CONTRACTOR		o. Date Received.	TO. MIN Date.
use only	(1) As Submitted		11. Contractor's Vendor Code: 4
<u> </u>	(2) Settled without Audit	8. [N] Initial Report for this Provider CCN	12.[0]If line 5, column 1 is 4: Enter
		9. [N] Final Report for this Provider CCN	number of times reopened = 0-9.
	(3) Settled with Audit		number of trines reopened = 0-7.
	(4) Reopened		
	(5) Amended		
	(3) Allerided		

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH WHITE HOSPITAL (15-1312) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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.

(0)		-	
(SI	ane	ed)	

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

05/26/2017

			Title XVIII				
	Cost Center Description	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	-56, 626	160, 102	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-66, 337	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-122, 963	160, 102	0	0	200.00

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

	n Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX		TH WHITE H		L er CCN: 1	15 1010	Peri od:		of For Workshe		2552-10
позы	TAL AND HUSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	IA	PLOVIU	er con.	10-1312	From 01/01	/2016 /2016	Part I Date/Ti	me Pre	pared:
	1.00	2.	00		3.00			4.00	5/22/20	017 2:4	6 pm
1.00	Hospital and Hospital Health Care Co Street: 720 SOUTH SIXTH STREET	PO Box:									1.00
2.00	Ci ty: MONTI CELLO	State: I	N Z	ip Code	e: 47960		ity: WHITE				2.00
		Component Na		CCN umber	CBSA Number	Provi de Type	r Date Certified		nt Syst 0, or		
								V	XVIII	XIX	
	Hospital and Hospital-Based Componer	1.00 1.1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	IU HEALTH WHITE	1!	51312	99915	1	07/01/1966	5 N	0	0	3.00
4.00	Subprovider - IPF	HOSPI TAL									4.00
5.00 6.00	Subprovider - IRF Subprovider - (Other)										5.00
7.00	Swing Beds - SNF	IU HEALTH WHITE	1!	5Z312	99915		02/16/1990	D N	0	N	7.00
8.00	Swing Beds - NF	HOSPI TAL									8.00
9.00	Hospital-Based SNF										9.00
10.00 11.00	1										10.00
12.00		HOME CARE OF WHI	TE 1!	57514	99915		03/01/199	7 N	N	N	12.00
13.00	Separately Certified ASC	COUNTY									13.00
14.00	Hospi tal -Based Hospi ce										14.00
15.00 16.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.00
17.00	Hospital-Based (CMHC) I										17.00
18.00 19.00											18.00
		1					From		To		-
20.00	Cost Reporting Period (mm/dd/yyyy)						1.00		2. (12/31/		20.00
21.00	Type of Control (see instructions) Inpatient PPS Information						2				21.00
22.00	Does this facility qualify and is it								N		22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil		-								
	amendment hospital?) In column 2, en	iter "Y" for yes o	r "N" for	no.		. , .					
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						N		N		22.01
	reporting period occurring prior to	October 1. Enter	in column	2, "Y"	for yes	s or "N"					
	for no for the portion of the cost r (see instructions)	eporting period d	ccurring c	on or a	rter Uci	toper I.					
22. 02	Is this a newly merged hospital that determined at cost report settlement						N		N		22.02
	or "N" for no, for the portion of th	e cost reporting	period pri	or to	October	1. Enter					
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of the	cost r	eporting	g period o	on				
22. 03	Did this hospital receive a geograph								Ν		22.03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for						~				
	prior to October 1. Enter in column	2, "Y" for yes or	"N" for r	no for	the port	tion of th	ne				
	cost reporting period occurring on a hospital contain at least 100 but no						th				
22.00	42 CFR 412.105)? Enter in column 3,			1/ 05	h - l - 1/2	1		2			22.00
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i						1	3	N		23.00
	method of identifying the days in the used in the prior cost reporting per										
			In-State	In-St	ate (Out-of	Out-of	Medi cai		ther	
			Medicaid paid days	Medic eligi		State edi cai d	State Medi cai d	HMO day		li cai d lays	
				unpa		nid days	eligible			-	
			1.00	day 2. 0		3.00	unpai d 4. 00	5.00	6	. 00	-
24.00	If this provider is an IPPS hospital		C		0	0	0		0	0	24.00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu	it unpaid days in									
25 00	column 5, and other Medicaid days in If this provider is an IRF, enter th		C		0	0	0		0		25.00
20.00	Medicaid paid days in column 1, the	in-state	C		Ĭ	5	Ĭ				
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	umn 4, Medicaid									

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	TE HOSPITAL Provider CC		eriod: rom 01/01/2016	Worksheet S Part I Date/Time P	repared:
				Urban/Rural S	5/22/2017 2 Date of Geo	
				1.00	2.00	
 b. 00 Enter your standard geographic classification (not way cost reporting period. Enter "1" for urban or "2" foi 7. 00 Enter your standard geographic classification (not way reporting period. Enter in column 1, "1" for urban on 	r rural. age) sta	atus at the end	l of the cost		2	26.00 27.00
enter the effective date of the geographic reclassifi 5.00 f this is a sole community hospital (SCH), enter the effect in the cost reporting period.	i cati on	in column 2.			0	35.00
				Begi nni ng:	Endi ng:	
00 Estas and include having and and includes of COU	+ - + · · - (0/ fan muchan	1.00	2.00	24.00
 b. 00 Enter applicable beginning and ending dates of SCH so of periods in excess of one and enter subsequent date 7. 00 If this is a Medicare dependent hospital (MDH), enter 	es.				0	36.00 37.00
is in effect in the cost reporting period. 7.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions.				Ν		37.01
 instructions) 00 f line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates. 						38.00
				Y/N	Y/N	
2.00 Does this facility qualify for the inpatient hospital		nt adjustment f	for Low volume	1.00 N	2.00 N	39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i) or "N" for no. Does the facility meet the mileage rea CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Ente quiremen or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ice with 42 nstructions)			
0.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.	ber 1. I	Enter "Y" for y		N	N N	40.00
				V 1. 0		
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for (di sproporti onat	e share in acc	ordance N	N N	45.00
b. 00 Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N N	46.00
7.00 Is this a new hospital under 42 CFR §412.300 PPS capi 3.00 Is the facility electing full federal capital paymen Teaching Hospitals				IO. N		
b. 00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	? Enter "Y" f	for yes N		56.00
7.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes o th of th Y", comp	r "N" for no in nis cost report plete Worksheet	column 1. If ing period? E	column 1 inter "Y"		57. OC
3.00 fline 56 is yes, did this facility elect cost reim	bursemen	nt for physicia	ins' services a	IS		58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 2.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.	N		59.00
0.00 Are you claiming nursing school and/or allied health	costs	for a program t	hat meets the	N		60.00
provider-operated criteria under §413.85? Enter "Y"	for yes Y/N	<u>s or "N" for no</u> IME	<u>D. (see instruc</u> Direct GME	IME	Direct GME	<u> </u>
00 Did your beenitel receive FTF elete under ACA	1.00	2.00	3.00	4.00	5.00	00 (1 00
I.OO Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.0	0 0.	00 61.00
I.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00			61.01
I. 02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0. 00	0. 00			61.02
I.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0. OC	0.00			61. 03
instructions) 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0. 00	0.00			61.04
current cost reporting period. (see instructions).			0.00			61.05

OSPITAL AND HOSP	Systems PITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA	Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared
			Y/N	IME	Direct GME	IME	5/22/2017 2:4 Direct GME	6 pm
			1.00	2.00	3.00	4.00	5.00	
used for ca	amount of ACA §5503 aw ap relief and/or FTEs neral surgery. (see in	that are nonprimary		0.00	0.0	0		61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
				1.00	2.00	3.00	4.00	
special ty, for each ne column 1, f program coo unweighted FTE unweigh 1.20 Of the FTEs	s in line 61.05, speci if any, and the numbe ew program. (see instr the program name, ente de, enter in column 3, count and enter in co tted count. s in line 61.05, speci ecialty, if any, and t	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded				0.00		61.
residents f instruction enter in co 3, the IME	For each expanded prog ns) Enter in column 1, plumn 2, the program C FTE unweighted count GME FTE unweighted cou	ram. (see the program name, ode, enter in column and enter in column						
							1.00	
	ons Affecting the Hea number of FTE resident					ind for which	0.00	62.
	tal received HRSA PCRE			a in this cost	reporting per	rod for which	0.00	02.
during in t	number of FTE resident this cost reporting pe ospitals that Claim Re	riod of HRSA THC prog	gram. (s	see instruction		your hospital	0.00	62.
3.00 Has your fa	acility trained reside s or "N" for no in col	nts in nonprovider se	ettings	during this co		period? Enter	N	63.
					Unweighted		Ratio (col. 1/	
					FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
Section 550	04 of the ACA Base Yea	r FTE Residents in N	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
4.00 Enter in co in the base resident F settings. resident F	t begins on or after J olumn 1, if line 63 is e year period, the num TEs attributable to ro Enter in column 2 the TEs that trained in yo 1 divided by (column	uly 1, 2009 and befo yes, or your facili ber of unweighted nor tations occurring in number of unweightee ur hospital. Enter in	<u>re June</u> ty trair n-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	-		64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
is yes, or trained res year period associated FTEs for ea program in residents. the program column 3, f unweighted residents a rotations o non-provide column 4, f unweighted	blumn 1, if line 63 your facility sidents in the base d, the program name with primary care ach primary care which you trained Enter in column 2, m code, enter in the number of primary care FTE attributable to occurring in all er settings. Enter in the number of primary care EEs that trained in tal. Enter in column				0. 00	0.00	0. 000000	

Heal th	Financial Systems		LTH WHITE HOSPITAL			eu of Form CMS-2		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/22/2017 2:4	pared:	
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 sEffective fo	2.00 pr cost report	3.00 ing periods		
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0. 00	0. 00	0. 000000	66.00	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))		
(7.00	Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00	(7.00	
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	
					1.0	0 2.00 3.00		
	Inpatient Psychiatric Facility F					0 2.00 3.00	70.00	
75.00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRF), or does it c	ontain an IRF	N		75.00	
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Enter new teaching program for no. Column 3: If	program in the "Y" for yes or in accordance column 2 is Y,	most "N" for with 42	0	76.00	
						1.00		
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Enter	N N	80. 00 81. 00	
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit) under			N	85. 00 86. 00	
87.00	Is this hospital a "subclause (I for yes or "N" for no.			(1)(B)(iv)(II)?	'Enter "Y"	Ν	87.00	
					V	XI X		
	Title V and XIX Services				1.00	2.00		
90.00	Does this facility have title V yes or "N" for no in the applica		hospital services? E	nter "Y" for	Y	Y	90.00	
91.00	Is this hospital reimbursed for	title V and/or XIX th			N	N	91.00	
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certificat			N	92.00	
93. 00	instructions) Enter "Y" for yes Does this facility operate an IC "Y" for yes or "N" for no in the	F/IID facility for pu		d XIX? Enter	Ν	N	93. 00	
94.00	Does title V or XIX reduce capit applicable column.		or yes, and "N" for n	o in the	Ν	N	94.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TE HOSPITAL Provider C		Period: From 01/01/ To 12/31/	2016	u of Forr Workshe Part I Date/Ti 5/22/20	et S-2 me Pre	2 epared:
			V		XI >		
			1.00		2.0		
 P5.00 If line 94 is "Y", enter the reduction percentage in the app Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column. 			0.00 N		0. 0 N	0	95.00 96.00
07.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		n.	0.00		0.0	0	97.00
05.00 Does this hospital qualify as a critical access hospital (C/ 06.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of payment	t N				105.00 106.00
07.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see insti	ructions) lf	t N				107.00
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	L-	Dession		108.00
	Physi cal 1.00	Occupational 2.00	Speec 3.00		Respira 4.0		-
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N		109.00
10.00Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (41	10A Demo)for	-	1.0 N	0	110.0
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider	. If column 2 i nt for long te	is "E", enter rm care (inclu	in column udes	N		0	115. 00
Pub.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu no.			"N" for	N N			116. 0 117. 0
18.00 is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1 i	if the policy	is	1			118.00
		Premi ums	Losse	S	Insura	ance	
		1.00	2.00		3.0		-
18.01 List amounts of malpractice premiums and paid losses:		44, 30)9	0		(0 118. 0 ⁻
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N		2.0	0	118.0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in	n column 1, "Y	" for yes or	N		N		119. 0 120. 0
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.							
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impla	nts? (see insti	ructions)	Y				121.00
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	nts? (see instr antable device: Enter "Y" for	ructions) s charged to yes or "N"	YN				
 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for 	nts? (see inst antable device: Enter "Y" for he Worksheet A	ructions) s charged to yes or "N" line number					122. 0
 Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implationts? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, end 	nts? (see inst antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certi	ructions) s charged to yes or "N" line number for no. If	N				121. 00 122. 00 125. 00 126. 00
 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 	nts? (see inst antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certifi 2.	ructions) s charged to yes or "N" line number for no. If fication date ication date	N				122. 00 125. 00 126. 00 127. 00
 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2 	nts? (see inst antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certif 2. ter the certifi 2. ter the certifi 2.	ructions) s charged to yes or "N" line number for no. If fication date ication date	N				122. 00
 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 29.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 30.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	nts? (see insti- antable devices Enter "Y" for he Worksheet A or yes and "N" nter the certifi 2. ter the certifi 2. er the certifi 2. er the certifi anter the certifi	ructions) s charged to yes or "N" line number for no. If fication date ication date ication date in	N				122. 00 125. 00 126. 00 127. 00 128. 00
 Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implationts? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 128.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2 	nts? (see inst antable device: Enter "Y" for he Worksheet A or yes and "N" nter the certifi 2. ter the certifi 2. er the certifi 2. enter the certifi 3. enter the certifi 3. ent	ructions) s charged to yes or "N" line number for no. If fication date ication date ication date ication date in tification ertification	N				122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IU HEALTH WHIT IDENTIFICATION DATA	Provider CC	CN: 15-1312			u of Form CMS- Worksheet S-2 Part I Date/Time Pre	
					2010	5/22/2017 2:4	
					1.00	2.00	-
133.00 If this is a Medicare certified oth			cation date				133.00
in column 1 and termination date, i 134.00 If this is an organ procurement or and termination date, if applicable	ganization (OPO), enter th		n column 1				134.00
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or "I	N" for no in column 1. If	yes, and home	office cost	ts	Y	15H059	140. 00
are claimed, enter in column 2 the 1.00					3.00		
If this facility is part of a chai				name and	d address	of the	
home office and enter the home offi 141. 00Name: INDIANA UNIVERSITY HEALTH	<u>ce contractor name and co</u> Contractor's Name: WPS			tor's Nu	mber: 0810	1	141.00
142.00 Street: 340 WEST 10TH STREET	PO Box:	-					142.00
143.00 City: INDIANAPOLIS	State: IN		Zip Coc	le:	4620	2	143.00
						1.00	-
144.00 Are provider based physicians' cos	ts included in Worksheet A	1?				Y	144.00
					1.00	2.00	-
145.00 If costs for renal services are cla	aimed on Wkst. A, line 74,	are the costs	s for		Y	2.00	145.00
inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" 146.00 Has the cost allocation methodology	for yes or "N" for no in ude Medicare utilization for no in column 2. y changed from the previou	column 1. If c for this cost usly filed cost	column 1 is reporting t report?		N		146. 00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/do		5-2, chapter 4	40, §4020) I	f			
						1.00	147.00
147.00 Was there a change in the statistic 148.00 Was there a change in the order of						N	147.00 148.00
149.00 Was there a change to the simplifie				or no.		N	149.00
		Part A	Part B		itle V	Title XIX	-
Does this facility contain a provid	der that qualifies for an	1.00 exemption from	2.00		3.00 the Lowe	4.00	
or charges? Enter "Y" for yes or "I							
155.00 Hospi tal		N	N		N	N	155.00
156.00 Subprovi der – I PF 157.00 Subprovi der – I RF		N N	N N		N N	N	156.00 157.00
158. OO SUBPROVI DER		14				iv.	158.00
159. 00 SNF		Ν	N		Ν	Ν	159.00
160.00 HOME HEALTH AGENCY		N	N		N	N	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus				- I 0D	<u> </u>	N	1/5 00
165.00 Is this hospital part of a Multicar Enter "Y" for yes or "N" for no.	npus nospitai that has one	e or more campu	uses in ditt	erent CB	SAS?	N	165.00
	Name	County		Zip Code	CBSA	FTE/Campus	
1// 00/15 line 1/5 is yes far and	0	1.00	2.00	3.00	4.00	5.00	1((00
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,						0. 00	166.00
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)					<u> </u>		
						1.00	
Heal th Information Technology (HIT)) incentive in the America	an Recovery and	d Reinvestme	ent Act			4/7 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 109				') enter	the	Y	167.00 168.00
reasonable cost incurred for the H				, onter	2110		1.00.00
168.01 If this provider is a CAH and is no					shi p		168. 01
exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful us transition factor. (see instruction	ser (line 167 is "Y") and				nter the	0.00	169. 00

Health Financial Systems IU HEALTH WHI	TE HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1312	Period: From 01/01/2016	Worksheet S-2 Part I	2
		To 12/31/2016		
		Begi nni ng	Endi ng	
	1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00	
				-
		1.00	2.00	
171.00 If line 167 is "Y", does this provider have any days for in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. "Y" for yes and "N" for no in column 1. If column 1 is yes, 1876 Medicare days in column 2. (see instructions)	I, line 2, col. 6? Enter	P Y	28	3171.00

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2016 Part II Date/Time Prepared: То 12/31/2016 5/22/2017 2:46 pm Y/N Date 1.00 2.00 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 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 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 Туре 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 Y А 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 Ν 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing school 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 Ν 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 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A 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 16.00 Ν 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) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/03/2017 γ 04/03/2017 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) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

Ν

19.00

Ν

cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.

