Enter "Y" for	r ves or "N" for	no .		1.00 N	147. 00
148.00 Was there a change in the order o					N N	148. 00
149.00 Was there a change to the simplif				or no.	N	149.00
	-	Part A	Part B	Title V	Title XIX	
		1. 00	2. 00	3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or						
155. 00 Hospi tal		N	N	N	N	155. 00
156.00 Subprovi der - IPF		N	N	N	N	156. 00
157.00 Subprovi der - IRF		N	N	N	N	157. 00
158. 00 SUBPROVI DER						158. 00
159. 00 SNF		N	N N	N N	N N	159.00
160.00 HOME HEALTH AGENCY 161.00 CMHC		N	N N	N N	N N	160. 00 161. 00
161. 00 CMITC			Į IV	IN IN		161.00
Mul ti campus					1. 00	
165.00 s this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	one or more camp	uses in dif	ferent CBSAs?	N	165. 00
Effect 1 101 yes of N 101 Ho.	Name	County	State Z	ip Code CBSA	FTE/Campus	
	0	1. 00	2.00	3.00 4.00	5. 00	7
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. 0	00166.00
					1.00	
Health Information Technology (HI	T) incentive in the Amer	ican Recovery ar	nd Reinvestm	nent Act		
167.00 s this provider a meaningful use 168.00 f this provider is a CAH (line 1				"), enter the	Y	167. 00 168. 00
reasonable cost incurred for the 168.01 f this provider is a CAH and is	not a meaningful user, do	oes this provide	er qualify f	or a hardship		168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y") ar				e 9. 9	99169. 00
transition ractor. (see mistracti	5113)			Begi nni ng	Endi ng	
				1.00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and endino	g date for the r	eporti ng			170.00
1 22 22 22 2 2 3 3 4 4 4 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7				1.00	2.00	
171.00 If line 167 is "Y", does this pro section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2. (reported on Wkst. S-3, Pi umn 1. If column 1 is yes	t. I, line 2, co	ol. 6? Enter	Y		5 171. 00

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0158 Peri od: Worksheet S-2 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/25/2023 2:35 pm Y/N Date 1.00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If N 2 00 yes, enter in column 2 the date of termination and in column $\hat{\textbf{3}},$ "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Α 02/25/2022 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper. 1.00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7 00 7 00 N 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved 11.00 Ν 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, see instructions. 12.00 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? Ν N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for 04/03/2023 17.00 Υ 04/23/2023 Υ 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R 18.00 Ν 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report information? If yes, see instructions.

Promotorial Programme Promotorial Programme Promotorial Programme Promotorial Programme Prog		Financial Systems IU HEALTH WE AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-0158	In Lie	u of Form CM Worksheet S	
Bescription Y/N Y/N Y/N	1103F1 1	AL AND HOSFITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	riovidei	CON. 13-0136	From 01/01/2022	Part II Date/Time F	repared:
1.00 1 1 1 1 1 1 1 1 1			Descr	iption		Y/N	
Report data for Other? Describe (the other adjustments: Report data for Other? Describe (the other adjustments: Y/N	20.00	16.114747.1		0			00.00
1.00 Was the cost report prepared only using the provider's N 2.00 3.00 4.00 2.1. 1.00 Was the cost report prepared only using the provider's N N 2.00 3.00 4.00 2.1. 1.00 Exercity 1f yes, see instructions. 2.00 Have assets been relified for Medicare purposes? If yes, see instructions 3.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see Instructions. 1.00 Were new leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see Instructions. 1.00 Were new leases and/or Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 25.00 Has exists subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 25.00 Has existing debt been a funded depreciation account? If yes, see Instructions. 1.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 3.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 3.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 3.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 3.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 3.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 3.00 Has existing deb	20.00				N N	N	20.00
1.00 Was the cost report prepared only using the provider's N N 21.0		Troport data for other boods to the other day dot monto	Y/N	Date	Y/N	Date	
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Complete Day Cost Retirbulises AND TERRA Hospitals Oblity (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Capital Related Cost No Have changes occurred in the Medicare purposes? If yes, see instructions. 3.0 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 4.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions. 6.00 Were new leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see No instructions. 6.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see No instructions. 7.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit No copy. 8.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit No copy. 8.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting No period? If yes, see instructions. 8.00 If the provider have a funded depreciation account analyor bond funds (bebt Service Reserve Fund) 8.01 Instructions. 8.02 Instructions. 9.02 Instructions. 9.03 Instructions. 9.04 Have changes or new agreements occurred in patient care services furnished through contractual No see Instructions. 9.04 Have changes or new agreements occurred in patient care services furnished through contractual No See Instructions. 9.05 If line 3 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If No See Instructions. 9.06 If services furnished at the provider facility under an arrangement with the provider-based physicians? You have the reported provider facility under an arrangement with the provider-based No Sec. 11 in No See Instructions. 9.00 If line 3 is yes, were there new agreements or amended existing agreements with the provider-based No Sec. 11 in No Sec. No Sec. No Sec. No Sec.	21. 00		N		N		21.00
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the provider? If yes, enter in column 2 the fiscal year end of the home office. 9.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 0.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 43.00	38 00		fice different	t from that o	f N		38.00
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1.00 2.00 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00	39. 00	, i	ner chain compo	onents? If ye	s, Y		39.00
Instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer. INDIANA UNIVERSITY HEALTH 42. (Brutter the telephone number and email address of the cost 317. 962. 1093 RUTTER@IUHEALTH. ORG 43. (44. (45. (46. (47. (47. (47. (47. (47. (47. (47. (47. (47. (
Cost Report Preparer Contact Information 1.00	40.00		home office?	If yes, see	N		40.00
Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.0		THIST GET ONS.		_			
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RHONDA UTTER 41.0 42.0 42.0			1	. 00	2.	00	
held by the cost report preparer in columns 1, 2, and 3, respectively. 2.00 Enter the employer/company name of the cost report preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.0							
respectively. 2.00 Enter the employer/company name of the cost report preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.0	41. 00						41.00
2.00 Enter the employer/company name of the cost report preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.0							
preparer. 3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.0	42. 00		INDIANA UNIVE	RSITY HEALTH			42.00
3.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.0							12.30
report preparer in columns 1 and 2, respectively.	43. 00	Enter the telephone number and email address of the cost	317. 962. 1093		RUTTER@I UHEALT	H. ORG	43.00
		report preparer in columns 1 and 2, respectively.					

Health Financial Systems IU HEALTH	WEST HOSPITAL	In Lieu of For	rm CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0158		eet S-2
		From 01/01/2022 Part I To 12/31/2022 Date/T	
		5/25/2	023 2: 35 pm
	3.00		
Cost Report Preparer Contact Information			
41.00 Enter the first name, last name and the title/position	DIRECTOR - GOVERNMENT		41.00
held by the cost report preparer in columns 1, 2, and 3	, PROGRAMS		
respecti vel y.			
42.00 Enter the employer/company name of the cost report			42.00
preparer.			
43.00 Enter the telephone number and email address of the cos	t		43.00
report preparer in columns 1 and 2, respectively.			

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0158

						o 12/31/2022	Date/Time Pre 5/25/2023 2:3	
							1/P Days /	J piii
							0/P Visits /	
							Trips	
	Component	Worksheet A Line No.	No	. of Beds	Bed Days Available	CAH Hours	Title V	
		1. 00		2.00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA			<u> </u>				
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		149	54, 385	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 IPF Subprovi der							3.00
4. 00	HMO IRF Subprovi der						_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			4.40	E 4 00E	0.00	0	6.00
7. 00	Total Adults and Peds. (exclude observation			149	54, 385	0.00	0	7. 00
8. 00	beds) (see instructions)	31. 00		14	E 110	0. 00	0	8. 00
9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00		14	5, 110	0.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		11	4, 015	0.00	0	12.00
13. 00	NURSERY	43. 00		' '	4,013	0.00	0	13.00
14. 00	Total (see instructions)	43.00		174	63, 510	0.00	0	14.00
15. 00	CAH visits			177	03, 310	0.00	0	15.00
16. 00	SUBPROVIDER - I PF						Ü	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)	30.00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	RURAL HEALTH CLINIC							26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			174				27. 00
28. 00	Observation Bed Days						0	
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF			_	_			31.00
32.00	Labor & delivery days (see instructions)			0	C			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							22.00
33. 00 33. 01	LTCH non-covered days							33. 00 33. 01
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	30. 00		7	2, 555		0	34.00
34.00	Tremporary Expansion Covid-19 File Acute Care	30.00	l	/	۷, 555	'I	1	1 34.00

Provider CCN: 15-0158

Peri od: Worksheet S-3 From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2:35 pm

						5/25/2023 2: 3	5 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		,		•		'	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 058	620	37, 477	,		1.00
	8 exclude Swing Bed, Observation Bed and	12,000	020	0.,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)	13, 057	5, 779				2.00
3. 00	HMO IPF Subprovider	13, 037	3, 777				3.00
4. 00	HMO IRF Subprovider		0				4.00
5.00	· ·		0	(,		5.00
	Hospital Adults & Peds. Swing Bed SNF	ال ا	7.1				
6.00	Hospital Adults & Peds. Swing Bed NF	10.050	0	07.47			6.00
7. 00	Total Adults and Peds. (exclude observation	12, 058	620	37, 477			7. 00
	beds) (see instructions)	4 057	450	0 (0)			
8. 00	INTENSIVE CARE UNIT	1, 257	450	3, 628	3		8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	0	79	930)		12.00
13.00	NURSERY		1, 001	1, 816	b		13.00
14.00	Total (see instructions)	13, 315	2, 150	43, 851	0.00	922. 01	14.00
15.00	CAH visits	o	0	(15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00							20.00
21. 00							21.00
22. 00							22. 00
23. 00							23. 00
24. 00	` ,						24.00
24. 10				383	,		24. 10
25. 00	, ,			300	·		25.00
26. 00							26.00
		0	0	,	0.00	0. 00	
26. 25		U U	U	(
27. 00	`		00	0.046	0.00	922. 01	
28. 00		_	98	3, 813	3		28. 00
29. 00	•	0					29. 00
30.00				(1		30.00
31.00	1 3			(1		31.00
32.00	, , , , , , , , , , , , , , , , , , ,	0	33	547	'		32.00
32. 01	Total ancillary labor & delivery room			()		32. 01
	outpatient days (see instructions)						1
33.00	,	0					33.00
33. 01		0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	567	'		34.00

Provider CCN: 15-0158

				To	12/31/2022	Date/Time Pre 5/25/2023 2:3	
		Full Time		Di sch	arges	37 237 2023 2. 3	o piii
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	<u></u>	11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 234	184	7, 766	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, 938	1, 210		2. 00
3. 00	HMO IPF Subprovider			1, 730	1, 210		3.00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		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
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	C	2, 234	184	7, 766	14.00
15. 00	CAH visits						15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 21. 00
21.00	HOME HEALTH AGENCY						21.00
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 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)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.00	outpatient days (see instructions)						00.00
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care			1	I		34.00

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0158 Peri od: Worksheet S-3 From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/25/2023 2:35 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from Wkst 3) col 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 PART II - WAGE DATA SALARI ES 200 00 -253, 403 1.00 Total salaries (see 85, 345, 063 85, 091, 660 1, 917, 778. 67 44.37 1.00 instructions) 2.00 Non-physician anesthetist Part 0 0 0.00 0.00 2.00 3 00 O 0 00 3 00 Non-physician anesthetist Part 0 00 4.00 Physician-Part A -130, 750 130, 750 771.67 169.44 4.00 Administrative 4. 01 Physicians - Part A - Teaching 0.00 0.00 4.01 5.00 Physician and Non 114, 531 114, 531 2, 080. 00 55.06 5.00 Physician-Part B 6.00 Non-physician-Part B for 0 0.00 0.00 6.00 hospital-based RHC and FQHC servi ces Interns & residents (in an 21.00 7.00 7.00 0 0.00 0.00 approved program) 7.01 Contracted interns and 0 0.00 0.00 7.01 residents (in an approved programs) 8.00 Home office and/or related 0 0.00 0.00 8.00 organization personnel 9 00 44.00 SNF 0.00 0 00 9 00 10.00 Excluded area salaries (see 152, 611 359, 583 512, 194 8, 002. 66 64.00 10.00 instructions) OTHER WAGES & RELATED COSTS 625, 290 11.00 Contract labor: Direct Patient 625, 290 8, 385. 77 74.57 11.00 Contract Labor: Top Level 0.00 12.00 0 0 0.00 12.00 management and other management and administrative servi ces 13.00 Contract Labor: Physician-Part 834, 049 0 834, 049 5, 598. 67 148. 97 13.00 A - Administrative 14.00 Home office and/or related 0 0.00 14.00 0 0.00 organization salaries and wage-related costs 469, 475. 91 14.01 Home office salaries 18, 672, 322 18, 672, 322 39.77 14.01 Related organization salaries 0.00 14.02 14.02 0.00 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 - Administrative 0 16.00 Home office and Contract 0.00 0.00 16.00 Physicians Part A - Teaching 16.01 Home office Physicians Part A О 0.00 0.00 16.01 - Teachi ng Home office contract 16.02 0 0.00 0.00 16.02 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 20, 177, 299 20, 177, 299 17.00 instructions) 18.00 Wage-related costs (other) 18 00 (see instructions) 19.00 Excluded areas 61, 659 61, 659 19.00 20.00 Non-physician anesthetist Part 20.00 21.00 Non-physician anesthetist Part 21.00 0 22.00 Physician Part A -14, 170 14, 170 22.00 Administrative 22.01 Physician Part A - Teaching 22.01 Physician Part B 23.00 24, 440 24, 440 23 00 24.00 Wage-related costs (RHC/FQHC) 24.00 0 25.00 Interns & residents (in an 25.00 approved program) 25.50 0 Home office wage-related 6, 512, 036 6, 512, 036 25.50 (core) 25.51 Related organization 0 0 25.51 wage-related (core) 25.52 Home office: Physician Part A 0 25.52

- Administrative wage-related (core) HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0158 Peri od: Worksheet S-3 From 01/01/2022 Part II 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm Wkst. A Line Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Number Sal ari es Related to Reported ion of Sal ari es (col. 2 ± col. Salaries in (from Wkst. 3) col. 4 A-6) 1.00 2.00 3.00 4.00 5.00 6.00 25.53 Home office: Physicians Part A 25. 53 0 - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26.00 Employee Benefits Department 4.00 227 227 1.00 227. 00 26.00 27.00 Administrative & General 5.00 8, 917, 338 -3, 689, 752 5, 227, 586 101, 374. 02 51. 57 27.00 28.00 6, 325. 75 85. 57 28.00 Administrative & General under 541, 264 541, 264 contract (see inst.) 29.00 Maintenance & Repairs 6.00 1,042,357 1,042,357 35, 972. 30 28. 98 29.00 30.00 Operation of Plant 7.00 812, 086 812, 086 29, 949. 22 27. 12 30.00 C Laundry & Linen Service 8.00 0.00 0.00 31.00 31.00 Housekeepi ng 32.00 9.00 1, 741, 245 -4, 719 1, 736, 526 87, 688. 46 19.80 32.00 33.00 Housekeeping under contract 184, 704 184, 704 5, 863. 60 31.50 33.00 (see instructions) 34.00 Dietary 10.00 1, 844, 563 -769, 931 1,074,632 56, 507. 18 19. 02 34.00 35.00 Dietary under contract (see 182, 220 182, 220 6, 855. 52 26. 58 35.00 instructions) 36.00 Cafeteri a 11.00 766, 079 766, 079 40, 138. 00 19.09 36.00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 Nursing Administration 13.00 7, 387, 990 79, 582. 67 92.83 38.00 38.00 7, 445, 542 -57, 552 39.00 Central Services and Supply 14.00 1, 438 1,438 30.86 46. 60 39.00 3, 906, 860 45. 95 40.00 Pharmacy 15.00 12, 379 3, 919, 239 85, 296. 49 40.00 Medical Records & Medical Records Library 41.00 41.00 16.00 O 0 0 00 0.00

263, 783

0

0

263, 783

0.00

14, 761. 61

0.00 42.00

17. 87 43. 00

17.00

18.00

42.00

Social Service

43.00 Other General Service

near th i manci ai Systems		TO HEALTH WE	31 HUSFITAL		III LI E	u or rorm cw3-2	2002-10
HOSPITAL WAGE INDEX INFORMATION			Provi der C	CN: 15-0158	Peri od:	Worksheet S-3	
					From 01/01/2022	Part III	
					To 12/31/2022	Date/Time Pre	pared:
						5/25/2023 2: 3	5 pm
	Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
			(from	3)	col. 4	col. 5)	
			Worksheet				

		Worksheet A	Amount	Recl assi fi cat	,	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		86, 138, 720	-253, 403	85, 885, 317	1, 934, 743. 54	44. 39	1.00
	instructions)							
2.00	Excluded area salaries (see		152, 611	359, 583	512, 194	8, 002. 66	64. 00	2.00
	instructions)							
3.00	Subtotal salaries (line 1		85, 986, 109	-612, 986	85, 373, 123	1, 926, 740. 88	44. 31	3.00
	minus line 2)							
4.00	Subtotal other wages & related		20, 131, 661	0	20, 131, 661	483, 460. 35	41. 64	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 703, 505	0	26, 703, 505	0. 00	31. 28	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		132, 821, 275	-612, 986	132, 208, 289	2, 410, 201. 23	54. 85	6.00
7.00	Total overhead cost (see		26, 883, 627	-3, 743, 496	23, 140, 131	550, 346. 68	42. 05	7.00
	instructions)							

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0158	
		From 01/01/2022 Part IV

	To 12/31/2022	Date/Time Pre 5/25/2023 2:3	
		Amount	о ріп
		Reported	
	l l	1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 150, 243	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)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	10, 057, 168	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	196, 299	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	353, 321	13.00
14.00		0	14.00
15.00		336, 397	
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Noncumul ati ve portion)		
	TAXES		
17. 00		6, 184, 141	17.00
18. 00	Medicare Taxes - Employers Portion Only	0	18.00
19. 00	Unempl oyment Insurance	0	19. 00
20. 00		0	20.00
	OTHER	_	
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22.00
23.00		0	23.00
24. 00		20, 277, 569	24. 00
25 00	Part B - Other than Core Related Cost OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
25.00	OTHER WASE RELATED COSTS (SPECIFI)		∠5.00

IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
Provi der CCN: 15-0158	Peri od: Worksheet S-3
	From 01/01/2022 Part V

		T	0 12/31/2022		
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			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		0	0	1.00
2. 00	Hospi tal		0	0	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	SKILLED NURSING FACILITY				8. 00
9. 00	NURSING FACILITY				9.00
10. 00	OTHER LONG TERM CARE I				10.00
11. 00	Hospi tal -Based HHA				11.00
	AMBULATORY SURGICAL CENTER (D. P.) I				12.00
	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
	Hospi tal -Based-CMHC				16.00
	RENAL DIALYSIS I		0	0	17. 00
18. 00	Other		0	0	18. 00

OSPI TA	L UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN	: 15-0158	Peri od:	Worksheet S-1	0
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/25/2023 2:3	epare 85 pm
					1. 00	
ι	Uncompensated and indigent care cost computation				1.00	
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by lin	e 202 colum	n 8)	0. 184117] 1.
Λ	Medicaid (see instructions for each line)					
	Net revenue from Medicaid				24, 581, 848	
	Did you receive DSH or supplemental payments from Medicaid?				N	3.
	If line 3 is yes, does line 2 include all DSH and/or suppleme			ai d?	0	4.
	If line 4 is no, then enter DSH and/or supplemental payments Medicaid charges	rrom wedicald			0 210, 315, 287	_
	Medicald charges Medicald cost (line 1 times line 6)				38, 722, 620	
	Difference between net revenue and costs for Medicaid program	(line 7 minu	s sum of li	nes 2 and 5 if	14, 140, 772	
	< zero then enter zero)	(11110 / 1111110	3 3 4 11 01 11	nes z ana e, m	11, 110, 772	0.
	Children's Health Insurance Program (CHIP) (see instructions	for each line)			
	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)	(line 11 min	ua lina O	if . zono thon	0	
	Difference between net revenue and costs for stand-alone CHIP enter zero)	(Tine II min	us ime 9;	ii < Zero then	U	12
	Other state or local government indigent care program (see in	structions fo	r each line)		1
	Net revenue from state or local indigent care program (Not in				357, 963	13
. 00	Charges for patients covered under state or local indigent ca	re program (N	ot included	lin lines 6 or	1, 304, 696	14
- 1	10)					
	State or local indigent care program cost (line 1 times line				240, 217	
	Difference between net revenue and costs for state or local i	ndigent care	program (li	ne 15 minus line	. 0	16
C	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, C	HIP and state	/Local indi	gent care progra	ms (see	
	nstructions for each line)	in and State	/ rocar rnar	gent care progre		
- 1	Private grants, donations, or endowment income restricted to	J	,		0	
	Government grants, appropriations or transfers for support of				0	
	Total unreimbursed cost for Medicaid , CHIP and state and loc 8, 12 and 16)	al indigent c	are program	ns (sum of lines	14, 140, 772	19.
	0) 12 and 10)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
-	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00	
	Charity care charges and uninsured discounts for the entire f	acility	23, 645, 86	644, 899	24, 290, 762	20.
	(see instructions)			31.,, 31.		
. 00	Cost of patients approved for charity care and uninsured disc	ounts (see	4, 353, 60	05 644, 899	4, 998, 504	21.
	instructions)					
	Payments received from patients for amounts previously writte	n off as		0 0	0	22.
1	charity care Cost of charity care (line 21 minus line 22)		4, 353, 60	05 644, 899	4, 998, 504	22
. 00	cost of charity care (fille 21 illifius fille 22)		4, 333, 00	044, 699	4, 990, 304	23.
					1. 00	
. 00 I	Does the amount on line 20 column 2, include charges for pati	ent days beyo	nd a Length	of stay limit	N	24.
	imposed on patients covered by Medicaid or other indigent car					
	If line 24 is yes, enter the charges for patient days beyond	the indigent	care progra	m's length of	0	25.
- 1	stay limit Tatal had daht aynansa far the antire hasnital complay (see i	netruet: ana)			15 001 202	24
- 1	Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital compl		uctions)		15, 881, 383 249, 860	
4	Medicare reimbursable bad debts for the entire hospital complex				384, 400	1
()1 11	·	(SOC THIS HUCK	1 3113)		15, 496, 983	
- 1	NOUI-MEGICALE DAG GEDI EXDEUSE (SEE LISTIGICITOUS)					0.
3. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see i	nstructi ons	5)		29.
3. 00 I 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt e Cost of uncompensated care (line 23 column 3 plus line 29)	xpense (see i	nstructi ons	5)	2, 987, 798 7, 986, 302	1

	Financial Systems	IU HEALTH WES	T HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der C		Period: From 01/01/2022	Worksheet A	
					To 12/31/2022		
	Cost Center Description	Sal ari es	Other	Total (col 1	Reclassi fi cat	5/25/2023 2: 3 Recl assi fi ed	85 pm
	cost center bescription	Sararres	other	+ col . 2)	i ons (See	Trial Balance	
				,	A-6)	(col. 3 +-	
						col . 4)	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT		0		0 7, 563, 903	7, 563, 903	1.00
1. 01	00101 M0B		645, 530	1		736, 372	1
1. 02	00102 I NTEREST		0		0 37	37	
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	227	0	270 47	0 8, 170, 375	8, 170, 375	
4. 00 5. 01	OO400 EMPLOYEE BENEFITS DEPARTMENT OO540 NONPATIENT TELEPHONES	227	370, 249 49, 918	1		12, 737, 310 49, 918	1
5. 02	00550 DATA PROCESSING		47, 710	1	0 0	47, 710	1
5.03	00560 PURCHASING RECEIVING AND STORES	147	10, 444			9, 928	
5. 04	00590 ADMINISTRATIVE AND GENERAL	8, 917, 191	59, 527, 808			59, 428, 725	
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	1, 042, 357 812, 086	8, 905, 594 3, 161, 538			3, 865, 271 5, 987, 968	
8. 00	00800 LAUNDRY & LI NEN SERVI CE	012,080	252, 958			252, 958	
9. 00	00900 HOUSEKEEPI NG	1, 741, 245	1, 524, 174				1
10.00	01000 DI ETARY	1, 844, 563	1, 360, 497	1	· · ·		
11.00	01100 CAFETERI A	7 445 543	0 0 0 0 0 0		0 1, 083, 837		
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	7, 445, 542 1, 438	3, 862, 326 164, 474				
15. 00	01500 PHARMACY	3, 906, 860	9, 669, 408		· · ·		
17. 00	01700 SOCIAL SERVICE	0	677			677	1
18.00	01080 TRANSPORTATI ON	263, 783	179, 331	443, 11	4 -32, 809	410, 305	18. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	22 102 212	10 0/2 210	12 044 52	7 577 014	24 466 600	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	22, 182, 313 3, 613, 606	19, 862, 210 3, 912, 041				1
35.00	02080 NEONATAL INTENSIVE CARE UNIT	1, 245, 567	288, 927		4 -80, 890		1
43.00	04300 NURSERY	0	0		549, 371	549, 371	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	5, 701, 315 3, 453, 366	21, 058, 064 1, 298, 690			10, 744, 464 4, 204, 009	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 453, 300	1, 290, 090	1	3, 700, 626		
54.00	05400 RADI OLOGY-DI AGNOSTI C	6, 163, 305	6, 777, 624	12, 940, 92		9, 390, 165	
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 184, 610	2, 352, 774				
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 693, 231	6, 406, 198			3, 132, 378	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING, & TRANS.	629	10, 212, 773 676, 179			10, 213, 362 674, 541	1
65.00	06500 RESPIRATORY THERAPY	2, 473, 982	2, 438, 657				
66.00	06600 PHYSI CAL THERAPY	2, 165, 435	730, 982	2, 896, 41	7 -537, 255		
67.00	06700 OCCUPATI ONAL THERAPY	657, 674	131, 044	1			1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	299, 632 1, 232, 189	82, 154 839, 075				
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 232, 109	039,073	1	5, 255, 761	5, 255, 761	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	o	0		0 8, 545, 048	8, 545, 048	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		9, 533, 694	9, 533, 694	
	07400 RENAL DIALYSIS	0	1, 062, 623	1, 062, 62	3 -15, 139		
76. 00 76. 97	03950 OTHER ANCILLARY SERVICES 07697 CARDIAC REHABILITATION	0 267, 279	202, 969	470, 24	8 -131, 793	0 338, 455	
	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	170,21	0 0	0	1
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0	700.04	0 0	0	90.00
90. 01 90. 02	09001 BEHAVI ORAL HEALTH 09002 SLEEP LAB	575, 026	217, 022 790, 670		- ' ' ' '	634, 804 774, 959	
91. 00	09100 EMERGENCY	5, 688, 720	7, 138, 188			11, 399, 521	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,				92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	619, 134	356, 206	975, 34	0 -224, 282	751, 058	92. 01
100.00	OTHER REIMBURSABLE COST CENTERS	٥				^	100.00
102.00	10200 OPI OI D TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	102.00
113.00	11300 I NTEREST EXPENSE		0		0 0	0	113.00
118.00		85, 192, 452	176, 519, 996	261, 712, 44	-368, 034		1
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	119, 585 26, 466	237, 510 11, 567			280, 528	1
	19201 RETAIL PHARMACY	5, 175	15, 769				192. 00 192. 01
	19202 MARKETI NG	1, 385	348, 627			385, 944	1
	19203 BACK AND NECK	O	95, 905	1			192. 03
	19204 TI PTON SERVI CES	0	0	1	0 62, 668		192.04
	19205 NORTH SERVICES 19206 SAXONY SERVICES		0		0 359, 950 0 89, 023		192.05
200.00	1 1	85, 345, 063	177, 229, 374	262, 574, 43			
	· · · ·	. "		•		-	-

Health FinancialSystemsIU HEALTHRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-0158

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2: 35 pm

				5/25/2023 2: 3	<u>5 pm</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
		4 00	Allocation		
	OFNEDAL CEDILLOF COCT OFNEDC	6. 00	7. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	53, 900	7 417 902		1.00
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-353, 164	7, 617, 803 383, 208	•	1.00
1. 01	00101 MOB 00102 I NTEREST	4, 437, 932	4, 437, 969		1.01
2. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	873, 810	9, 044, 185	•	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	534, 222	13, 271, 532		4.00
5. 01	00540 NONPATIENT TELEPHONES	0	49, 918	•	5. 01
5. 02	00550 DATA PROCESSING	9, 567, 841	9, 567, 841		5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES	965, 236	975, 164		5. 03
5. 04	00590 ADMINISTRATIVE AND GENERAL	-28, 179, 157	31, 249, 568	•	5. 04
6. 00	00600 MAI NTENANCE & REPAI RS	-159, 221	3, 706, 050	•	6.00
7. 00	00700 OPERATION OF PLANT	63, 242	6, 051, 210	•	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	252, 958		8.00
9. 00	00900 HOUSEKEEPI NG	-740	2, 842, 019	•	9.00
10.00	01000 DI ETARY	720	1, 526, 543	1	10.00
11. 00	01100 CAFETERI A	o	1, 083, 837	1	11.00
13.00	01300 NURSING ADMINISTRATION	558, 136	10, 073, 456	1	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6, 035, 578	•	14.00
15.00	01500 PHARMACY	-64, 960	5, 196, 025	•	15.00
17.00	01700 SOCIAL SERVICE	O	677		17.00
18.00	01080 TRANSPORTATI ON	0	410, 305		18.00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-2, 151, 630	32, 314, 979		30.00
31.00	03100 INTENSIVE CARE UNIT	-1, 803, 262	5, 103, 391		31.00
35.00	02080 NEONATAL INTENSIVE CARE UNIT	0	1, 453, 604		35.00
43.00	04300 NURSERY	0	549, 371		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1, 394, 321	9, 350, 143	•	50.00
51. 00	05100 RECOVERY ROOM	0	4, 204, 009		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 700, 626		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	145, 431	9, 535, 596		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	-514, 546	2, 220, 541		55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	-915, 520	2, 216, 858		59.00
60.00	06000 LABORATORY	0	10, 213, 362		60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	674, 541	•	63.00
65.00	06500 RESPI RATORY THERAPY	0	4, 267, 526	1	65.00
66.00	06600 PHYSI CAL THERAPY	-2, 335	2, 356, 827		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	707, 236		67.00
68.00	06800 SPEECH PATHOLOGY	0	321, 961		68.00
69.00	06900 ELECTROCARDI OLOGY	-24, 162	1, 734, 665		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 255, 761		71.00
72. 00 73. 00	07300 DRUGS CHARGED TO PATIENTS	0	8, 545, 048		72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	9, 533, 694 1, 047, 484		74.00
76.00	03950 OTHER ANCILLARY SERVICES	0	1,047,464	•	76.00
76. 97	07697 CARDIAC REHABILITATION	0	338, 455	l .	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0		77.00
77.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	O		177.00
90.00	09000 CLINIC	0	0		90.00
90. 01	09001 BEHAVI ORAL HEALTH	o	634, 804	l .	90. 01
90. 02	09002 SLEEP LAB	0	774, 959		90.02
91.00	09100 EMERGENCY	-3, 056, 856	8, 342, 665	•	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, ,	., ,		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	o	751, 058		92. 01
	OTHER REIMBURSABLE COST CENTERS	'	·	,	1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102.00
	SPECIAL PURPOSE COST CENTERS	'		·	1
113.00	11300 INTEREST EXPENSE	0	0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-21, 419, 404	239, 925, 010		118.00
	NONREI MBURSABLE COST CENTERS				İ
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	280, 528		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	o	36, 958		192.00
	1 19201 RETAIL PHARMACY	o	20, 707		192. 01
192. 02	2 19202 MARKETI NG	0	385, 944		192. 02
192.03	B 19203 BACK AND NECK	0	-5, 755		192. 03
192.04	1 19204 TI PTON SERVI CES	0	62, 668		192. 04
	19205 NORTH SERVICES	0	359, 950		192. 05
	19206 SAXONY SERVICES	0	89, 023	•	192. 06
200.00	TOTAL (SUM OF LINES 118 through 199)	-21, 419, 404	241, 155, 033		200.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2: 35 pm Provider CCN: 15-0158

					5/25/2023 2:3	35 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3. 00	4. 00	5. 00		
1 00	A - DEPRECIATION	1 00	ما	/ 7/0 /10		1 00
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	6, 769, 613		1. 00
2. 00	NEW CAP REL COSTS-MVBLE	2. 00	o	8, 130, 378		2. 00
2.00	EQUIP	2.00	U	0, 130, 370		2.00
3. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	137, 394		3. 00
3. 00	FIXT	1.00	٥	137, 374		3.00
4.00	NEW CAP REL COSTS-BLDG &	1. 00	0	61, 793		4.00
	FIXT			21,112		
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0. 00	0	0		14.00
15.00		0.00	0	0		15. 00
16.00		0. 00	0	0		16. 00
17.00		0. 00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0. 00	0	0		19. 00
20.00		0. 00	0	0		20.00
21.00		0. 00	0	0		21.00
22.00		0. 00	0	0		22. 00
23.00		0. 00	0	0		23. 00
24.00		0.00	0	0		24. 00
	0		0	15, 099, 178		
	B - LEASE					
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	595, 103		1. 00
	FIXT					
2. 00	MOB	1. 01	0	383, 208		2. 00
3. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	45, 852		3. 00
	EQUI P		_			
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	277		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00		0.00	4	0		10. 00
	U INTERECT		0	1, 024, 440		
1 00	C - INTEREST	4 00	ام	0.7		4 00
1. 00	INTEREST	102	0			1. 00
	D - BENEFITS		U _I	37		
1 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	12, 366, 895		1 00
1.00	BACK AND NECK	192. 03	0	12, 300, 693		1.00
2. 00 3. 00	BACK AND NECK	0.00	0	1, 229 0		2. 00 3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0. 00	o	0		6. 00
7. 00		0. 00	0	0		7. 00
8. 00		0. 00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0. 00	0	Ö		10.00
11. 00		0.00	o	Ō		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14. 00		0. 00	o	0		14.00
15. 00		0. 00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0. 00	0	0		19. 00
20. 00		0. 00	o	0		20. 00
21. 00		0. 00	0	0		21.00
22. 00		0.00	o	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0. 00	o	0		25. 00
26. 00		0. 00	o	Ö		26. 00
	1	2: 29	٩١	<u> </u>		

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm Provider CCN: 15-0158

					10 1	5/25/2023	
		Increases		·			
	Cost Center	Li ne #	Sal ary	0ther			
27. 00	2.00	3.00	4. 00	5. 00 0			27. 00
28. 00		0.00	0	0			28.00
29. 00		0.00	o	0			29.00
30.00		0. 00	o	Ö			30.00
31.00		0.00	О	0			31.00
32.00		0. 00	0	0			32.00
33.00		000	0	0			33.00
	0		0	12, 368, 124			
1. 00	F - LABOR & DELIVERY DELIVERY ROOM & LABOR ROOM	52.00	2, 796, 661	674, 569			1.00
1.00	O A CABOK KOOM		2, 796, 661	674, 569			1.00
	H - NURSERY		277707001	07.17.007			
1.00	NURSERY	43. 00	394, 746	122, 248			1.00
	0		394, 746	122, 248			
	I - DI ETARY						
1. 00	CAFETERI A	<u>11.</u> 00	766, 079	31 <u>7, 7</u> 58			1.00
	K - STD		766, 079	317, 758			
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	0	22, 812			1.00
2. 00	HOUSEKEEPI NG	9. 00	o	4, 719			2.00
3. 00	DI ETARY	10.00	o	3, 852			3. 00
4.00	NURSING ADMINISTRATION	13. 00	О	47, 409			4.00
5. 00	PHARMACY	15. 00	0	7, 621			5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	83, 899			6.00
7. 00	INTENSIVE CARE UNIT	31. 00	0	5, 927			7. 00
8. 00 9. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	14, 587 13, 154			8. 00 9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	27, 565			10.00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	o	2, 480			11.00
12. 00	RESPI RATORY THERAPY	65. 00	o	5, 712			12.00
13.00	PHYSI CAL THERAPY	66. 00	o	1, 378			13.00
14.00	EMERGENCY	91. 00	0	1 <u>2, 2</u> 88			14.00
	0		0	253, 403			
4 00	L - UTILITIES	7 00	ما	0 407 005			
1.00	OPERATION OF PLANT	7. 00 0. 00	0	2, 187, 095 0			1.00
2. 00 3. 00		0.00	0	0			2. 00 3. 00
4. 00		0.00	o	0			4.00
5. 00		0. 00	o	Ö			5.00
	0			2, 187, 095			
	M - MARKETI NG		-1				
1.00	MARKETI NG	192. 02	0	40, 839			1.00
2. 00 3. 00		0. 00 0. 00	0	0			2. 00 3. 00
4. 00		0.00	o	0			4.00
1. 00			- — ŏ	4 0 , 839			1.00
	N - BILLABLE/NON-BILLABLE DRU	IGS					
1.00	PHARMACY	15. 00	0	914, 692			1.00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	0	9, 533, 694			2.00
3.00		0.00	0	0			3.00
4. 00 5. 00		0. 00 0. 00	0	0			4. 00 5. 00
6. 00		0.00	0	0			6.00
7. 00		0. 00	ő	Ö			7. 00
8.00		0.00	o	0			8.00
9.00		0.00	O	0			9. 00
10.00		0. 00	0	0			10.00
11. 00		0. 00	0	0			11.00
12.00		0.00	0	0			12.00
13. 00 14. 00		0. 00 0. 00	0	0			13. 00 14. 00
15. 00		0.00	o	0			15.00
16. 00		0.00	0	0			16.00
17. 00		0.00	ő	Ö			17. 00
18.00		0. 00	О	0			18. 00
19. 00		0.00	O	0			19. 00
20.00		0.00	0	0			20.00
21. 00				0			21.00
	O - MEDICAL SUPPLIES AND IMPL	ANTS	0	10, 448, 386			
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	5, 894, 897			1.00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	5, 255, 761			2. 00
	PATI ENTS						

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: | Dat Provider CCN: 15-0158

					5/25/2023 2:	
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
2.00	2.00	3.00	4. 00	5. 00		2.00
3. 00	IMPL. DEV. CHARGED TO PATIENT	72.00	O	8, 545, 048		3. 00
4. 00	PURCHASING RECEIVING AND	5. 03	0	141		4. 00
4.00	STORES	5.03		141		4.00
5.00	ADMINISTRATIVE AND GENERAL	5. 04	o	184, 755		5. 00
6.00	MAINTENANCE & REPAIRS	6. 00	0	1, 266		6. 00
7.00	OPERATION OF PLANT	7. 00	0	46, 610		7. 00
8.00	HOUSEKEEPI NG	9. 00	0	1, 564		8. 00
9. 00	LABORATORY	60.00	0	20		9. 00
10.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	29		10. 00
11 00	CANTEEN PHYSICIANS' PRIVATE OFFICES	102.00		2		11 00
11. 00 12. 00	MARKETING	192. 00 192. 02	0	2 25		11. 00 12. 00
13. 00	BACK AND NECK	192. 02	0	162		13. 00
14. 00	BACK AND NECK	0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	O	0		16.00
17.00		0.00	О	0		17. 00
18.00		0.00	O	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0. 00	0	0		20.00
21. 00		0. 00	0	0		21.00
22.00		0.00	0	0		22. 00
23.00		0.00	0	0		23. 00
24. 00				19, 930, 280		24. 00
	P - ROUTINE COSTS		U _I	17, 730, 200		-
1. 00	ADULTS & PEDIATRICS	30.00	203, 337	60, 615		1.00
2.00		0.00	0	0		2. 00
	0		203, 337	60, 615		
	Q - TIPTON, NORTH, SAXONY REC					4
1.00	TI PTON SERVI CES	192. 04	43, 976	18, 692		1.00
2.00	NORTH SERVICES	192. 05	253, 136	106, 814		2.00
3.00	SAXONY SERVICES	192.06	62, 471	26, 552		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6. 00
0.00			359, 583	152, 058		0.00
	R - SPOT AND RETENTION		55., 555	,		
1.00	NURSING ADMINISTRATION	13. 00	9, 000	1, 048		1.00
2.00	PHARMACY	15. 00	20, 000	2, 090		2.00
3.00	ADULTS & PEDIATRICS	30. 00	1, 059, 929	116, 657		3. 00
4. 00	INTENSIVE CARE UNIT	31. 00	302, 000	34, 063		4. 00
5.00	NEONATAL INTENSIVE CARE UNIT	35.00	91, 000	10, 182		5. 00
6.00	NURSERY	43.00	29, 165	3, 212		6.00
7. 00 8. 00	OPERATING ROOM RECOVERY ROOM	50.00	482, 000	54, 293		7.00
9. 00	DELIVERY ROOM & LABOR ROOM	51. 00 52. 00	354, 764 206, 642	40, 714 22, 754		8. 00 9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	28, 000	2, 582		10.00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	86, 000	9, 419		11.00
12. 00	CARDI AC CATHETERI ZATI ON	59. 00	53, 000	6, 175		12.00
13.00	RESPI RATORY THERAPY	65. 00	169, 000	18, 408		13.00
14.00	ELECTROCARDI OLOGY	69. 00	44, 000	4, 326		14.00
15.00	CARDIAC REHABILITATION	76. 97	20, 000	1, 970		15. 00
16.00	BEHAVI ORAL HEALTH	90. 01	11, 000	1, 282		16.00
17. 00	EMERGENCY	91.00	361, 000	40, 526		17. 00
E00 00	TOTALS		3, 326, 500	369, 701		E00.00
500.00	Grand Total: Increases		7, 846, 906	63, 048, 731		500.00

Provider CCN: 15-0158

						5/25/2023 2:	35 pm
		Decreases		0.11			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00 A - DEPRECIATION	7. 00	8. 00	9. 00	10. 00		
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	0	3, 405, 019	9		1.00
2. 00	MAINTENANCE & REPAIRS	6. 00	0	3, 737, 018			2.00
3. 00	NEW CAP REL COSTS-MVBLE	2. 00	0	2, 822			3.00
0.00	EQUI P	2.00		2, 022			0.00
4.00	NEW CAP REL COSTS-MVBLE	2. 00	О	3, 033	13		4.00
	EQUI P			•			
5.00	OPERATION OF PLANT	7. 00	0	11, 942	0		5. 00
6.00	HOUSEKEEPI NG	9. 00	0	2, 422	0		6. 00
7. 00	DI ETARY	10. 00	0	48, 739			7. 00
8. 00	NURSING ADMINISTRATION	13. 00	0	701, 221	0		8. 00
9. 00	PHARMACY	15. 00	0	217, 107	0		9. 00
10.00	ADULTS & PEDIATRICS	30. 00	0	342, 375	1		10.00
11.00	INTENSIVE CARE UNIT	31.00	0	160, 389	0		11.00
12. 00 13. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	2, 551, 191			12. 00 13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	12, 770 1, 833, 228			14.00
15. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	522, 241	0		15.00
16. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	615, 443			16.00
17. 00	RESPIRATORY THERAPY	65. 00	0	112, 475			17. 00
18. 00	PHYSI CAL THERAPY	66. 00	o	16, 030	o o		18.00
19. 00	ELECTROCARDI OLOGY	69. 00	O	130, 160			19. 00
20.00	CARDIAC REHABILITATION	76. 97	o	32, 175	o		20.00
21.00	SLEEP LAB	90. 02	О	465	O		21.00
22.00	EMERGENCY	91. 00	0	365, 696	0		22. 00
23.00	BACK AND NECK	192. 03	0	6, 370	0		23. 00
24.00	MOB	1.01	0	26 <u>8, 8</u> 47			24.00
	0		0	15, 099, 178			
	B - LEASE		_1				
1.00	ADMINISTRATIVE AND GENERAL	5. 04	0	674, 032			1.00
2.00	ADULTS & PEDIATRICS	30.00	0	18, 853			2.00
3.00	INTENSIVE CARE UNIT OPERATING ROOM	31. 00	0	4, 448			3.00
4. 00 5. 00	PHYSICAL THERAPY	50. 00 66. 00	0	21, 439 46, 904			4. 00 5. 00
6. 00	CARDIAC REHABILITATION	76. 97	0	46, 904			6.00
7. 00	BEHAVI ORAL HEALTH	90. 01	0	78, 721	0		7.00
8. 00	EMERGENCY	91. 00	0	1, 388	o		8.00
9. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	o	35, 070			9. 00
	CANTEEN						
10.00	BACK AND NECK	1 <u>92.</u> 03	0	9 <u>6, 6</u> 81	<u> </u>		10.00
	0		0	1, 024, 440			
1 00	C - INTEREST OPERATION OF PLANT	7. 00	٥	37	11		1.00
1. 00	0		0				1.00
	D - BENEFITS		<u> </u>	37			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	61	0		1.00
2. 00	PURCHASING RECEIVING AND	5. 03	0	37			2.00
	STORES						
3.00	ADMINISTRATIVE AND GENERAL	5. 04	0	903, 452	0		3.00
4.00	MAINTENANCE & REPAIRS	6. 00	0	186, 276			4.00
5.00	OPERATION OF PLANT	7. 00	0	207, 382	1		5.00
6. 00	HOUSEKEEPI NG	9. 00	0	421, 802	1		6.00
7. 00	DI ETARY	10.00	0	545, 657			7.00
8.00	NURSING ADMINISTRATION	13. 00	0	814, 107			8.00
9.00	CENTRAL SERVICES & SUPPLY	14. 00	0	479 510 570			9.00
10. 00 11. 00	PHARMACY TRANSPORTATION	15. 00 18. 00	0	512, 573 32, 809			10. 00 11. 00
12.00	ADULTS & PEDIATRICS	30. 00	0	3, 178, 758			12.00
13. 00	INTENSIVE CARE UNIT	31. 00	0	509, 579			13.00
14. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	Ö	157, 850			14.00
15. 00	OPERATING ROOM	50.00	o	956, 416			15.00
16.00	RECOVERY ROOM	51.00	0	630, 249	I I		16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0	807, 345			17. 00
18.00	RADI OLOGY-THERAPEUTI C	55. 00	0	257, 035			18.00
19. 00	CARDIAC CATHETERIZATION	59. 00	0	181, 744			19. 00
20.00	LABORATORY	60. 00	0	60			20.00
21.00	RESPIRATORY THERAPY	65. 00	0	323, 731	0		21.00
22. 00	PHYSI CAL THERAPY	66.00	0	357, 928			22.00
23. 00	OCCUPATI ONAL THERAPY	67. 00	0	80, 593	1		23.00
24.00	SPEECH PATHOLOGY	68. 00 69. 00	0	59, 268	1		24. 00 25. 00
25. 00 26. 00	ELECTROCARDI OLOGY CARDI AC REHABI LI TATI ON	76. 97	0	174, 395 73, 738			26.00
27. 00	BEHAVIORAL HEALTH	90. 01	0	90, 221			27.00
28. 00	EMERGENCY	91. 00	0	804, 655			28.00
	I	, 50	<u> </u>		, 9		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0158

Peri od: Worksheet A-6 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

						5/25/2023 2:	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
29. 00	6. 00	7. 00	8. 00	9. 00	10.00		29. 00
29.00	OBSERVATION BEDS (DISTINCT PART)	92. 01	۷	56, 903	١		29.00
30. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	41, 526	ol		30.00
	CANTEEN		1	,			
31.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	1, 077	0		31.00
32.00	RETAIL PHARMACY	192. 01	0	237	1		32. 00
33. 00	MARKETING	1 <u>92.</u> 02	9				33. 00
	0		0	12, 368, 124			
1. 00	F - LABOR & DELIVERY ADULTS & PEDIATRICS	30, 00	2, 796, 661	674, 569	0		1.00
1.00	n PEDIATRICS		2, 796, 661	67 <u>4, 5</u> 69 674, 569			1.00
	H - NURSERY		2, 770, 001	074, 307			
1.00	ADULTS & PEDIATRICS	30.00	394, 746	122, 248	0		1.00
	0		394, 746	122, 248			
	I - DIETARY						
1. 00	DI ETARY	1000	<u>766, 079</u>	31 <u>7, 7</u> 58			1.00
	0		766, 079	317, 758			
1. 00	K - STD ADMINISTRATIVE AND GENERAL	5. 04	22, 812	0	0		1.00
2. 00	HOUSEKEEPI NG	9. 00	4, 719	0	-		2.00
3. 00	DI ETARY	10.00	3, 852	0			3.00
4. 00	NURSING ADMINISTRATION	13. 00	47, 409	0	o o		4.00
5. 00	PHARMACY	15. 00	7, 621	0	o		5.00
6.00	ADULTS & PEDIATRICS	30. 00	83, 899	0	o		6. 00
7.00	INTENSIVE CARE UNIT	31. 00	5, 927	0	0		7. 00
8.00	OPERATING ROOM	50.00	14, 587	0	0		8. 00
9.00	RECOVERY ROOM	51. 00	13, 154	0	0		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54. 00	27, 565	0	0		10.00
11. 00	RADI OLOGY-THERAPEUTI C	55. 00	2, 480	0	0		11.00
12.00	RESPI RATORY THERAPY	65. 00	5, 712	0	0		12.00
13.00	PHYSI CAL THERAPY	66. 00	1, 378	0	0		13.00
14. 00	EMERGENCY	91.00	12, 288	0	<u> </u>		14. 00
	U LITELLITES		253, 403	0			
1. 00	L - UTILITIES MOB	1. 01	o	23, 519	10		1.00
2. 00	ADMINISTRATIVE AND GENERAL	5. 04	o	23, 317	1		2.00
3. 00	MAINTENANCE & REPAIRS	6. 00	0	2, 160, 652	1		3.00
4. 00	OPERATING ROOM	50. 00	o	1, 560	1		4. 00
5. 00	SLEEP LAB	90. 02	0	487			5.00
	0		0	2, 187, 095			
	M - MARKETING						
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	0	40, 285			1.00
2. 00	PHARMACY	15. 00	0	369	1		2.00
3.00	RADI OLOGY - DI AGNOSTI C	54.00	0	123	1		3.00
4. 00	RADI OLOGY-THERAPEUTI C	5500	— — — 0	62 40, 839			4. 00
	N - BILLABLE/NON-BILLABLE DRU	IGS	<u> </u>	40, 839			
1. 00	PHARMACY	15. 00	0	8, 484, 440	ol		1.00
2. 00	PURCHASING RECEIVING AND	5. 03	0	767	_		2.00
	STORES]				
3.00	ADMINISTRATIVE AND GENERAL	5. 04	0	833	0		3.00
4.00	NURSING ADMINISTRATION	13. 00	0	26, 528			4.00
5.00	CENTRAL SERVICES & SUPPLY	14. 00	0	536			5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	286, 196			6. 00
7. 00	INTENSIVE CARE UNIT	31. 00	0	100, 691			7. 00
8. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	2, 148			8. 00
9. 00	OPERATING ROOM	50. 00	0	165, 660			9. 00
10.00	RECOVERY ROOM	51. 00	0	126, 625	1		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	717, 725			11.00
12.00	RADI OLOGY-THERAPEUTI C	55. 00	0	83, 662	1		12.00
13.00	CARDI AC CATHETERI ZATI ON	59. 00	0	102, 990	1		13.00
14.00	RESPIRATORY THERAPY	65. 00 66. 00	0	14, 314			14. 00 15. 00
15.00	PHYSI CAL THERAPY	66. 00 69. 00	0	786 21 407			
16. 00 17. 00	ELECTROCARDI OLOGY RENAL DI ALYSI S	74.00	0	21, 407 4, 169	1		16. 00 17. 00
18.00	CARDIAC REHABILITATION	74.00 76.97	0	165	1		18. 00
19. 00	EMERGENCY	91. 00	0	295, 693	1		19.00
20. 00	OBSERVATION BEDS (DISTINCT	92. 01	o	8, 300	1		20.00
	PART)		٦	2, 300			
21. 00	MARKÉTI NG	1 <u>92.</u> 02	0	4, 751			21.00
	0		O	10, 448, 386			

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						5/25/2023 2:	35 pm
		Decreases				ı	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
4 00	0 - MEDICAL SUPPLIES AND IMP			1.004			4 00
1.00	DIETARY	10.00	0	1, 004	0	l I	1.00
2.00	NURSI NG ADMI NI STRATI ON	13. 00	0	229, 429		l e e e e e e e e e e e e e e e e e e e	2.00
3. 00	OPERATING ROOM	50.00	0	12, 854, 942		l	3.00
4.00	PHARMACY	15. 00	0	37, 576			4.00
5.00	ADULTS & PEDIATRICS	30.00	0	1, 204, 046			5.00
6. 00	INTENSIVE CARE UNIT	31. 00	0	179, 950			6. 00
7. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	22, 074	0		7.00
8. 00	RECOVERY ROOM	51. 00	0	57, 919			8. 00
9. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	223, 202	0		9. 00
10.00	RADI OLOGY-THERAPEUTI C	55. 00	0	34, 716			10.00
11. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	4, 126, 049	0		11.00
12. 00	BLOOD STORING, PROCESSING, &	63. 00	0	1, 638	0		12. 00
	TRANS.		_		_		
13.00	RESPIRATORY THERAPY	65.00	0	382, 001	0	l I	13.00
14.00	PHYSI CAL THERAPY	66.00	0	115, 607	0		14.00
15.00	OCCUPATIONAL THERAPY	67.00	0	889			15.00
16.00	SPEECH PATHOLOGY	68.00	0	557	0		16.00
17.00	ELECTROCARDI OLOGY	69. 00	0	34, 801	0		17.00
18. 00	RENAL DI ALYSI S	74. 00	0	10, 970	0		18. 00
19. 00	CARDI AC REHABI LI TATI ON	76. 97	0	781	0		19. 00
20.00	BEHAVI ORAL HEALTH	90. 01	0	584	0		20. 00
21. 00	SLEEP LAB	90. 02	0	14, 759	0		21.00
22. 00	EMERGENCY	91. 00	0	361, 481	0		22. 00
23. 00	OBSERVATION BEDS (DISTINCT	92. 01	0	11, 089	0		23. 00
04.00	PART)	44.00		04.047			04.00
24. 00	CENTRAL SERVICES & SUPPLY	1400		24, 216			24. 00
	P - ROUTINE COSTS		U	19, 930, 280			
1 00	RECOVERY ROOM	51, 00	101 422	14 520	_		1 00
1.00			101, 423	14, 539		l e e e e e e e e e e e e e e e e e e e	1.00
2. 00	OBSERVATION BEDS (DISTINCT	92. 01	101, 914	46, 076	0		2.00
	PART)	+	203, 337				
	Q - TIPTON, NORTH, SAXONY RE		203, 337	00, 013			
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	41, 635	17, 204	0		1.00
2. 00	NURSING ADMINISTRATION	13. 00	2, 341	1, 488		l e	2.00
3. 00	ADMINISTRATIVE AND GENERAL	5. 04	239, 660	98, 248		l e e e e e e e e e e e e e e e e e e e	3.00
4. 00	NURSING ADMINISTRATION	13. 00	13, 476	8, 566			4.00
5. 00	ADMINISTRATIVE AND GENERAL	5. 04	59, 145	24, 438			5.00
6. 00	NURSING ADMINISTRATION	13. 00	3, 326	2, 114	0		6.00
0.00	0		359, 583	152, 058			0.00
	R - SPOT AND RETENTION		337, 303	132, 030			
1. 00	ADMINISTRATIVE AND GENERAL	5. 04	3, 326, 500	369, 701	0		1.00
2. 00	Nomination of the service	0.00	0, 020, 000	0		l	2.00
3. 00		0.00	o	0	0		3.00
4. 00		0.00	o	0	0		4. 00
5. 00		0.00	o	0	0		5. 00
6. 00		0.00	o	0	_		6. 00
7. 00		0.00	Ö	0			7. 00
8. 00		0. 00	Ö	0		l l	8. 00
9. 00		0. 00	Ö	0		l l	9. 00
10.00		0.00	o	0		l e e e e e e e e e e e e e e e e e e e	10.00
11. 00		0.00	o	0		1	11.00
12. 00		0.00	0	0	0	l e	12.00
13. 00		0.00	o o	0	0		13.00
14. 00		0.00	o o	0	0		14. 00
15. 00		0.00	o o	0	0		15. 00
16. 00		0.00	Ö	0	0		16.00
17. 00		0.00	0	0			17. 00
00	TOTALS — — — —	<u> </u>	3, 326, 500	369, 701	<u> </u>		100
500.00	Grand Total: Decreases		8, 100, 309	62, 795, 328			500.00
5.00	1	ı	2, .00, 007	, , , 5, 520	ı	ı	,

| Peri od: | Worksheet A-7 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				10) 12/31/2022	5/25/2023 2: 3	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	6, 800, 703	0	0	0	0	2.00
3.00	Buildings and Fixtures	76, 957, 802	3, 610, 742		3, 610, 742	0	3.00
4.00	Building Improvements	103, 472, 772	91, 703	0	91, 703	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	93, 406, 077	7, 180, 428	-877, 830	6, 302, 598	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	280, 637, 354	10, 882, 873	-877, 830	10, 005, 043	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	280, 637, 354	10, 882, 873	-877, 830	10, 005, 043	0	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES	_				
1. 00	Land	0	0				1.00
2.00	Land Improvements	6, 800, 703	1, 615, 163				2.00
3.00	Buildings and Fixtures	80, 568, 544	0				3. 00
4.00	Building Improvements	103, 564, 475	2, 384, 906				4. 00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	99, 708, 675	49, 555, 629				6.00
7.00	HIT designated Assets	0	0				7. 00
8. 00	Subtotal (sum of lines 1-7)	290, 642, 397	53, 555, 698				8.00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	290, 642, 397	53, 555, 698				10.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-0158	From 01/01/2022	Worksheet A-7 Part II Date/Time Prepared: 5/25/2023 2:35 pm
	SUMMARY OF CAP	PITAL	

				Т	o 12/31/2022	Date/Time Pre 5/25/2023 2:3	pared: 5 pm
			SU	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11.00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2	1		
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	C	0	0	1.00
1. 01	MOB	268, 847	401, 911	C	0	0	1. 01
1. 02	INTEREST	0	0	(0	0	1. 02
2. 00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3. 00	Total (sum of lines 1-2)	268, 847	401, 911	(0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
	oost center bescription	Capi tal -Rel at					
		ed Costs (see					
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
1. 01	MOB	-25, 228	645, 530				1. 01
1. 02	INTEREST	0	0				1. 02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)	-25, 228	645, 530				3.00