HOSPI TAL		ITE HOSPITAL		In Lie	eu of Form CMS	S-2552-10
	AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-1312 P	eri od:	Worksheet S	
				rom 01/01/2016		
			1	o 12/31/2016	Date/Time P 5/22/2017 2	
		Descri	ntion	Y/N	Y/N	. 40 pm
				1.00	3.00	
20.00 If	fline 16 or 17 is yes, were adjustments made to PS&R)	N 1.00	N 3.00	20.00
	eport data for Other? Describe the other adjustments:			IN IN		20.00
	sport data for other: bescribe the other day distillents.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21 00 Wz	as the cost report prepared only using the provider's	N	2.00	N 0.00	1.00	21.00
	ecords? If yes, see instructions.			in in		21.00
					1.00	
00	MPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPLTALS)			
	ipital Related Cost		001111(20)			
	ave assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
	ave changes occurred in the Medicare depreciation expense		als made durin	a the cost	N	23.00
	eporting period? If yes, see instructions.			g the cost		20.00
	ere new leases and/or amendments to existing leases enter	rting period?	N	24.00		
	f yes, see instructions	ring periou:		24.00		
	ave there been new capitalized leases entered into during	f ves see	N	25.00		
	nstructions.	i yes, see		20.00		
	ere assets subject to Sec. 2314 of DEFRA acquired during t	ho cost roporti	ng poriod2 lf	V05 500	N	26.00
	nstructions.	ne cost reporti	ng periou: II	yes, see		20.00
	as the provider's capitalization policy changed during th	e cost reportin	a period2 lf v	os submit	N	27.00
	Dpy.	e cost reportin	g periou: ii y	es, subili t		27.00
	iterest Expense				l	
	ere new Loans, mortgage agreements or letters of credit e	ntorod into dur	ing the cost r	oporting	N	28.00
	eriod? If yes, see instructions.		ing the cost i	eportring		20.00
	d the provider have a funded depreciation account and/or	bond funds (Do	ht Sarvian Doc	arva Eurad)	N	29.00
			DI SELVICE RES	erve Fund)	I IN	29.00
	reated as a funded depreciation account? If yes, see inst		dabt2 If yoo	~~~	N	20.00
	as existing debt been replaced prior to its scheduled mate	unity with new	debt? IT yes,	see	N	30.00
	nstructions.	courses of now	dabt2 If yoo	~~~	N	21 00
	as debt been recalled before scheduled maturity without is	ssuance of new	debt? IT yes,	see	N	31.00
	nstructions.				l	
	irchased Services	and and for the	م		N	
	ave changes or new agreements occurred in patient care se		a through cont	ractual	N	32.00
	rrangements with suppliers of services? If yes, see instruction		a to compositi ti	va hidding? If		22.00
	fline 32 is yes, were the requirements of Sec. 2135.2 ap	pried pertainin	g to competiti	ve braarng? Ti	l I	33.00
	o, see instructions.				I	_
	rovi der-Based Physi ci ans			d about stars?	Y	- 24.00
	re services furnished at the provider facility under an a	rrangement with	provi der-base	a physicians?	l Y	34.00
	fyes, see instructions.					05.00
	fline 34 is yes, were there new agreements or amended ex		ts with the pr	ovi der-based	N	35.00
pr	nysicians during the cost reporting period? If yes, see i	nstructions.				
				Y/N	Date	
				1.00	2.00	
	ome Office Costs					
36.00 We	ere home office costs claimed on the cost report?			Y	1	36.00
	fline 36 is yes, has a home office cost statement been p	repared by the	home office?	Y	1	37.00
37.00 If	f yes, see instructions.					
37.00 I f I f		N	1			
37.00 If If 38.00 If	fline 36 is yes , was the fiscal year end of the home of			IN		38.00
37.00 f f 38.00 f th	ne provider? If yes, enter in column 2 the fiscal year en	d of the home o	ffi ce.			
37.00 f f 38.00 f th 39.00 f	ne provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth	d of the home o	ffi ce.	N		
37.00 f f 38.00 f 56 39.00 f 56	ne provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions.	d of the home o er chain compon	ffice. ents? If yes,	N		39.00
37.00 f 1 f 38.00 f 1 f 39.00 f 39.00 f 40.00 f	ne provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the	d of the home o er chain compon	ffice. ents? If yes,			39.00
37.00 f 1 f 38.00 f 1 f 39.00 f 39.00 f 40.00 f	ne provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions.	d of the home o er chain compon	ffice. ents? If yes,	N		39.00
37.00 f 1 f 38.00 f 1 f 39.00 f 39.00 f 40.00 f	ne provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see	N		39.00
37.00 f 1 38.00 f 39.00 f 39.00 f 56 10.00 f	ne provider? If yes, enter in column 2 the fiscal year end f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the hstructions.	d of the home o er chain compon	ffice. ents? If yes, If yes, see	N	00	39.00
37.00 f 1 38.00 f 39.00 f 39.00 f 40.00 f i r <u>Co</u>	ne provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to oth ee instructions. fline 36 is yes, did the provider render services to the instructions.	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see	N N 2.	00	39.00
37.00 f 1 f 38.00 f 39.00 f 39.00 f 40.00 f 41.00 Er	ne provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to othe ee instructions. fline 36 is yes, did the provider render services to the instructions. ext Report Preparer Contact Information inter the first name, last name and the title/position	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see	N	00	39.00 40.00
37.00 f 1 f 38.00 f 39.00 f 39.00 f 40.00 f 41.00 Er	ne provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to oth ee instructions. fline 36 is yes, did the provider render services to the instructions.	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see	N N 2.	00	39.00
37.00 f 1 f 38.00 f 39.00 f 39.00 f 56 40.00 f 1 f 1 f 56 1 f 56 1 f 56 1 f 56 1 f 38.00 1 f 1 f 1 f 38.00 1 f 1 f 1 f 38.00 1 f 1 f 39.00 1 f 1 f 39.00 1 f 56 1 f 1 f 1 f 39.00 1 f 56 1 f 1 f 1 f 1 f 39.00 1 f 1 f 1 f 39.00 1 f 1 f	ne provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to othe ee instructions. fline 36 is yes, did the provider render services to the instructions. ext Report Preparer Contact Information inter the first name, last name and the title/position	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see	N N 2.	00	39.00
37.00 f 1 f 38.00 f 1 f 39.00 f 1 f 39.00 f 1 f 	he provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to othe ee instructions. fline 36 is yes, did the provider render services to the instructions. <u>ext Report Preparer Contact Information</u> ther the first name, last name and the title/position eld by the cost report preparer in columns 1, 2, and 3,	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see 00	N N 2.	00	39. 00 40. 00 41. 00
37.00 f 1 f 38.00 f 1 f 39.00 f 1 f 39.00 f 40.00 1 f 38.00 1 f 1 f 1 f 38.00 1 f 1 f 1 f 39.00 1 f 1 f 1 f 1 f 39.00 1 f 	he provider? If yes, enter in column 2 the fiscal year end fline 36 is yes, did the provider render services to othe ee instructions. fline 36 is yes, did the provider render services to the hstructions.	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see 00	N N 2.	00	38.00 39.00 40.00 41.00 42.00
37.00 f 1 f 38.00 f 39.00 f 39.00 f 40.00 f 1 r 41.00 Er 66 67 67 67 7 7 7 7 7 7 7 7 7 	ne provider? If yes, enter in column 2 the fiscal year end f line 36 is yes, did the provider render services to othe ee instructions. f line 36 is yes, did the provider render services to the nstructions. est Report Preparer Contact Information neter the first name, last name and the title/position eld by the cost report preparer in columns 1, 2, and 3, espectively. neter the employer/company name of the cost report	d of the home o er chain compon home office?	ffice. ents? If yes, If yes, see 00	N N 2.		39. 00 40. 00 41. 00

Heal th	Financial Systems	U HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	I ONNAI RE	Provi der	CCN: 15-1312	Period: From 01/01/2016	Worksheet S-2 Part II	
					To 12/31/2016		
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/p	oosition (GOVERNMENT P	ROGRAMS DI RECTO	R		41.00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost rep	port					42.00
	preparer.						
43.00	Enter the telephone number and email address of	f the cost					43.00
	report preparer in columns 1 and 2, respectivel	y.					

Heal th	Financial Systems	IU HEALTH WHIT	TE HOSPITAL		In Lie	n Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016			
						I/P Days / O/P		
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V		
	Component	Line Number	NO. OT DEUS	Avai I abl e	CAIT HOULS	nuev		
		1.00	2.00	3.00	4.00	5.00		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	21	7, 68		0	1.00	
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00	
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00	
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		21	7, 68			7.00	
8.00	INTENSIVE CARE UNIT	31.00	4	1, 46	6, 312. 00	0	8.00	
9.00	CORONARY CARE UNI T						9.00	
10.00	BURN INTENSIVE CARE UNIT						10.00	
11.00	SURGICAL INTENSIVE CARE UNIT						11.00	
12.00	OTHER SPECIAL CARE (SPECIFY)	10.00					12.00	
13.00	NURSERY	43.00	0.5			0	13.00	
14.00	Total (see instructions)		25	9, 15	35, 736. 00	0	14.00	
15.00	CAH visits					0	15.00	
16. 00 17. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF						16.00 17.00	
17.00	SUBPROVIDER - TRF						17.00	
18.00	SUBPROVIDER SKILLED NURSING FACILITY						19.00	
20.00	NURSING FACILITY						20.00	
20.00	OTHER LONG TERM CARE						20.00	
21.00	HOME HEALTH AGENCY	101.00				0	22.00	
22.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				0	23.00	
24.00	HOSPI CE						24.00	
24.10	HOSPICE (non-distinct part)	30, 00					24.10	
25.00	CMHC - CMHC						25.00	
26.00	RURAL HEALTH CLINIC						26.00	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26. 25	
27.00	Total (sum of lines 14-26)		25				27.00	
28.00	Observation Bed Days					0	28.00	
29.00	Ambul ance Trips						29.00	
30.00	Employee discount days (see instruction)						30.00	
31.00	Employee discount days - IRF						31.00	
32.00	Labor & delivery days (see instructions)		0		0		32.00	
32.01	Total ancillary labor & delivery room						32. 01	
33.00	outpatient days (see instructions) LTCH non-covered days						33.00	

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	1, 001	11	1, 22			1.0
. 00	for the portion of LDP room available beds) HMO and other (see instructions)	185	67				2.0
. 00	HMO I PF Subprovi der	0	07				3.0
. 00	HMO I RF Subprovi der	o	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	311	0	31	1		5.0
. 00	Hospital Adults & Peds. Swing Bed NF	011	0		7		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 312	11	1, 59			7.0
. 00	INTENSIVE CARE UNIT	80	0	26	3		8.0
. 00	CORONARY CARE UNIT						9.1
0. OO	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		0		0		13. (
4.00	Total (see instructions)	1, 392	11	1, 85	0.00	131.19	14. (
5.00	CAH visits	0	0		0		15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER – IRF						17.
B. 00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19.
D. 00	NURSING FACILITY						20.
1. 00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY	0	0		0 0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
1.00	HOSPICE						24.
4. 10	HOSPICE (non-distinct part)	0	0		0		24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC						26.
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
7.00	Total (sum of lines 14-26)				0.00	131.19	
3.00	Observation Bed Days		114	96	0		28.
9.00	Ambul ance Trips	0			~		29.
0.00	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	0		0		32.
2. 01	Total ancillary labor & delivery room				0		32.
2 00	outpatient days (see instructions)						33.
3.00	LTCH non-covered days	0					

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016		pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0			540	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				58 23 0 0		2.00 3.00 4.00
5.00 6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						5.00 6.00 7.00 8.00
9.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00	0	35	53 4	540	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
22.00 23.00 24.00 24.10 25.00 26.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00					22.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

Heal th	Financial Systems	IU HEALTH WHITE	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	N: 15-1312	Period:	Worksheet S-1	0
					From 01/01/2016		
					To 12/31/2016		
						5/22/2017 2:4	
						1.00	
	Uncompensated and indigent care cost computa	tion				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I li		vided by li	ne 202 columr	1.8)	0. 323372	1.00
	Medicaid (see instructions for each line))		
2.00	Net revenue from Medicaid					2, 958, 083	2.00
3.00	Did you receive DSH or supplemental payments	from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all		al payments i	from Medicaid	1?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supplem					l c	
6.00	Medicaid charges					12, 402, 081	6.00
7.00	Medicaid cost (line 1 times line 6)					4, 010, 486	7.00
8.00	Difference between net revenue and costs for	Medicaid program	(line 7 minu	us sum of lir	nes 2 and 5; if	1, 052, 403	8.00
	< zero then enter zero)						
	Children's Health Insurance Program (CHIP) (see instructions 1	For each line	e)			
9.00	Net revenue from stand-alone CHIP					C	9.00
10.00	Stand-alone CHIP charges					C	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					C	11.00
12.00	Difference between net revenue and costs for	stand-alone CHIP	(line 11 min	nus line 9; i	f < zero then	C	12.00
	enter zero)						
	Other state or local government indigent care					I	
13.00	Net revenue from state or local indigent car					C	
14.00	Charges for patients covered under state or	local indigent ca	re program (I	Not included	in lines 6 or	C	14.00
	10)						
15.00	State or local indigent care program cost (I					C	
16.00	Difference between net revenue and costs for	state or local in	ndigent care	program (III	ne 15 minus line	C	16.00
	13; if < zero then enter zero)	h line)					
17.00	Uncompensated care (see instructions for each Private grants, donations, or endowment inco		Funding chari	ty care			17.00
17.00	Government grants, appropriations or transfe						
19.00	Total unreimbursed cost for Medicaid, CHIP				(cum of lines	1, 052, 403	
19.00	8, 12 and 16)		ai indigent o	Lare programs	s (sum of filles	1, 052, 403	19.00
		_		Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col. 2)	
			ľ	1.00	2.00	3.00	
20.00	Charity care charges for the entire facility	(see instruction	5)	2, 376, 6			20.00
21.00	Cost of patients approved for charity care (line 1 times line	20)	768, 54	15 16, 518	785, 063	21.00
22.00	Partial payment by patients approved for cha	rity care	-	31, 54	16 5, 980	37, 526	22.00
23.00	Cost of charity care (line 21 minus line 22)	-		736, 99	99 10, 538	747, 537	23.00
					· ·		
						1.00	
24.00	Does the amount in line 20 column 2 include			nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or o						
25.00	If line 24 is "yes," charges for patient da			ogram's lengt	h of stay limit	C	
26.00	Total bad debt expense for the entire hospit					2, 257, 067	
27.00	Medicare bad debts for the entire hospital c					387, 742	
28.00	Non-Medicare and non-reimbursable Medicare b					1, 869, 325	
29.00	Cost of non-Medicare and non-reimbursable Me		kpense (line	1 times line	28)	604, 487	
30.00	Cost of uncompensated care (line 23 column 3					1, 352, 024	
31.00	Total unreimbursed and uncompensated care co	st (line 19 plus	ine 30)			2, 404, 427	31.00

	Financial Systems	IU HEALTH WHITE			In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider CO	CN: 15-1312	Period: From 01/01/2016	Worksheet A	
					Foil 01/01/2018 Fo 12/31/2016	Date/Time Pre 5/22/2017 2:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	-	1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		2, 044, 692	2, 044, 69	2 -2, 033, 112	11, 580	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	(2, 650, 943	2, 650, 943	1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB		0		288, 133	288, 133	1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-394, 646	48, 530			991, 154	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 347, 328	4, 436, 851	5, 784, 17		5, 766, 056	5.00
7.00	00700 OPERATION OF PLANT	182, 076	1, 297, 882	1, 479, 95		574, 335	7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	0	0		826, 196	826, 196	
7.02 8.00	00702 OPERATION OF PLANT - TLMOB	0	0		260, 840	260, 840	7.02 8.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	295, 960	248, 169	544, 12	0 63, 471 9 -184, 517	63, 471 359, 612	9.00
10.00	01000 DI ETARY	495, 306	362, 967	858, 27		550, 189	
11.00	01100 CAFETERI A	493, 300	302, 907 O		110, 508	110, 508	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	580, 678	207, 628			689, 951	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	000,070	20, 468			497,008	
15.00	01500 PHARMACY	366, 704	1, 715, 126			457, 539	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					
30.00	03000 ADULTS & PEDIATRICS	810, 448	595, 056	1, 405, 50	4 -252, 445	1, 153, 059	30.00
31.00	03100 INTENSIVE CARE UNIT	176, 605	65, 767	242, 37	2 -52, 091	190, 281	31.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	436, 254	741, 919	1, 178, 17	-363, 600	814, 573	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	340, 721	315, 197			412, 086	
55.00	05500 RADI OLOGY-THERAPEUTI C	60, 733	89, 691	150, 42		96, 708	
56.00	05600 RADI OI SOTOPE	108, 484	120, 421	228, 90		152, 298	
57.00	05700 CT SCAN	178, 201	149, 212			226, 138	
58.00 60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	89, 580 0	114, 999 1, 264, 391	204, 57 1, 264, 39		96, 508 1, 264, 391	58.00 60.00
66.00	06600 PHYSI CAL THERAPY	277, 691	1, 204, 391	393, 99		323, 983	66.00
67.00	06700 OCCUPATI ONAL THERAPY	97, 317	22, 833			104, 897	67.00
68.00	06800 SPEECH PATHOLOGY	70, 632	18, 377			75, 710	
69.00	06900 ELECTROCARDI OLOGY	77, 420	36, 457			86, 316	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		4, 703	4, 703	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		7, 287	7, 287	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		1, 598, 306		73.00
76.00	03020 CARDI OPULMONARY	341, 489	127, 460	468, 94	- 100, 917	368, 032	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	128, 779	86, 003			182, 376	
91.00	09100 EMERGENCY	1, 141, 700	1, 314, 939	2, 456, 63	-358, 021	2, 098, 618	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	198, 053	25, 249	223, 30	2 -10, 613	212, 689	92.01
101 00	OTHER REIMBURSABLE COST CENTERS						101 00
101.00	DIO100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
118.00		7, 407, 513	15, 586, 591	22, 994, 104	1 572, 370	23, 566, 474	110 00
110.00	NONREI MBURSABLE COST CENTERS	7,407,515	15, 560, 571	22, 994, 10	+ 572, 570	23, 300, 474	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			0	190.00
	19100 RESEARCH	0	0				191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	83, 551	29, 010	112, 56	-23, 397	89, 164	
	19202 MOB	00,001	548, 973				192.02
	19203 ARNETT SURGERY OFFICE	0	0		0		192.02
192.04	19201 OCCUPATIONAL MEDICINE	o	0		o o		192.04
	19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00		7, 491, 064	16, 164, 574	23, 655, 63	3 0	23, 655, 638	200. 00