Heal th Financial Systems
Cost Center Description
Leases for Ratio (col. 1 - col. 2)
Col . 1 - Col . 2) 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
PART - RECONCILIATION OF CAPITAL COSTS CENTERS
1.00
1. 01 MOB
2.00 NEW CAP REL COSTS-MVBLE EQUIP 99,708,675 0 99,708,675 0.343063 0 2.00 3.00 Total (sum of lines 1-2) 290,642,397 0 290,642,397 1.000000 0 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes Other Capital -Relat ed Costs through 7) 6.00 7.00 8.00 9.00 10.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
3.00 Total (sum of lines 1-2) 290, 642, 397 0 290, 642, 397 1.000000 0 3.00
Cost Center Description Taxes Other Capital -Relat ed Costs through 7) 6.00 PART III - RECONCILIATION OF CAPITAL SUMMARY OF CAPITAL Cols. 5 through 7) 8.00 9.00 10.00
Cost Center Description Taxes Other Capital -Relat cols. 5 ed Costs through 7) 6.00 7.00 8.00 9.00 10.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
Capital -Relat cols. 5 ed Costs through 7)
Capital -Relat cols. 5 ed Costs through 7)
ed Costs through 7)
6.00 7.00 8.00 9.00 10.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 0 6,823,513 595,103 1.00
1. 01 MOB 0 0 -214, 065 622, 501 1. 01
1. 02 I NTEREST 0 0 0 0 0 0 1. 02
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 0 9,004,188 45,852 2.00
3.00 Total (sum of lines 1-2) 0 0 15,613,636 1,263,456 3.00
SUMMARY OF CAPITAL
Cost Center Description Interest Insurance Taxes (see Other Total (2)
(see instructions) Capital -Relat (sum of cols.
instructions) ed Costs (see 9 through 14)
instructions)
11. 00
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
1.00 NEW CAP REL COSTS-BLDG & FIXT 0 137,394 61,793 0 7,617,803 1.00
1. 01 MOB 0 0 0 -25, 228 383, 208 1. 01
1. 02 I NTEREST 4, 437, 969 0 0 4, 437, 969 1. 02
2. 00 NEW CAP REL COSTS-MVBLE EQUIP 0 -2, 822 -3, 033 0 9, 044, 185 2. 00
3.00 Total (sum of lines 1-2) 4,437,969 134,572 58,760 -25,228 21,483,165 3.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0158 Peri od: Worksheet A-8 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - NEW CAP Α -469, 618 NEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter lfi xt 2) 1.01 -214, 065 MOB Investment income - MOB Α 1.01 1.01 (chapter 2) -3, 287, 782 I NTEREST 1.02 Investment income - INTEREST 1.02 11 1.02 (chapter 2) Investment income - NEW CAP ONEW CAP REL COSTS-MVBLE 2.00 2.00 2.00 REL COSTS-MVBLE EQUIP (chapter EQUI P Investment income - other 3.00 3.00 0.00 (chapter 2) Trade, quantity, and time 4 00 0 0.00Ω 4 00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 ONEW CAP REL COSTS-BLDG & 1.00 10 6.00 FLXT 7.00 Tel ephone services (pay 7.00 0.00 stations excluded) (chapter 8.00 Television and radio service 8.00 0.00 (chapter 21) 9.00 Parking Lot (chapter 21) 0.009.00 10.00 Provi der-based physici an A-8-2 -17, 934, 275 10.00 adjustment 11.00 Sale of scrap, waste, etc. 0 0.00 11.00 (chapter 23) 12.00 Related organization 26, 417, 616 12 00 A-8-1 transactions (chapter 10) Laundry and linen service 0.00 13.00 13.00 14.00 Cafeteria-employees and guests В O CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than 17.00 17.00 0.00 0 pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20 00 Vending machines 0 00 ol 20.00 Income from imposition of 21.00 21.00 0.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 22.00 0.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 Adjustment for physical A-8-3 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review 0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 COSTS-BLDG & FLXT FLXT омов 26.01 Depreciation - MOB 1.01 26.01 Depreciation - INTEREST Depreciation - NEW CAP REL OI NTEREST 1. 02 26.02 0 26 02 27.00 ONEW CAP REL COSTS-MVBLE 2.00 27.00 COSTS-MVBLE EQUIP EQUI P 0 *** Cost Center Deleted *** 28.00 Non-physician Anesthetist 19.00 28.00

Heal	th Financial Systems		IU HEALTH WE	ST HOSPITAL	In Lie	u of Form CMS-2	2552-10
	JSTMENTS TO EXPENSES		-	Provider CCN: 15-0158 P	eri od:	Worksheet A-8	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre 5/25/2023 2:3	
				Expense Classification on	Worksheet A	1072072020 2.0	<u>Б.</u>
				To/From Which the Amount is	to be Adjusted		
					T		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)	0.00	2.00	4.00	Ref.	
20. (00 Db!	1.00	2. 00	3.00	4. 00	5. 00	29. 00
29. (A-8-3	0	OCCUPATIONAL THERAPY	67. 00	Ü	30.00
30. (Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30.		•		 ADULTS & PEDIATRICS	30. 00		30. 99
30. \	instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
21 (00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
31. (pathology costs in excess of	A-0-3		SFEECH FAIHOLOGI	08.00		31.00
	limitation (chapter 14)						
32 (OO CAH HIT Adjustment for		0		0.00	0	32.00
02. (Depreciation and Interest				0.00	· ·	02.00
33. (OO MISCELLANEOUS INCOME	В	-502, 333	ADMINISTRATIVE AND GENERAL	5. 04	0	33.00
33. (4	В		DI ETARY	10. 00	0	33. 01
33. (4	В		NURSING ADMINISTRATION	13. 00	0	33. 02
33. (4	В	1	PHARMACY	15. 00	0	33. 03
33. (04 MISCELLANEOUS INCOME	В	-24, 162	ELECTROCARDI OLOGY	69. 00	0	33. 04
33. (D5 CONTRIBUTION EXPENSE	l A	-2, 540	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 05
33. (06 CONTRIBUTION EXPENSE	A	0	NURSING ADMINISTRATION	13. 00	0	33. 06
33. (O7 CONTRIBUTION EXPENSE	A	0	ADULTS & PEDIATRICS	30.00	0	33. 07
33. (08 HAF FEES	A	-14, 612, 283	ADMINISTRATIVE AND GENERAL	5. 04	0	33. 08
33. (9 EMPLOYEE BENEFITS	A	-12, 366, 896	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 09
33. 1	TELEPHONE EQUIPMENT	A	-740	HOUSEKEEPI NG	9. 00	0	33. 10
33. 1	11 TELEPHONE EQUIPMENT	A	-3, 558	ADULTS & PEDIATRICS	30. 00	0	33. 11
33. 1	12 TELEPHONE EQUIPMENT	A	-2, 335	PHYSI CAL THERAPY	66. 00	0	33. 12
33. 1		A		EMERGENCY	91. 00	0	33. 13
00 /	IN WEST EVENNELON START UP OSST		4 ((0 700	A DALL ALL CEDATILIZE AND CENEDAL	F 0.4	_	00 40

1, 668, 793 ADMINISTRATIVE AND GENERAL

-399 OPERATING ROOM

-150 EMERGENCY

-21, 419, 404

-15, 975 ADULTS & PEDIATRICS

5.04

50.00

30.00

91.00

0.00

33.19

33.20

33. 21

33. 22

33. 23

50.00

Α

Α

WEST EXPANSION START-UP COST

UNWONTED SITUATIONS

UNWONTED SITUATIONS

UNWONTED SITUATIONS

33. 23 OTHER ADJUSTMENTS (SPECIFY)

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

33. 19

33. 20

33. 21

33. 22

(3)

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-0158
Period: From 01/01/2022 To 12/31/2022
Date/Time Prepared: 5/25/2023 2: 35 pm

				10 12/31/2022	5/25/2023 2: 3	
	Li ne No.	Cost Center	Expense Items	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 ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	CLAIMED HOME	
	OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	HO CR ALLOCATIONS	965, 911	442, 393	1.00
2.00	1. 02	INTEREST	HO CR ALLOCATIONS	7, 725, 714	0	2.00
3.00	2.00	NEW CAP REL COSTS-MVBLE EQUI		873, 810	O	3.00
3. 01	1. 01	l	HO CR ALLOCATIONS	0	139, 099	3. 01
4.00	4 00	EMPLOYEE BENEFITS DEPARTMENT		12, 901, 118	0	4.00
4. 01		DATA PROCESSING	HO CR ALLOCATIONS	9, 567, 841	0	4. 01
4. 02		PURCHASING RECEIVING AND STO		965, 236	0	4. 02
4. 03		1	HO CR ALLOCATIONS	22, 228, 191	29, 040, 554	4. 03
4. 04			HO CR ALLOCATIONS	0	159, 221	4. 04
4. 05		NURSING ADMINISTRATION	HO CR ALLOCATIONS	558, 636	0	4. 05
4. 07		EMPLOYEE BENEFITS DEPARTMENT		13, 980	13, 980	4. 07
4. 08	l .		I NTERCOMPANY	8, 459, 469	8, 459, 469	4. 08
4. 09			I NTERCOMPANY	577, 217	577, 217	4. 09
4. 09		ADULTS & PEDIATRICS	I NTERCOMPANY	2, 572, 541	2, 572, 541	4. 09
	l control of the cont	1		1		
4. 11		INTENSIVE CARE UNIT	I NTERCOMPANY	1, 803, 262	1, 803, 262	4. 11
4. 12		OPERATING ROOM	I NTERCOMPANY	1, 435, 311	1, 435, 311	4. 12
4. 13		RECOVERY ROOM	I NTERCOMPANY	47, 075	47, 075	4. 13
4. 14	l control of the cont	RADI OLOGY-DI AGNOSTI C	I NTERCOMPANY	214, 023	214, 023	4. 14
4. 15		RADI OLOGY-THERAPEUTI C	INTERCOMPANY	597, 801	597, 801	4. 15
4. 16		CARDI AC CATHETERI ZATI ON	INTERCOMPANY	952, 069	952, 069	4. 16
4. 17		LABORATORY	I NTERCOMPANY	10, 117, 563	10, 117, 563	4. 17
4. 18	l control of the cont	l ·	I NTERCOMPANY	41, 178	41, 178	4. 18
4. 19		PHYSI CAL THERAPY	I NTERCOMPANY	16, 403	16, 403	4. 19
4. 20	l control of the cont	ELECTROCARDI OLOGY	I NTERCOMPANY	360, 467	360, 467	4. 20
4. 21	74. 00	RENAL DIALYSIS	I NTERCOMPANY	8, 600	8, 600	4. 21
4. 22	76. 97	CARDIAC REHABILITATION	I NTERCOMPANY	17, 867	17, 867	4. 22
4. 23	90. 01	BEHAVI ORAL HEALTH	I NTERCOMPANY	27, 766	27, 766	4. 23
4. 24	90. 02	SLEEP LAB	I NTERCOMPANY	717, 587	717, 587	4. 24
4. 25	91.00	EMERGENCY	I NTERCOMPANY	3, 197, 358	3, 197, 358	4. 25
4. 26	92. 01	OBSERVATION BEDS (DISTINCT P	I NTERCOMPANY	74	74	4. 26
4. 28	192. 02	MARKETI NG	I NTERCOMPANY	25, 134	25, 134	4. 28
4. 29	192. 03	BACK AND NECK	INTERCOMPANY	29, 578	29, 578	4. 29
4. 30		ADMINISTRATIVE AND GENERAL	NORTH ALLOCATION	197, 963	0	4. 30
4. 31	1		NORTH ALLOCATION	63, 242	0	4. 31
4. 32			NORTH ALLOCATION	151, 221	n o	4. 32
4. 33			I NTERCOMPANY	12, 119	12, 119	4. 33
4. 34			I NTERCOMPANY	-50, 033	-50, 033	4. 34
4. 35		HOUSEKEEPI NG	I NTERCOMPANY	93, 870	93, 870	4. 35
5. 00	9.00	I I I I I I I I I I I I I I I I I I I	n All Live Collin All I	87, 487, 162	61, 069, 546	5. 00
3. 00	<u></u>		lo.	07,407,102	01,009,340	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.

Huo	110 t	been posted to worksheet 7t,	cordinate randon 2, the amou	iit di l'owabi c si	iodi a be i ilai catca i ii coi alliii	i or time part.		
					Related Organization(s) and/	or Home Office		
		Symbol (1)	Name	Percentage of	Name	Percentage of		
		•		Ownershi p		Ownershi p		
		1. 00	2. 00	3.00	4. 00	5. 00		
	B INTERPLATIONSHIP 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

rerilibur	Sement under title XVIII.					
6.00	В	IU HEALTH	100.00	IU HEALTH-HO	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	FINANCIAL				100.00
	non-financial) specify:				1	l

STATEME OFFICE	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 15-0158	Peri od: From 01/01/2022	Worksheet A-8	3-1
OTTICE						Date/Time Pre 5/25/2023 2:3	
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of Ownership	N	lame	Percentage of Ownership	
	1. 00	2. 00	3. 00	4	1. 00	5. 00	

IU HEALTH WEST HOSPITAL

In Lieu of Form CMS-2552-10

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

Health Financial Systems

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- 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.

reriiibur	impursement under title XVIII.									
6. 00	HEALTHCARE	6.00								
7.00		7. 00 8. 00								
8.00		8.00								
9.00		9.00								
10.00		10.00								
100.00		100.00								

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0158	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/25/2023 2:35 pm
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

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

- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- 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.

						10 12/31/2022	5/25/2023 2:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					· ·		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 04	ADMINISTRATIVE AND GENERAL	8, 118, 934	8, 118, 934	0	C	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	2, 132, 097		0	C	0	2. 00
3.00	31. 00	INTENSIVE CARE UNIT	1, 803, 262	1, 803, 262	0	C	0	3. 00
4.00	50.00	OPERATING ROOM	1, 393, 922		0	C	0	4. 00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	3, 250	3, 250	0	l c	0	5. 00
6.00	55. 00	RADI OLOGY-THERAPEUTI C	514, 546	514, 546	0	l c	0	6. 00
7.00	59. 00	CARDIAC CATHETERIZATION	915, 520	915, 520	0	l c	0	7. 00
8.00	91. 00	EMERGENCY	3, 052, 744	3, 052, 744	0	l c	0	8. 00
9.00	0.00		0	0	0	l c	0	9. 00
10.00	0.00		0	0	0	l c	0	10.00
200.00			17, 934, 275	17, 934, 275	0		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12.00	13. 00	14. 00	
1. 00		ADMINISTRATIVE AND GENERAL	0	0		C	0	
2.00		ADULTS & PEDIATRICS	0	1	_	C	0	2. 00
3.00		INTENSIVE CARE UNIT	0	0	_	C	0	3.00
4.00		OPERATING ROOM	0	0	_	C	0	4. 00
5. 00		RADI OLOGY-DI AGNOSTI C	0	0	0	C	0	5. 00
6.00		RADI OLOGY-THERAPEUTI C	0	0	0	C	0	6. 00
7. 00		CARDIAC CATHETERIZATION	0	0	0	C	0	7. 00
8.00		EMERGENCY	0	0	0	C	0	8. 00
9. 00	0. 00		0	0	0	C	0	9. 00
10.00	0. 00		0	0	_	C	0	
200.00			0	0		C	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1, 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADMI NI STRATI VE AND GENERAL	15.00	16.00		8, 118, 934		1.00
2. 00		ADULTS & PEDIATRICS		1	_	2, 132, 097		2.00
3. 00		INTENSIVE CARE UNIT		0	_	1, 803, 262		3.00
4. 00		OPERATING ROOM		0	0	1, 393, 922		4.00
5. 00		RADI OLOGY-DI AGNOSTI C		0	0	3, 250		5.00
6. 00		RADI OLOGY-THERAPEUTI C		0	_	514, 546		6.00
7. 00		CARDI AC CATHETERI ZATI ON		0	J	915, 520		7.00
7. 00 8. 00		EMERGENCY		0		3, 052, 744		8.00
9. 00	0.00	1	0	1	_	3, 052, 744	1	9.00
9. 00 10. 00	0.00			0	_			10.00
200.00	0.00			_	_	17, 934, 275	(200.00
200.00	I	I	1	1	1	17,734,273	'I	200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0158

					5/25/2023 2: 3	
			CAPITAL REL	ATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	MOB	INTEREST	NEW MVBLE EQUIP	
	0	1. 00	1. 01	1. 02	2. 00	
GENERAL SERVICE COST CENTERS	7, 617, 803 383, 208 4, 437, 969		678, 946	4, 437, 969		1. 00 1. 01 1. 02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATIENT TELEPHONES 5.02 00550 DATA PROCESSING	9, 044, 185 13, 271, 532 49, 918 9, 567, 841	34, 172 0 0	0	20, 712 0 0	9, 044, 185 0 0 0	4. 00 5. 01 5. 02
5. 03	975, 164 31, 249, 568 3, 706, 050 6, 051, 210	177, 222	0	0 303, 413 704, 237 107, 416	0 248, 984 880, 337 13, 019	6. 00 7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	252, 958 2, 842, 019 1, 526, 543 1, 083, 837	106, 757 235, 348 167, 166	10, 597 5, 191 0	15, 254 64, 706 142, 646 101, 321	0 0 30, 945 21, 979	9. 00 10. 00 11. 00
13. 00 01300 NURSI NG ADMINISTRATION 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 17. 00 01700 SOCI AL SERVI CE	10, 073, 456 6, 035, 578 5, 196, 025 677	111, 196 126, 978 0	0 0	29, 816 67, 397 76, 962 0	764, 463 0 236, 688 0	14. 00 15. 00 17. 00
18. 00 01080 TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	410, 305	0		0	0	18. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02080 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	32, 314, 979 5, 103, 391 1, 453, 604 549, 371	1, 734, 966 239, 370 55, 118 40, 351	0 0	1, 051, 580 145, 084 33, 407 24, 457	201, 939 180, 359 0 12, 271	31. 00 35. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 59. 00 05900 CARDI AC CATHETERI ZATI ON	9, 350, 143 4, 204, 009 3, 700, 626 9, 535, 596 2, 220, 541 2, 216, 858	285, 845 324, 710 174, 015	0 0 0 0	416, 924 198, 853 173, 253 196, 810 105, 472 53, 867	2, 801, 078 13, 393 86, 941 1, 834, 095 552, 910 650, 135	51. 00 52. 00 54. 00 55. 00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSICAL THERAPY 67. 00 06700 0CCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	10, 213, 362 674, 541 4, 267, 526 2, 356, 827 707, 236 321, 961	68, 526 0 48, 523 3, 062 3, 062 3, 062	0 0 33, 494 33, 494	41, 534 0 29, 410 1, 856 1, 856	0 0 103, 033 5, 964 0	63. 00 65. 00 66. 00 67. 00
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	1, 734, 665 5, 255, 761 8, 545, 048 9, 533, 694 1, 047, 484	0 0 0	0 0 0	0 0 0 0 24, 413	141, 421 0 0 0 0	69. 00 71. 00 72. 00 73. 00 74. 00
76. 00 03950 OTHER ANCILLARY SERVICES 76. 97 07697 CARDIAC REHABILITATION 77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	338, 455 0	0 0 0	20, 414	0 0 0	0 32, 929 0	76. 97
90. 00 09000 CLINI C 90. 01 09001 BEHAVI ORAL HEALTH 90. 02 09002 SLEEP LAB 91. 00 09100 EMERGENCY 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART)	0 634, 804 774, 959 8, 342, 665	0 0 2, 682 407, 333	25, 226 75, 543	0 0 1, 625 246, 888	0 0 0 224, 357	90. 01 90. 02
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	751, 058	82, 133	0	49, 782	0	
102.00 OPEN RETWINDSTRANCE COST CENTERS 102.00 TO200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE	0	0	0	0	0	102. 00 113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	239, 925, 010	7, 609, 287	329, 718	4, 432, 807	9, 037, 240	1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 192. 01 19201 RETAIL PHARMACY 192. 02 19202 MARKETING 192. 03 19203 BACK AND NECK 192. 04 19204 TIPTON SERVICES 192. 05 19205 NORTH SERVICES 192. 06 19206 SAXONY SERVICES 200. 00 Cross Foot Adjustments	280, 528 36, 958 20, 707 385, 944 -5, 755 62, 668 359, 950 89, 023	0 0 0 0 1, 033	138, 560 47, 692 8, 166 83, 206 0	0 0 0 0 0 626 3, 635 901	0 0 0 6, 945 0 0	190. 00 192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 200. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022		pared:
					5/25/2023 2: 3	
			CAPITAL RE	ELATED COSTS		
Cost Center Description	Net Expenses	NEW BLDG &	MOB	INTEREST	NEW MVBLE	
	for Cost	FLXT			EQUI P	
	Allocation					
	(from Wkst A					
	col. 7)					
	0	1. 00	1. 01	1. 02	2. 00	
201.00 Negative Cost Centers		0	(0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	241, 155, 033	7, 617, 803	678, 946	4, 437, 969	9, 044, 185	202. 00

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2:35 pm

			'	0 12/31/2022	5/25/2023 2: 3	
Cost Center Description	EMPLOYEE	NONPATI ENT	DATA	PURCHASI NG	Subtotal	
	BENEFITS	TELEPHONES	PROCESSI NG	RECEIVING AND		
	DEPARTMENT	F 01	F 00	STORES	FA 02	
GENERAL SERVICE COST CENTERS	4. 00	5. 01	5. 02	5. 03	5A. 03	
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 MOB						1.00
1. 02 00102 NTEREST						1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	13, 326, 416					4.00
5. 01 00540 NONPATI ENT TELEPHONES	0	49, 918				5. 01
5. 02 00550 DATA PROCESSING	0	0	9, 567, 841			5. 02
5. 03 00560 PURCHASING RECEIVING AND STORES	23	0	0	,		5. 03
5. 04 00590 ADMI NI STRATI VE AND GENERAL	818, 685	2, 638			33, 721, 853	5. 04
6. 00 00600 MAI NTENANCE & REPAI RS	163, 247	936		0	6, 796, 126	6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	127, 183 0	780 0	149, 431	13	6, 626, 274 293, 379	7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG	271, 963	2, 283	1	0	3, 735, 826	9.00
10. 00 01000 DI ETARY	168, 301	1, 471	281, 947	31	2, 392, 423	
11. 00 01100 CAFETERI A	119, 978	1, 045			1, 695, 627	1
13. 00 01300 NURSING ADMINISTRATION	1, 157, 055	2, 071	397, 030		12, 480, 101	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	225	1	104		6, 216, 825	1
15. 00 01500 PHARMACY	613, 804	2, 220	425, 567	1, 900	6, 680, 144	15.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	677	17. 00
18. 00 01080 TRANSPORTATION	41, 312	384	73, 678	0	525, 679	18. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 158, 919	11, 097	2, 127, 421		40, 640, 851	
31. 00 03100 INTENSIVE CARE UNIT	612, 307	1, 806	346, 078		6, 636, 184	1
35. 00 02080 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	209, 324 66, 390	557 208	106, 677		1, 859, 651 733, 906	
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	00, 390	200	39, 952	900	733, 900	43.00
50. 00 05000 OPERATING ROOM	966, 103	3, 800	728, 373	164, 911	15, 119, 201	50.00
51. 00 05100 RECOVERY ROOM	578, 458	2, 027	388, 521		5, 716, 085	
52.00 05200 DELIVERY ROOM & LABOR ROOM	470, 356	1, 478			5, 008, 213	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	965, 322	3, 444	660, 091	12, 668	13, 532, 736	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	198, 606	743	142, 375	2, 090	3, 396, 752	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	273, 482	864	165, 619		3, 487, 027	1
60. 00 06000 LABORATORY	99	1, 301	249, 363		10, 574, 185	1
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0		674, 618	1
65. 00 06500 RESPI RATORY THERAPY	413, 031	1, 326			5, 135, 032	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	338, 919	1, 358			3, 003, 624	
68. 00 06800 SPEECH PATHOLOGY	103, 000 46, 926	408 165			927, 241 439, 140	
69. 00 06900 ELECTROCARDI OLOGY	199, 868	779			2, 227, 416	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	177, 666	0	0		5, 503, 223	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	o	0	Ö		8, 947, 377	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	9, 533, 694	
74.00 07400 RENAL DIALYSIS	0	0	0	168	1, 112, 344	74.00
76. 00 03950 OTHER ANCI LLARY SERVI CES	0	0	0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	44, 992	245			483, 989	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	ما	0			0	00 00
90. 00 09000 CLI NI C 90. 01 09001 BEHAVI ORAL HEALTH	91, 779	421	80, 630	46	0 832, 906	90.00
90. 02 09002 SLEEP LAB	71, 777	421	00,030	737	855, 546	
91. 00 09100 EMERGENCY	945, 540	3, 574	684, 996		10, 870, 806	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	710,010	0,071	001,770	10, 100	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	81, 003	279	53, 442	404	1, 018, 101	1
OTHER REIMBURSABLE COST CENTERS				,	,	
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 246, 200	49, 709	9, 527, 889	975, 187	239, 434, 782	118. 00
NONREI MBURSABLE COST CENTERS	40.700	404	05 (00		20/ /27	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18, 729	134	25, 632		396, 627	
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 RETAIL PHARMACY	4, 145 810	0	311 0		179, 976	192.00
192. 01 1920 RETAIL PHARMACY 192. 02 19202 MARKETI NG	217	1	208		394, 536	
192. 03 19203 BACK AND NECK	0	2	415			192.02
192. 04 19204 TI PTON SERVI CES	6, 887	9	1, 660			192.03
192. 05 19205 NORTH SERVICES	39, 644	49			418, 718	1
192. 06 19206 SAXONY SERVI CES	9, 784	12			103, 489	
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0	0	-		201. 00
202.00 TOTAL (sum lines 118 through 201)	13, 326, 416	49, 918	9, 567, 841	975, 187	241, 155, 033	202. 00

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2:35 pm

					7 12/31/2022	5/25/2023 2: 3	
	Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E AND GENERAL	REPAIRS	PLANT 7.00	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5. 04	6. 00	7. 00	8. 00	9. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB						1.01
1.02	00102 I NTEREST						1. 02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00590 ADMINISTRATIVE AND GENERAL	33, 721, 853	ł				5.04
6. 00	00600 MAI NTENANCE & REPAI RS	1, 104, 826	1				6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	1, 077, 213 47, 694	l .		413, 156		7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	607, 322	149, 942		413, 130	i e	9.00
10.00	01000 DI ETARY	388, 929	l .		0		1
11. 00	01100 CAFETERI A	275, 653	234, 787	244, 002	0	146, 182	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 028, 853	l .	71, 804	0	43, 018	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 010, 651	156, 177	162, 307	0	97, 238	14.00
15.00	01500 PHARMACY	1, 085, 971	178, 342	185, 342	5	111, 039	15. 00
17.00	01700 SOCIAL SERVICE	110	l	0	0	1	17.00
18. 00	01080 TRANSPORTATI ON	85, 458	0	0	0	0	18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			0 500 404	444 570	4 547 470	
30.00	03000 ADULTS & PEDIATRICS	6, 606, 922		2, 532, 431	141, 570		
31.00	03100 I NTENSI VE CARE UNI T	1, 078, 825	l .		·		31.00
35. 00 43. 00	02080 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	302, 318 119, 309		80, 453 58, 898	680 0		35. 00 43. 00
43.00	ANCI LLARY SERVICE COST CENTERS	119, 309	30, 073	30, 090	U	33, 260	43.00
50.00	05000 OPERATING ROOM	2, 457, 883	966, 122	1, 004, 043	31, 976	601, 522	50.00
51.00	05100 RECOVERY ROOM	929, 247	460, 793		21, 466	1	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	814, 170	1		30, 658	1	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 199, 976			84, 520		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	552, 200	244, 406	253, 999	5, 170	152, 171	55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	566, 876	124, 824	129, 724	8, 430	77, 718	59.00
60.00	06000 LABORATORY	1, 719, 014	96, 246	100, 023	0	59, 924	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	109, 671	0	0	0	0	63.00
65. 00	06500 RESPI RATORY THERAPY	834, 787	68, 151	70, 826	0	42, 432	65.00
66.00	06600 PHYSI CAL THERAPY	488, 290		4, 470	14, 042	2, 678	66.00
67.00	06700 OCCUPATI ONAL THERAPY	150, 739		4, 470	0	2, 678	1
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	71, 390	4, 301	4, 470	0	2, 678 0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	362, 104 894, 642	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 454, 548	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 549, 864	0	o o	0	Ö	73.00
74. 00	07400 RENAL DI ALYSI S	180, 830	56, 572	58, 792	0	35, 222	74.00
76.00	03950 OTHER ANCILLARY SERVICES	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	78, 681	0	0	743	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 BEHAVI ORAL HEALTH	135, 403		0	0 470	0	90. 01
90. 02	09002 SLEEP LAB	139, 084	1	· ·		1	90.02
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 767, 234	572, 105	594, 561	48, 745	356, 201	91. 00 92. 00
92.00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	165, 510	115, 357	119, 885	6, 378	71, 823	92.00
72.01	OTHER REIMBURSABLE COST CENTERS	103, 310	113, 337	117,003	0, 370	71,023	72.01
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	_					
113.00	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	33, 442, 197	7, 888, 991	7, 939, 967	413, 156	4, 641, 470	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	64, 478		0	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	29, 258	i e	0	0		192.00
	19201 RETAIL PHARMACY	11, 251	0	0	0		192. 01
	19202 MARKETI NG	64, 139	l e	0	0		192. 02
	19203 BACK AND NECK	13, 788		1 507	0		192. 03 192. 04
	19204 TI PTON SERVI CES 19205 NORTH SERVI CES	11, 848 68, 070	l .	1, 507 8, 754	0	•	192. 04 192. 05
	19205 NORTH SERVICES	16, 824	2, 087	2, 169	0		192.05
200.00		10, 024	2,007	2, 109	U		200.00
201.00		0	0	0	n		201.00
202. 00		33, 721, 853	· -	-	413, 156	l e	
			•				-