ECLASSIFICATION AND AD	s JUSTMENTS OF TRIAL BALANCE (IU HEALTH WHI DF EXPENSES		CN: 15-1312	Peri od:	of Form CMS- Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	
Cost Contor	Description	Adjustments	Net Expenses			5/22/2017 2:4	16 pm
cost center	Description		For Allocation				
		6.00	7.00	-			
GENERAL SERVICE	COST CENTERS	0.00	1.00	1			
00 00100 CAP REL COS		144, 387	155, 967	,			1 1
	STS-BLDG & FIXT - HOSPITAL	256, 346		1			1
	STS-BLDG & FIXT - TLMOB	366, 578		1			1
	ENEFITS DEPARTMENT	76, 161					4
00 00500 ADMI NI STRAT		612, 341					5
. 00 00700 OPERATI ON (012, 341	574, 335	1			7
	DF PLANT - HOSPITAL	0	826, 196	1			7
. 02 00702 OPERATION (0	260, 840				7
. 00 00800 LAUNDRY & L		0	63, 471				8
00 00900 HOUSEKEEPI N		0	359, 612				9
0.00 01000 DI ETARY	10			1			10
1. 00 01100 CAFETERIA		-210, 460 -83, 727		1			11
		-34, 159		1			
3.00 01300 NURSING ADM 4.00 01400 CENTRAL SEF		- 34, 159		1			13
	AVICES & SUPPLY			1			
		-8, 982					15
5.00 01600 MEDICAL REC		0	0	'I			- 10
	E SERVICE COST CENTERS	245 452	007 (07	1			1 20
		-245, 452		1			30
1.00 03100 I NTENSI VE (ARE UNIT	0		1			31
3. 00 04300 NURSERY	COST CENTERS	0	C	1			43
ANCI LLARY SERVI C		44 70/	7/0.027	1			1 - 0
0.00 05000 OPERATING F		-44, 736		1			50
2. 00 05200 DELIVERY R		0	0	•			52
4. 00 05400 RADI OLOGY-E		-2, 369		1			54
5. 00 05500 RADI OLOGY-1		0	96, 708	1			55
6. 00 05600 RADI OI SOTOF	È.	0	152, 298	1			56
7. 00 05700 CT SCAN	CONANCE LMACING (NDL)	0	226, 138	1			57
	SONANCE IMAGING (MRI)	0	96, 508				58
0.00 06000 LABORATORY		0	1, 264, 391				60
5. 00 06600 PHYSI CAL TH		-4, 218					66
7.00 06700 0CCUPATI 0NA		0	104, 897				67
3.00 06800 SPEECH PATH		0	75, 710				68
9.00 06900 ELECTROCARE		0	86, 316				69
	PPLIES CHARGED TO PATIENTS	0	4, 703				71
	CHARGED TO PATIENTS	0		1			72
3. 00 07300 DRUGS CHAR		0	1, 598, 306	1			73
6. 00 03020 CARDI OPULMO		-1, 855	366, 177	1			76
OUTPATIENT SERVI	LE CUST CENTERS	-	100.5				1
0.00 09000 CLINIC		0		1			90
1.00 09100 EMERGENCY		0	2, 098, 618	•			91
	BEDS (NON-DISTINCT PART)						92
	I BEDS (DI STI NCT PART)	0	212, 689	1			92
OTHER REIMBURSAB			1	1			
01.0010100 HOME HEALTH		0	0	l			101
SPECIAL PURPOSE				1			1.
	SUM OF LINES 1-117)	809, 803	24, 376, 277				118
NONREI MBURSABLE (1	1			
	R, COFFEE SHOP & CANTEEN	0					190
91.00 19100 RESEARCH		0	0				191
2. 00 19200 PHYSI CI ANS'	PRI VATE OFFI CES	0	89, 164				192
92.02 19202 MOB		0	C				192
2.03 19203 ARNETT SUR		0	C				192
2.04 19201 OCCUPATI ON	AL MEDICINE	0	C				192
93. 00 19300 NONPALD WOF	RKERS	0	C				193
00.00 TOTAL (SUM	OF LINES 118-199)	809, 803	24, 465, 441				200

SSIFICATIONS			Provider CCN: 15-1		Worksheet A-6
				From 01/01/2016 To 12/31/2016	
	Increases				1 57 227 2017 2.40 pm
Cost Center 2.00	Line # 3.00	Salary 4.00	Other 5.00		
A - CAFETERIA	3.00	4.00	5.00		
		81, 573	2 <u>8, 9</u> 35		1. (
0		81, 573	28, 935		
B - DRUGS EXPENSE PHARMACY	15.00	0	2, 995		1. (
DRUGS CHARGED TO PATIENTS	73.00	0	1, 598, 306		2. (
	0.00	0	0		3.
	0.00 0.00	0	0		4. (
	0.00	0	0		6.
	0.00	0	0		7.
	0.00	0	0		8.
	0.00 0.00	0	0		9. 10.
	0.00	0	0		11.
	0.00	0	0		12.
	0.00 0.00	0	0		13.
	0.00	0	0		14.
0			1, 601, 301		
C - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY	14.00	0	401 004		1
MEDICAL SUPPLIES CHARGED TO	14.00 71.00	0	481, 934 4, 703		1.
PATI ENTS			1,700		
I MPL. DEV. CHARGED TO PATIENTS	72.00	0	7, 287		3.
PATTENTS	0.00	0	о		4.
	0.00	0	0		5.
	0.00 0.00	0	0		6.
	0.00	0	0		7.
	0.00	0	0		9.
	0.00	0	0		10.
	0.00 0.00	0	0		11.
	0.00	Ő	Ő		13.
	0.00	0	0		14.
	0.00 0.00	0	0		15. 16.
	0.00	0	0		10.
	0.00	0	0		18.
	0.00 0.00	0	0		19. 20.
	0.00	0	0		20.
	0.00	0	0		22.
		0	493, 924		23.
D - LAUNDRY		0	473, 724		
LAUNDRY & LINEN SERVICE	8.00	0	63, 471		1.
<u> </u>		0			2.
E - DEPRECIATION		0	03, 471		
CAP REL COSTS-BLDG & FIXT -	1.01	0	1, 512, 675		1.
HOSPITAL CAP REL COSTS-BLDG & FIXT -	1.02	0	256, 233		2.
TLMOB			2007 200		
	0.00	0	0		3.
	0.00 0.00	0	0		4.
	0.00	0	0		6.
	0.00	0	0		7.
	0.00 0.00	0	0		8.
	0.00	0	ŏ		10.
	0.00	0	0		11.
	0.00	0	0		12.
	0.00 0.00	0	0		13. 14.
	0.00	Ő	Ō		15.
	0.00	0	0		16.
	0.00 0.00	0	0		17. 18.
	0.00	0	õ		19.
	0.00	0	0		20.

IU HEALTH WHITE HOSPITAL

Provider CCN: 15-1312

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2016 To 12/31/001/

Increases Increases <t< th=""><th></th><th></th><th></th><th></th><th></th><th>From 01/01/2016 To 12/31/2016</th><th>Date/Time Prepared:</th></t<>						From 01/01/2016 To 12/31/2016	Date/Time Prepared:
2.00 3.00 4.00 5.00 21.00 0.00 0 0 21.00 21.00 21.00 21.00 21.00 21.00 21.00 22.00 20.00			Increases				5/22/2017 2:46 pm
21.00 0.00 0 0 21.00 21.00 22.00 20.00 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>							
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	1.00				113. 384		1.00
	500.00			81, 573			500.00

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		Decreases					
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A – CAFETERIA						
1.00	DI ETARY	10.00	81, 573	28, 935	0		1.00
1.00			<u>81,573</u>	<u>28, 9</u> 35 28, 935			1.00
			01, 373	20, 930			-
	B – DRUGS EXPENSE						4
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	4, 989			1.00
2.00	PHARMACY	15.00	0	1, 547, 171	0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	4, 904			3.00
4.00	INTENSIVE CARE UNIT	31.00	0	2, 205			4.00
			-				1
5.00	OPERATING ROOM	50.00	0	2, 315			5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	817	0		6.00
7.00	RADI OLOGY-THERAPEUTI C	55.00	0	23, 559	0		7.00
8.00	RADI OI SOTOPE	56.00	0	2, 190			8.00
			0				1
9.00	MAGNETIC RESONANCE I MAGING	58.00	0	1, 891	0		9.00
	(MRI)						
10.00	PHYSI CAL THERAPY	66.00	0	23	0		10.00
11.00	ELECTROCARDI OLOGY	69.00	0	432	0		11.00
12.00	CARDI OPULMONARY	76.00	0	623	-		12.00
			0				
13.00	CLINIC	90.00	0	818			13.00
14.00	EMERGENCY	91.00	0	9, 350	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	14	0		15.00
			o	1,601,301			1
	C - MEDI CAL SUPPLI ES		0	1,001,001			1
1 00		4.00		4.05			1 1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	105			1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	490			2.00
3.00	OPERATION OF PLANT -	7.01	0	20, 817	0		3.00
2.00	HOSPITAL		Ű	20, 017	Ĭ		
1 00		0.00	_	20 400			4 00
4.00	HOUSEKEEPING	9.00	0	29, 498			4.00
5.00	DI ETARY	10.00	0	2, 979	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	2, 554	0		6.00
7.00	PHARMACY	15.00	0	8, 824			7.00
8.00	ADULTS & PEDIATRICS		0		-		4
		30.00	0	55, 825	-		8.00
9.00	INTENSIVE CARE UNIT	31.00	0	11, 227	0		9.00
10.00	OPERATING ROOM	50.00	0	137, 720	0		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	5, 094	0		11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	0	1, 162			12.00
			0		-		1
13.00	RADI OI SOTOPE	56.00	0	3, 778			13.00
14.00	CT SCAN	57.00	0	38, 585	0		14.00
15.00	MAGNETIC RESONANCE IMAGING	58.00	0	6, 707	0		15.00
	(MRI)		-				
16.00	PHYSICAL THERAPY	66.00	0	7, 215	0		16.00
			0				
17.00	OCCUPATI ONAL THERAPY	67.00	0	667	0		17.00
18.00	ELECTROCARDI OLOGY	69.00	0	3, 558	0		18.00
19.00	CARDI OPULMONARY	76.00	0	13, 503	0		19.00
20.00	CLINIC	90.00	0	5, 816			20.00
21.00	EMERGENCY	91.00	0	132, 008			21.00
			0				
22.00	OBSERVATION BEDS (DISTINCT	92.01	0	2, 355	0		22.00
	PART)						
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	3, 437	0		23.00
			d	493, 924			
	D - LAUNDRY		0	170,721			
1 00		0.00	0	50.004			1 1 00
1.00	HOUSEKEEPI NG	9.00	0	58, 884			1.00
2.00	DI ETARY	10.00	0	<u>4, 5</u> 87	0		2.00
	0		0	63, 471			
	E - DEPRECIATION	I					1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	782, 149	9		1.00
			-				
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 649			2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	0	27, 059			3.00
4.00	OPERATION OF PLANT	7.00	0	10, 857	0		4.00
5.00	DI ETARY	10.00	o	56, 150			5.00
	CENTRAL SERVICES & SUPPLY		0	5, 345			
6.00		14.00	U		-		6.00
7.00	PHARMACY	15.00	0	28, 813			7.00
8.00	ADULTS & PEDIATRICS	30.00	0	36, 037	0		8.00
9.00	INTENSIVE CARE UNIT	31.00	o	259	0		9.00
10.00	OPERATING ROOM	50.00	0	126, 251	0		10.00
	1		-				
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	175, 329	-		11.00
12.00	RADI OLOGY-THERAPEUTI C	55.00	0	16, 095			12.00
13.00	RADI OI SOTOPE	56.00	0	57, 520	0		13.00
14.00	CT SCAN	57.00	0	32, 479			14.00
15.00	MAGNETIC RESONANCE IMAGING	58.00	0	78, 181			15.00
15.00		50.00	0	70, 101			15.00
	(MRI)						
16.00	PHYSICAL THERAPY	66.00	0	4, 461	0		16.00
17.00	OCCUPATI ONAL THERAPY	67.00	0	120	0		17.00
18.00	ELECTROCARDI OLOGY	69.00	0	11, 330			18.00
19.00	CARDI OPULMONARY	76.00	0	1, 289			19.00
17.00		/0.00		1, 289		1	1 17.00

Health Financial Systems RECLASSIFICATIONS

IU HEALTH WHITE HOSPITAL

Provider CCN: 15-1312

In Lieu of Form CMS-2552-10

Period: From 01/01/2016 To 12/31/2016 Worksheet A-6 Date/Time Prepared: 5/22/2017 2:46 pm

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

IU HEALTH WHITE HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1312

Period: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					1	o 12/31/2016 Date/lime Pr 5/22/2017 2:	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
00.00	6.00	7.00	8.00	9.00	10.00		
20.00	CLINIC EMERGENCY	90.00 91.00	0	29 59, 346	0		20.00 21.00
21.00 22.00	OBSERVATION BEDS (DISTINCT	91.00	0	59, 346	0		21.00
22.00	PART)	92.01	0	232	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 695	o		23.00
24.00	MOB	192.02	0	256, 233			24.00
	0 — — — — — —			1,768,908			
	F - OTHER CAPITAL EXPENSES						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 116, 035			1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21, 544	12		2.00
3.00	PHARMACY	15.00	0	650	13		3.00
4.00	MOB	192.02	0	31, 900			4.00
5.00	ADMI NI STRATI VE_& GENERAL	5.00	0				5.00
	TOTALS G - OPERATION OF PLANT		0	1, 170, 168			_
1.00	OPERATION OF PLANT	7.00	0	847,013	0		1.00
2.00	MOB	192.02	0	260, 840			2.00
2.00			— — — 0	1, 107, 853			2.00
	H - EMPLOYEE BENEFITS			1,107,000			_
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	103, 919	0		1.00
2.00	OPERATION OF PLANT	7.00	0	47, 753	0		2.00
3.00	HOUSEKEEPI NG	9.00	0	102, 955	0		3.00
4.00	DI ETARY	10.00	0	128, 316	0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	95, 592	0		5.00
6.00	PHARMACY	15.00	0	41, 419	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	155, 423	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	38, 400	0		8.00
9.00	OPERATING ROOM	50.00 54.00	0	97, 150			9.00
10. 00 11. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	62, 548 12, 900			10.00 11.00
12.00	RADI OLOGI - MEKAPLOTI C	56.00	0	12, 900			12.00
13.00	CT SCAN	57.00	0	30, 211	0		13.00
14.00	MAGNETIC RESONANCE IMAGING	58.00	0	21, 292	0		14.00
	(MRI)		-	,	-		
15.00	PHYSI CAL THERAPY	66.00	0	58, 316	0		15.00
16.00	OCCUPATI ONAL THERAPY	67.00	0	14, 466	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	13, 295			17.00
18.00	ELECTROCARDI OLOGY	69.00	0	12, 241	0		18.00
19.00	CARDI OPULMONARY	76.00	0	85, 502	0		19.00
20.00		90.00	0	25, 710			20.00
21.00	EMERGENCY	91.00	0	157, 213	0		21.00
22.00	OBSERVATION BEDS (DISTINCT PART)	92.01	0	8, 026	0		22.00
23.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	18, 251	о		23.00
23.00		172.00	— — — ,	1, 344, 013			23.00
	I - HOUSEKEEPING SUPPLIES	I		1/011/010			-
1.00	DI ETARY	10.00	0	5, 544	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	209	О		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	49	0		3.00
4.00	PHARMACY	15.00	0	409			4.00
5.00	ADULTS & PEDIATRICS	30.00	0	256			5.00
6.00	OPERATING ROOM	50.00	0	164	0		6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	44	0		7.00
8.00		56.00	0	4	0		8.00
9.00	SPEECH PATHOLOGY CLINIC	68.00 90.00	0	4 33	9		9.00 10.00
10. 00 11. 00	EMERGENCY	90.00 91.00	0	33 104	0		10.00
11.00		91.00	— — — 0	6, 820			11.00
	J - NON-CAPITAL EXPENSES		U	0, 020			-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	o	113, 384	12		1.00
	TOTALS	+	— — — ō	113, 384			
500.00	Grand Total: Decreases		81, 573	7, 698, 777			500.00

Heal th	Financial Systems	IU HEALTH WHI			In Lie	eu of Form CMS-:	2EE2 10
	Financial Systems	TU HEALTH WHI	Provi der CCN: 15-1312		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part I	pared:
				Acqui si ti ons	S		
		Begi nni ng	Purchases	Donation	Total	Disposals and	
		Bal ances				Retirements	
	T	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE					1	
1.00	Land	954, 570	0		0 0	0	
2.00	Land Improvements	1, 948, 206	0		0 0	712, 186	
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	40, 540, 941	0		0 0	68, 120	
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	4, 173, 860	864, 351		0 864, 351	154, 787	6.00
7.00	HIT designated Assets	78, 430	0		0 0	63, 430	7.00
8.00	Subtotal (sum of lines 1-7)	47, 696, 007	864, 351		0 864, 351	998, 523	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	47, 696, 007	864, 351		0 864, 351	998, 523	10.00
		Endi ng Bal ance	Fully				
		5	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		•			
1.00	Land	954, 570	0				1.00
2.00	Land Improvements	1, 236, 020	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	40, 472, 821	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4, 883, 424	174, 992				6.00
7.00	HIT designated Assets	15,000	15,000				7.00
8.00	Subtotal (sum of lines 1-7)	47, 561, 835	189, 992				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	47, 561, 835	189, 992				10.00
				1			

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		narodi
					10 12/31/2010	Date/Time Pre 5/22/2017 2:4	
			SI	UMMARY OF CAPI	TAL		
				1			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)	, ,	
	DADT IL DEGONOLILIATION OF ANOUNTO FROM WORL	9.00	10.00	11.00	12.00	13.00	
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK				124.020	0	1 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - HOSPITAL	793, 728		1, 116, 03	6 134, 928	0	1.00
1.01 1.02	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0			0 0	0	1. 01 1. 02
3.00	Total (sum of lines 1-2)	793, 728		1, 116, 03	6 134, 928	0	3.00
5.00		SUMMARY 0		1, 110, 03	0 134,720	0	3.00
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)		_			
		14.00	15.00				
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM		1			1 00
1.00	CAP REL COSTS-BLDG & FLXT	0	2,044,692				1.00
1.01 1.02	CAP REL COSTS-BLDG & FIXT - HOSPITAL CAP REL COSTS-BLDG & FIXT - TLMOB	0					1. 01 1. 02
1.02 3.00	Total (sum of lines 1-2)		2,044,692				3.00
5.00		0	2,044,072	-1			J 3.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	1		F	Period: From 01/01/2016 To 12/31/2016	Date/Time Prep 5/22/2017 2:46	
		COME	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00	CAP REL COSTS-BLDG & FIXT	2, 190, 590		2, 190, 590		0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	29, 732, 383		29, 732, 383		0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	15, 638, 863		15, 638, 863		0	1.02
3.00	Total (sum of lines 1-2)	47, 561, 836		47, 561, 836			3.00
			FION OF OTHER (F CAPI TAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	C) (155, 966	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	C) (1, 674, 440	90, 840	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	C) (622, 811	0	1.02
3.00	Total (sum of lines 1-2)	0	C) (2, 453, 217	90, 840	3.00
			SI	JMMARY OF CAPI	ΓAL		
	Cost Center Description		Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	1	C) (0 0	155, 967	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1, 119, 815	21, 544	650	0 0		1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	C	31, 900	0 0	654, 711	1.02
3.00	Total (sum of lines 1-2)	1, 119, 816	21, 544			3, 717, 967	3.00
					,		

				F	Period: From 01/01/2016		
					o 12/31/2016	Date/Time Prep 5/22/2017 2:46	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00		1.00	2.00	3.00	4.00	5.00	1.0
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1.0
01	Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL (chapter 2)	В	-30, 696	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1. C
02	Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB		C	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1. C
00	(chapter 2) Investment income - CAP REL		C	*** Cost Center Deleted ***	2.00	0	2.0
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3.0
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.0
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5. C
00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6. (
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C		0.00		7. (
00	21) Television and radio service		C		0.00	0	8. (
	(chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	C -262, 458		0.00	0 0	9. 10.
. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
	Related organization transactions (chapter 10)	A-8-1	2, 758, 530			0	
	Laundry and linen service Cafeteria-employees and guests	В	C -51, 676	CAFETERI A	0.00 11.00		13. 14.
. 00	Rental of quarters to employee and others		C		0.00	0	15.
. 00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16.
. 00	Sale of drugs to other than patients		C		0.00	0	17.
3. 00	Sale of medical records and		C		0.00	0	18.
9. 00	abstracts Nursing school (tuition, fees, books, etc.)		C		0.00	0	19.
	Vending machines Income from imposition of		C		0.00 0.00		
. 00	interest, finance or penalty charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.
. 00	overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory	A-8-3	C	*** Cost Center Deleted ***	65.00		23.
	therapy costs in excess of limitation (chapter 14)						
. 00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
. 00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.
. 00	(chapter 21) Depreciation - CAP REL	A	144, 387	CAP REL COSTS-BLDG & FIXT	1.00	9	26.
. 01	COSTS-BLDG & FIXT Depreciation - CAP REL	А	105, 725	CAP REL COSTS-BLDG & FIXT -	1.01	9	26.
. 02	COSTS-BLDG & FIXT - HOSPITAL Depreciation - CAP REL	А	366, 578	HOSPITAL CAP REL COSTS-BLDG & FIXT -	1.02	9	26.
. 00	COSTS-BLDG & FIXT - TLMOB Depreciation - CAP REL		C	TLMOB *** Cost Center Deleted ***	2.00	0	27.
	COSTS-MVBLE EQUIP						

Heal th	Fi nan	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

In Lieu of Form CMS-2552-10

ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016	Date/Time Prep 5/22/2017 2:40	pared: 6 pm
				Expense Classification or	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cont Conton Deceminting		A	Cast Castar	1.5		
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
30,00	Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	4.00	5.00	30.00
30.00	therapy costs in excess of	A-0-3	0	OCCUPATIONAL THERAPT	07.00		30.00
	limitation (chapter 14)						
30, 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30, 99
00177	i nstructi ons)		0		00100		00177
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	A	-41, 488	CAP REL COSTS-BLDG & FIXT -	1.01	9	32.00
	Depreciation and Interest			HOSPI TAL			
33.00	EMPLOYEE BENEFITS	A	-1, 346, 418	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	33.00
33.01	INVESTMENT FEES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.02	ROUTINE CAPITAL LEASE	A	45, 143	CAP REL COSTS-BLDG & FIXT -	1.01	10	33. 02
				HOSPITAL			
33.03	DIETARY CAPITAL LEASE	A		CAP REL COSTS-BLDG & FIXT -	1.01	10	33.03
22.04		٨			20.00		22.04
33. 04 33. 05	ROUTINE LEASES SURGERY LEASES	A A		ADULTS & PEDIATRICS OPERATING ROOM	30.00	0	
33.05 33.06	LOSS ON ABANDONMENT	A		CAP REL COSTS-BLDG & FIXT -	50.00 1.01	9	
33.00	LUSS ON ABANDONMENT	A		HOSPITAL	1.01	9	33.00
33.07	CATERING / OTHER REVENUE	В		CAFETERIA	11.00	0	33.07
33.08	MEDICALD HAF FEES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.09	MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.10	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13.00	0	
33.11	MI SCELLANEOUS I NCOME	В		CENTRAL SERVICES & SUPPLY	14.00	0	
33. 12	MI SCELLANEOUS I NCOME	В	-8, 982	PHARMACY	15.00	0	33. 12
33.13	MI SCELLANEOUS I NCOME	В	-2, 970	OPERATING ROOM	50.00	0	33.13
33.14	MI SCELLANEOUS I NCOME	В	-2, 369	RADI OLOGY-DI AGNOSTI C	54.00	0	33.14
33. 15	MI SCELLANEOUS I NCOME	В	-4, 218	PHYSICAL THERAPY	66.00	0	33.15
33.16	MI SCELLANEOUS I NCOME	В	-1, 855	CARDI OPULMONARY	76.00	0	33.16
33. 17	WIC PROGRAM COSTS	A	-210, 460	DI ETARY	10.00	0	33. 17
33. 18	WIC PROGRAM BENEFIT COSTS	A	-27, 238	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	
33. 19	CRNA COSTS	A		OPERATING ROOM	50.00	0	
33.20	ACCRUED PTO - HR	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33. 21	ACCRUED PTO - GENERAL	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 22	CONTRI BUTI ON EXPENSE	A	-9, 500	ADMINISTRATIVE & GENERAL	5.00	0	00.22
33.23			0		0.00	0	
33.24			0		0.00	0	00121
33.25			0		0.00	0	00.20
50.00	TOTAL (sum of lines 1 thru 49)		809, 803				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

A. Costs - If Cost, find during appreciate overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	IU HEALTH WH	II TE HOSPI TAL	In Li€	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Period:	Worksheet A-8	8-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:	1	1	-		
1.00	1. 01	CAP REL COSTS-BLDG & FIXT -	BUILDING CAPITAL-HO DIRECT C	1, 150, 473	1, 116, 036	1.00
2.00		EMPLOYEE BENEFITS DEPARTMENT		1, 055, 171	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	A&G HOME OFFICE AND ARNETT	3, 275, 968	3, 798, 204	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	A&G ARNETT ALLOCATION	2, 088, 108	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	A&G HO POOLED CAPITAL	128, 694	0	3. 02
4.00	13.00	NURSING ADMINISTRATION	EDUCATION-HOME OFFICE	0	25, 644	4.00
4.01	30.00	ADULTS & PEDIATRICS	A&P - SHARED EMPLOYEES	277, 199	277, 199	4.01
4.02	50.00	OPERATING ROOM	OR - SHARED EMPLOYEES	283, 958	283, 958	4.02
4.03	56.00	RADI OI SOTOPE	RADI OI SOTOPE - SHARED EMPLOY	31, 200	31, 200	4.03
4.04	60.00	LABORATORY	LAB - SHARED EMPLOYEES	1, 228, 843	1, 228, 843	4.04
4.05	69.00	ELECTROCARDI OLOGY	ECG - SHARED EMPLOYEES	31, 200	31, 200	4.05
4.06			PHYSICIAN OFFICES - SHARED E	25, 265	25, 265	4.06
5.00	TOTALS (sum of lines 1-4).			9, 576, 079		5.00
	Transfer column 6, line 5 to				,	
	Worksheet A-8, column 2,					
	line 12.					

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

has no	t been posted to Worksheet A,	columns 1 and/or 2, the amou	nt allowable sh	ould be indicated in column 4	of this part.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	В	IU HEALTH	100.00	0.00	6.00
7.00	В	IUH ARNETT	1.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

C. Provider has financial interest in corporation, partnership, or other organization.

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems	IU HEALTH WHITE HOSPITAL			u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1312	Period: From 01/01/2016	Worksheet A-8-1
OTTICE COSTS			To 12/31/2016	Date/Time Prepared:

			5/22/2017 2:46 pm
	Net	Wkst. A-7 Ref.	
	Adjustments		
	(col. 4 minus		
	col. 5)*		
	6.00	7.00	
			VENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED
	HOME OFFICE CO		
1.00	34, 437		1.0
2.00	1, 055, 171	0	2.0
3.00	-522, 236	0	3.0
3.01	2,088,108	0	3.0
3.02	128, 694	0	3.0
4.00	-25,644	0	4.0
4.01	0	0	4.0
4.02	0	0	4.0
4.03	0	0	4.0
4.04	0	0	4.0
4.05	0	0	4.0
4.06	0	0	4.0
5.00	2, 758, 530		5.0

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

Related Organization(s)				
and/or Home Office				
 Type of Business				
51				
6.00				
 B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:				

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
6.00 7.00 8.00 9.00 10.00 100.00	100.00

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

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

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

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

organi zati on. E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Heal th	Financial Syste	ems	IU HEALTH WH	ITE HOSPITAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider (Period: From 01/01/2016		
						To 12/31/2016	Date/Time Pre 5/22/2017 2:4	epared:
	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		ADULTS & PEDIATRICS	262, 458	262, 458				
2.00		LABORATORY	-938				-	2.00
3.00			22, 500	0			0	3.00
4.00	0.00	EMERGENCY	855, 607	0	855, 607		0	4.00
5.00 6.00	0.00		0	0	-	-	0	5.00 6.00
8.00 7.00	0.00		0	0		-	0	8.00 7.00
8.00	0.00		0	0			0	8.00
9.00	0.00		0	0			0	9.00
10.00	0.00		0	0			0	10.00
200.00	0.00		1, 139, 627	262, 458	877, 169))	0	
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200100
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0					1.00
2.00		LABORATORY	0				-	2.00
3.00			0	-			0	3.00
4.00	91.00 0.00	EMERGENCY	0	0	-	-	0	4.00
5.00 6.00	0.00		0	0		-	0	5.00 6.00
7.00	0.00		0	0			0	7.00
8.00	0.00		0	0	(0	8.00
9.00	0.00		0	0		-	0	9,00
10.00	0.00		0	0	-		0	10.00
200.00			0	0		-	-	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0	-				1.00
2.00		LABORATORY	0					2.00
3.00 4.00		CLINIC EMERGENCY	0	0	-	-		3.00 4.00
	0.00	EMERGENCY	0					4.00 5.00
5.00 6.00	0.00		0	0		-		5.00 6.00
8.00 7.00	0.00		0			-		8.00 7.00
8.00	0.00		0					8.00
9.00	0.00		0			-		9.00
10.00	0.00		0					10.00
200.00	0.00		0					200.00
	I .	1				,,	•	

	NABLE COST DETERMINATION FOR THERAPY SERVICES I DE SUPPLIERS	FURNI SHED BY	Provider CC	N: 15-1312	Period: From 01/01/2016 To 12/31/2016		pared:
					Physical Therapy		
						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			10	1.00
2.00	Line 1 multiplied by 15 hours per week					150	2.00
3.00 4.00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy					047	3.00 4.00
4.00	nor therapist was on provider site (see instr				ier supervisor	47	4.00
5.00	Number of unduplicated offsite visits - super					0	5.00
6.00	Number of unduplicated offsite visits - there					0	6.00
	assistant and on which supervisor and/or ther instructions)	apist was not p	present during	the visit(s	(see		
7.00	Standard travel expense rate					4. 82	7.00
8.00	Optional travel expense rate per mile	0				0.00	8.00
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4. 00	Trai nees 5.00	
9.00	Total hours worked	0.00	0.00	374.			9.00
10.00	AHSEA (see instructions)	0.00	0.00	80.			
11.00	Standard travel allowance (columns 1 and 2,	0.00	0.00	40.	05		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12. 0 [′]
13.00		0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.0
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1	
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0	14.00 15.00
16.00	Assistants (column 3, line 9 times column 3,					30, 017	
17.00	Subtotal allowance amount (sum of lines 14 ar		ratory therapy	or lines 14	-16 for all	30, 017	17.0
	others)					0	18.00
18.00 19.00							
20.00	Total allowance amount (sum of lines 17-19 for		therapy or line	es 17 and 18	for all others)	0 30, 017	19. 0 20. 0
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than		no entries on l	ines 21 and	1 22 and enter on	line 23	
21.00	the amount from line 20. Otherwise complete		divided by sur	n of columns	1 and 2 line 9	0.00	21.00
211.00					, i dild 2, i i i o ,		2
22.00	 Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others) Weighted allowance excluding aides and trainees (line 2 times line 21) 						
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	INNCE AND TRAVEL	EXDENSE COMDI		DAVIDED SITE	30, 017	23.00
	Standard Travel Allowance	ANGE AND TRAVEL			OVIDER SITE		
24.00	Therapists (line 3 times column 2, line 11)					0	24.00
25.00						1, 882	
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	1, 882 227	26.00 27.00
27.00	others)	Tor respirator	y therapy of st			227	27.00
28. 00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum	n of lines 26 and	2, 109	28.00
	27) Optional Travel Allowance and Optional Travel	Evnense					
29.00	Therapists (column 2, line 10 times the sum of		d 2, line 12)			0	29.00
30.00	Assistants (column 3, line 10 times column 3,	line 12)				0	30.00
31.00	Subtotal (line 29 for respiratory therapy or				-	0	31.00
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s I and 2, line	13 for respira	atory therap	by or sum of	0	32.00
33.00	Standard travel allowance and standard travel	expense (line	28)			2, 109	33.00
34.00	Optional travel allowance and standard travel			d 31)		0	34.0
0 00							35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPUT	ATTON - SEF	VICES OUTSIDE PRO	OVIDER SITE	
	Standard Travel Expense					0	36.00
35.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	37.0
35.00 36.00 37.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0	38.0
35.00 36.00 37.00 38.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	of Linco F :	4 4)			-	20 0
35. 00 36. 00 37. 00 38. 00 39. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum		d 6)			0	39.0
35.00 36.00 37.00 38.00 39.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	Expense				-	
 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	Expense 01 times column				0	40. 0 41. 0
 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	Expense D1 times column D3, line 10)	2, line 10)			0 0 0 0	40. 0 41. 0 42. 0
 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	Expense D1 times column D3, line 10) D of columns 1-3	2, line 10) 3, line 13.01)	of the fel	lowing three line	0 0 0 0 0	40. 0 41. 0
 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12. C Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C	Expense D1 times column D3, line 10) D of columns 1-3	2, line 10) 3, line 13.01)	e of the fol	lowing three line	0 0 0 0 0	40. 0 41. 0 42. 0
 35.00 36.00 37.00 38.00 39.00 40.00 41.00 44.00 	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	Expense 11 times column 13, line 10) 1 of columns 1-3 iffsite Services expense (sum of	2, line 10) 3, line 13.01) 5; Complete one of lines 38 and	d 39 - see i	nstructions)	0 0 0 0 es 44, 45,	40. 0 41. 0 42. 0

alth Financial Systems EASONABLE COST DETERMINATION FOR THERAPY SERVI	IU HEALTH WHITE CES FURNISHED BY	Provider C		eriod:	u of Form CMS-2 Worksheet A-8	
JTSI DE SUPPLI ERS			Т	rom 01/01/2016 o 12/31/2016	Date/Time Pre 5/22/2017 2:40	pared: 6 pm
			P	nysical Therapy	Cost	
					1.00	
5.00 Optional travel allowance and optional t						46.0
	Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
PART V - OVERTIME COMPUTATION				1		
7.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in e column of line 56)	0. 00	0.00	0.00	0.00	0.00	47.0
3.00 Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48. (
7.00 Total overtime (including base and overt allowance) (multiply line 47 times line	ime 0.00	0.00				49. (
CALCULATION OF LIMIT 0.00 Percentage of overtime hours by category	0.00	0.00	0.00	0.00	0.00	50.0
(divide the hours in each column on line by the total overtime worked - column 5, line 47)		0.00	0.00	0.00	0.00	50.0
 Allocation of provider's standard work y for one full-time employee times the percentages on line 50) (see instruction 		0.00	0.00	0.00	0.00	51.(
2.00 Adjusted hourly salary equivalency amoun	t 0.00	80. 10	0.00	0.00		52.0
(see instructions) 3.00 Overtime cost limitation (line 51 times		0				53.
4.00 Maximum overtime cost (enter the lesser line 49 or line 53)	of 0	0	С	0		54.
5.00 Portion of overtime already included in hourly computation at the AHSEA (multipl	y O	0	С	0		55.
 6.00 line 47 times line 52) 6.00 Overtime allowance (line 54 minus line 5 if negative enter zero) (Enter in colum the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 throug for the statement. 	n 5	0	с	0	0	56.
for all others.)					1.00	
Part VI - COMPUTATION OF THERAPY LIMITAT	ON AND EXCESS COST A	ADJUSTMENT			1.00	-
7.00 Salary equivalency amount (from line 23)					30, 017	57.
3.00 Travel allowance and expense - provider					2, 109	
9.00 Travel allowance and expense - Offsite s 0.00 Overtime allowance (from column 5, line		44, 45, OF 46)		0	
1.00 Equipment cost (see instructions)	50)				0	
2.00 Supplies (see instructions)					0	
3.00 Total allowance (sum of lines 57-62)					32, 126	
4.00 Total cost of outside supplier services	(from your records)				20, 237	64.
5.00 Excess over limitation (line 64 minus li	ne 63 - if negative,	enter zero)			0	65.
LINE 33 CALCULATION	. on our of lines 24	and DE fam a	ll athons		1 000	1100
00.00 Line 26 = line 24 for respiratory therap 00.01 Line 27 = line 7 times line 3 for respir 00.02 Line 33 = line 28 = sum of lines 26 and	atory therapy or sum			thers	1, 882 227 2, 109	100.
LINE 34 CALCULATION		<u> </u>			007	1101
01.00 Line 27 = line 7 times line 3 for respir 01.01 Line 31 = line 29 for respiratory therap				thers		101.
	y of sum of fines 29	and 30 ror a	TT others			101. 101.
D1. 02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						
01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therap						102.
01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				ns 1-3, line		102. 102.

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH WHI	TE HOSPITAL Provider CO	°N- 15 1212 [In Lie Period:	u of Form CMS-2 Worksheet B	2552-10
CUST A	LLUCATION - GENERAL SERVICE COSTS			F	From 01/01/2016 o 12/31/2016	Part I Date/Time Pre	
			CAP	ITAL RELATED C	OSTS	5/22/2017 2:4	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	HOSPI TAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFI TS DEPARTMENT	
	GENERAL SERVICE COST CENTERS	0	1.00	1.01	1.02	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	155, 967	155, 967				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	2, 907, 289	0	2, 907, 289			1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB	654, 711	0	0		1 0/7 015	1.02
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT	1,067,315	0			1, 067, 315	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 378, 397 574, 335	17, 261	80, 821	161, 940	182, 356 24, 644	5.00 7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL	826, 196	20, 532	614, 781		0	7.01
7.02	00702 OPERATION OF PLANT - TLMOB	260, 840	13, 177	C	146, 540	0	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	63, 471	531	15, 893		0	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	359, 612	1, 962			40, 058	9.00
10. 00 11. 00	01100 CAFETERIA	339, 729 26, 781	4, 524 1, 458			55, 998 11, 041	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	655, 792	518			78, 594	13.00
	01400 CENTRAL SERVICES & SUPPLY	486, 956	4, 691	140, 476	0	0	14.00
	01500 PHARMACY	448, 557	2, 004			49, 633	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	(0 0	0	16.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	907.607	14, 360	429, 977	0	109, 693	30.00
	03100 I NTENSI VE CARE UNI T	190, 281	1, 482			23, 903	31.00
43.00	04300 NURSERY	0	0	C	0 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	7/0.007	10 (10	077.05		50.04/	
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	769, 837 0	12, 619 0	377, 854		59, 046 0	50.00 52.00
52.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	409, 717	5, 823	-		46, 116	
	05500 RADI OLOGY-THERAPEUTI C	96, 708	660			8, 220	
56.00	05600 RADI OI SOTOPE	152, 298	455			14, 683	56.00
57.00	05700 CT SCAN	226, 138	621	18, 605		24, 119	57.00
58. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	96, 508 1, 264, 391	877 3, 242	26, 250 97, 090		12, 124 0	58.00 60.00
66. 00	06600 PHYSI CAL THERAPY	319, 765	2, 826			37, 585	66.00
67.00	06700 OCCUPATI ONAL THERAPY	104, 897	225	6, 741		13, 172	67.00
68.00	06800 SPEECH PATHOLOGY	75, 710	106			9, 560	
69.00	06900 ELECTROCARDI OLOGY	86, 316	655			10, 479	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 703 7, 287	0			0	71.00
72.00	07300 DRUGS CHARGED TO PATIENTS	1, 598, 306				0	72.00
76.00	03020 CARDI OPULMONARY	366, 177	1, 815	54, 345	0	46, 220	
	OUTPATIENT SERVICE COST CENTERS			· · · · ·			
		182, 376				17, 430	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 098, 618	8, 202	245, 588	3 0	154, 527	91.00 92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	212, 689	8, 816	263, 967	0	26, 806	1
	OTHER REIMBURSABLE COST CENTERS		· · · · ·				
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	24 274 277	131, 476	2, 907, 289	382, 360	1 05/ 007	110 00
118.00	NONREI MBURSABLE COST CENTERS	24, 376, 277	131,470	2,907,289	382, 300	1, 056, 007	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0) 0	0	190.00
191.00	19100 RESEARCH	0	0	C	0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	89, 164	5, 001	0	55, 612	11, 308	
		0	16, 171				192.02
	19203 ARNETT SURGERY OFFICE 19201 OCCUPATIONAL MEDICINE	0	3, 319 0		36, 911		192.03 192.04
	19300 NONPALD WORKERS	0	0				192.04
200.00							200.00
201.00	8		0	C	0		201.00
202.00	TOTAL (sum lines 118-201)	24, 465, 441	155, 967	2, 907, 289	654, 711	1, 067, 315	202.00

COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/22/2017 2:4	epared: 6 pm
	Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
		4A	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS	1	•				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	(000 775					4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	6, 820, 775		000 50	_		5.00
7.00		598, 979		830, 52			7.00
7.01 7.02	00701 OPERATION OF PLANT - HOSPITAL	1, 461, 509		122, 93		442 021	7.01
7.02 8.00	00702 OPERATION OF PLANT - TLMOB 00800 LAUNDRY & LINEN SERVICE	420, 557 79, 895		78, 90 3, 17		662, 031 0	8.00
8.00 9.00	00900 HOUSEKEEPING	457, 685		11, 74		3, 049	
10.00	01000 DI ETARY	450, 562		27, 08		96, 200	
11.00	01100 CAFETERI A	55, 491		8, 72		30, 997	
13.00	01300 NURSI NG ADMI NI STRATI ON	740, 667		3, 10	-	11,019	
14.00	01400 CENTRAL SERVICES & SUPPLY	632, 123		28, 09		0	
15.00	01500 PHARMACY	560, 188		11, 99		0	
16.00	01600 MEDICAL RECORDS & LI BRARY	000,100			0 0	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		<u> </u>	0	10.00
30.00	03000 ADULTS & PEDIATRICS	1, 461, 637	565, 015	85, 98	1 417, 870	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	260, 031		8, 87		0	
43.00	04300 NURSERY	C			0 0	0	
	ANCI LLARY SERVICE COST CENTERS				· · · · ·		
50.00	05000 OPERATI NG ROOM	1, 219, 356	471, 358	75, 55	8 367, 214	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	636, 027	245, 865	34, 86	8 169, 461	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	125, 360	48, 460	3, 95	4 19, 215	0	55.00
56.00	05600 RADI OI SOTOPE	181, 069	69, 995	2, 72	6 13, 249	0	56.00
57.00	05700 CT SCAN	269, 483	104, 172	3, 72	0 18, 081	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	135, 759	52, 479	5, 24	9 25, 511	0	
60.00	06000 LABORATORY	1, 364, 723		19, 41		0	60.00
66.00	06600 PHYSI CAL THERAPY	444, 801		16, 92		0	
67.00	06700 OCCUPATI ONAL THERAPY	125, 035		1, 34		0	
68.00	06800 SPEECH PATHOLOGY	88, 540		63		0	
69.00	06900 ELECTROCARDI OLOGY	117,071		3, 92		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 703			0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	7, 287			0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 598, 306			0 0	0	
76.00	O3020 CARDI OPULMONARY	468, 557	181, 127	10, 86	7 52, 815	0	76.00
00 00	OUTPATIENT SERVICE COST CENTERS	2(2,720	101 5/5	10 17	0 F0 100	0	1 00 00
90.00		262, 738		12, 17		0	
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 506, 935		49, 10	9 238, 673	0	
92.00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	C 512, 278		52, 78	5 256, 534	0	92.00 92.01
92.01	OTHER REIMBURSABLE COST CENTERS	512,270	190, 020	52,76	200, 034	0	92.01
101 00	D10100 HOME HEALTH AGENCY	C	0		0 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS		ν <u>ι</u> υ		<u> </u>	0	101.00
118.00		24, 068, 127	6, 667, 188	683, 87	9 2, 149, 410	141, 265	118 00
110.00	NONREI MBURSABLE COST CENTERS	24,000,127	0,007,100	003, 07	2, 147, 410	141,200	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0		0 0	0	190.00
	19100 RESEARCH		0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	161, 085	62, 270	29, 94	-	106, 336	
	2 19202 MOB	195, 999		96, 82		343, 852	
	19203 ARNETT SURGERY OFFICE	40, 230		19, 87			192.03
	19201 OCCUPATIONAL MEDICINE	C	0		0 0		192.04
	19300 NONPALD WORKERS	C	0		0 0		193.00
200.00							200.00
			0		0 0	0	201.00
201.00					0	0	

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2016 To 12/31/2016		pared:
						5/22/2017 2:4	6 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE 8.00	9.00	10.00	11.00	ADMI NI STRATI ON 13. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATI ON OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	129, 402					8.00
9.00	00900 HOUSEKEEPI NG	1, 525					9.00
10.00	01000 DI ETARY	735					10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	234	8, 968 0		0 125, 869 0 10, 916		11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0			0 0	1, 052, 019	14.00
15.00	01500 PHARMACY	0	26, 037		5, 812	0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0			0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1			
30.00	03000 ADULTS & PEDIATRICS	42, 500				282, 200	30.00
31.00	03100 I NTENSI VE CARE UNI T	9, 115				88, 385	31.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	43.00
50.00	05000 OPERATING ROOM	9, 562	99, 228	(9, 526	118, 854	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 626	24, 879		8, 925	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	254	2, 893		1, 283	0	55.00
56.00	05600 RADI OI SOTOPE	962	2,025		1, 764	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1,862 295) 3, 981 2, 298	0	57.00 58.00
60.00	06000 LABORATORY	199			0 2,290	0	60.00
66.00	06600 PHYSI CAL THERAPY	2, 810			6, 814	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	543			1, 349	0	67.00
68.00	06800 SPEECH PATHOLOGY	192			935	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		1, 336	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	71.00 72.00
72.00 73.00	07200 TMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
76.00	03020 CARDI OPULMONARY	1,236	24, 012		9,446	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	982					90.00
91.00	09100 EMERGENCY	49, 423	107, 329	(24, 610	442, 302	1
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART)	804	27, 772		4, 502	120 279	92.00 92.01
92.01	09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	604	21,112		4, 502	120, 278	92.01
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS			•			
118.00		128, 859	598, 842	777, 108	3 123, 197	1, 052, 019	118.00
100.00	NONREIMBURSABLE COST CENTERS		0			0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00 191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	543			2,672		192.00
	19202 MOB	0	105, 014		0		192.02
	19203 ARNETT SURGERY OFFICE	0	0	(0 0		192. 03
	19201 OCCUPATI ONAL MEDI CI NE	0	0	(0		192.04
	19300 NONPAID WORKERS	0	0	(0 0	0	193.00
200.00 201.00			0			0	200. 00 201. 00
201.00		129, 402	703, 856	777, 108	125, 869		
_02.00			, 55, 550	, , , , , , , , , , , , , , , , , , , ,	.20,007	., 332, 617	

Heal th	Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/22/2017 2:4	pared: 6 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	·	14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
1.01 1.02	00102 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01 1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
	01300 NURSI NG ADMI NI STRATI ON	1 0 4 4 5 4 0					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1,044,560	000 544				14.00
		19, 654 0	898, 541 0		0		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	<u> </u>	16.00
30.00	03000 ADULTS & PEDI ATRI CS	123, 107	0		0 3, 791, 374	0	30.00
	03100 I NTENSI VE CARE UNI T	23, 520	0		0 681, 643	0	31.00
	04300 NURSERY	0	0		0 0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	247, 151	0		0 2, 617, 807	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 567	0		0 1, 136, 218	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	2,434	0		0 203, 853	0	55.00
56.00	05600 RADI OI SOTOPE	6, 796	0		0 278, 586	0	56.00
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	85, 016 14, 051	0		0 488, 919 0 239, 403	0	57.00 58.00
60.00	06000 LABORATORY	14,031	0		0 2,046,456	0	60.00
66.00	06600 PHYSI CAL THERAPY	14, 562	0		0 763, 239	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 209	0		0 186, 106	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 128, 468	0	68.00
	06900 ELECTROCARDI OLOGY	7, 454	0		0 194, 109	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	136, 808	0		0 143, 329	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	15, 266	0		0 25, 370	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	898, 541		0 3, 114, 693	0	73.00
76.00	03020 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	28,068	0		0 776, 128	0	76.00
90.00	09000 CLINIC	12, 184	0		0 466, 038	0	90.00
	09100 EMERGENCY	284, 579	0		0 4, 672, 048		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	201,017	0		1,072,010	0	
	09201 OBSERVATION BEDS (DISTINCT PART)	4, 934	0		0 1, 177, 915		92.01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		1,037,360	898, 541		0 23, 131, 702	0	118.00
100 00	NONREIMBURSABLE COST CENTERS		0		0 0	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0		0 0		190. 00 191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	7, 200	0		0 370, 049		192.00
	19202 MOB	,,200	0		0 817, 457		192.00
	19203 ARNETT SURGERY OFFICE	0	0		0 146, 233		192.02
	19201 OCCUPATIONAL MEDICINE	0	0		0 0		192.04
193.00	19300 NONPALD WORKERS	0	О		0 0	0	193.00
200.00					0		200. 00
201.00		0 1, 044, 560	0 898, 541		0 0		201. 00 202. 00
202.00	TOTAL (sum lines 118-201)				0 24, 465, 441		

	Financial Systems	IU HEALTH WHITE			u of Form CMS-2	552-
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Prep 5/22/2017 2:46	
	Cost Center Description	Total 26.00		- <u> </u>	072272017 2.40	5 pm
G	GENERAL SERVICE COST CENTERS	20.00		· · · · ·		
1.00 C	DO100 CAP REL COSTS-BLDG & FIXT					1. (
1.01 0	DO101 CAP REL COSTS-BLDG & FIXT - HOSPITAL					1. (
. 02 0	DO102 CAP REL COSTS-BLDG & FIXT - TLMOB					1. (
. 00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT					4. (
.00 0	DO5OO ADMI NI STRATI VE & GENERAL					5.
7.00 C	DO700 OPERATION OF PLANT					7.
.01 C	DO701 OPERATION OF PLANT - HOSPITAL					7.
	00702 OPERATION OF PLANT - TLMOB					7.
	DO800 LAUNDRY & LINEN SERVICE					8.
	00900 HOUSEKEEPI NG					9.
	D1000 DI ETARY					10.
	D1100 CAFETERIA					11. (
	01300 NURSI NG ADMI NI STRATI ON					13.
	01400 CENTRAL SERVICES & SUPPLY					14.
						15.
	01600 MEDI CAL RECORDS & LI BRARY					16.
	NPATIENT ROUTINE SERVICE COST CENTERS	2 701 274				20
	D3100 INTENSIVE CARE UNIT	3, 791, 374 681, 643				30. 31.
	04300 NURSERY	001, 043				31. 43.
	ANCI LLARY SERVICE COST CENTERS	0				43.
	D5000 OPERATI NG ROOM	2, 617, 807				50.
	D5200 DELIVERY ROOM & LABOR ROOM	2,017,007				50. 52.
	05400 RADI OLOGY-DI AGNOSTI C	1, 136, 218				54.
	D5500 RADI OLOGY-THERAPEUTI C	203, 853				55.
	D5600 RADI OI SOTOPE	278, 586				56.
	D5700 CT SCAN	488, 919				57.
8.00 0	D5800 MAGNETIC RESONANCE IMAGING (MRI)	239, 403				58.
o. oo c	D6000 LABORATORY	2, 046, 456				60.
6.00 0	D6600 PHYSI CAL THERAPY	763, 239				66.
7.00 0	06700 OCCUPATI ONAL THERAPY	186, 106				67.
8.00 0	06800 SPEECH PATHOLOGY	128, 468				68.
9.00 0	06900 ELECTROCARDI OLOGY	194, 109				69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	143, 329				71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	25, 370				72.
	D7300 DRUGS CHARGED TO PATIENTS	3, 114, 693				73.
	03020 CARDI OPULMONARY	776, 128				76.
	DUTPATIENT SERVICE COST CENTERS	444.000				~~
		466, 038				90. 01
	09100 EMERGENCY	4, 672, 048				91. 02
	D9200 OBSERVATION BEDS (NON-DISTINCT PART) D9201 OBSERVATION BEDS (DISTINCT PART)	1, 177, 915				92. (92. (
	THER REIMBURSABLE COST CENTERS	1, 177, 915				92.1
	10100 HOME HEALTH AGENCY	0				101.
	SPECIAL PURPOSE COST CENTERS	0				
18.00	SUBTOTALS (SUM OF LINES 1-117)	23, 131, 702				118.
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				190.
	19100 RESEARCH	0			·	191.
92.001	19200 PHYSI CLANS' PRI VATE OFFI CES	370, 049			·	192.
	19202 MOB	817, 457				192.
92.03	19203 ARNETT SURGERY OFFICE	146, 233			-	192.
92. 04 1	19201 OCCUPATIONAL MEDICINE	0			·	192.
	19300 NONPALD WORKERS	0			·	193.
200.00	Cross Foot Adjustments	0				200.
201.00	Negative Cost Centers	0				201. (
202.00	TOTAL (sum lines 118-201)	24, 465, 441				202.