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2:35 pm

) 12/31/2022	5/25/2023 2: 3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O N	SERVI CES & SUPPLY		
		10. 00	11. 00	13.00	14.00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 M0B						1.01
1. 02 2. 00	O0102 INTEREST O0200 NEW CAP REL COSTS-MVBLE EQUIP						1. 02 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5.02	00550 DATA PROCESSING						5. 02
5. 03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00590 ADMI NI STRATI VE AND GENERAL						5.04
6. 00 7. 00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	3, 661, 229					10.00
11.00	01100 CAFETERI A	0	2, 596, 251				11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	131, 923 34		7, 643, 232		13. 00 14. 00
15. 00	01500 PHARMACY	0	141, 405		15, 035	8, 476, 560	1
17. 00	01700 SOCIAL SERVICE	O	0	0	0	0	17.00
18. 00	01080 TRANSPORTATI ON	0	24, 481	0	0	0	18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 342, 326	706, 887 114, 993		316, 170 61, 644	144, 479 65, 759	
35.00	02080 NEONATAL INTENSIVE CARE UNIT	318, 903	35, 446		7, 628	65, 759 1, 471	1
43.00	04300 NURSERY	ő	13, 275		7, 169	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	242, 019		1, 305, 147	26, 495	ł
51. 00 52. 00	05100 RECOVERY ROOM	0	129, 095		21, 712	88, 203	
54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	94, 132 219, 331	832, 408 118, 915	50, 795 100, 261	0 29, 315	
55. 00	05500 RADI OLOGY-THERAPEUTI C	ő	47, 307		16, 544	62, 790	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	55, 031		295, 420	41, 690	
60.00	06000 LABORATORY	0	82, 857		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	04 443	I ~	610	0	63.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	84, 443 86, 477		142, 821 14, 918	72 0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	25, 964		358	0	67.00
68.00	06800 SPEECH PATHOLOGY	O	10, 517		208	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	49, 618	158, 554	10, 729	15, 312	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	1, 958, 475	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	3, 184, 173 0	7 700 924	
74. 00	07400 RENAL DIALYSIS	0	0	0	1, 332	7, 790, 826 194	•
76.00	03950 OTHER ANCI LLARY SERVICES	Ö	0	Ö	0	0	1
	07697 CARDIAC REHABILITATION	O	15, 585	39, 638	389	135	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0		ol	0	90.00
90.00	09001 BEHAVI ORAL HEALTH	0	26, 791	39, 638	364	0	90.00
90. 02	09002 SLEEP LAB	0	0	0	5, 831	0	90. 02
91.00	09100 EMERGENCY	0	227, 606	1, 783, 732	122, 303	205, 619	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		47.750	440.045	0.405		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	17, 758	118, 915	3, 195	4, 200	92. 01
102 00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		
	11300 I NTEREST EXPENSE						113.00
118.00		3, 661, 229	2, 582, 975	14, 824, 791	7, 643, 231	8, 476, 560	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 517	0	ol	<u> </u>	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	103		0		192.00
	19201 RETAIL PHARMACY	O	0		ō		192. 01
	19202 MARKETI NG	0	69	0	1		192. 02
	19203 BACK AND NECK	0	138		0		192.03
	19204 TI PTON SERVI CES 19205 NORTH SERVI CES	0	552 3, 138		0		192. 04 192. 05
	19206 SAXONY SERVICES	0	3, 138 759		ol Ol		192.05
200.00		Ĭ	,3,	l ~	Ĭ	O	200.00
201.00	Negative Cost Centers	o	0	0	o		201.00
202.00	TOTAL (sum lines 118 through 201)	3, 661, 229	2, 596, 251	14, 824, 791	7, 643, 232	8, 476, 560	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH WEST HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0158 Peri od: Worksheet B From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/25/2023 2:35 pm OTHER GENERAL SERVI CE SOCI AL TRANSPORTATI O Subtotal Intern & Total Cost Center Description SERVI CE Residents N Cost & Post Stepdown Adjustments 17. 00 18. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 MOB 1.01 00102 I NTEREST 1.02 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 5 02 00560 PURCHASING RECEIVING AND STORES 5.03 5.04 00590 ADMINISTRATIVE AND GENERAL 6.00 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 01100 CAFETERI A 11 00 13.00 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 14.00

Health Financial Systems	IU HEALTH WE	IU HEALTH WEST HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre			
Cost Center Description	SOCI AL SERVI CE	OTHER GENERAL SERVICE TRANSPORTATIO N	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5/25/2023 2: 3 Total	5 pm		
	17. 00	18. 00	24.00	25. 00	26.00			
201.00 Negative Cost Centers	0	0		0 0	0	201.00		
202.00 TOTAL (sum lines 118 through 201)	787	635, 618	241, 155, 03	3 0	241, 155, 033	202.00		

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To 12/31/2022 | Date/Time Prepared: | Part | | P Provider CCN: 15-0158

				То		Date/Time Pre 5/25/2023 2:3	
				CAPI TAL REL	ATED COSTS		
	Cost Center Description	Di rectly	NEW BLDG &	MOB	INTEREST	NEW MVBLE	
		Assigned New Capital	FLXT			EQUI P	
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	2. 00	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
	00101 MOB						1. 01
	00102 INTEREST 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 02 2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	o	34, 172	0	20, 712	0	4. 00
	00540 NONPATIENT TELEPHONES	0	0	0	0	0	5. 01
4	00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES	0	0	0	0	0	5. 02 5. 03
	00590 ADMINISTRATIVE AND GENERAL	l o	500, 591	92, 265	303, 413	248, 984	5. 04
4	00600 MAINTENANCE & REPAIRS	0	1, 161, 898		704, 237	880, 337	6.00
1	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	177, 222 25, 167		107, 416 15, 254	13, 019 0	7. 00 8. 00
	00900 HOUSEKEEPI NG		106, 757		64, 706	0	9. 00
4	01000 DI ETARY	0	235, 348		142, 646	30, 945	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	167, 166 49, 193		101, 321 29, 816	21, 979 764, 463	11. 00 13. 00
4	01400 CENTRAL SERVI CES & SUPPLY	l o	111, 196		67, 397	0	14. 00
4	01500 PHARMACY	0	126, 978		76, 962	236, 688	15.00
	01700 SOCI AL SERVI CE 01080 TRANSPORTATI ON	0 0	0	0	0	0	17. 00 18. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		0	0	o _l	0	10.00
	03000 ADULTS & PEDIATRICS	0	1, 734, 966		1, 051, 580	201, 939	30.00
	03100 INTENSIVE CARE UNIT 02080 NEONATAL INTENSIVE CARE UNIT	0 0	239, 370 55, 118		145, 084 33, 407	180, 359 0	31. 00 35. 00
	04300 NURSERY	Ö	40, 351		24, 457	12, 271	43.00
	ANCILLARY SERVICE COST CENTERS		(07.0(0		417 004	2 001 070	FO 00
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0 0	687, 869 328, 081	0	416, 924 198, 853	2, 801, 078 13, 393	50. 00 51. 00
1	05200 DELIVERY ROOM & LABOR ROOM	o o	285, 845	- 1	173, 253	86, 941	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	324, 710		196, 810	1, 834, 095	54.00
4	05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON	0 0	174, 015 88, 874		105, 472 53, 867	552, 910 650, 135	55. 00 59. 00
60.00	06000 LABORATORY	l o	68, 526		41, 534	0	60.00
	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
4	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		48, 523 3, 062		29, 410 1, 856	103, 033 5, 964	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	l o	3, 062		1, 856	0	67. 00
4	06800 SPEECH PATHOLOGY	0	3, 062	33, 494	1, 856	0	68.00
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	141, 421 0	69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	l o	0	0	o	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DIALYSIS 03950 OTHER ANCILLARY SERVICES		40, 279 0		24, 413	0	74. 00 76. 00
76. 97	07697 CARDIAC REHABILITATION	o	0	20, 414	O	32, 929	76. 97
	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
	09000 CLINIC	l ol	0	0	0	0	90. 00
	09001 BEHAVI ORAL HEALTH	o	0	25, 226	0	0	90. 01
	09002 SLEEP LAB 09100 EMERGENCY	0	2, 682 407, 333		1, 625 246, 888	0 224, 357	90. 02 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		407, 333		240, 000	224, 337	92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	82, 133	0	49, 782	0	92. 01
	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	l ol	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	<u> </u>	U _I	0	102. 00
	11300 I NTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	7, 313, 549	329, 718	4, 432, 807	9, 037, 240	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l	0	71, 604	0	0	190. 00
192. 00	19200 PHYSICIANS' PRIVATE OFFICES	o	0	138, 560	0	0	192. 00
	19201 RETAIL PHARMACY	0	0	47, 692 9, 166	0		192.01
	19202 MARKETI NG 19203 BACK AND NECK		0	8, 166 83, 206	0		192. 02 192. 03
192. 04	19204 TIPTON SERVICES		1, 033	0	626	0	192. 04
	19205 NORTH SERVICES	0	5, 997 1, 494		3, 635		192.05
200.00	19206 SAXONY SERVICES Cross Foot Adjustments		1, 486		901		192. 06 200. 00
201. 00	Negative Cost Centers		0	0	0		201. 00

Health Fin	ancial Systems	IU HEALTH WES	IU HEALTH WEST HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS			Provi der Co		eriod: rom 01/01/2022	Worksheet B Part II		
				ˈT				
				CAPITAL RE	LATED COSTS			
	Cost Center Description	Di rectly	NEW BLDG &	MOB	INTEREST	NEW MVBLE		
		Assigned New Capital	FIXT			EQUI P		
		Related Costs						
		0	1. 00	1. 01	1. 02	2. 00		
202.00	TOTAL (sum lines 118 through 201)	0	7, 322, 065	678, 946	4, 437, 969	9, 044, 185	202.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0158

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/25/2023 2:35 pm Cost Center Description Subtotal **EMPLOYEE** NONPATI ENT DATA **PURCHASI NG TELEPHONES** PROCESSI NG RECEIVING AND **BENEFITS** DEPARTMENT **STORES** 2A 5. 01 5. 02 5 03 4 00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 MOB 1.01 00102 I NTEREST 1 02 1 02 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 54, 884 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 54,884 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 0 5.02 0 C 5.02 5.03 00560 PURCHASING RECEIVING AND STORES 0 0 5.03 5 04 00590 ADMINISTRATIVE AND GENERAL 1, 145, 253 3, 372 0 0 0 0 0 0 0 0 0 0 5.04 00600 MAINTENANCE & REPAIRS 0 2, 746, 472 0 6.00 672 6.00 0 00700 OPERATION OF PLANT 297, 657 0 7 00 524 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 40, 421 0 8.00 9.00 00900 HOUSEKEEPI NG 182, 060 1, 120 0 9.00 01000 DI ETARY 0 10.00 414, 130 0 10.00 693 11.00 01100 CAFETERI A 290, 466 494 0 0 11.00 01300 NURSING ADMINISTRATION 0 13.00 13 00 843, 472 4.765 0 01400 CENTRAL SERVICES & SUPPLY 0 14.00 178.593 0 14.00 01500 PHARMACY 0 15 00 440, 628 2, 528 0 15.00 01700 SOCIAL SERVICE 0 0 0 17.00 17.00 01080 TRANSPORTATION 18.00 170 0 0 0 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 988, 485 13,013 0 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 564, 813 2, 522 0 0 0 31.00 o 35.00 02080 NEONATAL INTENSIVE CARE UNIT 88, 525 0 0 35.00 862 <u>7</u>7, 079 04300 NURSERY 0 43.00 273 0 0 43.00 ANCILLARY SERVICE COST CENTERS 3, 979 05000 OPERATING ROOM 3, 905, 871 0 50.00 05100 RECOVERY ROOM 2.382 0 0 0 0 51.00 540, 327 51.00 05200 DELIVERY ROOM & LABOR ROOM 546, 039 0 52.00 1, 937 0 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 355, 615 3, 976 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 832, 397 818 0 0 0 0 0 0 0 0 55.00 59 00 05900 CARDI AC CATHETERI ZATI ON 792 876 0 0 59.00 1, 126 0 06000 LABORATORY 60.00 110,060 C 0 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 0 63.00 63.00 06500 RESPIRATORY THERAPY 65.00 180, 966 1, 701 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 44, 376 1, 396 0 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 38, 412 424 0 67.00 06800 SPEECH PATHOLOGY 38, 412 193 0 68.00 68.00 69 00 06900 ELECTROCARDI OLOGY 141, 421 823 0 0 0 Ω 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07400 RENAL DIALYSIS 0 74 00 64, 692 74 00 0 0 76.00 03950 OTHER ANCILLARY SERVICES C 0 76.00 76.97 07697 CARDIAC REHABILITATION 53, 343 185 0 0 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 BEHAVI ORAL HEALTH 25, 226 0 0 0 90.01 90.01 378 09002 SLEEP LAB 79, 850 0 0 90.02 90.02 0 \mathcal{C} 09100 EMERGENCY 91.00 91 00 878.578 3.894 0 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 131, 915 334 0 0 O 92.01 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 21, 113, 314 54, 555 0 0 0 1118, 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 71.604 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 138, 560 0 0 0 192.00 17 192. 01 19201 RETAIL PHARMACY 0 47.692 0 0 192. 01 192. 02 19202 MARKETI NG 8, 166 0 192.02 192. 03 19203 BACK AND NECK 90, 151 C 0 0 0 0 192.03 192. 04 19204 TI PTON SERVICES 1, 659 0 0 192, 04 28 192. 05 19205 NORTH SERVICES 0 9,632 163 0 192.05 192.06 19206 SAXONY SERVICES 0 0 0 192.06 2, 387 40 Cross Foot Adjustments 200.00 200.00 0 201.00 201.00 Negative Cost Centers 0 0 202.00 TOTAL (sum lines 118 through 201) 21, 483, 165 54,884 0 0 202.00

	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/25/2023 2: 3 HOUSEKEEPI NG	5 pm
	'	E AND GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	GENERAL SERVICE COST CENTERS	5. 04	6. 00	7. 00	8. 00	9. 00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB						1. 01
1. 02	00102 NTEREST						1.02
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 01	00540 NONPATI ENT TELEPHONES						5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04	00590 ADMINISTRATIVE AND GENERAL	1, 148, 625	0 704 774				5.04
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	37, 630 36, 690	2, 784, 774 87, 731	422, 602			6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 624	12, 459		56, 456		8.00
9. 00	00900 HOUSEKEEPI NG	20, 685	52, 849		0	264, 995	9. 00
10.00	01000 DI ETARY	13, 247	116, 505		0	11, 731	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	9, 389	82, 753		0	8, 333	11.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	69, 102 34, 423	24, 352 55, 046		0	2, 452 5, 543	13. 00 14. 00
15. 00	01500 PHARMACY	36, 988	62, 859		1	6, 329	15. 00
17. 00	01700 SOCIAL SERVICE	4	0		0	0	17. 00
18. 00	01080 TRANSPORTATI ON	2, 911	0	0	0	0	18. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	225 002	050 040	134, 578	10 245	86, 479	20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	225, 093 36, 745	858, 869 118, 497		19, 345 2, 091	11, 932	30. 00 31. 00
35. 00	02080 NEONATAL INTENSIVE CARE UNIT	10, 297	27, 285		93	2, 747	35. 00
43.00	04300 NURSERY	4, 064	19, 975		0	2, 011	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	83, 715	340, 520		4, 369	34, 288	50.00
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	31, 650 27, 730	162, 412 141, 504		2, 933 4, 189	16, 354 14, 248	51. 00 52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	74, 931	160, 743		11, 549	16, 186	1
55.00	05500 RADI OLOGY-THERAPEUTI C	18, 808	86, 143			8, 674	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	19, 308	43, 996		1, 152	4, 430	1
60.00	06000 LABORATORY	58, 549	33, 923		0	3, 416	60.00
63. 00 65. 00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY	3, 735 28, 433	0 24, 020	-	0	0 2, 419	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	16, 631	1, 516		1, 919	153	1
67.00	06700 OCCUPATI ONAL THERAPY	5, 134	1, 516		0	153	1
68. 00	06800 SPEECH PATHOLOGY	2, 432	1, 516		0	153	1
69. 00	06900 ELECTROCARDI OLOGY	12, 333	0	1	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	30, 471 49, 542	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	52, 788	0	0	0	0	73.00
74. 00	07400 RENAL DIALYSIS	6, 159	19, 939	3, 124	O	2, 008	74.00
76. 00	03950 OTHER ANCI LLARY SERVI CES	0	0		0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 680	0		102	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	77. 00
90.00	09000 CLINIC	l ol	0	0	ol	0	90.00
90. 01	09001 BEHAVI ORAL HEALTH	4, 612	0	0	0	0	90. 01
90. 02	09002 SLEEP LAB	4, 737	1, 327		475	134	90. 02
91.00	09100 EMERGENCY	60, 192	201, 644	31, 596	6, 661	20, 304	
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	5, 637	40, 659	6, 371	871	4, 094	92. 00 92. 01
72.01	OTHER REIMBURSABLE COST CENTERS	5,037	40, 039	0,371	671[4, 074	72.01
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	4 400 000	0 700 550	404 040	E (4E (0/4 574	113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 139, 099	2, 780, 558	421, 942	56, 456	264, 571]118.00]
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 196	0	0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	997	0	Ö	o		192.00
	1 19201 RETAIL PHARMACY	383	0	0	0		192. 01
	19202 MARKETI NG	2, 185	0	1	0		192. 02
	3 19203 BACK AND NECK 1 19204 TIPTON SERVICES	470 404	0 511	0 80	0	0 51	192. 03 192. 04
	19204 TIPTON SERVICES 19205 NORTH SERVICES	2, 318	2, 969		0		192. 04 192. 05
	19206 SAXONY SERVICES	573	736		ol		192.06
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	1, 148, 625	2, 784, 774	422, 602	56, 456	264, 995	J202. 00

					12/31/2022	5/25/2023 2: 3	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
				ADMI NI STRATI O N	SERVI CES & SUPPLY		
		10.00	11. 00	13.00	14. 00	15.00	
	ENERAL SERVICE COST CENTERS						
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0101 MOB						1. 01
	0102 I NTEREST						1. 02
	0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0540 NONPATI ENT TELEPHONES						5. 01
	0550 DATA PROCESSING						5. 02 5. 03
	0560 PURCHASING RECEIVING AND STORES 0590 ADMINISTRATIVE AND GENERAL						5.03
	0600 MAINTENANCE & REPAIRS						6.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG						9. 00
	1000 DI ETARY	574, 561					10.00
	1100 CAFETERI A	0	404, 402	,			11.00
	1300 NURSING ADMINISTRATION	o	20, 549				13.00
	1400 CENTRAL SERVICES & SUPPLY	0	5	0	282, 236		14.00
	1500 PHARMACY	ol	22, 026	5, 179	555	586, 942	15.00
	1700 SOCIAL SERVICE	o	0	o	0	0	17. 00
18. 00 0°	1080 TRANSPORTATI ON	O	3, 813	0	o	0	18. 00
11	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	524, 515	110, 107	432, 461	11, 675	10, 004	30. 00
	3100 INTENSIVE CARE UNIT	50, 046	17, 912		2, 276	4, 553	31.00
	2080 NEONATAL INTENSIVE CARE UNIT	0	5, 521		282	102	35. 00
	4300 NURSERY	0	2, 068	7, 769	265	0	43. 00
	NCILLARY SERVICE COST CENTERS		27 (00	00.005	40.404	4 005	F0 00
	5000 OPERATING ROOM	0	37, 698		48, 194	1, 835	50.00
	5100 RECOVERY ROOM	0	20, 108		802	6, 108	51.00
	5200 DELIVERY ROOM & LABOR ROOM	0 0	14, 662		1, 876	0	52. 00 54. 00
	5400 RADI OLOGY-DI AGNOSTI C 5500 RADI OLOGY-THERAPEUTI C		34, 164 7, 369		3, 702 611	2, 030 4, 348	55.00
	5900 CARDI AC CATHETERI ZATI ON	ol ol	8, 572		10, 909	2, 887	59.00
	6000 LABORATORY	0	12, 906		10, 707	2, 887	60.00
	6300 BLOOD STORING, PROCESSING, & TRANS.		12, 700		23	0	63.00
	6500 RESPIRATORY THERAPY	0	13, 153		5, 274	5	65.00
	6600 PHYSI CAL THERAPY	o o	13, 470		551	0	66.00
	6700 OCCUPATI ONAL THERAPY	ol	4, 044		13	0	67. 00
	6800 SPEECH PATHOLOGY	0	1, 638		8	0	68.00
69.00 0	6900 ELECTROCARDI OLOGY	0	7, 729	10, 358	396	1, 060	69. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	0	0	72, 319	0	71.00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	117, 580	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	539, 459	73.00
	7400 RENAL DIALYSIS	0	0	0	49	13	74.00
	3950 OTHER ANCILLARY SERVICES	0	0	0	0	0	76. 00
	7697 CARDI AC REHABI LI TATI ON	0	2, 428		14	9	76. 97
	7700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	UTPATIENT SERVICE COST CENTERS	ام	0	ا	٥	0	00.00
	9000 CLI NI C 9001 BEHAVI ORAL HEALTH	0 0	4, 173	2, 590	13	0	90. 00 90. 01
	9001 SLEEP LAB		4, 1/3	2, 390	215	0	90.01
	9100 EMERGENCY	o	35, 453	116, 532	4, 516	14, 238	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	١	33, 433	110, 332	4, 510	14, 230	92.00
	9201 OBSERVATION BEDS (DISTINCT PART)	0	2, 766	7, 769	118	291	92. 01
	THER REIMBURSABLE COST CENTERS	-1	=,	.,	,		
	0200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
SF	PECIAL PURPOSE COST CENTERS						
113. 00 1	1300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	574, 561	402, 334	968, 508	282, 236	586, 942	118. 00
NO SO I	ONREI MBURSABLE COST CENTERS		1 007	ا ما	al		400 00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 327		0		190.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	16		0		192.00
	9201 RETAI L PHARMACY 9202 MARKETI NG	0	0		O		192. 01
	•	0	11		o ₀		192. 02 192. 03
	9203 BACK AND NECK 9204 TIPTON SERVICES		21 86		0		192. 03 192. 04
	9205 NORTH SERVICES		489		٥		192. 04
	9206 SAXONY SERVICES		118		0		192.05
200.00	Cross Foot Adjustments		110	<u> </u>	٩		200. 00
201.00	Negative Cost Centers	ol	0	ol ol	ol		201.00
202.00	TOTAL (sum lines 118 through 201)	574, 561	404, 402	968, 508	282, 236		
,	, , , , , , , , , , , , , , , , , , ,	,					

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0158 Peri od: Worksheet B From 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/25/2023 2:35 pm OTHER GENERAL SERVI CE Cost Center Description SOCI AL TRANSPORTATI O Subtotal Intern & Total SERVI CE Residents N Cost & Post Stepdown Adjustments 17. 00 18. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 00101 MOB 1.01 1.01 00102 I NTEREST 1.02 1.02 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 00550 DATA PROCESSING 5.02 5 02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00590 ADMINISTRATIVE AND GENERAL 5.04 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11 00 11 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 17.00 01700 SOCIAL SERVICE 17.00 01080 TRANSPORTATION 18.00 6.894 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4 758 5, 415, 386 5, 415, 386 30.00 0 31.00 03100 INTENSIVE CARE UNIT 147 907, 789 0 907, 789 31.00 02080 NEONATAL INTENSIVE CARE UNIT 0 0 165, 904 35.00 19 165, 904 35.00 04300 NURSERY 0 43.00 15 116, 649 0 116, 649 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 868 4, 607, 918 0 4, 607, 918 50.00 05100 RECOVERY ROOM 0 51.00 166 894, 147 0 894, 147 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000000 828.858 828, 858 52.00 120 05400 RADI OLOGY-DI AGNOSTI C 54 00 652 2, 696, 504 2, 696, 504 54 00 05500 RADI OLOGY-THERAPEUTI C 994, 337 0 994, 337 55.00 248 55.00 05900 CARDI AC CATHETERI ZATI ON 59.00 346 910, 623 0 0 910, 623 59.00 06000 LABORATORY 224, 535 60.00 224, 535 60.00 366 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 18 3,776 3,776 63.00 259, 835 65.00 06500 RESPIRATORY THERAPY 100 259, 835 0 0 0 65.00 06600 PHYSI CAL THERAPY 80, 306 80, 306 66.00 56 66.00 06700 OCCUPATI ONAL THERAPY 49, 952 67.00 18 49, 952 67 00 68.00 06800 SPEECH PATHOLOGY 44, 599 44, 599 68.00 69.00 06900 ELECTROCARDI OLOGY 248 174, 368 0 0 174, 368 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 206 102, 996 71.00 102, 996 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 167, 583 72.00 461 167, 583 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 510 592, 757 0 592, 757 73.00 0 74.00 07400 RENAL DIALYSIS 96,001 96,001 17 74.00 03950 OTHER ANCILLARY SERVICES 76.00 C Ω 76.00 76.97 07697 CARDIAC REHABILITATION 21 61, 372 0 61, 372 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 C 0 Ω 90.00 90.01 09001 BEHAVI ORAL HEALTH 0 36, 999 0 36, 999 90.01 86, 992 09002 SLEEP LAB 0 90.02 0 46 86, 992 90.02 0 o 91 00 09100 EMERGENCY 1, 450 1, 375, 058 1, 375, 058 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 22 200, 847 92.01 0 200, 847 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 118.00 4 6,894 21, 096, 091 0 21, 096, 091 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 75, 204 0 75, 204 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 139, 590 192. 00 139, 590 0 0 48, 078 192. 01 192. 01 19201 RETAIL PHARMACY 0 0 0 48, 078 192. 02 19202 MARKETI NG 0 10.363 10, 363 192. 02 192.03 19203 BACK AND NECK 90,642 0 90, 642 192. 03 0 0 192. 04 19204 TIPTON SERVICES 0 2, 819 2, 819 192. 04 16, 335 192. 05 192, 05 19205 NORTH SERVICES 0 16, 335 192.06 19206 SAXONY SERVICES 4,043 0 4, 043 192. 06 0 200.00 200.00 Cross Foot Adjustments

Heal th Finar	ncial Systems	IU HEALTH WE	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/25/2023 2:3	
	Cost Center Description	SOCI AL SERVI CE	OTHER GENERAL SERVI CE TRANSPORTATI O N	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17. 00	18. 00	24.00	25. 00	26.00	
201.00	Negati ve Cost Centers	C	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	4	6, 894	21, 483, 16	5 0	21, 483, 165	202.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm Provi der CCN: 15-0158

						12/31/2022	5/25/2023 2: 3	
				CAPI TAL REI	LATED COSTS			
		Cost Center Description	NEW BLDG &	MOB	INTEREST	NEW MVBLE	EMPLOYEE	
		555 Conton 5555 Ft. 6.1	FLXT	(MOB SQUARE	(SQUARE FEET)	EQUI P	BENEFI TS	
			(SQUARE FEET)	FEET)		(DOLLAR	DEPARTMENT	
						VALUE)	(GROSS	
			1. 00	1. 01	1. 02	2. 00	SALARI ES) 4. 00	
	GENER	AL SERVICE COST CENTERS	1.00	1.01	1.02	2.00	4.00	
1.00		NEW CAP REL COSTS-BLDG & FIXT	420, 432					1.00
1. 01	00101	•	16, 322	66, 184	1			1.01
1. 02 2. 00		INTEREST NEW CAP REL COSTS-MVBLE EQUIP	0	0	404, 110	8, 295, 981		1. 02 2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	1, 886	0	1, 886	0, 243, 401	85, 091, 433	4.00
5. 01		NONPATI ENT TELEPHONES	0	Ō	0	O	0	5. 01
5. 02		DATA PROCESSING	0	0	0	0	0	5. 02
5. 03		PURCHASING RECEIVING AND STORES	0 27 420	0 004	_	220 204	147	5.03
5. 04 6. 00	1	ADMINISTRATIVE AND GENERAL MAINTENANCE & REPAIRS	27, 628 64, 126			228, 386 807, 509	5, 227, 439 1, 042, 357	5. 04 6. 00
7. 00		OPERATION OF PLANT	9, 781	Ö		11, 942	812, 086	1
8.00		LAUNDRY & LINEN SERVICE	1, 389		,	0	0	
9.00		HOUSEKEEPI NG	5, 892	1, 033		0	1, 736, 526	
10. 00 11. 00	1	DI ETARY CAFETERI A	12, 989 9, 226	506 0	1	28, 385 20, 161	1, 074, 632 766, 079	•
13. 00	1	NURSING ADMINISTRATION	2, 715	Ö		701, 221	7, 387, 990	1
14.00		CENTRAL SERVICES & SUPPLY	6, 137	0	6, 137	0	1, 438	14. 00
15.00		PHARMACY	7, 008			217, 107	3, 919, 239	1
17. 00 18. 00	1	SOCIAL SERVICE TRANSPORTATION	0	0		0	0 263, 783	17. 00 18. 00
16.00		I ENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u> </u>	203, 703	16.00
30.00	03000	ADULTS & PEDIATRICS	95, 754	0	95, 754	185, 233	20, 170, 273	30.00
31.00		INTENSIVE CARE UNIT	13, 211	0		165, 438	3, 909, 679	1
35. 00 43. 00	1	NEONATAL INTENSIVE CARE UNIT NURSERY	3, 042 2, 227	0		11 254	1, 336, 567 423, 911	35. 00 43. 00
43.00		LARY SERVICE COST CENTERS	2, 221	0	2, 221	11, 256	423, 911	43.00
50.00		OPERATING ROOM	37, 964	0	37, 964	2, 569, 352	6, 168, 728	50.00
51.00	1	RECOVERY ROOM	18, 107	0		12, 285	3, 693, 553	
52. 00 54. 00		DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	15, 776 17, 921	0		79, 749 1, 682, 364	3, 003, 303 6, 163, 740	1
55. 00		RADI OLOGY-DI AGNOSTI C	9, 604	0	1	507, 169	1, 268, 130	1
59. 00		CARDI AC CATHETERI ZATI ON	4, 905	Ō	4, 905	596, 351	1, 746, 231	59.00
60.00		LABORATORY	3, 782	0	-,	0	629	ł
63. 00 65. 00		BLOOD STORING, PROCESSING, & TRANS. RESPIRATORY THERAPY	2 479	0	_	0 94, 509	2 427 270	63.00
66.00		PHYSICAL THERAPY	2, 678 169		-,	5, 471	2, 637, 270 2, 164, 057	1
67. 00		OCCUPATI ONAL THERAPY	169		1	0	657, 674	1
68. 00		SPEECH PATHOLOGY	169	3, 265	I	0	299, 632	
69. 00 71. 00		ELECTROCARDI OLOGY	0	0	0	129, 722	1, 276, 189	1
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0	1 0	0	0	0	71. 00 72. 00
		DRUGS CHARGED TO PATIENTS	o	Ö	l .	o	0	•
	07400	RENAL DIALYSIS	2, 223	0	2, 223	0	0	1
76.00		OTHER ANCILLARY SERVICES	0	0		0	0	
76. 97 77. 00		CARDIAC REHABILITATION ALLOGENEIC HSCT ACQUISITION	0	1, 990 0	1	30, 205	287, 279 0	
77.00		TIENT SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		77.00
90.00		CLI NI C	0	0	- 1	0	0	90.00
90. 01		BEHAVI ORAL HEALTH	0	2, 459		0	586, 026	1
90. 02 91. 00		SLEEP LAB EMERGENCY	148 22, 481	7, 364 0	1	205, 796	0 6, 037, 432	90. 02 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	22, 401		22, 401	203, 770	0, 037, 432	92.00
	09201	OBSERVATION BEDS (DISTINCT PART)	4, 533	0	4, 533	0	517, 220	92. 01
100.00		REIMBURSABLE COST CENTERS					-	100.00
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
113.00		INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	419, 962	32, 141	403, 640	8, 289, 611	84, 579, 239	118. 00
100 0		IMBURSABLE COST CENTERS				-1	440 555	100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	6, 980 13, 507		0	119, 585 26, 466	190. 00 192. 00
	1	RETAIL PHARMACY	0	4, 649	1	0		192.00
192. 02	19202	MARKETI NG	0	796	1	ō	1, 385	192. 02
		BACK AND NECK	_0	8, 111		6, 370		192.03
		TIPTON SERVICES NORTH SERVICES	57 331	0		0	43, 976 253, 136	
	1	SAXONY SERVICES	82		82	0	62, 471	1
200.00		Cross Foot Adjustments				٦		200. 00
					<u>.</u>			