Health Financial Syste	ms	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL			Provi der C	CN: 15-1312 P	eriod: rom 01/01/2016	Worksheet B	
					0 12/31/2016	Part II Date/Time Pre	pared:
			CAP	I TAL RELATED CO	STS	5/22/2017 2:4	6 pm
			CAI	TAL RELATED CO	5313		
Cost Cente	er Description	Directly	BLDG & FIXT	BLDG & FIXT -		Subtotal	
		Assigned New Capital		HOSPI TAL	TLMOB		
		Related Costs					
		0	1.00	1.01	1.02	2A	
GENERAL SERVICE	<u>COST CENTERS</u> DSTS-BLDG & FLXT						1.00
	OSTS-BLDG & FIXT - HOSPITAL						1.00
	OSTS-BLDG & FIXT - TLMOB						1. 02
	BENEFITS DEPARTMENT	0	0	0	0	0	4.00
5.00 00500 ADMI NI STR/ 7.00 00700 OPERATI ON		128, 694	17, 261	80, 821	161, 940 0	388, 716 0	5.00 7.00
	OF PLANT - HOSPITAL	0	20, 532	614, 781	0	635, 313	7.01
	OF PLANT - TLMOB	0	13, 177	0	146, 540	159, 717	7.02
8.00 00800 LAUNDRY &		0	531	15, 893		16, 424	8.00
9.00 00900 HOUSEKEEP 10.00 01000 DI ETARY	ING	0	1, 962 4, 524	54, 458	1, 595 50, 311	58, 015 54, 835	9.00 10.00
11.00 01100 CAFETERIA		0	1, 458	, °	16, 211	17,669	
13.00 01300 NURSING A		0	518		5, 763	6, 281	
	ERVICES & SUPPLY	0	4, 691	140, 476		145, 167	
15.00 01500 PHARMACY 16.00 01600 MEDICAL RI	ECORDS & LI BRARY	0	2,004	59, 994 0		61, 998 0	
	NE SERVICE COST CENTERS		0				10.00
30.00 03000 ADULTS & I		0	14, 360	429, 977	0	444, 337	30.00
31.00 03100 I NTENSI VE	CARE UNIT	0	1, 482	44, 365		45, 847	31.00
43.00 04300 NURSERY ANCLULARY SERVI	CE COST CENTERS	0	0	0	0	0	43.00
50.00 05000 OPERATI NG		0	12, 619	377, 854	0	390, 473	50.00
	ROOM & LABOR ROOM	0	0	0	0	0	52.00
54. 00 05400 RADI OLOGY 55. 00 05500 RADI OLOGY		0	5, 823 660	174, 371 19, 772		180, 194 20, 432	
56. 00 05600 RADI 01 SOT		0	455	13, 633		14, 088	
57.00 05700 CT SCAN		0	621	18, 605		19, 226	
	RESONANCE IMAGING (MRI)	0	877	26, 250		27, 127	
60. 00 06000 LABORATOR 66. 00 06600 PHYSI CAL		0	3, 242 2, 826	97, 090 84, 625		100, 332 87, 451	
67. 00 06700 0CCUPATI 0		0	225	6, 741		6, 966	
68.00 06800 SPEECH PA		0	106	3, 164	0	3, 270	68.00
69.00 06900 ELECTROCAL		0	655		0	20, 276	
	JPPLIES CHARGED TO PATIENTS CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
	RGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 CARDI OPULI		0	1, 815	54, 345	0	56, 160	76.00
90. 00 09000 CLINIC	I CE COST CENTERS	0	2, 034	(0.000	0	(2.022	
90.00 09000 CLINIC 91.00 09100 EMERGENCY		0	2, 034 8, 202			253, 790	90.00 91.00
	ON BEDS (NON-DISTINCT PART)		0,202	210,000		0	92.00
	ON BEDS (DISTINCT PART)	0	8, 816	263, 967	0	272, 783	92.01
OTHER REIMBURSA 101.00 10100 HOME HEAL	BLE COST CENTERS	0	0	0	0	0	101 00
SPECIAL PURPOSE		0	0	0	0	0	101.00
	(SUM OF LINES 1-117)	128, 694	131, 476	2, 907, 289	382, 360	3, 549, 819	118.00
NONREI MBURSABLE							400.00
190.0019000 GFFT, FLO 191.00 19100 RESEARCH	NER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00 191. 00
192. 00 19200 PHYSI CI AN	S' PRIVATE OFFICES	0	5, 001	0	55, 612	60, 613	192.00
192. 02 19202 MOB		0	16, 171	0	179, 828	195, 999	192. 02
192.03 19203 ARNETT SUI		0	3, 319	0	36, 911	40, 230	
192.04 19201 OCCUPATIO 193.00 19300 NONPALD W					0		192. 04 193. 00
	t Adjustments	0	0				200.00
201.00 Negative (Cost Centers		0	0	0		201.00
202.00 TOTAL (su	n lines 118-201)	128, 694	155, 967	2, 907, 289	654, 711	3, 846, 661	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH WHI	Provider C	CN: 15-1312 P	eri od:	u of Form CMS-2 Worksheet B	
				F	rom 01/01/2016 o 12/31/2016	Part II	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
		4.00	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00 1.01
	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0					4.00
	00500 ADMINISTRATIVE & GENERAL	(388, 716				5.00
	00700 OPERATION OF PLANT	0	13, 196	13, 196			7.00
	00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - TLMOB		32, 197	1, 955		170 224	7.01
	00800 LAUNDRY & LINEN SERVICE		9, 265 1, 760	1, 254 50		170, 236 0	7.02 8.00
	00900 HOUSEKEEPI NG		10, 083	187	16, 484	784	9.00
	01000 DI ETARY		9, 926	430		24, 737	10.00
	01100 CAFETERI A	0	1, 222	139		7, 971	11.00
	01300 NURSI NG ADMI NI STRATI ON	0	16, 317	49	0	2, 833	13.00
	01400 CENTRAL SERVICES & SUPPLY	0		446		0	14.00
	01500 PHARMACY	0		191	18, 160	0	15.00
	01600 MEDI CAL RECORDS & LI BRARY	(0 0	0	0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	32, 200	1, 366	130, 151	0	30.00
	03100 I NTENSI VE CARE UNI T			141	13, 429	0	31.00
	04300 NURSERY			0		0	43.00
	ANCI LLARY SERVI CE COST CENTERS		1				
	05000 OPERATING ROOM	(26, 862	1, 201	114, 374	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	° .	0	0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	(14,012	554	52, 781	0	54.00
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		2,762	63 43		0	55.00 56.00
	05700 CT SCAN) 3, 989 5, 937	59		0	58.00 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	(2, 991	83		0	58.00
	06000 LABORATORY	0	30, 065	308		0	60.00
66.00	06600 PHYSI CAL THERAPY	0	9, 799	269		0	66.00
	06700 OCCUPATI ONAL THERAPY	0	2, 755	21	2, 041	0	67.00
	06800 SPEECH PATHOLOGY	0	1, 951	10		0	68.00
		0	2, 579	62	5, 939	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS) 104) 161	0	0	0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS			0	-	0	72.00
	03020 CARDI OPULMONARY	(173	-	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	(5, 788	193	18, 433	0	90.00
	09100 EMERGENCY	(55, 229	780	74, 338	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		11.005		70.004		92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	(11, 285	839	79, 901	0	92.01
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY		0 0	0	0	0	101. 00
H	SPECIAL PURPOSE COST CENTERS			0	0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	(379, 963	10, 866	669, 465	36, 325	118.00
	NONREI MBURSABLE COST CENTERS						
			0 0	0	-	0	190. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0	0	101 00
190.00 191.00	19100 RESEARCH	0	0	0	-		191.00
190.00 191.00 192.00	19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES		0 3, 549	476	0	27, 343	192.00
190.00 191.00 192.00 192.02	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES 19202 MOB		4, 318	476 1, 538	0	27, 343 88, 419	192. 00 192. 02
190.00 191.00 192.00 192.02 192.03	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19202 MOB 19203 ARNETT SURGERY OFFICE		4, 318 886	476	0	27, 343 88, 419 18, 149	192. 00 192. 02 192. 03
190.00 191.00 192.00 192.02 192.03 192.04	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES 19202 MOB 19203 ARNETT SURGERY OFFI CE 19201 OCCUPATI ONAL MEDI CLNE		4, 318	476 1, 538	0	27, 343 88, 419 18, 149 0	192. 00 192. 02 192. 03 192. 04
190.00 191.00 192.00 192.02 192.03 192.04	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19202 MOB 19203 ARNETT SURGERY OFFICE		4, 318 886	476 1, 538	0	27, 343 88, 419 18, 149 0 0	192. 00 192. 02 192. 03
190.00 191.00 192.00 192.02 192.03 192.04 193.00	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFICES 19202 MOB 19203 ARNETT SURGERY OFFICE 19201 OCCUPATIONAL MEDICINE 19300 NONPALD WORKERS		4, 318 886	476 1, 538	0	27, 343 88, 419 18, 149 0 0	192. 00 192. 02 192. 03 192. 04 193. 00 200. 00 201. 00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH WHI	TE HOSPITAL Provider CC	N. 15_1312	In Lie Period:	u of Form CMS-2 Worksheet B	2552-10
ALLUCA	HOW OF CAPITAL RELATED COSTS				From 01/01/2016 To 12/31/2016	Part II	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS	1	1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02 4.00	00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT						1.02 4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	23, 045					8.00
9.00	00900 HOUSEKEEPI NG	272	85, 825				9.00
10.00	01000 DI ETARY	131		93, 51			10.00
11.00	01100 CAFETERIA	42	1, 094		0 28, 137		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	-		0 2,440	27, 920	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0			0 0 0 1,299	0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0			0 1, 299 0 0	0	16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	<u> </u>		0 0	0	10.00
30.00	03000 ADULTS & PEDIATRICS	7, 569	14, 957	80, 27	2 5, 221	7, 489	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 623	4, 233	13, 24	4 741	2, 346	31.00
43.00	04300 NURSERY	0	0		0 0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 703			0 2, 129	3, 154	50.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0			0 0 0 1,995	0	52.00 54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	45			0 287	0	55.00
56.00	05600 RADI OI SOTOPE	171	247		0 394	0	56.00
57.00	05700 CT SCAN	332			0 890	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	53	459		0 514	0	58.00
60.00	06000 LABORATORY	35			0 0	0	60.00
66.00	06600 PHYSI CAL THERAPY	500			0 1, 523	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	97	212		0 302	0	67.00
68.00	06800 SPEECH PATHOLOGY	34	106		0 209 0 299	0	68.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 299 0 0	0	69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03020 CARDI OPULMONARY	220			0 2, 112	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	175			0 678		90.00
91.00	09100 EMERGENCY	8, 801	13, 087		0 5, 501	11, 739	91.00
92.00 92.01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	143	2 204		0 1,006	2 102	92.00
92.01	OTHER REIMBURSABLE COST CENTERS	143	3, 386		0 1,006	3, 192	92.01
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS				-	-	
118.00	SUBTOTALS (SUM OF LINES 1-117)	22, 948	73, 020	93, 51	6 27, 540	27, 920	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0 0 597		191.00 192.00
	19202 MOB	97	12, 805		0 0		192.00
	19203 ARNETT SURGERY OFFICE	0	12,000		0 0		192.02
	19201 OCCUPATI ONAL MEDI CI NE	0	Ő		0 0		192.04
	19300 NONPALD WORKERS	0	0		0 0		193.00
200.00							200. 00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	23, 045	85, 825	93, 51	6 28, 137	27, 920	202.00

Heal th	Financial Systems	IU HEALTH WHIT	LE HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2016	Worksheet B	
					To 12/31/2016		pared:
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	
		SERVICES & SUPPLY		RECORDS & LI BRARY		Residents Cost & Post	
		001121		Li Divitti		Stepdown	
		14.00	15.00	16.00	24.00	Adjustments 25.00	
0	GENERAL SERVICE COST CENTERS	14.00	13.00	10.00	24.00	23.00	
	DO100 CAP REL COSTS-BLDG & FIXT						1.00
	DO101 CAP REL COSTS-BLDG & FIXT - HOSPITAL DO102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.01 1.02
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL						7.00 7.01
	DO702 OPERATION OF PLANT - TLMOB						7.02
	DO800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	D1100 CAFETERI A						11.00
	D1300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY	202, 483	100.074				14.00
	01500 PHARMACY 01600 MEDI CAL_RECORDS & LI BRARY	3, 810 0	100, 974 0		0		15.00 16.00
-	NPATIENT ROUTINE SERVICE COST CENTERS						10.00
	D3000 ADULTS & PEDIATRICS	23, 864	0		0 747, 426		30.00
	D3100 I NTENSI VE CARE UNI T D4300 NURSERY	4, 559 0	0		0 91, 891 0 0	0	31.00 43.00
	ANCI LLARY SERVICE COST CENTERS		0		0 0	0	43.00
	D5000 OPERATING ROOM	47, 909	0		0 599, 904		50.00
	D5200 DELIVERY ROOM & LABOR ROOM D5400 RADIOLOGY-DIAGNOSTIC	0 2, 048	0		0 0 0 255, 620	-	52.00 54.00
	05500 RADI OLOGY-THERAPEUTI C	472	0		0 200, 30, 399		55.00
	05600 RADI OI SOTOPE	1, 317	0		0 24, 376		56.00
	D5700 CT SCAN	16, 480	0		0 48, 873 0 41, 897		57.00 58.00
	D5800 MAGNETIC RESONANCE IMAGING (MRI) D6000 LABORATORY	2, 724	0		0 41, 897		60.00
66.00	D6600 PHYSI CAL THERAPY	2, 823	0		0 130, 802		66.00
	06700 OCCUPATI ONAL THERAPY	234	0		0 12,628		67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 1, 445	0		0 6, 538 0 30, 600		68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 520	0		0 26, 624		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 959	0		0 3, 120		72.00
	07300 DRUGS CHARGED TO PATIENTS 03020 CARDI OPULMONARY	0 5, 441	100, 974 0		0 136, 185 0 93, 806		73.00 76.00
	DUTPATIENT SERVICE COST CENTERS	5,441	0			0	/0.00
	09000 CLINIC	2, 362	0		0 92, 289		90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	55, 164	0		0 478, 429		91.00 92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	956	0		0 373, 491		92.00
C	OTHER REIMBURSABLE COST CENTERS					1	
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	201, 087	100, 974		0 3, 389, 930	0	118.00
ľ	NONREI MBURSABLE COST CENTERS		,				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0 1, 396	0		0 0 0 94,071		191. 00 192. 00
	19202 MOB	0	0		0 303, 079	0	192.00
	19203 ARNETT SURGERY OFFICE	0	0		0 59, 581		192.03
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0	0				192. 04 193. 00
200.00	Cross Foot Adjustments		0				200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	202, 483	100, 974		0 3, 846, 661	0	202.00

Health Financial Systems	IU HEALTH WHIT			u of Form CMS-2552-1
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Prepared: 5/22/2017 2:46 pm
Cost Center Description	Total 26.00			
GENERAL SERVICE COST CENTERS	20.00	· · · · · · · · · · · · · · · · · · ·		
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.0
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.0
1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB				1.0
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
5. 00 00500 ADMI NI STRATI VE & GENERAL				5.0
7.00 00700 OPERATION OF PLANT				7.0
7.01 00701 OPERATION OF PLANT - HOSPITAL				7.0
7.02 00702 OPERATION OF PLANT - TLMOB				7.0
8.00 00800 LAUNDRY & LINEN SERVICE				8.0
9. 00 00900 HOUSEKEEPI NG				9.0
10. 00 01000 DI ETARY				10.0
11. 00 01100 CAFETERIA				11.0
13.00 01300 NURSING ADMINISTRATION				13.0
14.00 01400 CENTRAL SERVICES & SUPPLY				14.0
15. 00 01500 PHARMACY				15.0
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 0
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	747, 426			30.0
31. 00 03100 I NTENSI VE CARE UNI T	91, 891			31.0
43. 00 04300 NURSERY	0			43.0
ANCI LLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	599, 904			50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			52.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	255, 620			54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	30, 399			55.0
56. 00 05600 RADI OI SOTOPE	24, 376			56.0
57. 00 05700 CT SCAN	48, 873			57.0
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	41, 897			58.0
	165,032			60.0
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	130, 802			66. 0 67. 0
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	12, 628 6, 538			68.0
69. 00 06900 ELECTROCARDI OLOGY	30, 600			69.0
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 624			71.0
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	3, 120			71.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	136, 185			73.0
76. 00 03020 CARDI OPULMONARY	93, 806			76.0
OUTPATIENT SERVICE COST CENTERS	70,000			70.0
90. 00 09000 CLINIC	92, 289			90.0
91. 00 09100 EMERGENCY	478, 429			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.0
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	373, 491			92.0
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	0			101. 0
SPECIAL PURPOSE COST CENTERS	_			
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 389, 930			118.0
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 0
191. 00 19100 RESEARCH	0			191.0
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	94,071			192.0
192. 02 19202 MOB	303, 079			192.0
192. 03 19203 ARNETT SURGERY OFFICE	59, 581			192.0
192. 04 19201 OCCUPATI ONAL MEDI CI NE 193. 00 19300 NONPAI D WORKERS	0			192.0
	0			193.0
· · · · · · · · · · · · · · · · · · ·	0			200. 0 201. 0
201.00 Negative Cost Centers	0			201.0
202.00 TOTAL (sum lines 118-201)	3, 846, 661			J202. 0

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH WHI	TE HOSPITAL Provider C	°N: 15 1212 □Dc	In Lie eriod:	u of Form CMS-2 Worksheet B-1	2552-10
COST ALLOCATION - STATISTICAL DASIS		Thomas de la		om 01/01/2016		nared
	CAD	I TAL RELATED CO		, 12/31/2010	5/22/2017 2:4	
	CAP	TTAL RELATED CU	515			
Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	EMPLOYEE BENEFI TS	Reconciliation	
		(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		
				(GROSS SALARI ES)		
	1.00	1.01	1.02	4.00	5A	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT	124,005		1			1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	77, 196				1.00
1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	46, 809	7 005 710		1.02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	13, 724	2, 146	0 11, 578	7, 885, 710 1, 347, 328	-6, 820, 775	4.00 5.00
7.00 00700 OPERATION OF PLANT	0	0	0	182, 076	0	7.00
7. 01 00701 OPERATION OF PLANT - HOSPITAL 7. 02 00702 OPERATION OF PLANT - TLMOB	16, 324 10, 477		0 10, 477	0	0	7.01 7.02
8.00 00800 LAUNDRY & LINEN SERVICE	422		0	0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 560 3, 597		114 3, 597	295, 960 413, 733	0	9.00 10.00
11. 00 01100 CAFETERI A	1, 159		1, 159	81, 573	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	412		412	580, 678	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	3, 730 1, 593			0 366, 704	0	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0			0	0	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	11, 417	11, 417	0	810, 448	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 178			176, 605	0	31.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50. 00 05000 OPERATI NG ROOM	10, 033	10, 033	0	436, 254	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 630 525		0	340, 721 60, 733	0	54.00 55.00
56. 00 05600 RADI OI SOTOPE	362	362	0	108, 484	0	56.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	494 697		0	178, 201 89, 580	0	57.00 58.00
60. 00 06000 LABORATORY	2, 578			07, 500	0	60.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	2, 247 179		0	277, 691	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	84		0	97, 317 70, 632	0	67.00 68.00
69.00 06900 ELECTROCARDI OLOGY	521	521	0	77, 420	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03020 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	1, 443	1, 443	0	341, 489	0	76.00
90. 00 09000 CLINIC	1, 617	1, 617	0	128, 779	0	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 521	6, 521	0	1, 141, 700	0	91.00 92.00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	7,009	7, 009	0	198, 053	0	
				0	0	101 00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	104, 533	77, 196	27, 337	7, 802, 159	-6, 820, 775	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	-	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 02 19202 MOB	3, 976 12, 857		3, 976 12, 857	83, 551 0		192. 00 192. 02
192.03 19203 ARNETT SURGERY OFFICE	2,639		2, 639	0		192.02
192. 04 19201 OCCUPATI ONAL MEDI CI NE	0	0	0	0		192.04
193.00 19300 NONPAID WORKERS 200.00 Cross Foot Adjustments			0	0	0	193. 00 200. 00
201.00 Negative Cost Centers	455 015	0.007.007	/	1 0/7 0/-		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	155, 967	2, 907, 289	654, 711	1, 067, 315		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 257748	37. 661135	13. 986862	0. 135348		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)				0		204.00
205.00 Unit cost multiplier (Wkst. B, Part				0. 000000		205. 00
11)	I	I	I	I		l

	Financial Systems	IU HEALTH WHI			In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1312 P	eriod: rom 01/01/2016	Worksheet B-1	
					o 12/31/2016		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	5/22/2017 2:4 LAUNDRY &	
		& GENERAL	PLANT	PLANT -	PLANT - TLMOB		
		(ACCUM. COST)	(SQUARE FEET)	HOSPI TAL (SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	
		5.00	7.00	7. 01	7.02	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.01
1.02 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						1.02 4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	17, 644, 666					5.00
7.00	00700 OPERATION OF PLANT	598, 979	110, 281				7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	1, 461, 509					7.01
7.02	00702 OPERATION OF PLANT - TLMOB	420, 557		0	24, 754	10 020	7.02
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	79, 895 457, 685		422	0	18, 838 222	8.00 9.00
10.00	01000 DI ETARY	450, 562		0	3, 597	107	10.00
11.00	01100 CAFETERI A	55, 491		0	1, 159	34	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	740, 667		0	412	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	632, 123				0	14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	560, 188 0				0	15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	10.00
30.00	03000 ADULTS & PEDIATRICS	1, 461, 637	11, 417	11, 417	0	6, 187	30.00
31.00	03100 I NTENSI VE CARE UNI T	260, 031				1, 327	31.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
F0 00	ANCILLARY SERVICE COST CENTERS	1, 219, 356	10.022	10.022	0	1, 392	
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 219, 350	10, 033	10, 033 0	0	1, 392	50.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	636, 027	-			819	•
55.00	05500 RADI OLOGY-THERAPEUTI C	125, 360			0	37	55.00
56.00	05600 RADI OI SOTOPE	181, 069		362	0	140	•
57.00	05700 CT SCAN	269, 483		494	0	271	57.00
58.00 60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	135, 759 1, 364, 723		697 2, 578	0	43	
66.00	06600 PHYSI CAL THERAPY	444, 801		2, 378	0	409	
67.00	06700 OCCUPATI ONAL THERAPY	125, 035			0	79	•
68.00	06800 SPEECH PATHOLOGY	88, 540			0	28	•
69.00	06900 ELECTROCARDI OLOGY	117,071		521	0	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 703 7, 287		0	0	0	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 598, 306		0	0	0	73.00
76.00	03020 CARDI OPULMONARY	468, 557		1, 443	-	180	•
	OUTPATIENT SERVICE COST CENTERS		1	1	1		
90.00		262, 738				143	•
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 506, 935	6, 521	6, 521	0	7, 195	91.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	512, 278	7, 009	7, 009	0	117	
	OTHER REIMBURSABLE COST CENTERS			.,			
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS	17 047 050	00.000	F0 701	E 000	40 752	110.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	17, 247, 352	90, 809	58, 726	5, 282	18, 759	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	0	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	161, 085	3, 976	0	3, 976		192.00
	19202 MOB	195, 999			12, 857		192. 02
	19203 ARNETT SURGERY OFFICE	40, 230	2, 639	0	2, 639	0	192.03
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0			0		192. 04 193. 00
200.00		0			0	0	200.00
200.00	,						201.00
202.00	Cost to be allocated (per Wkst. B,	6, 820, 775	830, 522	2, 149, 410	662, 031	129, 402	
202.00	Part I)	0 20/5/2	7 5200/2	24 400454	26 744405	4 040201	202 00
203.00 204.00		0. 386563 388, 716				6. 869201 23. 045	203.00
204.00	Part II)	300,710	13, 190	007,403	170, 230	23, 045	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 022030	0. 119658	11. 399806	6. 877111	1. 223325	205.00
	11)	1	l				I

COCT	Financial Systems	IU HEALIH WHI	TE HOSPITAL	N. 1E 1010		u of Form CMS-	
CUST	ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2016	Worksheet B-1	
				T	o 12/31/2016	Date/Time Pre 5/22/2017 2:4	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	·	(TIME SPENT)	(PATIENT DAYS)	(FTE'S)	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
						(COSTED	
		9.00	10.00	11.00	NURSING HOURS) 13.00	REQUIS.) 14.00	
	GENERAL SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100		101.00	11100	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	2, 433					9.00
10.00	01000 DI ETARY	98		0.401			10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	31	0	9, 421 817			11.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12		017		498, 618	1
15.00	01500 PHARMACY	90		435	-	9, 382	1
16.00	01600 MEDICAL RECORDS & LIBRARY	0		C		0	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	424		1, 748		58, 765	
31.00	03100 I NTENSI VE CARE UNI T	120		248		11, 227	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		0 0	0	43.00
50.00	05000 OPERATING ROOM	343	0	713	6, 924	117, 977	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.0		(0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	86	0	668	3 0	5,044	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	10		96	0	1, 162	55.00
56.00	05600 RADI OI SOTOPE	7		132		3, 244	
57.00	05700 CT SCAN	9		298		40, 582	
58.00 60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	13		172		6, 707 0	
66.00	06600 PHYSI CAL THERAPY	80		510		6, 951	1
67.00	06700 OCCUPATI ONAL THERAPY	6	0	101		577	1
68.00	06800 SPEECH PATHOLOGY	3	0	70	0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	100	0 0	3, 558	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		65, 305	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		7, 287	
73.00 76.00	07300 DRUGS CHARGED TO PATI ENTS 03020 CARDI OPULMONARY	83		707		0 13, 398	
78.00	OUTPATIENT SERVICE COST CENTERS	03	0	/0/	0	13, 390	78.00
90.00	09000 CLINIC	49	0	227	0	5, 816	90.00
	09100 EMERGENCY	371				135, 844	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01		96	0	337	7, 007	2, 355	92.01
	OTHER REIMBURSABLE COST CENTERS	-	-	-			
101.00	10100 HOME HEALTH AGENCY	0	0 0	(0 0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS D SUBTOTALS (SUM OF LINES 1-117)	2,070	1, 857	9, 221	61, 287	495, 181	118 00
110.00	NONREI MBURSABLE COST CENTERS	2,070	1,037	7,22	01,207	475, 101	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
191.00	19100 RESEARCH	0	0	C	0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	200	0 0		192.00
	2 19202 MOB	363	0	C	0 0		192. 02
	3 19203 ARNETT SURGERY OFFICE	0	0		0		192.03
	4 19201 OCCUPATIONAL MEDICINE D 19300 NONPAID WORKERS	0	0				192.04 193.00
200.00			0		, 0	0	200.00
200.00							201.00
202.00	S S	703, 856	777, 108	125, 869	1, 052, 019	1, 044, 560	1
_	Part I)						
203.00		289. 295520		13. 360471		2.094910	
204.00		85, 825	93, 516	28, 137	27, 920	202, 483	204.00
204.00	LUORT LLA	T					1
	Part II)	25 275200	EU 3E0743	2 004424		N 104000	205 00
205.00		35. 275380	50. 358643	2.986626	0. 455562	0. 406088	205.00

				From 01/01/2016 To 12/31/2016	Date/Time Pre 5/22/2017 2:4	
	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	1	572272017 2.4	
	GENERAL SERVICE COST CENTERS	15.00	16.00			-
1.00	00100 CAP REL COSTS-BLDG & FIXT	1				1.00
1.01 1.02 4.00 5.00 7.00 7.01 7.02	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - TLMOB					1. 01 1. 02 4. 00 5. 00 7. 00 7. 01 7. 01
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY					10.00
						11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY					13.00
	01500 PHARMACY	100				15.00
		0	o			16.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS	0	0			30. 00
	03100 I NTENSI VE CARE UNI T	0	0			31.00
43.00	04300 NURSERY	0	0			43.00
	ANCI LLARY SERVI CE COST CENTERS	0	0			
	05200 DELIVERY ROOM & LABOR ROOM	0	0			50.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
	05500 RADI OLOGY-THERAPEUTI C	Ő	o			55.00
56.00	05600 RADI OI SOTOPE	0	o			56.00
57.00	05700 CT SCAN	0	0			57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0			58.00
		0	0			60.00 66.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0			67.00
	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDI OLOGY	0	o			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
	07300 DRUGS CHARGED TO PATIENTS	100	0			73.00
76.00	03020 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0			76.00
90.00	09000 CLINIC	0	0			90.00
		0	0			91.00
7 2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
} 2. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0			92.01
101 00	OTHER REIMBURSABLE COST CENTERS	0	0			101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0			
118.00		100	0			118.00
	NONREI MBURSABLE COST CENTERS					1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190. 00
	19100 RESEARCH	0	0			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
	19202 MOB 19203 ARNETT SURGERY OFFICE	0	0			192.02 192.03
	19201 OCCUPATIONAL MEDICINE	0	0			192.03
	19300 NONPALD WORKERS	0	o			193.00
200.00						200.00
201.00						201.00
202.00		898, 541	0			202.00
203.00	Part I)	8 085 410000	0. 000000			203.00
203.00 204.00		8, 985. 410000 100, 974				203.00
-04.00	Part II)	100, 774	0			204.00
	Unit cost multiplier (Wkst. B, Part	1,009.740000	0. 000000			205.00

Health Fin	nancial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016	Worksheet C Part I	
					To 12/31/2016		
			Title	XVIII	Hospi tal	Cost	
	· · ·				Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	PATIENT ROUTINE SERVICE COST CENTERS	1					
	DOO ADULTS & PEDIATRICS	3, 791, 374		3, 791, 37		0	
	IOO INTENSIVE CARE UNIT	681, 643		681, 64	3 0	0	31.00
	300 NURSERY	0			0 0	0	43.00
	CILLARY SERVICE COST CENTERS	1					
	DOO OPERATING ROOM	2, 617, 807		2, 617, 80	07 0	0	
	200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
	100 RADI OLOGY-DI AGNOSTI C	1, 136, 218		1, 136, 21	8 0	0	54.00
	500 RADI OLOGY-THERAPEUTI C	203, 853		203, 85	3 0	0	55.00
	500 RADI OI SOTOPE	278, 586		278, 58		0	56.00
	700 CT SCAN	488, 919		488, 91	9 0	0	57.00
	BOO MAGNETIC RESONANCE IMAGING (MRI)	239, 403		239, 40	03 0	0	58.00
60.00 060	DOO LABORATORY	2, 046, 456		2, 046, 45	6 0	0	60.00
	500 PHYSI CAL THERAPY	763, 239	C	763, 23		0	66.00
	00 OCCUPATIONAL THERAPY	186, 106	C	186, 10	06 0	0	67.00
	300 SPEECH PATHOLOGY	128, 468		128, 46		0	68.00
	200 ELECTROCARDI OLOGY	194, 109		194, 10	09 0	0	69.00
	IOO MEDICAL SUPPLIES CHARGED TO PATIENTS	143, 329		143, 32		0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	25, 370		25, 37	0 0	0	72.00
	BOO DRUGS CHARGED TO PATIENTS	3, 114, 693		3, 114, 69	03 0	0	73.00
	020 CARDI OPULMONARY	776, 128		776, 12	.8 0	0	76.00
	PATIENT SERVICE COST CENTERS						
	DOO CLINIC	466, 038		466, 03	8 0	0	
	IOO EMERGENCY	4, 672, 048		4, 672, 04	8 0	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 454, 630		1, 454, 63		0	
	201 OBSERVATION BEDS (DISTINCT PART)	1, 177, 915		1, 177, 91	5 0	0	92.01
	IER REI MBURSABLE COST CENTERS	1					
	IOO HOME HEALTH AGENCY	0			0		101.00
200.00	Subtotal (see instructions)	24, 586, 332					200.00
201.00	Less Observation Beds	1, 454, 630		1, 454, 63			201.00
202.00	Total (see instructions)	23, 131, 702	0	23, 131, 70	02 0	0	202.00

Health Financial Systems	IU HEALTH WHIT	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/22/2017 2:4	
	-	Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	LL					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 699, 428		2, 699, 42	8		30.00
31.00 03100 INTENSIVE CARE UNIT	399, 348		399, 34	8		31.00
43. 00 04300 NURSERY	0			0		43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	17, 760	5, 817, 756	5, 835, 51	6 0.448599	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	105, 334	5, 653, 485	5, 758, 81	9 0. 197301	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	13,030	972, 929	985, 95	0. 206756	0. 000000	55.00
56. 00 05600 RADI 0I SOTOPE	227, 867	2, 219, 817	2, 447, 68	0. 113816	0. 000000	56.00
57.00 05700 CT SCAN	186, 841	4, 341, 065	4, 527, 90	0. 107979	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	60, 336	1, 042, 593	1, 102, 92	0. 217061	0.000000	58.00
60. 00 06000 LABORATORY	1,014,103	6, 202, 377	7, 216, 48	0. 283581	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY	270, 179	1, 003, 846	1, 274, 02	0. 599077	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	110, 765	159, 657	270, 42	0. 688206	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	20, 122	173, 231	193, 35	0. 664422	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	180, 392	3, 666, 401	3, 846, 79	0. 050460	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 940	362, 331	369, 27	0. 388140	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	109, 595	109, 59	0. 231489	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 747, 094	8, 907, 375	10, 654, 46	0. 292337	0.000000	73.00
76. 00 03020 CARDI OPULMONARY	380, 144	447, 642	827, 78	0. 937595	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	684, 001	684, 00	0. 681341	0. 000000	90.00
91. 00 09100 EMERGENCY	195, 940	16, 209, 784	16, 405, 72	0. 284782	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 355	3, 784, 410	3, 799, 76	0. 382821	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	105, 333	2, 018, 149	2, 123, 48	0. 554709	0.00000	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	7, 756, 311	63, 776, 444	71, 532, 75	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 756, 311	63, 776, 444	71, 532, 75	5		202.00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/22/2017 2:4	pared: 6 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30, 00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					45.00
50. 00 05000 OPERATING ROOM	0.000000				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
57. 00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03020 CARDI OPULMONARY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0.000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,000000				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000				92.01
OTHER REI MBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Sv	ystems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RAT	IO OF COSTS TO CHARGES		Provider C	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/22/2017 2:4	
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
Cost C	Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs		Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	DUTINE SERVICE COST CENTERS						
	S & PEDIATRICS	3, 791, 374		3, 791, 37		3, 791, 374	
	SIVE CARE UNIT	681, 643		681, 64	13 0	681, 643	31.00
43.00 04300 NURSER		0			0 0	0	43.00
	ERVICE COST CENTERS						
50.00 05000 OPERAT		2, 617, 807		2, 617, 80	07 0	2, 617, 807	
	RY ROOM & LABOR ROOM	0			0 0	0	
	LOGY-DI AGNOSTI C	1, 136, 218		1, 136, 21		1, 136, 218	1
	LOGY-THERAPEUTI C	203, 853		203, 85		203, 853	
56.00 05600 RADI 0I		278, 586		278, 58		278, 586	
57.00 05700 CT SCA		488, 919		488, 91	9 0	488, 919	
	IC RESONANCE IMAGING (MRI)	239, 403		239, 40	03 0	239, 403	
60.00 06000 LABORA		2,046,456		2, 046, 45	6 0	2, 046, 456	
66.00 06600 PHYSI C		763, 239	0	763, 23	39 0	763, 239	
67.00 06700 0CCUPA	TIONAL THERAPY	186, 106	0	186, 10		186, 106	67.00
68.00 06800 SPEECH		128, 468	0	128, 46	0 8	128, 468	
69.00 06900 ELECTR		194, 109		194, 10)9 0	194, 109	
71.00 07100 MEDI CA	AL SUPPLIES CHARGED TO PATIENTS	143, 329		143, 32	29 0	143, 329	71.00
72.00 07200 IMPL.	DEV. CHARGED TO PATIENTS	25, 370		25, 37	0 0	25, 370	72.00
	CHARGED TO PATIENTS	3, 114, 693		3, 114, 69	03 0	3, 114, 693	73.00
76.00 03020 CARDI 0	PULMONARY	776, 128		776, 12	28 0	776, 128	76.00
OUTPATIENT S	SERVICE COST CENTERS			_			
90.00 09000 CLINIC		466, 038		466, 03	38 0	466, 038	90.00
91.00 09100 EMERGE	NCY	4, 672, 048		4, 672, 04	8 0	4, 672, 048	91.00
92.00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART)	1, 454, 630		1, 454, 63	30	1, 454, 630	92.00
92.01 09201 0BSERV	ATION BEDS (DISTINCT PART)	1, 177, 915		1, 177, 91	5 0	1, 177, 915	92.01
	JRSABLE COST CENTERS						
101.00 10100 HOME H		0			0	0	101.00
	al (see instructions)	24, 586, 332		24, 586, 33	32 0		
	Observation Beds	1, 454, 630		1, 454, 63		1, 454, 630	1
202.00 Total	(see instructions)	23, 131, 702	0	23, 131, 70	02 0	23, 131, 702	202.00

Health Financial Systems	IU HEALTH WHIT	TE HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/22/2017 2:4	
	-	Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient	
	6.00	7.00	8.00	9,00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 699, 428		2, 699, 42	00		30,00
31. 00 03100 INTENSIVE CARE UNIT	399, 348		399, 34			31.00
43. 00 04300 NURSERY	399, 348		399, 34	+0 0		43.00
ANCI LLARY SERVI CE COST CENTERS	0			0		43.00
50. 00 05000 OPERATING ROOM	17, 760	5, 817, 756	5, 835, 5	0. 448599	0. 000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0,017,700		0 0.000000	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	105, 334	5, 653, 485			0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	13,030	972, 929			0, 000000	
56. 00 05600 RADI OI SOTOPE	227, 867	2, 219, 817			0. 000000	
57. 00 05700 CT SCAN	186, 841	4, 341, 065			0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	60, 336	1,042,593			0.000000	•
60. 00 06000 LABORATORY	1,014,103	6, 202, 377			0.000000	
66. 00 06600 PHYSI CAL THERAPY	270, 179	1,003,846			0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	110, 765	159, 657			0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	20, 122	173, 231	193, 3	0. 664422	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	180, 392	3, 666, 401	3, 846, 79	0. 050460	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 940	362, 331	369, 2	0. 388140	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	109, 595	109, 59	0. 231489	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 747, 094	8, 907, 375	10, 654, 40	0. 292337	0. 000000	73.00
76.00 03020 CARDI OPULMONARY	380, 144	447, 642	827, 78	0. 937595	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	684, 001	684, 00	0. 681341	0. 000000	90.00
91. 00 09100 EMERGENCY	195, 940	16, 209, 784	16, 405, 72	0. 284782	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	15, 355	3, 784, 410	3, 799, 70		0.00000	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	105, 333	2, 018, 149	2, 123, 48	0. 554709	0.00000	92.01
OTHER REIMBURSABLE COST CENTERS			1			
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	7, 756, 311	63, 776, 444	71, 532, 75	55		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 756, 311	63, 776, 444	71, 532, 75	55		202.00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1312	Period:	Worksheet C	
			From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	pared:
				5/22/2017 2:4	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1 20 00
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	0.000000				50.00
50.00 05000 OPERATING ROOM	0.00000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI OI SOTOPE	0. 000000				56.00
57.00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
60. 00 06000 LABORATORY	0. 000000				60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76.00 03020 CARDI OPULMONARY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS					_
90. 00 09000 CLI NI C	0. 000000				90.00
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REI MBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/22/2017 2:4	pared: 6 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	1	-	
50.00 05000 OPERATING ROOM	599, 904	5, 835, 516				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	255, 620	5, 758, 819				
55. 00 05500 RADI OLOGY-THERAPEUTI C	30, 399					
56. 00 05600 RADI OI SOTOPE	24, 376					56.00
57.00 05700 CT SCAN	48, 873	4, 527, 906				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	41, 897	1, 102, 929				
60. 00 06000 LABORATORY	165, 032	7, 216, 480			13, 250	60.00
66. 00 06600 PHYSI CAL THERAPY	130, 802	1, 274, 025	0. 10266	58 124, 489	12, 781	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 628	270, 422	0. 04669	43, 306	2, 022	67.00
68.00 06800 SPEECH PATHOLOGY	6, 538	193, 353	0. 03382	4 17,038	576	68.00
69. 00 06900 ELECTROCARDI OLOGY	30, 600	3, 846, 793	0.00795	55 107, 822	858	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 624	369, 271	0. 07209	99 5, 184	374	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 120	109, 595	0. 02846	0 8	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	136, 185	10, 654, 469	0. 01278	32 1, 034, 178	13, 219	73.00
76.00 03020 CARDI OPULMONARY	93, 806	827, 786	0. 11332	22 241, 658	27, 385	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	92, 289	684, 001	0. 13492	25 0	0	90.00
91.00 09100 EMERGENCY	478, 429	16, 405, 724	0. 02916	14, 215	415	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	286, 764	3, 799, 765	0. 07546			92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	373, 491	2, 123, 482	0. 17588	4, 668	821	92.01
200.00 Total (lines 50-199)	2, 837, 377	68, 433, 979		2, 518, 120	79, 862	200. 00

Health Financial Systems	IU HEALTH WHITE	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provider C	CN: 15-1312	Period: From 01/01/2016	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2016	Date/Time Pre	
					5/22/2017 2:4	6 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Nu	ursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	5	
	1.00	2.00	3.00	4.00	4) 5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	52.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05500 RADI 0LOGI - THERAPEOTIC	0	0		0 0	0	56.00
57. 00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0			0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	0			0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03020 CARDI OPULMONARY	0	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		1		_	
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
200.00 Total (lines 50-199)	0	0		0 0	0	200.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/22/2017 2:4	
			XVIII	Hospi tal	Cost	
Cost Center Description	Total	Total Charges		0utpati ent	Inpati ent	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS		r		1		
50.00 05000 OPERATI NG ROOM	0	5, 835, 516				
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	5, 758, 819				
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	985, 959				
56. 00 05600 RADI OI SOTOPE	0	2, 447, 684				
57.00 05700 CT SCAN	0	4, 527, 906				
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 102, 929			31, 984	
60. 00 06000 LABORATORY	0	7, 216, 480				
66. 00 06600 PHYSI CAL THERAPY	0	1, 274, 025			124, 489	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	270, 422	0.00000	0 0.000000	43, 306	67.00
68.00 06800 SPEECH PATHOLOGY	0	193, 353	0.00000	0 0.000000	17, 038	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 846, 793	0.00000	0 0.000000	107, 822	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	369, 271	0.00000	0 0.000000	5, 184	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	109, 595	0.00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 654, 469	0.00000	0.000000	1, 034, 178	73.00
76. 00 03020 CARDI OPULMONARY	0	827, 786	0.00000	0.000000	241, 658	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	684, 001	0.00000	0.000000	0	90.00
91.00 09100 EMERGENCY	0	16, 405, 724	0.00000	0.000000	14, 215	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	3, 799, 765	0.00000	0.000000	518	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	2, 123, 482	0.00000	0.000000	4, 668	92.01
200.00 Total (lines 50-199)	0	68, 433, 979			2, 518, 120	200. 00