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0158	Period: Worksheet B-1 From 01/01/2022
		To 12/31/2022 Date/Time Prepared:

						5/25/2023 2: 3	5 pm
			CAPI TAL REI	_ATED COSTS			
				=====			
	Cost Center Description	NEW BLDG &	MOB	INTEREST	NEW MVBLE	EMPLOYEE	
		FI XT	(MOB SQUARE	(SQUARE FEET)	EQUI P	BENEFITS	
		(SQUARE FEET)	FEET)		(DOLLAR	DEPARTMENT	
					VALUE)	(GROSS	
						SALARI ES)	
		1. 00	1. 01	1. 02	2. 00	4. 00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	7, 617, 803	678, 946	4, 437, 969	9, 044, 185	13, 326, 416	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 118990	10. 258461	10. 982082	1. 090189	0. 156613	203.00
204.00	Cost to be allocated (per Wkst. B,					54, 884	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part					0. 000645	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)						
·					'		•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2:35 pm Provider CCN: 15-0158

11. 00	1. 00 1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00 43. 00
CFTES CFTES STORES (PURCHASED REQ) COST	1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
COST S. 01 S. 02 S. 03 SA. 04 S. 04	1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
S. 01 S. 02 S. 03 SA. 04 S. 04	1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
S. 01 S. 02 S. 03 SA. 04 S. 04	1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
CENERAL SERVICE COST CENTERS	1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 0 00101 MOB 0 00102 INTEREST 0 00102 INTEREST 0 00540 NONPATIENT S DEPARTMENT 0 00540 NONPATIENT TELEPHONES 92, 201 00540 NONPATIENT TELEPHONES 92, 201 00550 DATA PROCESSI NG 0 0 0 0 0 0 0 0 0	1. 01 1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
1. 02	1. 02 2. 00 4. 00 5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 31. 00 31. 00 35. 00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 01 00540 NOMPATI ENT TELEPHONES 92, 201 5. 02 00550 DATA PROCESSI NG 0 92, 201 6. 03 00560 PURCHASI NG RECEI VI NG AND STORES 0 0 20, 711, 799 0 0 6, 796, 126 6. 00 00600 MAI NTENANCE & REPAI RS 1, 729 1, 729 0 0 6, 796, 126 7. 00 00700 OPERATI ON OF PLANT 1, 440 1, 440 267 0 6, 626, 274 8. 00 00800 LAUNDRY & LI NEN SERVI CE 0 0 0 0 0 293, 379 9. 00 00900 HOUSEKEEPI NG 4, 216 4, 216 0 0 0 3, 735, 826 10. 00 01000 DI ETARY 2, 717 2, 717 669 0 2, 392, 423 11. 00 01100 CAFETERI A 1, 930 1, 930 475 0 1, 695, 627 15. 00 01300 NURSI NG ADMINI STRATI ON 3, 826 3, 826 149, 021 0 12, 480, 101 14. 00 01400 CENTRAL SERVI CE 0 0 0 0 0 0 0 0 0	2.00 4.00 5.01 5.02 5.03 5.04 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4.00 5.01 5.02 5.03 5.04 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00
5. 01 00540 NONPATI ENT TELEPHONES 92, 201	5. 01 5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
5. 02 00550 DATA PROCESSING 5. 03 00560 PURCHASI NG RECEIVING AND STORES 0 0 20,711,799 5. 04 00590 ADMINISTRATIVE AND GENERAL 4,873 4,873 638 -33,721,853 207,433,180 6. 00 00600 MAINTEMANCE & REPAIRS 1,729 1,729 0 0 6,796,126 7. 00 00700 OPERATION OF PLANT 1,440 1,440 267 0 6,626,274 8. 00 00800 LAUNDRY & LINEN SERVICE 0 0 0 0 0 293,379 9. 00 00900 HOUSEKEEPING 4,216 4,216 0 0 3,735,826 10. 00 01000 DI ETARY 2,717 2,717 669 0 2,392,423 11. 00 01100 CAFETERIA 1,930 1,930 475 0 1,695,627 13. 00 01300 NURSI NG ADMINISTRATION 3,826 3,826 149,021 0 12,480,101 14. 00 01400 CENTRAL SERVICES & SUPPLY 1 1 49,358 0 6,216,825 15. 00 01500 PHARMACY 4,101 4,101 40,348 0 6,680,144 17. 00 01700 SOCI AL SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5. 02 5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
5. 03	5. 03 5. 04 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
5. 04	5. 04 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
6. 00	6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00 30.00 31.00 35.00
7. 00 00700 OPERATI ON OF PLANT	7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00 30.00 31.00 35.00
8.00 00800 LAUNDRY & LINEN SERVICE 0 0 0 0 0 293, 379 9.00 00900 HOUSEKEEPING 4, 216 4, 216 0 0 3, 735, 826 10.00 1000 DI ETARY 2, 717 2, 717 669 0 2, 392, 423 11.00 01100 CAFETERIA 1, 930 1, 930 475 0 1, 695, 627 13.00 01300 NURSING ADMINISTRATION 3, 826 3, 826 149, 021 0 12, 480, 101 14.00 01400 CENTRAL SERVICES & SUPPLY 1 1 1 49, 358 0 6, 216, 825 15.00 01500 PHARMACY 4, 101 4, 101 40, 348 0 6, 680, 144 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 677 18.00 01080 TRANSPORTATION 710 710 0 0 525, 679 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 20, 501 20, 501 848, 474 0 40, 640, 851 31.00 03100 INTENSIVE CARE UNIT 3, 335 3, 335 165, 429 0 6, 636, 184 35.00 04300 NURSERY 385 00 6, 286, 184 10, 288 10, 288 20, 471 0 1, 859, 651 43.00 04300 NURSERY 385 00 6, 385 19, 239 0 733, 906 ANCILLARY SERVICE COST CENTERS	8.00 9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00 30.00 31.00 35.00
9. 00 00900 HOUSEKEEPING 4, 216 4, 216 0 0 3, 735, 826 10. 00 01000 DI ETARY 2, 717 2, 717 669 0 2, 392, 423 11. 00 01100 CAFETERIA 1, 930 1, 930 475 0 1, 695, 627 13. 00 01300 NURSERY 2, 717 1 1 1 49, 358 0 6, 216, 825 145. 00 01400 CENTRAL SERVICES & SUPPLY 1 1 1 49, 358 0 6, 216, 825 145. 00 01500 PHARMACY 4, 101 4, 101 40, 348 0 6, 680, 144 17. 00 01700 SOCI AL SERVICE 0 0 0 0 0 677 18. 00 01800 TRANSPORTATION 710 710 0 0 525, 679 1	9.00 10.00 11.00 13.00 14.00 15.00 17.00 18.00 30.00 31.00 35.00
10. 00 01000 DI ETARY 2,717 2,717 669 0 2,392,423 11. 00 01100 CAFETERI A 1,930 1,930 475 0 1,695,627 13. 00 01300 NURSI NG ADMI NI STRATI ON 3,826 3,826 149,021 0 12,480, 101 14. 00 01400 CENTRAL SERVI CES & SUPPLY 1 1 49,358 0 6,216,825 15. 00 01500 PHARMACY 4,101 4,101 40,348 0 6,680,144 17. 00 01700 SOCI AL SERVI CE 0 0 0 0 0 677 18. 00 01800 TRANSPORTATI ON 710 710 710 0 0 525,679 1	10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
11. 00	11. 00 13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON 3,826 3,826 149,021 0 12,480,101 14. 00 01400 CENTRAL SERVI CES & SUPPLY 1 1 49,358 0 6,216,825 15. 00 01500 PHARMACY 4,101 4,101 40,348 0 6,680,144 17. 00 01700 SOCI AL SERVI CE 0 0 0 0 0 18. 00 01800 TRANSPORTATI ON 710 710 710 0 0 1 NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 20,501 20,501 848,474 0 40,640,851 31. 00 03100 INTENSI VE CARE UNI T 3,335 3,335 165,429 0 6,636,184 35. 00 02080 NEONATAL I NTENSI VE CARE UNI T 1,028 1,028 20,471 0 1,859,651 43. 00 04300 NURSERY 385 385 19,239 0 733,906 ANCI LLARY SERVI CE COST CENTERS	13. 00 14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
14. 00	14. 00 15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
15. 00	15. 00 17. 00 18. 00 30. 00 31. 00 35. 00
18. 00 01080 TRANSPORTATION 710 710 0 0 525, 679 INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 20, 501 20, 501 848, 474 0 40, 640, 851 31. 00 03100 INTENSIVE CARE UNIT 3, 335 3, 335 165, 429 0 6, 636, 184 35. 00 02080 NEONATAL INTENSIVE CARE UNIT 1, 028 1, 028 20, 471 0 1, 859, 651 43. 00 04300 NURSERY 385 385 19, 239 0 733, 906 ANCILLARY SERVICE COST CENTERS	18. 00 30. 00 31. 00 35. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 20, 501 20, 501 848, 474 0 40, 640, 851 31. 00 03000 ADULTS & PEDI ATRI CS 20, 501 33. 335 3, 335 165, 429 0 6, 636, 184 35. 00 02080 NEONATAL I NTENSI VE CARE UNI T 1, 028 1, 028 20, 471 0 1, 859, 651 43. 00 04300 NURSERY 385 385 385 19, 239 0 733, 906 ANCI LLARY SERVI CE COST CENTERS	30. 00 31. 00 35. 00
30. 00 03000 ADULTS & PEDIATRICS 20, 501 20, 501 848, 474 0 40, 640, 851 31. 00 03100 INTENSI VE CARE UNI T 3, 335 3, 335 165, 429 0 6, 636, 184 35. 00 02080 NEONATAL INTENSI VE CARE UNI T 1, 028 1, 028 20, 471 0 1, 859, 651 43. 00 04300 NURSERY 385 385 19, 239 0 733, 906 ANCI LLARY SERVI CE COST CENTERS	31. 00 35. 00
31. 00 03100 INTENSI VE CARE UNI T 3, 335 3, 335 165, 429 0 6, 636, 184 35. 00 02080 NEONATAL INTENSI VE CARE UNI T 1, 028 1, 028 20, 471 0 1, 859, 651 43. 00 04300 NURSERY 385 385 19, 239 0 733, 906 ANCI LLARY SERVI CE COST CENTERS	31. 00 35. 00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT 1,028 1,028 20,471 0 1,859,651 43. 00 04300 NURSERY 385 385 19,239 0 733,906 ANCILLARY SERVICE COST CENTERS	35.00
43. 00 04300 NURSERY 385 385 19, 239 0 733, 906 ANCI LLARY SERVI CE COST CENTERS	
ANCILLARY SERVICE COST CENTERS	43.00
50. 00 05000 OPERATI NG ROOM 7, 019 7, 019 3, 502, 490 0 15, 119, 201	50.00
	51.00
	52.00
	54.00
	55.00
	59.00
	60.00
	63.00
	65.00
	66.00
	67.00
	68. 00 69. 00
	71.00
	72.00
	73.00
	74.00
	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 452 452 1, 045 0 483, 989	76. 97
	77.00
OUTPATIENT SERVICE COST CENTERS	
	90.00
	90. 01
	90.02
	91. 00 92. 00
	92.00
OTHER REI MBURSABLE COST CENTERS	72.01
	02.00
SPECIAL PURPOSE COST CENTERS	
	13.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 91,816 91,816 20,711,797 -33,721,853 205,712,929 1	18.00
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 247 0 0 396, 627 1	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3 3 0 0 179, 976 1	
192. 01 19201 RETAIL PHARMACY 0 0 0 69, 209 1	
192. 02 19202 MARKETI NG 2 2 2 0 394, 536 192. 03 19203 BACK_AND_NECK 4 4 0 0 0 84, 813 1	
192. 04 19204 TI PTON SERVICES 16 0 0 72, 883 1	
192. 05 19205 NORTH SERVICES 91 91 0 0 418, 718 1	
192. 06 19206 SAXONY SERVICES 22 22 0 0 103, 489 1	
	200.00
201.00 Negative Cost Centers 2	201.00

Health Fina	ncial Systems	IU HEALTH WES	T HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	Reconciliatio		
		TELEPHONES	PROCESSI NG	RECEIVING AND) n	E AND GENERAL	
		(FTES)	(FTES)	STORES		(ACCUM.	
				(PURCHASED		COST)	
				REQ)	54.04		
		5. 01	5. 02	5. 03	5A. 04	5. 04	
202. 00	Cost to be allocated (per Wkst. B, Part I)	49, 918	9, 567, 841	975, 18	7	33, 721, 853	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 541404	103. 771553	0. 04708	4	0. 162567	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	0		0	1, 148, 625	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00000	0	0. 005537	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0158 | Period: From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/25/2023 2: 35 pm

				T	12/31/2022	Date/Time Pre 5/25/2023 2:3	
	Cost Center Description	MAI NTENANCE & REPAI RS	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT	S piii
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)		DAYS)	
	OFNEDAL CEDILLOS COCT CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 MOB						1. 01
1. 02	00102 I NTEREST						1. 02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 01	OO4OO						4. 00 5. 01
5. 02	00550 DATA PROCESSING						5. 02
5.03	00560 PURCHASING RECEIVING AND STORES						5. 03
5. 04 6. 00	00590 ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS	310, 470					5. 04 6. 00
7. 00	00700 OPERATION OF PLANT	9, 781	300, 689				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	1, 389					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 892 12, 989	5, 892 12, 989		293, 408 12, 989	41, 652	9. 00 10. 00
11. 00	01100 CAFETERI A	9, 226			9, 226	41,032	11.00
13.00	01300 NURSING ADMINISTRATION	2, 715	2, 715		2, 715	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 137	6, 137		6, 137	0	14.00
15. 00 17. 00	01500 PHARMACY 01700 SOCI AL SERVI CE	7, 008	7, 008 0		7, 008 0	0	15. 00 17. 00
	01080 TRANSPORTATION	0	Ö		0	0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	95, 754			95, 754 12, 211	38, 024	30.00
31. 00 35. 00	03100 INTENSI VE CARE UNIT 02080 NEONATAL INTENSI VE CARE UNIT	13, 211 3, 042	13, 211 3, 042		13, 211 3, 042	3, 628 0	31. 00 35. 00
43. 00	04300 NURSERY	2, 227	2, 227		2, 227	0	43.00
	ANCILLARY SERVICE COST CENTERS	1				_	
50. 00 51. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	37, 964 18, 107	37, 964 18, 107		37, 964 18, 107	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 776			15, 776	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 921	17, 921	258, 778	17, 921	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	9, 604	9, 604		9, 604	0	55.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	4, 905 3, 782	4, 905 3, 782		4, 905 3, 782	0	59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	63.00
65.00	06500 RESPI RATORY THERAPY	2, 678			2, 678	0	65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	169 169	B .		169 169	0	66. 00 67. 00
68. 00	106800 SPEECH PATHOLOGY	169	B .	•	169	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	_	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	2, 223	2, 223	0	2, 223	Ö	74.00
76.00	03950 OTHER ANCI LLARY SERVICES	0	0	0	0	0	76. 00
	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	0		· ·	0		
77.00	OUTPATIENT SERVICE COST CENTERS			U	U	U	77.00
	09000 CLI NI C	0	0	0	0	0	90.00
	09001 BEHAVI ORAL HEALTH	0	0	-	0	0	90. 01 90. 02
	09002 SLEEP LAB 09100 EMERGENCY	148 22, 481	148 22, 481		148 22, 481	0	90.02
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	22, 101	22, 101	117,211	22, 101		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	4, 533	4, 533	19, 527	4, 533	0	92. 01
100.00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM				٥	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	U	102. 00
113.00	11300 INTEREST EXPENSE						113.00
118.00		310, 000	300, 219	1, 264, 978	292, 938	41, 652	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	1 0	0	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES				0		192.00
192. 01	19201 RETAIL PHARMACY	0	o	0	0	0	192. 01
	19202 MARKETI NG	0	0		0		192.02
	19203 BACK AND NECK 19204 TIPTON SERVICES	57	0 57		0 57		192. 03 192. 04
192.05	19205 NORTH SERVICES	331	331		331		192.05
192.06	19206 SAXONY SERVICES	82			82	0	192. 06
200.00	, ,						200.00
201. 00 202. 00		7, 900, 952	7, 952, 397	413, 156	4, 648, 917		201. 00 202. 00
	Part I)				., , , , ,	_,,	55

Heal th Fina	ncial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(PATI ENT	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		DAYS)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	25. 448359	26. 447249	0. 32661	1 15. 844548	87. 900437	203.00
204. 00	Cost to be allocated (per Wkst. B,	2, 784, 774	422, 602	56, 45	6 264, 995	574, 561	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	8. 969543	1. 405445	0. 04463	0. 903162	13. 794320	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 ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0158 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY SOCI AL ADMI NI STRATI O SERVICES & SERVI CE (FTES) (COSTED **SUPPLY** REQUIS.) (PATIENT (DI RECT (PURCHASED DAYS) NURS FTES) REQ) 11.00 13.00 14.00 15.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.01 00101 MOB 1 01 1.02 00102 I NTEREST 1.02 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 00590 ADMINISTRATIVE AND GENERAL 5.04 5 04 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 75, 296 11.00 01300 NURSING ADMINISTRATION 374 13 00 3,826 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY C 20, 511, 371 14.00 01500 PHARMACY 15.00 4, 101 2 40, 348 10, 372, 830 15.00 01700 SOCIAL SERVICE 0 43, 851 17.00 17.00 01080 TRANSPORTATION 18.00 710 C \cap 0 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 20, 501 167 848, 474 176, 800 37, 477 30.00 31 00 03100 INTENSIVE CARE UNIT 3 335 165 429 80 470 3, 628 31 00 30 35.00 02080 NEONATAL INTENSIVE CARE UNIT 1,028 10 20, 471 1,800 930 35.00 04300 NURSERY 19, 239 1, 816 43.00 43.00 385 ANCILLARY SERVICE COST CENTERS 7.019 50 00 05000 OPERATING ROOM 36 3, 502, 490 32, 422 0 50 00 51.00 05100 RECOVERY ROOM 3,744 33 58, 266 107, 935 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 2,730 21 136, 313 52.00 52.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 6, 361 269,060 35, 873 0 54.00 05500 RADI OLOGY-THERAPEUTI C 1, 372 44, 397 76, 837 55 00 8 55 00 0 59.00 05900 CARDIAC CATHETERIZATION 1,596 792, 788 51,016 0 59.00 06000 LABORATORY 60.00 2, 403 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0 1.638 0 0 63.00 06500 RESPIRATORY THERAPY 383.274 65.00 2 449 C 88 0 65.00 2, 508 66.00 06600 PHYSI CAL THERAPY 40,034 0 66.00 0 67 00 06700 OCCUPATIONAL THERAPY 753 961 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 305 557 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 1, 439 28, 791 18, 738 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 5, 255, 761 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 0 0 8, 545, 048 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 9, 533, 693 73.00 0 C C 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 3,574 237 0 74.00 76 00 03950 OTHER ANCILLARY SERVICES 0 0 76.00 07697 CARDIAC REHABILITATION 1, 045 76. 97 0 452 76.97 165 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 C n 0 0 90.00 09001 BEHAVI ORAL HEALTH 977 90.01 90.01 777 0 0 90.02 09002 SLEEP LAB r 15, 649 0 90.02 91.00 09100 EMERGENCY 6,601 45 328, 211 251, 617 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 515 8, 574 5, 139 0 92.01 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 74, 911 374 20, 511, 369 10, 372, 830 43, 851 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 247 0 190, 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 C 0 192. 01 19201 RETAIL PHARMACY 0 0 0 0 0 192.01 192. 02 19202 MARKETI NG 0 2 0 2 0 192.02 0 192. 03 19203 BACK AND NECK 0 0 192. 03 4 Ω 192. 04 19204 TIPTON SERVICES 16 0 0 0 0 192.04 192. 05 19205 NORTH SERVICES 91 0 0 0 0 192.05 192.06 19206 SAXONY SERVICES 22 O 0 192.06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Health Fina	ncial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	SOCI AL	
		(FTES)	ADMI NI STRATI O	SERVICES &	(COSTED	SERVI CE	
			N	SUPPLY	REQUIS.)	(PATI ENT	
			(DI RECT	(PURCHASED		DAYS)	
			NURS FTES)	REQ)			
		11. 00	13. 00	14.00	15. 00	17. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 596, 251	14, 824, 791	7, 643, 23	2 8, 476, 560	787	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	34. 480597	39, 638. 478610	0. 37263	4 0. 817189	0. 017947	203.00
204. 00	Cost to be allocated (per Wkst. B, Part II)	404, 402	968, 508	282, 23	6 586, 942	4	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	5. 370830	2, 589. 593583	0. 01376	0. 056585	0. 000091	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0158 Period: Worksheet B-1

From 01/01/2022 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm OTHER GENERAL SERVI CE Cost Center Description TRANSPORTATI O N (GROSS CHARGES) 18.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 MOB 1.01 00102 I NTEREST 1.02 1.02 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.01 00540 NONPATIENT TELEPHONES 5.01 5.02 00550 DATA PROCESSING 5.02 00560 PURCHASING RECEIVING AND STORES 5.03 5.03 5.04 00590 ADMINISTRATIVE AND GENERAL 5.04 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11 00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01700 SOCIAL SERVICE 17 00 17 00 01080 TRANSPORTATION 18.00 1, 298, 682, 066 18.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 151, 578, 987 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 29, 311, 689 35.00 02080 NEONATAL INTENSIVE CARE UNIT 3, 814, 306 35.00 04300 NURSERY 3, 094, 730 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 173, 674, 292 50.00 51.00 05100 RECOVERY ROOM 33, 154, 594 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 23, 949, 161 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 130, 431, 462 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 49, 674, 045 55.00 05900 CARDIAC CATHETERIZATION 69, 180, 411 59.00 59.00 60.00 06000 LABORATORY 73, 291, 036 60.00 06300 BLOOD STORING, PROCESSING, & TRANS. 63.00 63.00 3, 521, 641 65.00 06500 RESPIRATORY THERAPY 19, 930, 385 65.00 66.00 06600 PHYSI CAL THERAPY 11, 246, 611 66.00 06700 OCCUPATI ONAL THERAPY 3, 636, 659 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 1, 864, 993 68.00 69.00 06900 ELECTROCARDI OLOGY 49, 508, 191 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 41, 215, 167 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 92, 168, 887 72.00 72.00 73.00 102, 074, 234 73.00 74.00 07400 RENAL DIALYSIS 3, 335, 209 74.00 76.00 03950 OTHER ANCILLARY SERVICES 76.00 07697 CARDIAC REHABILITATION 76.97 4, 194, 597 76.97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 90.00 09001 BEHAVI ORAL HEALTH 90.01 1, 426, 017 90.01 90.02 09002 SLEEP LAB 9, 198, 267 90.02 91.00 09100 EMERGENCY 209, 870, 366 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
09201 OBSERVATION BEDS (DISTINCT PART) 92 00 92 00 92.01 4, 336, 129 92.01 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,298,682,066 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 01 19201 RETAIL PHARMACY 0 0 0 192.01 192. 02 19202 MARKETI NG 192 02 192.03 19203 BACK AND NECK 192.03 192. 04 19204 TIPTON SERVICES 192.04 192. 05 19205 NORTH SERVICES 0 192.05 192.06 19206 SAXONY SERVICES 0 192.06 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Heal th Fi	nancial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provi der CCN: 15-0158	Peri od:	Worksheet B-1
				From 01/01/2022 To 12/31/2022	Date/Time Prepared: 5/25/2023 2:35 pm
		OTHER GENERAL			
		SERVI CE			
	Cost Center Description	TRANSPORTATI 0			
		N			
		(GROSS			
		CHARGES)			
		18. 00			
202.00	Cost to be allocated (per Wkst. B,	635, 618			202. 00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000489			203. 00
204.00	Cost to be allocated (per Wkst. B,	6, 894			204.00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	0. 000005			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)				
					·

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Peri od:	Worksheet C
		From 01/01/2022	
		To 10/01/0000	Doto/Time Dropored.

				rom 01/01/2022 o 12/31/2022		
		Title	XVIII	Hospi tal	5/25/2023 2: 3 PPS	o piii
		11110	XVIII	Costs	110	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	65, 080, 017		65, 080, 017	0	65, 080, 017	30.00
31. 00 03100 NTENSI VE CARE UNI T	10, 390, 075		10, 390, 075		10, 390, 075	1
35. 00 02080 NEONATAL INTENSIVE CARE UNIT	2, 811, 527		2, 811, 527		2, 811, 527	1
43. 00 04300 NURSERY	1, 144, 977		1, 144, 977		1, 144, 977	1
ANCILLARY SERVICE COST CENTERS	1, 144, 777	L	1, 177, 777	<u> </u>	1, 177, 777	1 43.00
50. 00 05000 OPERATING ROOM	23, 266, 320		23, 266, 320	ol	23, 266, 320	50.00
51. 00 05100 RECOVERY ROOM	9, 456, 661		9, 456, 661		9, 456, 661	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 910, 756		7, 910, 756		7, 910, 756	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 562, 806	ł .	17, 562, 806		17, 562, 806	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 072, 738		5, 072, 738	1	5, 072, 738	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 098, 038		5, 098, 038	1	5, 098, 038	1
60. 00 06000 LABORATORY	12, 668, 088	ł .	12, 668, 088	1	12, 668, 088	1
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	786, 621	ł .	786, 621	-	786, 621	1
65. 00 06500 RESPIRATORY THERAPY	6, 388, 310				6, 388, 310	1
66. 00 06600 PHYSI CAL THERAPY	3, 624, 300	ł .			3, 624, 300	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 117, 529		1, 117, 529		1, 117, 529	1
68. 00 06800 SPEECH PATHOLOGY	533, 616	l e	533, 616		533, 616	1
69. 00 06900 ELECTROCARDI OLOGY	2, 847, 943		2, 847, 943		2, 847, 943	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 376, 494		8, 376, 494		8, 376, 494	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 631, 169		13, 631, 169		13, 631, 169	
73. 00 07300 DRUGS CHARGED TO PATIENTS	18, 924, 298		18, 924, 298		18, 924, 298	
74. 00 07400 RENAL DI ALYSI S	1, 446, 917		1, 446, 917		1, 446, 917	
76. 00 03950 OTHER ANCILLARY SERVICES	0			o	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	621, 211		621, 211	O	621, 211	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		C	o	0	
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0		C	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	1, 035, 799		1, 035, 799	o	1, 035, 799	90. 01
90. 02 09002 SLEEP LAB	1, 018, 457		1, 018, 457	0	1, 018, 457	90.02
91. 00 09100 EMERGENCY	16, 652, 102		16, 652, 102	0	16, 652, 102	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 009, 936		6, 009, 936		6, 009, 936	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	1, 643, 242		1, 643, 242	0	1, 643, 242	92.01
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0		C		0	102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	245, 119, 947		, ,	1	= , ,	
201.00 Less Observation Beds	6, 009, 936		6, 009, 936		6, 009, 936	1
202.00 Total (see instructions)	239, 110, 011	0	239, 110, 011	0	239, 110, 011	202. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Period: Worksheet C From 01/01/2022 Part I

				i	o 12/31/2022	Date/Time Pre 5/25/2023 2:3	
			Title	XVIII	Hospi tal	PPS	<u></u>
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		·		+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7.00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	130, 481, 764		130, 481, 764			30.00
31.00	03100 INTENSIVE CARE UNIT	29, 311, 689		29, 311, 689			31.00
	02080 NEONATAL INTENSIVE CARE UNIT	3, 814, 306		3, 814, 306			35.00
43.00	04300 NURSERY	3, 094, 730		3, 094, 730)		43.00
	ANCILLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,					
	05000 OPERATING ROOM	37, 445, 068	136, 229, 224			0. 000000	1
51.00	05100 RECOVERY ROOM	4, 512, 942	28, 641, 652			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	18, 429, 567	5, 519, 594			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	27, 579, 628	102, 851, 834			0. 000000	1
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 109, 390	47, 564, 655			0. 000000	1
	05900 CARDI AC CATHETERI ZATI ON	34, 741, 867	34, 438, 544			0. 000000	1
60.00	06000 LABORATORY	38, 167, 464	35, 123, 572			0. 000000	
	06300 BLOOD STORING, PROCESSING, & TRANS.	2, 978, 447	543, 194			0. 000000	1
65.00	06500 RESPI RATORY THERAPY	12, 852, 627	7, 077, 758			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	4, 645, 783	6, 600, 828			0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	2, 448, 520	1, 188, 139			0. 000000	1
	06800 SPEECH PATHOLOGY	1, 396, 396	468, 597			0. 000000	1
	06900 ELECTROCARDI OLOGY	24, 523, 044	24, 985, 147			0. 000000	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 763, 521	26, 451, 646			0. 000000	1
	07200 I MPL. DEV. CHARGED TO PATIENT	24, 983, 927	67, 184, 960			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	60, 235, 259	41, 838, 975			0.000000	1
	07400 RENAL DIALYSIS	3, 032, 377	302, 832			0.000000	1
	03950 OTHER ANCILLARY SERVICES	0	0			0.000000	1
	07697 CARDI AC REHABI LI TATI ON	68, 021	4, 126, 576			0.000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0. 000000	0. 000000	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC				0.000000	0.000000	00.00
		0	1 42(017			0.000000	90.00
	09001 BEHAVI ORAL HEALTH	0	1, 426, 017			0.000000	1
	09002 SLEEP LAB	10, 560	9, 187, 707			0.000000	1
	09100 EMERGENCY	48, 395, 067	161, 475, 299			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	265, 428	20, 831, 795			0.000000	1
	09201 OBSERVATION BEDS (DISTINCT PART)	62, 806	4, 273, 323	4, 336, 129	0. 378965	0. 000000	92. 01
	OTHER REIMBURSABLE COST CENTERS				\		100.00
	10200 OPI OI D TREATMENT PROGRAM	0	0)		102.00
	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE	E20 2E0 100	740 221 040	1 200 402 044			113.00
200.00	1 ,	530, 350, 198	168, 331, 868	1, 298, 682, 066	9		200.00
201.00		E20 2E0 100	740 221 040	1 200 402 044			201. 00 202. 00
202. 00	Total (see instructions)	530, 350, 198	100, 331, 868	1, 298, 682, 066	PI I		1202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0158
Period: Worksheet C
From 01/01/2022
To 12/31/2022 Date/Time Prepared:

Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Hospital PPS Title XVIII Hospital PPS Title XVIII Title XVIII Hospital PPS Title XVIII Title XVI
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 31.00 3100 INTENSIVE CARE UNIT 31.00 35.00 02080 NEONATAL INTENSIVE CARE UNIT 35.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.133965 51.00 05100 RECOVERY ROOM 0.285229 51.00 52.00 DELIVERY ROOM & LABOR ROOM 0.330315 52.00 55.00 05400 RADIOLOGY-DIAGNOSTIC 0.134652 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.102120 55.00 59.00 05900 CARDIAC CATHETERIZATION 0.073692 59.00
11.00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 30.00 31.00 3100 INTENSIVE CARE UNIT 31.00 35.00 02080 NEONATAL INTENSIVE CARE UNIT 35.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.133965 50.00 05100 RECOVERY ROOM 0.285229 51.00 52.00 DELIVERY ROOM & LABOR ROOM 0.330315 52.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0.134652 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0.102120 55.00 59.00 05900 CARDIAC CATHETERIZATION 0.073692 59.00
30. 00 310. 00 310. 00 310. 01 31. 00 310. 01 31. 00 310. 01 31. 00 310. 01 31. 00 310. 01 31. 00 31. 00 310. 01 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 31. 00 3
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35. 00 02080 NEONATAL I NTENSI VE CARE UNI T 35. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00 43. 00
43. 00 04300 NURSERY 43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0. 133965 50. 00 51. 00 05100 RECOVERY ROOM 0. 285229 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 330315 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 134652 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
50. 00 05000 OPERATI NG ROOM 0. 133965 50. 00 51. 00 05100 RECOVERY ROOM 0. 285229 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 330315 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 134652 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
51. 00 05100 RECOVERY ROOM 0. 285229 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 330315 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 134652 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 330315 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 134652 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 134652 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 55. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 073692 59. 00
60. 00 06000 LABORATORY 0. 172846 60. 00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0.223368 63.00
65. 00 06500 RESPI RATORY THERAPY 0. 320531 65. 00
66. 00 06600 PHYSI CAL THERAPY 0. 322257 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 307296 67. 00
68. 00 06800 SPEECH PATHOLOGY
69. 00 06900 ELECTROCARDI OLOGY 0. 057525 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.203238 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT 0. 147893 72. 00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 185397 73. 00
74. 00 07400 RENAL DI ALYSI S 0. 433831 74. 00
76. 00 03950 OTHER ANCI LLARY SERVI CES 0. 000000 76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 148098 76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0. 000000 77. 00
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLI NI C 0. 000000 90. 00
90. 01 09001 BEHAVI ORAL HEALTH 0. 726358 90. 01
90. 02 09002 SLEEP LAB 0. 110723 90. 02
91. 00 09100 EMERGENCY
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0. 284869 92. 00
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0. 378965 92. 01
OTHER REIMBURSABLE COST CENTERS
102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00
SPECIAL PURPOSE COST CENTERS
113. 00 11300 I NTEREST EXPENSE 113. 00
200.00 Subtotal (see instructions) 200.00
201.00 Less Observation Beds 201.00
202.00 Total (see instructions) 202.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Peri od: Worksheet C
		From 01/01/2022 Part I
		To 12/31/2022 Date/Time Prepared

				To 12/31/2022	Date/Time Pre 5/25/2023 2:3	pared: 5 pm
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col . 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS	65, 080, 017		65, 080, 01	7 0	65, 080, 017	30.00
31.00 03100 INTENSIVE CARE UNIT	10, 390, 075		10, 390, 07	5 0	10, 390, 075	31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT	2, 811, 527		2, 811, 52	7 0	2, 811, 527	35.00
43. 00 04300 NURSERY	1, 144, 977		1, 144, 97	7 0	1, 144, 977	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	23, 266, 320		23, 266, 32	0	23, 266, 320	50.00
51.00 05100 RECOVERY ROOM	9, 456, 661		9, 456, 66	1 0	9, 456, 661	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 910, 756		7, 910, 75	6 0	7, 910, 756	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 562, 806		17, 562, 80	6 0	17, 562, 806	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 072, 738		5, 072, 73	8 0	5, 072, 738	
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 098, 038		5, 098, 03	8 0	5, 098, 038	59.00
60. 00 06000 LABORATORY	12, 668, 088		12, 668, 08	8 0	12, 668, 088	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	786, 621		786, 62	1 0	786, 621	63.00
65. 00 06500 RESPIRATORY THERAPY	6, 388, 310	0	6, 388, 31	0	6, 388, 310	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 624, 300	0	3, 624, 30	0	3, 624, 300	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 117, 529	0	1, 117, 52	9 0	1, 117, 529	67.00
68.00 06800 SPEECH PATHOLOGY	533, 616	0	533, 61	6 0	533, 616	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 847, 943		2, 847, 94	3 0	2, 847, 943	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 376, 494		8, 376, 49	4 0	8, 376, 494	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 631, 169		13, 631, 16	9 0	13, 631, 169	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	18, 924, 298		18, 924, 29	8 0	18, 924, 298	73.00
74. 00 07400 RENAL DI ALYSI S	1, 446, 917		1, 446, 91	7 0	1, 446, 917	74.00
76. 00 03950 OTHER ANCI LLARY SERVI CES	0			0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	621, 211		621, 21	1 0	621, 211	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		(0	0	77. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	0			0	· ·	90.00
90. 01 09001 BEHAVI ORAL HEALTH	1, 035, 799		1, 035, 79		.,,	
90. 02 09002 SLEEP LAB	1, 018, 457		1, 018, 45		1, 018, 457	1
91. 00 09100 EMERGENCY	16, 652, 102		16, 652, 10		16, 652, 102	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 009, 936		6, 009, 93		6, 009, 936	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	1, 643, 242		1, 643, 24	2 0	1, 643, 242	92. 01
OTHER REIMBURSABLE COST CENTERS						100 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0			0	0	102. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE						l 113. 00
200.00 Subtotal (see instructions)	245 110 047	0	245, 119, 94 ⁻	7 0	245, 119, 947	
201.00 Subtotal (see Instructions) 201.00 Less Observation Beds	245, 119, 947		6, 009, 93		6, 009, 936	
202.00 Total (see instructions)	6, 009, 936 239, 110, 011					
202.00 Total (See Histiactions)	239, 110, 011	l O	239, 110, 01	יו	239, 110, 011	1202.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0158	Period: Worksheet C
		From 01/01/2022 Part I
		T- 12 (21 (2022) D-+- /T: D

			Т	o 12/31/2022	Date/Time Pre 5/25/2023 2:3	pared:
		Ti tI	e XIX	Hospi tal	PPS	<u> Бііі</u>
		Charges				
Cost Center Description	Inpatient	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	130, 481, 764		130, 481, 764			30.00
31.00 03100 INTENSIVE CARE UNIT	29, 311, 689		29, 311, 689			31.00
35.00 02080 NEONATAL INTENSIVE CARE U	NIT 3, 814, 306		3, 814, 306			35.00
43. 00 04300 NURSERY	3, 094, 730		3, 094, 730			43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	37, 445, 068	136, 229, 224	173, 674, 292	0. 133965	0.000000	50.00
51.00 05100 RECOVERY ROOM	4, 512, 942	28, 641, 652	33, 154, 594	0. 285229	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	M 18, 429, 567	5, 519, 594	23, 949, 161	0. 330315	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	27, 579, 628	102, 851, 834	130, 431, 462	0. 134652	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 109, 390	47, 564, 655	49, 674, 045	0. 102120	0.000000	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	34, 741, 867	34, 438, 544	69, 180, 411	0. 073692	0.000000	59.00
60. 00 06000 LABORATORY	38, 167, 464	35, 123, 572	73, 291, 036	0. 172846	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING	, & TRANS. 2, 978, 447	543, 194	3, 521, 641	0. 223368	0.000000	63.00
65. 00 06500 RESPIRATORY THERAPY	12, 852, 627			0. 320531	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	4, 645, 783	6, 600, 828	11, 246, 611	0. 322257	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 448, 520	1, 188, 139	3, 636, 659	0. 307296	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	1, 396, 396	468, 597	1, 864, 993	0. 286122	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	24, 523, 044	24, 985, 147	49, 508, 191	0. 057525	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED	TO PATIENTS 14, 763, 521	26, 451, 646	41, 215, 167	0. 203238	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PAT	I ENT 24, 983, 927	67, 184, 960	92, 168, 887	0. 147893	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 235, 259	41, 838, 975			0.000000	73.00
74.00 07400 RENAL DIALYSIS	3, 032, 377	302, 832			0.000000	74.00
76.00 03950 OTHER ANCILLARY SERVICES	0	0	0	0. 000000	0.000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	68, 021	4, 126, 576	4, 194, 597	0. 148098	0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	ON O	0	0	0. 000000	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS	i					
90. 00 09000 CLI NI C	0	0	0	0. 000000	0.000000	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0	1, 426, 017	1, 426, 017	0. 726358	0.000000	90. 01
90. 02 09002 SLEEP LAB	10, 560	9, 187, 707	9, 198, 267	0. 110723	0.000000	90. 02
91. 00 09100 EMERGENCY	48, 395, 067	161, 475, 299	209, 870, 366	0. 079345	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DIS	TINCT PART) 265, 428	20, 831, 795	21, 097, 223	0. 284869	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINC	T PART) 62, 806	4, 273, 323	4, 336, 129	0. 378965	0.000000	92. 01
OTHER REIMBURSABLE COST CENTERS						1
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0			102.00
SPECIAL PURPOSE COST CENTERS	<u>.</u>					
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions	s) 530, 350, 198	768, 331, 868	1, 298, 682, 066			200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	530, 350, 198	768, 331, 868	1, 298, 682, 066			202.00
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Health Financial Systems IU HEALTH WEST HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0158
Period: From 01/01/2022 To 12/31/2022 Date/Time Prepared:

				10 12/31/2022	5/25/2023 2:35	
			Title XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	PPS Inpatient		<u> </u>		
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30. 00
						31. 00
35.00	02080 NEONATAL INTENSIVE CARE UNIT					35. 00
43. 00					4	43. 00
	ANCILLARY SERVICE COST CENTERS	0.1000/5				
50.00	05000 OPERATING ROOM	0. 133965				50.00
51.00		0. 285229			l l	51.00
		0. 330315				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 134652				54.00
55.00		0. 102120			l l	55.00
		0. 073692				59.00
60.00	06000 LABORATORY	0. 172846			•	60.00
63.00		0. 223368				63.00
65.00	06500 RESPI RATORY THERAPY	0. 320531				65.00
66.00		0. 322257			•	66.00
67. 00		0. 307296				67.00
68.00	06800 SPEECH PATHOLOGY	0. 286122			l l	68.00
	06900 ELECTROCARDI OLOGY	0. 057525				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 203238				71. 00 72. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0. 147893 0. 185397				72.00 73.00
	07400 RENAL DIALYSIS	0. 183397				73.00 74.00
	03950 OTHER ANCI LLARY SERVI CES	0. 000000				74. 00 76. 00
	07697 CARDI AC REHABI LI TATI ON	0. 148098				76. 00 76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				70. 97 77. 00
77.00	OUTPATIENT SERVICE COST CENTERS	0.000000				77.00
90 00	09000 CLINIC	0. 000000			c	90. 00
	09001 BEHAVI ORAL HEALTH	0. 726358				90. 00
	09002 SLEEP LAB	0. 110723				90. 02
91. 00		0. 079345				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 284869				92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 378965				92. 01
,2.0.	OTHER REIMBURSABLE COST CENTERS	0.070700			· ·	, 2. 0 .
102.00	10200 OPIOID TREATMENT PROGRAM				10	02.00
	SPECIAL PURPOSE COST CENTERS	1				
113.00	11300 I NTEREST EXPENSE				11	13.00
200.00	Subtotal (see instructions)				20	00.00
201.00	Less Observation Beds				20	01.00
202.00	Total (see instructions)				20	02.00

REDUCTIONS FOR WEDICALD ONE!			j	To 12/31/2022	Date/Time Pre 5/25/2023 2:3		
			Ti tl	e XIX	Hospi tal	PPS	.с р
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operating	
	·	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	23, 266, 320	4, 607, 918			0	
51.00	05100 RECOVERY ROOM	9, 456, 661	894, 147			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 910, 756	828, 858			0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	17, 562, 806	2, 696, 504			0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	5, 072, 738	994, 337			0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 098, 038	910, 623			0	
60.00	06000 LABORATORY	12, 668, 088	224, 535			0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	786, 621	3, 776			0	
65.00	06500 RESPI RATORY THERAPY	6, 388, 310				0	
66.00	06600 PHYSI CAL THERAPY	3, 624, 300	80, 306			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 117, 529	49, 952			0	67.00
68.00	06800 SPEECH PATHOLOGY	533, 616	44, 599			0	
69.00	06900 ELECTROCARDI OLOGY	2, 847, 943	174, 368	2, 673, 575	5 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 376, 494	102, 996	8, 273, 498	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	13, 631, 169	167, 583	13, 463, 586	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	18, 924, 298	592, 757			0	
74.00	07400 RENAL DI ALYSI S	1, 446, 917	96, 001	1, 350, 916	0	0	74.00
76.00	03950 OTHER ANCI LLARY SERVI CES	0	0	(0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	621, 211	61, 372	559, 839	0	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0			0	
90. 01	09001 BEHAVI ORAL HEALTH	1, 035, 799	36, 999	998, 800	0	0	90. 01
90. 02	09002 SLEEP LAB	1, 018, 457	86, 992	931, 465	0	0	90.02
91.00	09100 EMERGENCY	16, 652, 102	1, 375, 058			0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 009, 936				0	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	1, 643, 242	200, 847	1, 442, 395	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	(0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00		165, 693, 351					200.00
201.00		6, 009, 936					201. 00
202.00	Total (line 200 minus line 201)	159, 683, 415	14, 490, 363	145, 193, 052	의 이	0	202. 00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10 IU HEALTH WEST HOSPITAL Provi der CCN: 15-0158

						5/25/2023 2:35 pm
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to		
		Operati ng	Part I,	Charge Ratio		
		Cost	column 8)	(col. 6 /		
		Reduction		col. 7)		
		6. 00	7. 00	8. 00		
	NCILLARY SERVICE COST CENTERS	1				
	5000 OPERATING ROOM	23, 266, 320				50.00
	5100 RECOVERY ROOM	9, 456, 661	33, 154, 594			51.00
	5200 DELIVERY ROOM & LABOR ROOM	7, 910, 756				52.00
	5400 RADI OLOGY-DI AGNOSTI C	17, 562, 806				54.00
	5500 RADI OLOGY-THERAPEUTI C	5, 072, 738	49, 674, 045	0. 10212	20	55.00
	5900 CARDI AC CATHETERI ZATI ON	5, 098, 038	69, 180, 411	0. 07369	92	59.00
	6000 LABORATORY	12, 668, 088	73, 291, 036			60.00
63.00 0	6300 BLOOD STORING, PROCESSING, & TRANS.	786, 621	3, 521, 641	0. 22336	58	63.00
65.00 0	6500 RESPI RATORY THERAPY	6, 388, 310	19, 930, 385	0. 32053	31	65.00
66.00 0	16600 PHYSI CAL THERAPY	3, 624, 300	11, 246, 611	0. 32225	57	66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	1, 117, 529	3, 636, 659	0. 30729	96	67. 00
68.00 0	6800 SPEECH PATHOLOGY	533, 616	1, 864, 993	0. 28612	22	68.00
69.00 0	6900 ELECTROCARDI OLOGY	2, 847, 943	49, 508, 191	0. 05752	25	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 376, 494	41, 215, 167	0. 20323	38	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENT	13, 631, 169	92, 168, 887	0. 14789	93	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	18, 924, 298	102, 074, 234	0. 18539	97	73.00
74.00 0	7400 RENAL DIALYSIS	1, 446, 917	3, 335, 209	0. 43383	31	74.00
76.00 0	3950 OTHER ANCILLARY SERVICES	0	0	0. 00000	00	76.00
76. 97 0	7697 CARDIAC REHABILITATION	621, 211	4, 194, 597	0. 14809	98	76. 97
77. 00 0	7700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	00	77. 00
OI	UTPATIENT SERVICE COST CENTERS					
90.00	9000 CLI NI C	0	0	0. 00000	00	90.00
90. 01 0	9001 BEHAVI ORAL HEALTH	1, 035, 799	1, 426, 017	0. 72635	58	90. 01
90. 02 0	9002 SLEEP LAB	1, 018, 457	9, 198, 267	0. 11072	23	90. 02
91.00 0	9100 EMERGENCY	16, 652, 102	209, 870, 366	0. 07934	15	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 009, 936	21, 097, 223	0. 28486	59	92.00
92. 01 0	9201 OBSERVATION BEDS (DISTINCT PART)	1, 643, 242	4, 336, 129	0. 37896	55	92. 01
0	THER REIMBURSABLE COST CENTERS				*	
102.001	0200 OPIOID TREATMENT PROGRAM	0	0	0.00000	00	102. 00
	PECIAL PURPOSE COST CENTERS					
113.001	1300 I NTEREST EXPENSE					113. 00
200.00	Subtotal (sum of lines 50 thru 199)	165, 693, 351	1, 131, 979, 577			200.00
201.00	Less Observation Beds	6, 009, 936	0			201.00
202.00	Total (line 200 minus line 201)	159, 683, 415	1, 131, 979, 577			202. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provi der C		Period: From 01/01/2022 To 12/31/2022		nared:
				10 12/31/2022	5/25/2023 2: 3	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5, 415, 386	0	5, 415, 386			1
31.00 INTENSIVE CARE UNIT	907, 789		907, 789			
35.00 NEONATAL INTENSIVE CARE UNIT	165, 904		165, 904			
43. 00 NURSERY	116, 649		116, 649			1
200.00 Total (lines 30 through 199)	6, 605, 728		6, 605, 728	47, 664		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	12, 058				l	30.00
31.00 INTENSIVE CARE UNIT	1, 257	314, 527			ļ	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0			l	35.00
43. 00 NURSERY	0	0			ļ	43.00
200.00 Total (lines 30 through 199)	13, 315	1, 895, 934				200. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022	Part II	norod.
				To 12/31/2022	Date/Time Pre 5/25/2023 2:3	pareu: 5 nm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 607, 918					50.00
51.00 05100 RECOVERY ROOM	894, 147			1 '	•	
52.00 05200 DELIVERY ROOM & LABOR ROOM	828, 858					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 696, 504	130, 431, 462		1 '		
55. 00 05500 RADI OLOGY-THERAPEUTI C	994, 337	49, 674, 045				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	910, 623	69, 180, 411	0. 01316		128, 866	
60. 00 06000 LABORATORY	224, 535					60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	3, 776	3, 521, 641				63.00
65. 00 06500 RESPI RATORY THERAPY	259, 835	19, 930, 385	0. 01303	7 4, 217, 388	54, 982	65.00
66. 00 06600 PHYSI CAL THERAPY	80, 306	11, 246, 611	0. 00714	0 1, 801, 507	12, 863	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	49, 952	3, 636, 659	0. 01373	6 935, 971	12, 856	67.00
68.00 06800 SPEECH PATHOLOGY	44, 599	1, 864, 993	0. 02391	4 785, 172	18, 777	68.00
69. 00 06900 ELECTROCARDI OLOGY	174, 368			2 7, 815, 022	27, 525	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	102, 996	41, 215, 167	0. 00249	9 4, 178, 125	10, 441	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	167, 583	92, 168, 887	0. 00181	8 10, 242, 176	18, 620	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	592, 757	102, 074, 234	0. 00580	7 17, 342, 361	100, 707	73.00
74.00 07400 RENAL DIALYSIS	96, 001	3, 335, 209	0. 02878	4 1, 069, 071	30, 772	74.00
76.00 03950 OTHER ANCILLARY SERVICES	0	0	0. 00000	0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	61, 372	4, 194, 597	0. 01463	1 20, 230	296	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		0.00000	0 0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	36, 999	1, 426, 017	0. 02594	6 0	0	90. 01
90. 02 09002 SLEEP LAB	86, 992	9, 198, 267	0. 00945	7 4, 356	41	90. 02
91. 00 09100 EMERGENCY	1, 375, 058	209, 870, 366	0. 00655	2 15, 748, 668	103, 185	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	500, 093	21, 097, 223	0. 02370	4 10, 996	261	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	200, 847	., ,		9 10, 630	492	92. 01
200.00 Total (lines 50 through 199)	14, 990, 456	1, 131, 979, 577		112, 272, 117	1, 173, 420	200. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	STS Provider C		Period: From 01/01/2022 To 12/31/2022		
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Healt Post-Stepdow Adjustments	h Allied Health Cost	All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I IA	1.00	ZA	2.00	3.00	
30. 00	0 0 0 0	0 0		0 0 0 0 0 0 0 0 0 0	0 0 0 0	31. 00 35. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	(col. 5 ÷ col. 6)	Inpatient Program Days	
LADATI FAT DOUTING OFFILIAGE COOT OFFITTEDS	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02080 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY 200.00 Total (Lines 30 through 199)	0	000000000000000000000000000000000000000	41, 29 3, 62 93 1, 81 47, 66	0. 00 0. 00 6 0. 00	0	31.00 35.00
Cost Center Description INPATIENT ROUTINE SERVICE COST CENTERS	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		7 47, 60		13,310	
30. 00	0 0 0					30. 00 31. 00 35. 00 43. 00 200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT AN	CILLARY SERVICE OTHER PASS Provider CCN: 15-0158	Period: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

111100011 0031				-	To 12/31/2022	Date/Time Pre 5/25/2023 2:3	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	0)	0	0	00.00
	RECOVERY ROOM	0	0)	0	0	51.00
	DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52.00
	RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
55.00 05500	RADI OLOGY-THERAPEUTI C	0	0)	0	0	55.00
59. 00 05900	CARDI AC CATHETERI ZATI ON	0	0)	0	0	59.00
60.00 06000	LABORATORY	0	0)	0	0	60.00
63.00 06300	BLOOD STORING, PROCESSING, & TRANS.	0	0)	0	0	63.00
65.00 06500	RESPI RATORY THERAPY	0	0		0	0	65.00
66.00 06600	PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700	OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0		0	0	68.00
69.00 06900	ELECTROCARDI OLOGY	0	0		0	0	69.00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
74. 00 07400	RENAL DIALYSIS	0	0		0	0	74.00
76. 00 03950	OTHER ANCILLARY SERVICES	0	0		0	0	76.00
76. 97 07697	CARDIAC REHABILITATION	0	0		0	0	76. 97
77. 00 07700	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
OUTPA ⁻	TIENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0	0)	0	0	90.00
90. 01 09001	BEHAVI ORAL HEALTH	0	0		0	0	90. 01
90. 02 09002	SLEEP LAB	0	0		0	0	90. 02
91.00 09100	EMERGENCY	0	0)	0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0)		O	0	92.00
92. 01 09201	OBSERVATION BEDS (DISTINCT PART)	0	0)	0	0	92. 01
200. 00	Total (lines 50 through 199)	0	0)	0	0	200.00

Health Financial Systems	IU HEALTH WEST HOS	SPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIE	T ANCILLARY SERVICE OTHER PASS P			Worksheet D
THROUGH COSTS			From 01/01/2022	Part IV

THROUGI	H COSTS				rom 01/01/2022 Fo 12/31/2022	Date/Time Pre	
			Ti +l c	e XVIII	Hospi tal	5/25/2023 2: 3 PPS	<u>5 pm</u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col . 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col . 7)	
			.,	and 4)	,	(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	(173, 674, 292	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0	(33, 154, 594	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(23, 949, 161	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(130, 431, 462	0.000000	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(49, 674, 045	0.000000	55.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(69, 180, 411	0.000000	59.00
60.00	06000 LABORATORY	0	0	(73, 291, 036	0.000000	60.00
63. 00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(3, 521, 641	0.000000	63.00
	06500 RESPI RATORY THERAPY	0	0	(19, 930, 385	0.000000	65.00
	06600 PHYSI CAL THERAPY	0	0	(11, 246, 611		
	06700 OCCUPATI ONAL THERAPY	0	0	(3, 636, 659		
	06800 SPEECH PATHOLOGY	0	0	(1, 864, 993	0.000000	
	06900 ELECTROCARDI OLOGY	0	0	(49, 508, 191	0.000000	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(41, 215, 167	0.000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(92, 168, 887	•	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(1
	07400 RENAL DIALYSIS	0	0	(3, 335, 209		1
	03950 OTHER ANCILLARY SERVICES	0	0	(1	0.00000	1
	07697 CARDI AC REHABI LI TATI ON	0	0		4, 194, 597		
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS	_		1			4
	09000 CLI NI C	0	1	1	1	0.000000	1
	09001 BEHAVI ORAL HEALTH	0	0		1, 426, 017		
	09002 SLEEP LAB	0	0	(9, 198, 267		
	09100 EMERGENCY	0	0				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	1	1,000,12,		1
200.00	Total (lines 50 through 199)	0	0	il () 1, 131, 979, 577		200. 00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provi der CCN: 15-0158	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Prepared: 5/25/2023 2:35 pm

			To	12/31/2022	Date/Time Pre 5/25/2023 2:3	
		Title	XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	, ,		,			
50.00 05000 OPERATING ROOM	0. 000000	13, 208, 090		21, 428, 761	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	1, 482, 745		5, 373, 919	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	51, 248		9, 451	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	9, 513, 187		16, 567, 668		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 334, 312		11, 293, 600		55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 790, 032		5, 707, 296	0	59.00
60. 00 06000 LABORATORY	0. 000000	11, 810, 385		2, 517, 011	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	900, 445		80, 862	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	4, 217, 388		1, 462, 714	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 801, 507		278, 827	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	935, 971		7, 098		67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	785, 172	0	4, 878	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	7, 815, 022	0	7, 583, 473	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 178, 125	0	5, 464, 648	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	10, 242, 176	0	14, 887, 362	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	17, 342, 361	0	7, 993, 343	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	1, 069, 071	0	18, 125	0	74.00
76.00 03950 OTHER ANCILLARY SERVICES	0. 000000	0	0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	20, 230	0	1, 154, 642	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0. 000000	0	0	74, 257	0	90. 01
90. 02 09002 SLEEP LAB	0. 000000	4, 356	0	1, 566, 443	0	90. 02
91. 00 09100 EMERGENCY	0. 000000	15, 748, 668		16, 913, 761	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	10, 996	0	1, 510, 501	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	10, 630		682, 161	0	92. 01
200.00 Total (lines 50 through 199)		112, 272, 117	0	122, 580, 801	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-0158 Peri od: Worksheet D From 01/01/2022 Part V Date/Time Prepared: 12/31/2022 5/25/2023 2:35 pm Title XVIII Hospi tal PPS Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 21, 428, 761 50.00 0. 133965 2, 870, 704 50.00 05100 RECOVERY ROOM 0 5, 373, 919 1, 532, 798 51.00 0. 285229 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0. 330315 9, 451 3, 122 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.134652 16, 567, 668 0 2, 230, 870 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0. 102120 11, 293, 600 0 0 1, 153, 302 55.00 0 5, 707, 296 59 00 05900 CARDIAC CATHETERIZATION 0.073692 0 420, 582 59 00 0 0 60.00 06000 LABORATORY 0.172846 2, 517, 011 435, 055 60.00 63.00 06300 BLOOD STORING, PROCESSING, & TRANS. 0. 223368 80, 862 0 18, 062 63.00 0 0 06500 RESPIRATORY THERAPY 0.320531 1, 462, 714 65.00 468, 845 65.00 0 06600 PHYSI CAL THERAPY 89, 854 66.00 0.322257 278, 827 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.307296 7,098 0 2, 181 67.00 06800 SPEECH PATHOLOGY 0 0 68.00 0. 286122 4,878 1, 396 68.00 06900 ELECTROCARDI OLOGY 0 0 69 00 0.057525 7 583 473 436 239 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.203238 5, 464, 648 0 1, 110, 624 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.147893 14, 887, 362 0 0 2, 201, 737 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.185397 7, 993, 343 0 45, 342 1, 481, 942 73.00 07400 RENAL DIALYSIS 0 74 00 0 433831 74 00 18, 125 0 7,863 0 76.00 03950 OTHER ANCILLARY SERVICES 0.000000 0 0 76.00 0. 148098 1, 154, 642 76. 97 07697 CARDIAC REHABILITATION 0 0 171,000 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 n 90.00 09001 BEHAVI ORAL HEALTH 74, 257 0 0 53, 937 90.01 0.726358 90.01 09002 SLEEP LAB 0 0 90.02 0.110723 1, 566, 443 173.441 90.02 0 91. 00 09100 EMERGENCY 0.079345 16, 913, 761 0 1, 342, 022 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 284869 1,510,501 0 0 430, 295 92.00 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.378965 682, 161 0 0 258, 515 92.01 0 16, 894, 386 200. 00 200.00 Subtotal (see instructions) 122, 580, 801 45, 342 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

122, 580, 801

0

45, 342

16, 894, 386 202. 00

202.00

Net Charges (line 200 - line 201)

ATTORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	WOOTNE COST			SN. 13 0130	From 01/01/2022 To 12/31/2022	Part V Date/Time Pr 5/25/2023 2:	epared: 35 pm
			Title	XVIII	Hospi tal	PPS	
		sts					
Cost Center Description	Cost		Cost				
	Rei mbursed		ei mbursed				
	Servi ces		rvices Not				
	Subject To		ubject To				
	Ded. & Coins.		l. & Coins.				
	(see inst.) 6.00	(s	ee inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	6.00		7.00				
50. 00 05000 OPERATING ROOM		1	0				50.00
51. 00 05100 RECOVERY ROOM		()	0				51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		íl .	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		íl .	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		í	0				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		íl .	0				59.00
60. 00 06000 LABORATORY		á	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.			0				63.00
65. 00 06500 RESPIRATORY THERAPY			0				65.00
66. 00 06600 PHYSI CAL THERAPY			0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0		0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0)	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0)	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		8, 406				73.00
74.00 07400 RENAL DIALYSIS	0		0				74.00
76.00 03950 OTHER ANCILLARY SERVICES	0		0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0)	0				76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0)	0				77. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	0		0				90.00
90. 01 09001 BEHAVI ORAL HEALTH	0		0				90. 01
90. 02 09002 SLEEP LAB	0		0				90. 02
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
200.00 Subtotal (see instructions)	0)	8, 406				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	9					201. 00
Only Charges			0.404				202.00
202.00 Net Charges (line 200 - line 201)	0	וי	8, 406				202. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAP	ITAL COSTS	Provi der C		eriod: rom 01/01/2022	Worksheet D Part I	
			Т	o 12/31/2022	Date/Time Pre 5/25/2023 2:3	pared: 5 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			,	,		
30.00 ADULTS & PEDIATRICS	5, 415, 386		5, 415, 386		131. 15	
31.00 INTENSIVE CARE UNIT	907, 789		907, 789		250. 22	
35.00 NEONATAL INTENSIVE CARE UNIT	165, 904		165, 904		178. 39	
43. 00 NURSERY	116, 649		116, 649	1, 816	64. 23	43.00
200.00 Total (lines 30 through 199)	6, 605, 728		6, 605, 728	47, 664		200.00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	620					30.00
31.00 INTENSIVE CARE UNIT	450					31.00
35.00 NEONATAL INTENSIVE CARE UNIT	79					35.00
43. 00 NURSERY	1, 001					43.00
200.00 Total (lines 30 through 199)	2, 150	272, 299				200. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der CO		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	nared:
				10 12/31/2022	5/25/2023 2: 3	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
ANOLILIADIV OFFICIAL OCCUPANTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4 (07 040	470 (74 000	0.00/50	050 500	/ 700	F0 00
50. 00 05000 OPERATING ROOM	4, 607, 918	173, 674, 292	0. 02653		6, 728	
51. 00 05100 RECOVERY ROOM	894, 147	33, 154, 594			356	51.00 52.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM 54.00 O5400 RADIOLOGY-DIAGNOSTIC	828, 858 2, 696, 504	23, 949, 161 130, 431, 462	0. 03460 0. 02067		10, 950 8, 391	54.00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	994, 337	49, 674, 045			1, 933	
59. 00 05900 CARDI AC CATHETERI ZATI ON	910, 623	69, 180, 411	0. 01316		1, 933 2, 479	59.00
60. 00 06000 LABORATORY	224, 535	73, 291, 036				60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	3, 776	3, 521, 641	0. 00300		58	63.00
65. 00 06500 RESPIRATORY THERAPY	259, 835	19, 930, 385	0. 01303		3, 518	
66. 00 06600 PHYSI CAL THERAPY	80, 306	11, 246, 611	0. 00714		403	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	49, 952	3, 636, 659			447	67.00
68. 00 06800 SPEECH PATHOLOGY	44, 599	1, 864, 993			668	68.00
69. 00 06900 ELECTROCARDI OLOGY	174, 368		0. 00352		955	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	102, 996	41, 215, 167	0. 00249		209	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	167, 583	92, 168, 887	0. 00181	·	145	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	592, 757	102, 074, 234	0. 00580	7 1, 052, 363	6, 111	73.00
74. 00 07400 RENAL DI ALYSI S	96, 001	3, 335, 209	0. 02878	4 70, 137	2, 019	74.00
76.00 03950 OTHER ANCILLARY SERVICES	0	0	0.00000	0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	61, 372	4, 194, 597	0. 01463	1 365	5	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000		0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	36, 999	1, 426, 017	0. 02594		0	90. 01
90. 02 09002 SLEEP LAB	86, 992	9, 198, 267	0. 00945		0	90. 02
91. 00 09100 EMERGENCY	1, 375, 058	209, 870, 366			4, 732	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	500, 093	21, 097, 223			0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	200, 847	4, 336, 129			0	92. 01
200.00 Total (lines 50 through 199)	14, 990, 456	1, 131, 979, 577		4, 679, 270	52, 206	200. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA		TS Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/25/2023 2:3	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDLATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02080 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY 200. 00 Total (Lines 30 through 199)	0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	30. 00 31. 00 35. 00 43. 00 200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patien	Per Diem	I npati ent	200.00
oust center bescription	Adjustment Amount (see	(sum of cols. 1 through 3, minus col. 4)	Days	(col. 5 ÷ col. 6)	Program Days	
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02080 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0	0 0	41, 29 3, 62 93 1, 81	8 0. 00 0 0. 00	450 79	31.00 35.00
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		47, 00	*1	2, 130	200.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 35. 00 02080 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0 0 0					30.00 31.00 35.00 43.00
200.00 Total (lines 30 through 199)	0					200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0158	
THROUGH COSTS		From 01/01/2022 Part IV

			7	To 12/31/2022	Date/Time Pre 5/25/2023 2:3	
		Ti tl	e XIX	Hospi tal	PPS	<u>o p</u>
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
· ·	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING 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	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59.00
60. 00 06000 LABORATORY	0	0	(0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0	0	(0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICES	0	0	(0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	(0	0	
90. 01 09001 BEHAVI ORAL HEALTH	0	0	(0	0	90. 01
90. 02 09002 SLEEP LAB	0	0	(0	0	90. 02
91. 00 09100 EMERGENCY	0	0	(0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(0	0	92. 01
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0158	Period: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

THROUG	H COSTS				Froii 01/01/2022 Γο 12/31/2022		
				e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col . 7)	
				and 4)		(see	
						instructions)	
	ANOLULARY OFRICAS COOT OFFITERS	4. 00	5. 00	6. 00	7. 00	8. 00	
50.00	ANCILLARY SERVICE COST CENTERS		1	1	170 (74 000	0.00000	
50.00	05000 OPERATI NG ROOM	0	0	(173, 674, 292		
51. 00	05100 RECOVERY ROOM	0	0	(00, 101, 071		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(23, 949, 161		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(130, 431, 462		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(49, 674, 045		
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(07, 100, 111	0.000000	
60.00	06000 LABORATORY	0	0	(
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	(3, 521, 641		
65. 00	06500 RESPI RATORY THERAPY	0	0	(, ,		
	06600 PHYSI CAL THERAPY	0	0	(, = ,	0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0	(3, 636, 659		
	06800 SPEECH PATHOLOGY	0	0	(1, 864, 993		
	06900 ELECTROCARDI OLOGY	0	0	(49, 508, 191	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(41, 215, 167		
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	(,,		
	07300 DRUGS CHARGED TO PATIENTS	0	0	(.02,07.7201		
	07400 RENAL DI ALYSI S	0	0	(3, 335, 209		
	03950 OTHER ANCILLARY SERVICES	0	0	(0	0.000000	
	07697 CARDI AC REHABI LI TATI ON	0	0	1	., ,		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(0 0	0. 000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			1	-1		
	09000 CLINIC	0				0.000000	
	09001 BEHAVI ORAL HEALTH	0	0	(1, 426, 017		
	09002 SLEEP LAB	0	0	(9, 198, 267		
	09100 EMERGENCY	0	0	(209, 870, 366		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(21, 097, 223		
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(1,000,12,		
200.00	Total (lines 50 through 199)	0	0	(1, 131, 979, 577		200. 00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0158	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2022 Part IV

THROUGH COSTS				rom 01/01/2022		
				To 12/31/2022		pared:
		Ti +1	e XIX	Hospi tal	5/25/2023 2: 3 PPS	5 piii
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
cost center bescription	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	char ges				
	col. 7)		Costs (col. 8 x col. 10)		Costs (col. 9 x col. 12)	
	9.00	10. 00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	253, 590		0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	13, 200			0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	316, 381			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	405, 888			0	54.00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	1				0	55.00
· · · · · · · · · · · · · · · · · · ·	0.000000	96, 564			0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000	188, 366			0	59.00
60. 00 06000 LABORATORY	0.000000	685, 090		,	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	53, 759		1	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	269, 867	(,	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	56, 506		,	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	32, 568		-	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	27, 933		-	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	271, 211	(-	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	83, 716		-	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	79, 539		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 052, 363		0	0	73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000	70, 137	(0	0	74.00
76.00 03950 OTHER ANCILLARY SERVICES	0. 000000	0	(0	0	76. 00
76. 97 O7697 CARDIAC REHABILITATION	0. 000000	365	(0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	(0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0. 000000	0	(0	0	90. 01
90. 02 09002 SLEEP LAB	0. 000000	0	(0	0	90.02
91. 00 09100 EMERGENCY	0. 000000	722, 227		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	(0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	(0	0	92. 01
200.00 Total (lines 50 through 199)		4, 679, 270	(0	0	200.00
			•	•		•

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0158	Peri od: From 01/01/2022	Worksheet D-1	
		To 12/31/2022	Date/Time Pre 5/25/2023 2:3	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

PART - ALL PROPIER COMPONENTS 1.00	-		Ti +1 o V/// / /	Haani tal	5/25/2023 2: 3	5 pm
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description	Title XVIII	Hospi tal	PPS	
MARTIERT DAYS 1.00 Inputiert days (including private room days and saing-bed days, excluding newborm) 41,290 1.00 1.00 Inputiert days (including private room days, excluding saing-bed and newborm days) 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0					1. 00	
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32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65,080,017) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 34 x line 35) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 65,080,017) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)						
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35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65, 080, 017 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			nue line 33)(see instru	rtions)		
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,576.17 38.00 Program general inpatient routine service cost (line 9 x line 38) 19,005,458 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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41.00 lotal Program general inpatient routine service cost (line 39 + line 40) 19,005,458 41.00		, , , , , , , , , , , , , , , , , , , ,				
	41.00	ιοται Program general inpatient routine service cost (line 39	+ IIne 40)	l	19, 005, 458	41.00

Heal th	Financial Systems	IU HEALTH WES	ST HOSPLTAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2022	Worksheet D-1	
					o 12/31/2022		
			Title	e XVIII	Hospi tal	5/25/2023 2: 3 PPS	5 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	10, 390, 075	3, 628	2, 863. 86	1, 257	3, 599, 872	43.00
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	NEONATAL INTENSIVE CARE UNIT	2, 811, 527	930	3, 023. 15	0	0	
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			16, 787, 778	48. 00
48. 01	Program inpatient cellular therapy acquisiti				column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	01)(see instru	ctions)		39, 393, 108	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	1, 895, 934	50.00
51. 00		ationt ancilla	rv sarvicas (f	rom Wket D si	ım of Darts II	1, 173, 420	51.00
31.00	and IV)	atrent ancirra	ry services (i	TOIII WKSt. D, St	um of Farts II	1, 173, 420	31.00
52.00	Total Program excludable cost (sum of lines					3, 069, 354	
53. 00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line	9 1	erated, non-pn	ysician anestne	etist, and	36, 323, 754	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor					0. 00	
56.00	Target amount (line 54 x sum of lines 55, 55			lino E4 minus l	ino E2)	0	56. 00 57. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (TITTE SO IIITTUS I	THE 53)	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54,		m the cost rep	orting period o	endi ng 1996,	0.00	
60. 00	updated and compounded by the market basket) 60.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the					0. 00	60.00
61. 00	market basket)					0	61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)						
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instr	uctions)			0	62. 00 63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos		,	e cost reporti:	na period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	· ·		·		0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line	65)(TITIE XVIII	oniy); for	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost rep	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after l	December 31 of	the cost repo	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil	ity/ICF/IID ro	utine service	cost (line 37)			70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (71. 00
72.00	Program routine service cost (line 9 x line	,	(1: 14)	: 25)			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 26, line 45)				art II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provider recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp				ıs line 79)		80.00
81. 00	Inpatient routine service cost per diem limi				·		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84.00	Program inpatient ancillary services (see in		113)				84.00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		hrough 85)				86. 00
87. 00	Total observation bed days (see instructions					3, 813	87. 00
	Adjusted general inpatient routine cost per		÷ line 2)			1, 576. 17	88. 00

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			6, 009, 936	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	5, 415, 386	65, 080, 017	0. 08321	1 6, 009, 936	500, 093	90.00
91.00 Nursing Program cost	0	65, 080, 017	0. 00000	6, 009, 936	ol	91.00
92.00 Allied health cost	0	65, 080, 017	0. 00000	6, 009, 936	ol	92.00
93.00 All other Medical Education	0	65, 080, 017	0. 00000	6, 009, 936	ol	93.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0158	Peri od: From 01/01/2022	Worksheet D-1	
			Date/Time Pre	
			5/25/2023 2: 3	5 pm
	Title XIX	Hospi tal	PPS	
Cost Center Description				

PART - ALL PROVIDER CONFIDENTS 1.00			Title XIX	Hospi tal	5/25/2023 2: 3 PPS	5 pm
INPATED IMPS IM		Cost Center Description	THE XIX	1103pi tui	113	
INPARTENT MAYS		·			1. 00	
Impattient days (including private room days and swing-bed days, excluding newborn)						
Impatient days (including private room days, excluding sking-bed and newborn days) 41,290 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00	1 00		s excluding newborn)		41 290	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00					•	
5.00 Total swin,p-bet SMF type inpatient days (including private room days) after December 31 of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients of the cost reporting period for five all patients days (including private room days) after December 31 of the cost reporting period for called any special cost of the Program (excluding private room days) after December 31 of the cost reporting period for the cost reporting period (see instructions) 10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed WF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (if called private room days) after December 31 of the cost reporting period (if called private room this line) 14.00 Medically necessary private room days applicable to the Program (excluding private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Indical nursery days (title V or XIX only) 18.00 Medical nursery days (title V or XIX only) 18.00 Medical room of the cost reporting period (if called and reporting period (if called and reporting period (if reporting period of reporting period (if real ender year, enter 0 on this line) 18.00 Medical room of the cost reporting period (if called room of the cost reporting period (if reporting period (if real ender year) 18.00 Medical rate for swing-bed NF s	3.00			ivate room days,	0	3.00
Total iswing-bed SNF type inpatient days (including private room days) through becember 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including private room days) through December 31 of the cost capetring period (including private room days) through December 31 of the cost capetring period (including private room days) through December 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including private room days) after December 31 of the cost capetring period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period on days) after December 31 of the cost reporting period (including period on through December 31 of the cost reporting period (including period on through December 31 of the cost reporting period (including period on the period on this iline) and through December 31 of the cost reporting period (including period on the period on this iline) and the period (including period on the period (including period (i						
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SWT type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10.00 Swing-bed SWF type inpatient days applicable to this line) 10.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after through Becember 31 of the cost reporting period (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after through Becember 31 of the cost reporting period (see instructions) 12.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) 13.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) 14.00 Swing-bed KF type inpatient days applicable to title XVIII only (including private room days) 15.00 Swing-bed KF type inpatient days applicable to title XVIII only (including private room days) 16.00 Swing-bed KF type inpatient days applicable to title XVIII only (including private room days) 17.00 Swing-bed KF type inpatient days applicable to title XVIII only (including private room days) 18.00 Swing-bed KF type inpatient days applicable to title XVIII only (including private room days) 18.00 Medically necessary private room days applicable to title XVIII only (including private room days) 18.00 Medically necessary private room days applicable to the Program (excluding swing-bed days				n 21 of the coef		
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7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost preporting period (if calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and private room days) 7.00 Swing-bed SNF type inpatient days applicable to the Itile XVIII only (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to the Itile XVIII only (including private room days) 8.00 Swing-bed SNF type inpatient days applicable to the Itile XVIII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to the Itile XVIII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to the Program (excluding Swing-bed days) 9.00 Swing-bed NF type inpatient days applicable to the Program (excluding Swing-bed days) 9.00 Swing-bed Swing-bed SWF services applicable to services after December 31 of the cost program (excluding Swing-bed SWF services) 9.00 Swing-bed Swing-bed SWF services applicable to services after December 31 of the cost program (excluding Swing-bed SWF services) 9.00 Swing-bed cost applicable to SWF type services shrough December 31 of the cost reporting period (line Swing-bed cost applicable to SWF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SWF type services afte	6.00		om days) after December	31 of the cost	0	6.00
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84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)		·)				82.00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				ıs)				83.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				une)				84.00
DADT IV COMPUTATION OF ORCEDVATION REP PAGE TURNICUL COST								85. 00 86. 00
PART IV - CUMPUTATION OF OBSERVATION BED PASS THROUGH COST		PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	. 3/				1
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,576.17				11 0				

Health Financial Systems	IU HEALTH WES	ST HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0158 Peri od:			Worksheet D-1		
				From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			6, 009, 936	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	5, 415, 386	65, 080, 017	0. 08321	1 6, 009, 936	500, 093	90.00
91.00 Nursing Program cost	0	65, 080, 017	0. 00000	6, 009, 936	ol	91.00
92.00 Allied health cost	0	65, 080, 017	0. 00000	6, 009, 936	ol	92.00
93.00 All other Medical Education	0	65, 080, 017	0. 00000	6, 009, 936	ol	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-0158	Peri od: From 01/01/2022 To 12/31/2022		epared:
	Ti tl e	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
10.00 03000 ADULTS & PEDIATRICS 11.00 03100 INTENSIVE CARE UNIT 15.00 02080 NEONATAL INTENSIVE CARE UNIT 13.00 04300 NURSERY			41, 442, 064 10, 234, 072 0		30.00 31.00 35.00 43.00
ANCILLARY SERVICE COST CENTERS					1 43.00
0.00 05000 OPERATING ROOM 01.00 05100 RECOVERY ROOM		0. 1339 0. 2852			1
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3303	15 51, 248	16, 928	52.00
64. 00 05400 RADI OLOGY-DI AGNOSTI C 65. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1346 0. 1021			1
9. 00 05900 CARDI AC CATHETERI ZATI ON		0. 0736			
0. 00 06000 LABORATORY		0. 1728		l	
3.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 2233			
5. 00 06500 RESPIRATORY THERAPY		0. 3205			65.00
6. 00 06600 PHYSI CAL THERAPY		0. 3222		580, 548	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 3072			
8. 00 06800 SPEECH PATHOLOGY		0. 2861			
99. 00 06900 ELECTROCARDI OLOGY		0. 0575			
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2032			
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 1478			
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 1853		3, 215, 222	
4. 00 07400 RENAL DI ALYSI S		0. 4338		463, 796	
6.00 03950 OTHER ANCILLARY SERVICES		0.0000		1	
6. 97 O7697 CARDI AC REHABI LI TATI ON		0. 1480		l	
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0.0000	00 0	0	77.00
OUTPATIENT SERVICE COST CENTERS OO. 00 09000 CLINIC		0.0000	00 0	0	90.00
0.00 09000 CETNIC 0.01 09001 BEHAVI ORAL HEALTH		0. 7263			
0.02 09001 BEHAVTORAL HEALTH		0. 7263		1	
11. 00 09100 EMERGENCY		0. 1107.			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.0793			
22.01 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2848	·		
2.01 09201 0BSERVATION BEDS (DISTINCT PART) 200.00 Total (sum of lines 50 through 94 and 96	through 00)	0.3789	·	l	
201.00 Less PBP Clinic Laboratory Services-Progra			112, 272, 117		201. 00
or our less for criffic Laboratory services-frogra	am only charges (Title 61)	1	1 0	I	120 L. U

Health Financial Systems	IU HEALTH WEST HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022	Date/Time Pre	nared·
				5/25/2023 2: 3	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	The state of the s	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1 00	0.00	col . 2)	
INDATI ENT. DOUTINE CERVI OF COCT OFFITERS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			0.007.500		00.00
30. 00 03000 ADULTS & PEDI ATRI CS			2, 286, 538		30.00
31. 00 03100 INTENSIVE CARE UNIT			581, 836		31.00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT			489, 719		35.00
43. 00 04300 NURSERY			201, 086		43.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM		0. 13396	5 252 500	22.072	F0 00
				33, 972	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 28522 0. 33031		3, 765	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33031		104, 505 54, 654	
55. 00 05500 RADI OLOGY-DI AGNOSTI C		0. 13465		9, 861	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10212		13, 881	
60. 00 06000 LABORATORY		0. 07389		118, 415	
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 17284		12, 008	
65. 00 06500 RESPIRATORY THERAPY		0. 32053		86, 501	
66. 00 06600 PHYSI CAL THERAPY		0. 32033		18, 209	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 32223		10, 008	
68. 00 06800 SPEECH PATHOLOGY		0. 30729		7, 992	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 25012		15, 601	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 20323		17, 014	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 20323		11, 763	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 14789		195, 105	
74. 00 07400 RENAL DI ALYSI S		0. 43383		30, 428	
76. 00 03950 OTHER ANCILLARY SERVICES		0. 00000		30, 420	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 14809		54	76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUISITION		0. 00000		0	77.00
OUTPATIENT SERVICE COST CENTERS		0.00000	<u> </u>		1
90. 00 09000 CLINIC		0.00000	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH		0. 72635		0	

0.726358

0.110723

0. 079345 0. 284869

0. 378965

722, 227

4, 679, 270

90.02

91.00

92.00 0

201.00

202.00

0 90.01

0

0 92.01

801, 041 200. 00

57, 305

90.01

90.02

200.00

201.00

202.00

09001 BEHAVI ORAL HEALTH

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

Net charges (line 200 minus line 201)

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

09002 SLEEP LAB

91. 00 09100 EMERGENCY

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0158	Period: Worksheet E From 01/01/2022 Part A To 12/31/2022 Date/Time Prepared: 5/25/2023 2: 35 pm

	Title XVIII Hospital	5/25/2023 2: 3! PPS	5 pm
		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS	1.00	
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0 16, 922, 886	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	6, 283, 324	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to Octo 1 (see instructions)	ber 0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2. 00	Outlier payments for discharges. (see instructions) Outlier reconciliation amount	0	2.00
2. 02 2. 03 2. 04	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	0 870, 284 228, 907	2. 02 2. 03 2. 04
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost reporting period (see instructions)	155. 50	3.00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending		5.00
5. 01	or before 12/31/1996. (see instructions) FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions)	0.00	5. 01
6. 00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap new programs in accordance with 42 CFR 413.79(e)	for 0.00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 the CAA 2021 (see instructions)		6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If t cost report straddles July 1, 2011 then see instructions.		7. 00 7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b and 87 FR 49075 (August 10, 2022) (see instructions)		7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the c report straddles July 1, 2011, see instructions.		8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus o minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions) FTE count for allopathic and osteopathic programs in the current year from your records	0.00 0.00	9.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)	0.00	11. 00 12. 00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 19 otherwise enter zero.		14.00
	Adjustment for residents in initial years of the program (see instructions)	0.00	15. 00 16. 00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	0.00	17. 00 18. 00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)	0. 000000 0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)	0. 000000	
22. 00 22. 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)	0	22. 00 22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$.	0.00	23. 00
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see	0. 00 0. 00	
26. 00 27. 00	Instructions) Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)	0. 000000 0. 000000	26. 00 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 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29. 00 29. 01
30. 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3. 90	30.00
31.00	Percentage of Medicaid patient days (see instructions)	17. 93	•
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)	21. 83 7. 22	32. 00 33. 00
	·		- '

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0158	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre	nared:
				5/25/2023 2: 3	
	<u> </u>	Title XVIII	Hospi tal	PPS	
				1. 00	
34.00	Disproportionate share adjustment (see instructions)			418, 872	34.00
			Pri or to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Payment Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)			6, 874, 403, 459	•
35. 01 35. 02	Factor 3 (see instructions) Hospital UCP, including supplemental UCP (If line 34 is zero	enter zero on this line	0. 000209130 e) 1, 504, 066	0. 000205272 1, 411, 124	•
	(see instructions)	,	.,,	.,,	
35. 03		CP (see instructions)	1, 124, 959		35.03
36.00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03) Additional payment for high percentage of ESRD beneficiary di	ischarges (lines 40 throu	1, 480, 640 uah 46)		36.00
40.00	Total Medicare discharges (see instructions)	,	0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	+!>	0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges (see instruc Divide line 41 by line 40 (if less than 10%, you do not qual		0.00		41. 01 42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	. Ty Tot day do timoty	0		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.00
45. 00	days) Average weekly cost for dialysis treatments (see instruction:	5)	0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 4	•	0		46.00
47.00	Subtotal (see instructions)		26, 204, 913		47.00
48. 00	Hospital specific payments (to be completed by SCH and MDH, sonly (see instructions)	smail rurai nospitais	0		48. 00
				Amount	
40.00	Total payment for innations appreting costs (occ. instruction	2)		1. 00	40.00
49. 00 50. 00	Total payment for inpatient operating costs (see instruction: Payment for inpatient program capital (from Wkst. L, Pt. I a)	26, 204, 913 1, 957, 330	•
51.00	Exception payment for inpatient program capital (Wkst. L, Pt		•	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, I	ine 49 see instructions).		0	52.00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 263, 938	53. 00 54. 00
54. 01	Islet isolation add-on payment			0	54. 01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	69)		0	55.00
55. 01 56. 00	Cellular therapy acquisition cost (see instructions) Cost of physicians' services in a teaching hospital (see int	ructions)		0	55. 01 56. 00
57. 00	Routine service other pass through costs (from Wkst. D, Pt.	III, column 9, lines 30 t	through 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.00
59. 00 60. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			28, 426, 181 0	59. 00 60. 00
61.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		28, 426, 181	61.00
62.00	Deductibles billed to program beneficiaries			2, 470, 036	
63.00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			115, 144 157, 388	
04.00				102, 302	1
65.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		15, 582	1
65. 00 66. 00				25, 943, 303	67. 00 68. 00
65. 00 66. 00 67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	applicable to MS DDCs (coo inetructione)		
65. 00 66. 00 67. 00 68. 00	Credits received from manufacturers for replaced devices for			0	ı
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	. (For SCH see instruction	ns)		69. 00 70. 00
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons	. (For SCH see instruction	ns)	0 0 0	69. 00 70. 00 70. 50
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	.(For SCH see instruction tration) adjustment (see	ns)	0	69. 00 70. 00
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	. (For SCH see instruction tration) adjustment (see	ns)	0 0 0	69. 00 70. 00 70. 50 70. 75 70. 87 70. 88
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see ins	. (For SCH see instruction tration) adjustment (see	ns)	0 0 0 0 0	69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions)	. (For SCH see instruction tration) adjustment (see	ns)	0 0 0 0 0	69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	. (For SCH see instruction tration) adjustment (see	ns)	0 0 0 0 0	69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90
65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90	Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demons N95 respirator payment adjustment amount (see instructions) Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HVBP adjustment amount (see instructions)	. (For SCH see instruction tration) adjustment (see	ns)	0 0 0 0 0 0	69. 00 70. 00 70. 50 70. 75 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92

lealth Financial Systems	IU HEALTH WEST H	HOSPI TAL		<u>In L</u> ie	u of Form CMS-2	<u> 2552-</u> 10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C		Peri od:	Worksheet E	
				From 01/01/2022 Fo 12/31/2022		naradi
				10 12/31/2022	5/25/2023 2: 3	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				Ō	1. 00	
70.96 Low volume adjustment for federal fis		n column 0		0	0	70. 90
the corresponding federal year for the						70.0
70.97 Low volume adjustment for federal fish the corresponding federal year for the				0	0	70. 9
70. 98 Low Volume Payment-3	ie period endring on or ar	ter 10/1)			0	70. 9
70.99 HAC adjustment amount (see instruction	one)				0	
71.00 Amount due provider (line 67 minus li		49 & 70)			25, 814, 676	
71.01 Sequestration adjustment (see instruc		3, 4, 10)			325, 265	
71.02 Demonstration payment adjustment amou					020,200	
71.03 Sequestration adjustment-PARHM or CHA					Ü	71.0
72.00 Interim payments	1				25, 290, 326	72.0
72.01 Interim payments-PARHM or CHART						72.0
73.00 Tentative settlement (for contractor	use only)				0	73.0
73.01 Tentative settlement-PARHM or CHART	(for contractor use only))				73.0
74.00 Balance due provider/program (line 7	1 minus lines 71.01, 71.02	2, 72, and			199, 085	74.0
73)						
74.01 Balance due provider/program-PARHM o						74.0
75.00 Protested amounts (nonallowable cost	report items) in accordan	nce with			546, 653	75.00
CMS Pub. 15-2, chapter 1, §115.2						
TO BE COMPLETED BY CONTRACTOR (lines			ı			
90.00 Operating outlier amount from Wkst. [E, Pt. A, line 2, or sum o	of 2.03			0	90.00
plus 2.04 (see instructions) 91.00 Capital outlier from Wkst. L, Pt. I,	Line 2				0	91.0
91.00 Capital outlier from wkst. E, Pt. 1, 92.00 Operating outlier reconciliation adju		ictions)			0	•
93.00 Capital outlier reconciliation adjus					0	
94.00 The rate used to calculate the time v					0.00	1
95.00 Time value of money for operating exp	3 `	actions)			0.00	
96.00 Time value of money for capital relations		tions)			0	
				Prior to 10/1	On/After 10/1	
				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						1
101.00 HVBP adjustment factor (see instructi		_		0. 0000000000	0. 0000000000	
102.00 HVBP adjustment amount for HSP bonus	payment (see instructions	s)		0	0	102. 0
HRR Adjustment for HSP Bonus Payment				0.0000	0.0000	
103.00 HRR adjustment factor (see instruction				0.0000	0. 0000	
104.00 HRR adjustment amount for HSP bonus			iotmont	0	0	104.00
Rural Community Hospital Demonstration 200.00 Is this the first year of the current						200. 00
Century Cures Act? Enter "Y" for yes		rou unaer	the 21St			200.00
Cost Reimbursement	OI IN TOT TIO.					
201.00 Medicare inpatient service costs (fro	om Wkst D-1 Pt II line	2 49)				201. 0
202.00 Medicare discharges (see instructions		,,				202. 0
203.00 Case-mix adjustment factor (see instr	•					203. 0
Computation of Demonstration Target A		first vear	of the curren	t 5-year demons		1
peri od)		, , , , , , , , , , , , , , , , , , ,		<i>y</i>		
04.00 14.15						1

75.00 Protested alliquits (horiar towable cost report realis) in accordance with		340, 033	75.00
CMS Pub. 15-2, chapter 1, §115.2			
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
plus 2.04 (see instructions)			
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	1
92.00 Operating outlier reconciliation adjustment amount (see instructions)		0	1 / 0
93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	
94.00 The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00 Time value of money for operating expenses (see instructions)		0	95.00
96.00 Time value of money for capital related expenses (see instructions)		0	96.00
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	7100. od
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 0000000000	0. 0000000000	101.00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0		102.00
HRR Adjustment for HSP Bonus Payment			1.02.0
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103 0
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0.0000	l .	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			1.01.0
200.00 Is this the first year of the current 5-year demonstration period under the 21st			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Rel mbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202. 00 Medi care di scharges (see i nstructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current contents)	at E year demons		1203.00
period)	it 5-year deliloris	stration	
204. 00 Medi care target amount			204.00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
205.00 Case-iii x adjusted target amount (Trie 205 tries Trie 204) 206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
			1200.00
Adjustment to Medicare Part A Inpatient Reimbursement			207. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions)			208.00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00 Adjustment to Medicare IPPS payments (see instructions)			
210.00 Reserved for future use			210.00
211.00 Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparision of PPS versus Cost Reimbursement			
212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			212. 00
213.00 Low-volume adjustment (see instructions)		l .	213.00
218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)			218. 00
(line 212 minus line 213) (see instructions)			1

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2022 Part A Exhibit 4 To 12/31/2022 Date/Time Prepared: 5/25/2023 2:35 pm Provider CCN: 15-0158

					10	12/31/2022	5/25/2023 2: 3	
		l			XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After	Total (Col 2 through 4)	
		Title	E, Pail A)	EIILI LI ellleiil	10 10/01	10/01	tili ough 4)	
		0	1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0	0	0	1.00
1 01	payments	1 01	44 000 004		1/ 000 00/		4/ 000 00/	4 04
1. 01	DRG amounts other than outlier payments for discharges	1. 01	16, 922, 886	0	16, 922, 886		16, 922, 886	1. 01
	occurring prior to October 1							
1. 02	DRG amounts other than outlier	1. 02	6, 283, 324	0		6, 283, 324	6, 283, 324	1. 02
	payments for discharges							
	occurring on or after October							
1. 03	DRG for Federal specific	1. 03	o	0	0		0	1. 03
	operating payment for Model 4							
	BPCI occurring prior to							
1. 04	October 1 DRG for Federal specific	1. 04	0	0		0	0	1. 04
1.04	operating payment for Model 4	1.04		J		O		1.04
	BPCI occurring on or after							
2.00	October 1 Outlier payments for	2.00						2 00
2. 00	discharges (see instructions)	2. 00						2.00
2. 01	Outlier payments for	2. 02	O	0	0	0	0	2. 01
	discharges for Model 4 BPCI							
2. 02	Outlier payments for discharges occurring prior to	2. 03	870, 284	0	870, 284		870, 284	2. 02
	October 1 (see instructions)							
2. 03	Outlier payments for	2. 04	228, 907	0		228, 907	228, 907	2. 03
	discharges occurring on or							
	after October 1 (see instructions)							
3. 00	Operating outlier	2. 01	0	0	0	0	0	3.00
	reconciliation							
4. 00	Managed care simulated	3. 00	0	0	0	0	0	4. 00
	payments Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
	A, line 21 (see instructions)		_	_	_	_	_	
6. 00	IME payment adjustment (see instructions)	22. 00	0	O	0	O	0	6. 00
6. 01	IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see							
	instructions) Indirect Medical Education Adj	ustmont for the	a Add on for Co	nation 122 of t	the 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
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
0.01	for managed care (see	20.01		0	J	0	0	0.01
	instructions)							
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed	29. 01	0	0	0	0	0	9. 01
	care (sum of lines 6.01 and					Ĭ		
	8.01)							
10. 00	Disproportionate Share Adjustm Allowable disproportionate	33. 00	0. 0722	0. 0722	0. 0722	0. 0722		10.00
	share percentage (see	00.00	0.0722	0.0722	0.0722	0.0722		10.00
44 00	instructions)	04.00	440 0==	_	005 455	440 441	440 0==	14 00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	418, 872	0	305, 458	113, 414	418, 872	11.00
11. 01	Uncompensated care payments	36. 00	1, 480, 640	0	1, 124, 959	355, 681	1, 480, 640	11. 01
	Additional payment for high pe	rcentage of ESI		di scharges	,			
12. 00	Total ESRD additional payment	46. 00	0	0	0	0	0	12.00
13. 00	(see instructions) Subtotal (see instructions)	47. 00	26, 204, 913	0	19, 223, 587	6, 981, 326	26, 204, 913	13 00
14. 00	Hospital specific payments	48. 00	20, 204, 713	0	0	0, 751, 320	0	14.00
	(completed by SCH and MDH,							
	small rural hospitals only.)							
15. 00	(see instructions) Total payment for inpatient	49. 00	26, 204, 913	0	19, 223, 587	6, 981, 326	26, 204, 913	15 00
10.00	operating costs (see	17.00	20, 204, 713		17,223,307	5, 761, 520	20,204,713	10.00
	instructions)							

LOW VC	OLUME CALCULATION EXHIBIT 4			Provi der C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/25/2023 2:3	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After	through 4)	
						10/01		
		0	1. 00	2. 00	3.00	4. 00	5. 00	
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 957, 330	0	1, 442, 47	1 514, 859	1, 957, 330	16. 00
17. 00	Special add-on payments for new technologies	54. 00	263, 938	0	255, 80	7 8, 131	263, 938	
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0 0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		O	0		0 0	0	18. 00
19 00	SUBTOTAL			0	20, 921, 86	5 7, 504, 316	28, 426, 181	19 00
		W/S L, line	(Amounts from	-		1,001,010		
			L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1.00	1, 738, 638	0	1, 273, 57	6 465, 062	1, 738, 638	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	140, 106	0	111, 33	0 28, 776	140, 106	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0452	0. 0452	0. 045	2 0. 0452		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	78, 586	0	57, 56	5 21, 021	78, 586	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 957, 330	0	1, 442, 47	1 514, 859	1, 957, 330	26. 00
		W/S E, Part A	(Amounts to					
		l i ne	E, Part A)					
	T	0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0.000000	0	27. 00 28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 Provider CCN: 15-0158 Peri od: Worksheet E From 01/01/2022 Part A Exhibit 5 Date/Time Prepared: 5/25/2023 2:35 pm 12/31/2022 Hospi tal Title XVIII PPS Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 16, 922, 886 16, 922, 886 16, 922, 886 1.01 discharges occurring prior to October 1 1 02 DRG amounts other than outlier payments for 1 02 6, 283, 324 6, 283, 324 6, 283, 324 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 2.01 **BPCI** 2.02 870, 284 870, 284 870, 284 2.02 Outlier payments for discharges occurring 2.03 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 228, 907 228, 907 228, 907 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 C 0 0 3.00 Managed care simulated payments 4.00 4.00 3.00 0 Indirect Medical Education Adjustment 0.000000 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 5.00 (see instructions) 6.00 IME payment adjustment (see instructions) 22.00 6.00 C 0 6.01 IME payment adjustment for managed care (see 22.01 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8.00 IME adjustment (see instructions) 28.00 0 0 8.00 0 IME payment adjustment add on for managed 0 28 01 0 8 01 8 01 0 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 9.00 0 Total IME payment for managed care (sum of 9.01 29.01 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 10.00 Allowable disproportionate share percentage 33.00 0.0722 0.0722 0.0722 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 418, 872 305, 458 113, 414 418, 872 11.00 instructions) 11.01 36 00 1, 480, 640 1, 124, 959 355, 681 1, 480, 640 Uncompensated care payments 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46.00 12.00 instructions) 6, 981, 326 47.00 13.00 Subtotal (see instructions) 26, 204, 913 19, 223, 587 26, 204, 913 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15 00 49 00 26 204 913 19 223 587 6 981 326 26, 204, 913 15 00 (see instructions) 16.00 Payment for inpatient program capital (from 50.00 1, 957, 330 1, 442, 471 514, 859 1, 957, 330 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 263, 938 255, 807 8, 131 263, 938 17.00 17.01 Net organ acquisition cost 17.01 17.02 Credits received from manufacturers for 68.00 0 0 Λ 17.02

93.00

20, 921, 865

7, 504, 316

0 18.00

28, 426, 181 19.00

18.00

19.00 SUBTOTAL

replaced devices for applicable MS-DRGs

amount (see instructions)

Capital outlier reconciliation adjustment

Heal th	In Lie	u of Form CMS-2	2552-10				
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5	Provi der Co		Period: From 01/01/2022 To 12/31/2022	Worksheet E Part A Exhibi Date/Time Pre 5/25/2023 2:3	pared:
			Title	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	1, 738, 638	1, 273, 57	6 465, 062	1, 738, 638	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(o o	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	140, 106	111, 33	0 28, 776	140, 106	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(o o	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0452	0. 045	0. 0452		24. 00
	12	1 1			_		

(see Tristructions)					l	1
Di sproporti onate share adjustment (see	11. 00	78, 586	57, 565	21, 021	78, 586	25.00
instructions)						
Total prospective capital payments (see	12. 00	1, 957, 330	1, 442, 471	514, 859	1, 957, 330	26.00
instructions)						
	Wkst. E, Pt.	(Amt. from				
	A, line	Wkst. E, Pt.				
		A)				
	0	1.00	2.00	3. 00	4. 00	
						27.00
Low volume adjustment prior to October 1	70. 96	o	0		0	28.00
Low volume adjustment on or after October 1	70. 97	o		0	0	29.00
HVBP payment adjustment (see instructions)	70. 93	l ol	0	0	0	30.00
HVBP payment adjustment for HSP bonus	70. 90	l ol	0	0	0	30.01
payment (see instructions)						
HRR adjustment (see instructions)	70. 94	-128, 627	-92, 766	-35, 861	-128, 627	31.00
HRR adjustment for HSP bonus payment (see	70. 91	ol	0	0	0	31.01
instructions)						
					(Amt. to	
					Wkst. E, Pt.	
					A)	
	0	1.00	2.00	3. 00	4. 00	
HAC Reduction Program adjustment (see	70. 99		0	0	0	32.00
instructions)						
Transfer HAC Reduction Program adjustment to		N				100.00
Wkst. E, Pt. A.		1			I	l
	instructions) Total prospective capital payments (see instructions) Low volume adjustment prior to October 1 Low volume adjustment on or after October 1 HVBP payment adjustment (see instructions) HVBP payment adjustment for HSP bonus payment (see instructions) HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HAC Reduction Program adjustment (see instructions) Transfer HAC Reduction Program adjustment to	instructions) Total prospective capital payments (see instructions) Wkst. E, Pt. A, line O Low volume adjustment prior to October 1 Low volume adjustment on or after October 1 HVBP payment adjustment (see instructions) HVBP payment adjustment for HSP bonus payment (see instructions) HRR adjustment (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment for HSP bonus payment (see instructions) To. 94 HAC Reduction Program adjustment (see 70.99 instructions) Transfer HAC Reduction Program adjustment to	instructions) Total prospective capital payments (see instructions) Wkst. E, Pt. A, line Wkst. E, Pt. A) O 1.00 Low volume adjustment prior to October 1 Total years and payment adjustment on or after October 1 Total years and payment adjustment (see instructions) Total years and payment adjustment for HSP bonus Total years and payment (see instructions) Total years adjustment (see instructions) Total years and payment to N	instructions) Total prospective capital payments (see instructions) Wkst. E, Pt. (Amt. from Wkst. E, Pt. A) O 1.00 2.00 Low volume adjustment prior to October 1 70.96 0 1.00 Low volume adjustment on or after October 1 70.97 0 10 HVBP payment adjustment (see instructions) 70.93 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Instructions Total prospective capital payments (see instructions) 12.00 1,957,330 1,442,471 514,859	Instructions Total prospective capital payments (see 12.00

Health Financial Systems	IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0158	Peri od:

	Title XVIII	Hospi tal	5/25/2023 2: 3 PPS	5 pm
		,	1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00	Medical and other services (see instructions)		8, 406	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructions)		16, 894, 386	2.00
3. 00	OPPS payments		14, 173, 542	3.00
4. 00	Outlier payment (see instructions)		79, 762	4.00
4. 01	Outlier reconciliation amount (see instructions)		0 000	4.01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5		0.000	l l
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	
8. 00	Transitional corridor payment (see instructions)		0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 20	00	0	9.00
10.00	Organ acquisitions		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)		8, 406	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			
40.00	Reasonable charges		45.040	10.00
12.00	Ancillary service charges		45, 342 0	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)		45, 342	
14.00	Customary charges		45, 342	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for services	on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for service		0	
	had such payment been made in accordance with 42 CFR §413.13(e)	•		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	
18. 00	Total customary charges (see instructions)		45, 342	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceed	ls line 11) (see	36, 936	19.00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only if line 11 exceed</pre>	le line 18) (eee	0	20.00
20.00	instructions)	13 TTHE 10) (366		20.00
21. 00	Lesser of cost or charges (see instructions)		8, 406	21.00
22. 00	Interns and residents (see instructions)		0	
23. 00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		14, 253, 304	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see i		2, 508, 793	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of line instructions)	es 22 and 23] (see	11, 752, 917	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00	Subtotal (sum of lines 27 through 29)		11, 752, 917	30.00
31.00	Primary payer payments		3, 451	
32. 00	Subtotal (line 30 minus line 31)		11, 749, 466	32.00
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)			22 00
33. 00 34. 00	Allowable bad debts (see instructions)		0 227, 012	33. 00 34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)		147, 558	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		73, 544	
37. 00	Subtotal (see instructions)		11, 897, 024	
38. 00	MSP-LCC reconciliation amount from PS&R		0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			39.50
39. 75	N95 respirator payment adjustment amount (see instructions)		0	
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced devices (see ins	tructions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	structions)		39. 99
40. 00	Subtotal (see instructions)		11, 897, 024	
40. 01	Sequestration adjustment (see instructions)		149, 903	
40. 02	Demonstration payment adjustment amount after sequestration		0	
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs			40. 03
41. 00	Interim payments		11, 794, 251	
41. 01	Interim payments-PARHM or CHART		_	41.01
42.00	Tentative settlement (for contractors use only)		0	l
42. 01 43. 00	Tentative settlement-PARHM or CHART (for contractor use only) Balance due provider/program (see instructions)		-47, 130	42. 01 43. 00
43. 00	Balance due provider/program-PARHM (see instructions)		-47, 130	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15	5-2, chapter 1.	3, 484	1
50	\$115. 2	,	3, 154	
	TO BE COMPLETED BY CONTRACTOR]
			0	
	Original outlier amount (see instructions)		1	
91. 00	Outlier reconciliation adjustment amount (see instructions)		0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money		0 0. 00	92.00
91. 00 92. 00 93. 00	Outlier reconciliation adjustment amount (see instructions)		0	92.00 93.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/25/2023 2:	35 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				(200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet E-1
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/25/2023 2:35 pm	Health Financial Systems IU I ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0158

					5/25/2023 2: 3	5 pm
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider		25, 257, 02	6	11, 794, 251	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2. 00
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3. 00
	Program to Provider		l			
3. 01	ADJUSTMENTS TO PROVIDER	09/28/2022	33, 30	n	0	3. 01
3. 02	ABSOSTIMENTS TO TROVIDER	077 207 2022		Ö	o o	3. 02
3. 03				o	l ol	3. 03
3. 04				o	ol	3. 04
3. 05				0	ol	3. 05
	Provider to Program		•	<u> </u>		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		33, 30	0	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		25, 290, 32	6	11, 794, 251	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	o	5. 02
5.03				0	o	5.03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		199, 08	5	o	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	47, 130	6. 02
7.00	Total Medicare program liability (see instructions)		25, 489, 41	1	11, 747, 121	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1.00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financ	ial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
CALCULATION (OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0158	Peri od:	Worksheet E-1	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/25/2023 2:3	
			Title XVIII	Hospi tal	PPS	о ріп
					1. 00	
TO BE	COMPLETED BY CONTRACTOR FOR NONSTANDAR	D COST REPORTS				
HEALTH	INFORMATION TECHNOLOGY DATA COLLECTIO	N AND CALCULATION				
1.00 Total	hospital discharges as defined in AARA	§4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00 Medi ca	re days (see instructions)					2.00
	re HMO days from Wkst. S-3, Pt. I, col	. 6. line 2				3.00
	inpatient days (see instructions)					4. 00
	hospital charges from Wkst C, Pt. I, c					5. 00
	hospital charity care charges from Wks					6. 00
	ly - The reasonable cost incurred for	the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
line 1						
	ation of the HIT incentive payment (se					8. 00
	tration adjustment amount (see instruc					9. 00
	ation of the HIT incentive payment aft		(see instructions)			10.00
	ENT HOSPITAL SERVICES UNDER THE IPPS &					
	I/interim HIT payment adjustment (see	instructions)				30.00
	Adjustment (specify)					31.00
32.00 Bal and	e due provider (line 8 (or line 10) mi	nus line 30 and l	ine 31) (see instruction	ns)		32.00

Heal th	Financial Systems IU HEALTH WEST	HOSPI TAL	In Lieu	of Form CMS-2	552-10
OUTLIE	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0158 Period: W				
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/25/2023 2:35	pared:
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.03 plus 2.04 (see	instructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see instr	ructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instruc	ctions)		0	4.00
5.00	The rate used to calculate the time value of money (see instr	ructions)		0. 00	5.00
6.00	Time value of money for operating expenses (see instructions))		0	6.00
7.00	Time value of money for capital related expenses (see instru	ctions)		0	7.00

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

Provi der CCN: 15-0158

Peri od: Worksheet G From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/25/2023 2:35 pm

		General Fund	Speci fi c	Endowment	Plant Fund	5 pili
			Purpose Fund	Fund		
	OUDDENT ACCETS	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	440, 382, 455	0	ol	0	1.00
2. 00	Temporary investments	1440, 302, 433	0	0	0	2.00
3. 00	Notes receivable	Ö	0	Ö	0	
4.00	Accounts recei vable	33, 549, 986	0	O	0	4.00
5.00	Other receivable	1, 805, 420	0	0	0	1
6. 00	Allowances for uncollectible notes and accounts receivable	l l	0	0	0	6.00
7. 00 8. 00	Inventory Prepai d expenses	5, 389, 855	1	0	0	
9. 00	Other current assets	673, 179	0	0	0	
10.00	Due from other funds	0	Ö	o	0	
11.00	Total current assets (sum of lines 1-10)	481, 800, 895	0	O	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	6, 800, 703	I I	0	0	13.00
14. 00 15. 00	Accumulated depreciation Buildings	-6, 102, 945 182, 871, 250	I	0	0	14. 00 15. 00
16. 00	Accumulated depreciation	-57, 975, 368		0	0	
17. 00	Leasehold improvements	1, 261, 768		Ö	0	17.00
18.00	Accumul ated depreciation	-1, 232, 504	0	0	0	18. 00
19. 00	Fi xed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21. 00 22. 00	Automobiles and trucks Accumulated depreciation	101, 218 -101, 218		0	0	21.00
23. 00	Major movable equipment	99, 607, 457		0	0	23.00
24. 00	Accumulated depreciation	-73, 419, 914		0	0	24.00
25. 00	Mi nor equipment depreciable	0	0	Ö	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00 30. 00	Mi nor equi pment-nondepreci abl e	151, 810, 447	0	0	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	131, 610, 447	<u> </u>	U _I	0	30.00
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on Leases	0	0	O	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	5, 704, 274		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	5, 704, 274 639, 315, 616		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	039, 313, 010	<u> </u>	U _I	0	30.00
37.00	Accounts payable	19, 671, 554	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4, 559, 647	I	О	0	
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00 42. 00	Deferred income	0	0	U	0	41. 00 42. 00
43. 00	Accel erated payments Due to other funds	0	0	0	0	1
44. 00	Other current liabilities	1, 758, 357	Ö	Ö	0	
	Total current liabilities (sum of lines 37 thru 44)	25, 989, 558		O	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	0	0	0	0	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	227 571	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	237, 571 237, 571		0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	26, 227, 129	1	o	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	613, 088, 487				52.00
53.00	Specific purpose fund		0	_		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57. 00	Plant fund balance - invested in plant			٩	0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	613, 088, 487	1	0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	639, 315, 616	0	0	0	60.00
	[59]	I	ı l	I		I

Peri od: Worksheet G-1 From 01/01/2022 Provi der CCN: 15-0158

					То	12/31/2022	Date/Time Pro 5/25/2023 2:3	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1. 00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	580, 641, 576			4.00	5.00	1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		32, 369, 605			J		2.00
3.00	Total (sum of line 1 and line 2)		613, 011, 181			0		3.00
4.00	DONATED PROPERTY	77, 305			0		C	
5.00		0			0		C	
6. 00 7. 00		0			0		(
7. 00 8. 00					0		C	
9. 00					0		(
10.00	Total additions (sum of line 4-9)		77, 305			0		10.00
11.00	Subtotal (line 3 plus line 10)		613, 088, 486			0		11.00
12.00	Deductions (debit adjustments) (specify)	0			0		C	
13.00		0			0		C	
14. 00 15. 00		0			0		C	
16. 00					0		C	1
17. 00		o			0		C	
18.00	Total deductions (sum of lines 12-17)		0			О		18.00
19. 00			613, 088, 486			0		19. 00
	sheet (line 11 minus line 18)	Endowment	PI ant	Fund				
		Fund	Prant	runu				
		7 4114						
	T	6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4. 00	DONATED PROPERTY	١	0		۷			4.00
5. 00	SOUTH EST THOUSEN		0					5.00
6.00			0					6.00
7.00			0					7. 00
8.00			0					8.00
9. 00 10. 00	Total additions (sum of line 4-9)		O		0			9. 00 10. 00
11.00	Subtotal (line 3 plus line 10)				0			11.00
12. 00	Deductions (debit adjustments) (specify)		0		Ĭ			12.00
13. 00	((0					13.00
14.00			0					14.00
15.00			0					15.00
16.00			0					16.00
17. 00 18. 00	Total deductions (sum of lines 12-17)		O		0			17. 00 18. 00
19.00	Fund balance at end of period per balance				0			19.00
50	sheet (line 11 minus line 18)							
		·						

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0158

	/2023 2: 35 otal	
	otai i	
	3. 00	
PART I - PATIENT REVENUES		
General Inpatient Routine Services		
1. 00 Hospi tal 133, 576, 494 133	3, 576, 494	1.00
2.00 SUBPROVIDER - IPF		2.00
3. 00 SUBPROVI DER - I RF		3.00
4. 00 SUBPROVI DER		4.00
5.00 Swing bed - SNF 0	o	5.00
6.00 Swing bed - NF 0	o	6.00
7.00 SKILLED NURSING FACILITY		7.00
8. 00 NURSING FACILITY	İ	8.00
9. 00 OTHER LONG TERM CARE	İ	9.00
10.00 Total general inpatient care services (sum of lines 1-9) 133,576,494 133	3, 576, 494	10.00
Intensive Care Type Inpatient Hospital Services		
11. 00 I NTENSI VE CARE UNIT 29, 311, 689 29	9, 311, 689	11.00
12. 00 CORONARY CARE UNIT		12.00
13.00 BURN INTENSIVE CARE UNIT		13.00
14.00 SURGICAL INTENSIVE CARE UNIT		14.00
15. 00 NEONATAL INTENSIVE CARE UNIT	3, 814, 306	15.00
16.00 Total intensive care type inpatient hospital services (sum of lines 33,125,995 33	3, 125, 995	16.00
11-15)		
17.00 Total inpatient routine care services (sum of lines 10 and 16) 166,702,489 166	5, 702, 489	17.00
18.00 Ancillary services 314, 913, 848 571, 137, 727 886	5, 051, 575	18.00
19. 00 Outpatient services 48, 733, 861 197, 194, 141 245	5, 928, 002	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 NRCC 0 856	856	27.00
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 530, 350, 198 768, 332, 724 1, 298	3, 682, 922	28.00
G-3, line 1)		
PART II - OPERATING EXPENSES		
29.00 Operating expenses (per Wkst. A, column 3, line 200) 262,574,437		29.00
30. 00 ADD (SPECI FY) 0		30.00
31.00		31.00
32. 00		32.00
33.00		33.00
34. 00		34.00
35. 00		35.00
36.00 Total additions (sum of lines 30-35)		36.00
37.00 DEDUCT (SPECIFY) 0		37.00
38.00		38.00
39.00		39.00
40.00	I	40.00
41. 00	1	41.00
42.00 Total deductions (sum of lines 37-41) 0	1	42.00
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 262,574,437		43.00
to Wkst. G-3, line 4)		

	Financial Systems IU HEALTH MENT OF REVENUES AND EXPENSES	WEST HOSPITAL Provider CCN: 15-0158	Peri od:	u of Form CMS-2 Worksheet G-3	
,,,,_,,	ENT OF REVENUES 7440 ENTENUES	11001 del 2000. 10 0100	From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/25/2023 2:3	
				0, 20, 2020 2. 0	<u> </u>
				1. 00	
00	Total patient revenues (from Wkst. G-2, Part I, column			1, 298, 682, 922	1. (
00	Less contractual allowances and discounts on patients'	accounts		1, 010, 016, 025	2. (
00	Net patient revenues (line 1 minus line 2)			288, 666, 897	3. (
00	Less total operating expenses (from Wkst. G-2, Part II,			262, 574, 437	4. (
00	Net income from service to patients (line 3 minus line	4)		26, 092, 460	5. (
	OTHER I NCOME				
00	Contributions, donations, bequests, etc			0	6.
00	Income from investments			0	7.
00	Revenues from telephone and other miscellaneous communi	cation services		0	
00	Revenue from television and radio service			0	
. 00	Purchase di scounts			0	10.
	Rebates and refunds of expenses			0	11.
	Parking lot receipts			0	12.
	Revenue from Laundry and Linen service			0	13.
	Revenue from meals sold to employees and guests			0	14.
	Revenue from rental of living quarters			0	15.
	Revenue from sale of medical and surgical supplies to o	other than patients		0	16.
	Revenue from sale of drugs to other than patients			0	17.
	Revenue from sale of medical records and abstracts			0	18.
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.
. 00	Rental of vending machines			0	21.
. 00	Rental of hospital space			0	22.
	Governmental appropriations			0	
	MISC INCOME			6, 277, 145	24.
. 50	COVI D-19 PHE Fundi ng			0	24.
. 00	Total other income (sum of lines 6-24)			6, 277, 145	25.
. 00	Total (line 5 plus line 25)			32, 369, 605	26.
. 00	OTHER EXPENSES (SPECIFY)			0	27.
3. 00	Total other expenses (sum of line 27 and subscripts)			0	28.
9. 00	Net income (or loss) for the period (line 26 minus line	28)		32, 369, 605	29.

Heal th	Financial Systems IU HEALTH W	EST HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0158	Peri od: From 01/01/2022 To 12/31/2022	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			1, 738, 638	
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1
2.00	Capital DRG outlier payments			140, 106	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the cos	t reporting period (see ins	tructions)	116. 66	
4.00	Number of interns & residents (see instructions)			0.00	1
5. 00	Indirect medical education percentage (see instructions)	the cum of lines 1 and 1 0	1 001	0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			0	
7. 00	Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		E, part A line	3. 90	
8. 00	Percentage of Medicaid patient days to total days (see in	structions)		17. 93	
9. 00	Sum of lines 7 and 8			21. 83	
10.00	Allowable disproportionate share percentage (see instruct	ions)		4. 52	
11.00	Disproportionate share adjustment (see instructions)			78, 586	
12. 00	Total prospective capital payments (see instructions)			1, 957, 330	12.00
				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 instruction	s)		0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
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	
2.00	Program inpatient capital costs for extraordinary circums	tances (see instructions)		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	1
4.00	Applicable exception percentage (see instructions)			0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	
6.00	Percentage adjustment for extraordinary circumstances (se			0.00	
7.00	Adjustment to capital minimum payment level for extraordi	nary circumstances (line 2	x line 6)	0	
8.00	Capital minimum payment level (line 5 plus line 7)			0	1
9.00	Current year capital payments (from Part I, line 12, as a		1 11 0	0	
10.00	Current year comparison of capital minimum payment level			0	
11. 00	Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)	er capital payment (from pr	ror year	0	11.00
12 00	Net comparison of capital minimum payment level to capita	l navments (line 10 nlus li	ne 11)	n	12 00

12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)
13.00 Current year exception payment (if line 12 is positive, enter the amount on this line)
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following period

(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)

0 17.00

0 12.00

0 13.00 14.00

0 15.00

0 16.00