Health Financial Systems	IU HEALTH WHIT	FE HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	-		1			
50.00 05000 OPERATI NG ROOM	0	C		0		50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0		55.00
56. 00 05600 RADI OI SOTOPE	0	0		0		56.00
57.00 05700 CT SCAN	0	0		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58.00
60. 00 06000 LABORATORY	0	0		0		60.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76. 00 03020 CARDI OPULMONARY	0	C		0		76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0		90.00
91. 00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	C		0		92.01
200.00 Total (lines 50-199)	0	C		0		200.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2016	Worksheet D Part V	
				To 12/31/2016	Date/Time Pre	pared:
					5/22/2017 2:4	6 pm
		l litle	XVIII	Hospi tal	Cost	
Cast Canton Description	Coot to Charge	DDC Doimhurood	Charges Cost	Cost	Costs PPS Services	
Cost Center Description	Ratio From	PPS Reimbursed Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(See That.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1,00	2.00	3.00	4.00	5,00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 448599	0	2, 027, 30	01 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 197301	0	1, 724, 82	3 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 206756	0	495, 67	1 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 113816	0	895, 86	9 0	0	56.00
57.00 05700 CT SCAN	0. 107979	0	1, 469, 87	1 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 217061	0	436, 41	6 0	0	58.00
60. 00 06000 LABORATORY	0. 283581	0	2, 589, 57	3 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 599077	0	363, 16	07 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 688206	0	38, 14	7 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 664422	0	20, 56	9 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 050460	0	1, 556, 05	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 388140	0	91, 53	8 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 231489	0	37, 19	07 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 292337	0	4, 239, 05	2, 845	0	73.00
76. 00 03020 CARDI OPULMONARY	0. 937595	0	189, 63	8 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 681341				0	
91. 00 09100 EMERGENCY	0. 284782		4, 517, 04	3 1, 231	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 382821		2, 014, 25		0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 554709	0	964, 90		0	
200.00 Subtotal (see instructions)		0	24, 112, 45	5 4, 076	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 +/- line 201)		0	24, 112, 45	4, 076	0	202.00

ealth Financial Systems	IU HEALTH WHIT			In Lie	u of Form CMS-2552-1
PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-1312	Period: From 01/01/2016	Worksheet D Part V
				To 12/31/2016	Date/Time Prepared:
		Titlo	XVIII	Hospi tal	5/22/2017 2:46 pm Cost
	Cos		AVI 11	nospitai	CUST
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coi ns.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6.00	7.00			
ANCILLARY SERVICE COST CENTERS	· · · · ·				
D. 00 05000 OPERATI NG ROOM	909, 445	0			50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	340, 309	0			54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	102, 483	0			55.0
6. 00 05600 RADI 0I SOTOPE	101, 964	0			56.0
7.00 05700 CT SCAN	158, 715	0			57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	94, 729	0			58.0
0. 00 06000 LABORATORY	734, 354	0			60.0
6. 00 06600 PHYSI CAL THERAPY	217, 565	0			66.0
7.00 06700 OCCUPATI ONAL THERAPY	26, 253	0			67.0
8.00 06800 SPEECH PATHOLOGY	13, 666	0			68.0
9.00 06900 ELECTROCARDI OLOGY	78, 518	0			69.0
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	35, 530	0			71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 611	0			72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	1, 239, 231	832			73.0
6. 00 03020 CARDI OPULMONARY	177, 804	0			76.0
OUTPATIENT SERVICE COST CENTERS	000 704	0			
0. 00 09000 CLINIC	300, 724	0			90.0
1.00 09100 EMERGENCY	1, 286, 373	351			91.0
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	771,098	0			92.0
2. 01 09201 OBSERVATION BEDS (DISTINCT PART)	535, 243	0			92.0
00.00 Subtotal (see instructions)	7, 132, 615	1, 183			200.0
01.00 Less PBP Clinic Lab. Services-Program	0				201. 0
001 y Charges 02.00 Net Charges (line 200 +/- line 201)	7 122 / 15	1 100			202.0
02.00 Net Charges (line 200 +/- line 201)	7, 132, 615	1, 183			202.0

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component (CN: 15-1312 CCN: 15-Z312	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	
				<u> </u>	5/22/2017 2:4	6 pm
		litle		Swing Beds - SNF		
Cret Creter Description			Charges	Cast	Costs	
Cost Center Description	Cost to Charge		Cost Reimbursed	Cost Reimbursed	PPS Services	
	Ratio From Worksheet C,	Services (see inst.)	Servi ces	Services Not	(see inst.)	
	Part I, col. 9	inst.)	Subject To			
	Fait I, CUI. 7		Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5.00	
ANCILLARY SERVICE COST CENTERS		2100	0.00		0,00	
50. 00 05000 0PERATI NG ROOM	0. 448599	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 197301	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 206756	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 113816	0		0 0	0	56.00
57.00 05700 CT SCAN	0. 107979	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 217061	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 283581	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 599077	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 688206	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 664422	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 050460	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 388140	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 231489	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 292337	0		0 0	0	73.00
76. 00 03020 CARDI OPULMONARY	0. 937595	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 681341	0		0 0	0	
91.00 09100 EMERGENCY	0. 284782	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 382821	0		0 0	0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 554709	0		0 0	0	,
200.00 Subtotal (see instructions)		0		0 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00
	1	0	I	U U	0	1202.00

Health Financial Systems	IU HEALTH WHIT	E HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider CCN: 15-1312	Peri od:	Worksheet D
			From 01/01/2016	Part V
		Component CCN: 15-Z312	To 12/31/2016	Date/Time Prepared: 5/22/2017 2:46 pm
		Title XVIII	Swing Beds - SNF	
	Cost		Joining Bodo on	
Cost Center Description	Cost	Cost		
'	Reimbursed	Reimbursed		
	Servi ces	Services Not		
	Subject To	Subject To		
		Ded. & Coins.		
		(see inst.)		
	6.00	7.00		
ANCI LLARY SERVI CE COST CENTERS		a		
50. 00 05000 OPERATING ROOM	0	0		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0		55.00 56.00
	0	0		57.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY	0	0		60.00
66. 00 06600 PHYSI CAL THERAPY	0	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 PATIENTS	0	0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		72.00
76. 00 03020 CARDI OPULMONARY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS	0	0		/0.00
90. 00 09000 CLINIC	0	0		90.00
91. 00 09100 EMERGENCY	0	o		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	o		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00 Subtotal (see instructions)	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program	0			201.00
Only Charges				
202.00 Net Charges (line 200 +/- line 201)	0	0		202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016		nared
				10 12/31/2010	5/22/2017 2:4	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 448599	0	1	0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 448399				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 197301			0 0	0	
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0. 206756			0 0	0	
56. 00 05600 RADI 01 SOTOPE	0. 200750			0 0	0	
57. 00 05700 CT SCAN	0. 107979			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 217061			0 0	0	
60. 00 06000 LABORATORY	0. 283581			0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 599077			0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 688206				0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 664422			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 050460				0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 388140				0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 231489			0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 292337			0 0	0	
76. 00 03020 CARDI OPULMONARY	0. 937595			0 0	0	
OUTPATIENT SERVICE COST CENTERS	01707070			0 0		10100
90. 00 09000 CLINIC	0. 681341	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 284782			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 382821			0 0	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 554709			0 0	0	
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CON: 15-1312 Period: Froid: To 12/31/2016 Worksheet D Part V Det Vice Prepared: 5/22/2017 2:46 pm 5/22/2017 2:46 pm 5/22/2017 2:46 pm 5/22/2017 2:46 pm 5/22/2017 2:46 pm 5/22/2017 2:46 pm Cost Cost Center Description Cost Cost Reinbursed Services Subject To Ded. & Coins. Provider CON: 15-1312 Period: Froid/01/2017 0: Ded. & Coins. Worksheet D Part V Description ANCILLARY SERVICE COST CENTERS Subject To Ded. & Coins. 0 0 0 0 50.00 50.00 50.00 50.00 50.00 05000 DELIVERY NOM & LABOR ROOM 0 0 0 0 52.0 50.00 05000 RADIOLOGY-DI READEUTIC 0 0 0 52.0 50.00 054.00 RADI DLOGY-DI READEUTIC 0 0 55.00 55.00 50.00 05600 RADI DLOGY-THERAPEUTIC 0 0 0 58.00 60.00 0 0 0 0 58.00 66.00 61.00 0 0 0 0 58.00 66.00 57.00 57.00 62.00 0	Health Financial Systems	IU HEALTH WHIT	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Cost Cost Reimbursed Subject To Ded. & Coins. Hospital Cost ANCILLARY SERVICE COST CENTERS Cost Cost Reimbursed Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. Services Subject To Ded. & Coins. ANCILLARY SERVICE COST CENTERS 6.00 7.00 50.00 50.00 ANCILLARY SERVICE COST CENTERS 0 0 0 50.00 52.00 05200 DELIVERY ROMA & LABOR ROM 0 0 52.00 52.00 05000 RADIOLOGY-THERAPEUTIC 0 0 55.00 55.00 05600 CABONICOGY OF SANNCE IMAGING (MRI) 0 0 55.00 60.00 0 0 0 0 58.00 66.00 06600 PHYSICAL THERAPY 0 0 0 58.00 66.00 06600 CABORTORY 0 0 0 0 0 67.00 0 0 0 0 0 0 0 72.00 0 0 0 <t< td=""><td>APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND</td><td>VACCINE COST</td><td>Provider CO</td><td>CN: 15-1312</td><td>From 01/01/2016</td><td>Part V Date/Time Pre</td><td>epared:</td></t<>	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1312	From 01/01/2016	Part V Date/Time Pre	epared:
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 50.00 05000 OPERATING ROOM 0 0 50.00 05000 RADIOLOCY-DI AGNOSTIC 0 0 50.00 05000 RADIOLOCY-THERAPEUTIC 0 0 51.00 05000 RADIOLOCY-THERAPEUTIC 0 0 58.00 05800 RADIOLOCY-THERAPEUTIC 0 0 60.00 0 0 0 0 60.00 0 0 0 0 60.00 0 0 0 0 61.00 0 0 0 0 62.00 0 0 0 0 63.00 0 0 0 0 60.00			Ti tl	e XIX	Hospi tal		•
ANCI LLARY SERVICE COST CENTERS Reimbursed Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) ANCI LLARY SERVICE COST CENTERS 6.00 7.00 6.00 7.00 50.00 52.00 05000 [DELVERY ROM & LABOR ROOM 0 0 52.00 05000 [DELVERY ROM & LABOR ROOM 0 0 52.00 05000 [DELVERY ROM & LABOR ROOM 0 0 55.00 05000 RADI 0LOGY- THERAPEUTI C 0 0 56.00 05000 RADI 0LOGY- THERAPEUTI C 0 0 58.00 05000 MAGNETI C RESONANCE I MGI NG (MRI) 0 0 58.00 06000 LABORATORY 0 0 58.00 66.00 06000 DELCETRO CARDI 0LOGY 0 0 66.00 67.00 06700 OCUPATI ONAL THERAPY 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 07300 MPL DEV. CHARGED TO PATIENTS 0 0 71.00 71.00 07300		Cos	ts		· · · · · ·		
ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 0 0 50.00 50.00 52.00 53.00 53.00 53.00 53.00 53.00 53.00 55.00 55.00 56.00 57.00 56.00 57.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 66.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 <td< td=""><td>Cost Center Description</td><td>Reimbursed Services Subject To Ded. & Coins. (see inst.)</td><td>Reimbursed Services Not Subject To Ded. & Coins. (see inst.)</td><td></td><td></td><td></td><td></td></td<>	Cost Center Description	Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
50.00 05000 0PERATI NG ROM 0 0 50.00 52.00 05200 DELI VERY ROM & LABOR ROM 0 0 52.00 54.00 05400 RADI OLOGY-J HERAPEUTI C 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 58.00 60.00 06000 LABORATORY 0 0 66.00 60.00 06400 PAYSI CAL THERAPY 0 0 67.00 63.00 06800 SPEECH PATHOLOGY 0 0 67.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 71.00 71.00 71.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 73.00 <t< td=""><td></td><td>6.00</td><td>7.00</td><td></td><td></td><td></td><td></td></t<>		6.00	7.00				
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 55.00 0500 RADI OLOGY-THERAPEUTI C 0 0 55.00 50.00 05500 RADI OLOGY-THERAPEUTI C 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 66.00 60.00 06000 LABORATORY 0 0 66.00 61.00 06000 LECTROCARDI OLOGY 0 0 66.00 62.00 068000 SPECH PATHOLOGY 0 0 68.00 69.00 068000 SPECH PATHOLOGY 0 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 74.00 03202 CARDI O				1			50.00
54.00 05400 RADI 0LOGY - DI AGNOSTI C 0 0 55.00 05500 RADI 0LOGY - THERAPEUTI C 0 0 56.00 05600 RADI 0LOGY - THERAPEUTI C 0 0 57.00 05500 RADI 0LOGY - THERAPEUTI C 0 0 57.00 05700 CT SCAN 0 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 60.00 06000 LABORATORY 0 0 60.00 06000 CUPATI ONAL THERAPY 0 0 61.00 06700 OCUPATI ONAL THERAPY 0 0 62.00 06400 SPEECH PATHOLOGY 0 0 63.00 06400 SPEECH PATHOLOGY 0 0 64.00 06400 SPEECH PATHOLOGY 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 72.00 73.00 0300 DRUGS CHARGED TO PATI ENTS 0 0 72.00 73.00 0300 DRUGS CHARGED TO PATI ENTS 0 0		0	0				
55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 56.00 05600 RADI OL SOTOPE 0 0 56.00 57.00 CT SCAN 0 0 57.00 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 58.00 60.00 06000 LABORATORY 0 0 60.00 61.00 06700 CCUPATI ONAL THERAPY 0 0 66.00 62.00 06700 0CUPATI ONAL THERAPY 0 0 67.00 68.00 63.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 69.00 69.00 69.00 69.00 69.00 71.00 71.00 71.00 72.00 72.00 73.00 74.00 90.00 91.00		0	0				
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58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 60.00 06000 LABORATORY 0 0 60.00 66.00 06600 PHYSICAL THERAPY 0 0 66.00 67.00 06700 0CCUPATIONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 69.00 71.00 MOI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 OT200 IMPL. DEV. CHARGED TO PATIENTS 0 0 73.00 73.00 OT300 DRUGS CHARGED TO PATIENTS 0 0 73.00 74.00 O3020 CARDI OPULMONARY 0 0 73.00 74.00 09000 CLARDI OPULMONARY 0 0 90.00 75.00 09000 CLARDI OPULMONARY 0 0 91.00 90.00 OPUTPATIENT SERVICE COST CENTERS 0 0 91.00 91.00 OPUTO EMERGENCY 0 <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
60.00 06000 LABORATORY 0 0 60.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 0CCUPATI 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 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 73.00 76.00 03020 CARDI OPULMONARY 0 0 0 73.00 73.00 76.00 09000 CLI NI C 0 0 0 90.00 91.00 91.00 91.00 09100 EMERGENCY 0 0 92.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 200.00 201.00<		0	0				
66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 68.00 68.00 68.00 68.00 68.00 69.00 0 0 0 68.00 69.00 69.00 69.00 0 0 0 0 69.00 69.00 71.00 71.00 71.00 71.00 71.00 72.00 72.00 72.00 73.00 74.00 90.00 91.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92		0	0				
67.00 06700 0CCUPATIONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 76.00 03020 CARDI OPULMONARY 0 0 0 76.00 90.00 09000 CLINIC 0 0 0 76.00 91.00 09100 EMERGENCY 0 0 90.00 92.01 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92.01 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 201.00 201.00 201.00 Less PBP Clinic Lab. Services-Program		0	0				
68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03020 CARDIOPULMONARY 0 0 73.00 76.00 0020 CLINIC 0 0 76.00 00171.00 09000 CLINIC 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 92.01 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 92.00 92.01 09201 OBSERVATION BEDS (DI STINCT PART) 0 0 92.01 200.00 Subtotal (see instructions) 0 0 201.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00		0	0				
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72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03020 CARDI OPULMONARY 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 76.00 90.00 09100 EMERGENCY 0 0 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 91.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92.01 92.01 09201 Chi to Lab. Services-Program 0 0 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00	69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.00 03020 CARDI OPULMONARY 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 76.00 90.00 09100 CLINIC 0 0 90.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 91.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 92.01 920.00 Subtotal (see instructions) 0 0 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
76. 00 03020 CARDI OPULMONARY 0 0 76. 00 OUTPATI ENT SERVICE COST CENTERS 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 90. 00 91. 00 90. 00 91. 00 92. 00 92. 00 92. 00 92. 01 92	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 90.00 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 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
90.00 09000 CLINIC 0 0 90.00 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.01 09201 DBSERVATION BEDS (DISTINCT PART) 0 0 92.01 200.00 Subtotal (see instructions) 0 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00	76.00 03020 CARDI OPULMONARY	0	0				76.00
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 0 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 201.00							
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92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 92. 01 200. 00 Subtotal (see instructions) 0 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 201. 00		0	0				
200.00Subtotal (see instructions)00200.00201.00Less PBP Clinic Lab. Services-Program0201.00201.00Only Charges0000		0	0				
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 0 0		0	0				
Only Charges		0	0				
		0					201.00
202.00 Net Charges (line 200 +/- line 201) 0 0 202.00							
	202.00 Net Charges (line 200 +/- line 201)	0	0	1			202.00

	FINANCIAL SYSTEMS IN HEALTH WHITE HEALTH WHI	Provider CCN: 15-1312	Period: From 01/01/2016	u of Form CMS-2 Worksheet D-1	
			To 12/31/2016	Date/Time Prep 5/22/2017 2:40	
		Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		2, 554	1.
00	Inpatient days (including private room days, excluding swing-be			2, 186	
00	Private room days (excluding swing-bed and observation bed days) do not complete this line.). If you have only pr	ivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation bed			1, 226	4.
00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through Decembe	r 31 of the cost	311	5
00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6
~ ~	reporting period (if calendar year, enter 0 on this line)				_
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	57	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)			1 001	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	1, 001	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	311	10
. 00	through December 31 of the cost reporting period (see instructions Swing-bed SNF type inpatient days applicable to title XVIII on the second s		nom days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, ent		com days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar yea	r, enter 0 on this lin	e)		
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
00	SWING BED ADJUSTMENT	there a December 21	6 the sect		1 1 7
. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 d	r the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	137.32	19
	reporting period	-			
. 00	Medicaid rate for swing-bed NF services applicable to services a reporting period	after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions)			3, 791, 374	21
. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 3 7 x line 19)	31 of the cost reporti	ng period (line	7, 827	24
5.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			470 047	26
	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		479, 067 3, 312, 307	20
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		· 1		
. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
. 00				∩	
. 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0 0	
. 00 . 00 . 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷			0 0. 000000	30 31
. 00 . 00 . 00 . 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3)			0 0. 000000 0. 00	30 31 32
. 00 . 00 . 00 . 00 . 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)	tions)	0 0. 000000	32 33
7.00 3.00 9.00 <t< td=""><td>Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu: Average per diem private room cost differential (line 34 x line</td><td>line 28) s line 33)(see instruc</td><td>tions)</td><td>0 0. 000000 0. 00 0. 00 0. 00 0. 00</td><td>30 31 32 33 34 35</td></t<>	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu: Average per diem private room cost differential (line 34 x line	line 28) s line 33)(see instruc	tions)	0 0. 000000 0. 00 0. 00 0. 00 0. 00	30 31 32 33 34 35
7.00 3.00 9.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu: Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	line 28) s line 33)(see instruc 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30 31 32 33 34 35 36
5.00 6.00 6.00 6.00 6.00 6.00 6.00 6.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	line 28) s line 33)(see instruc 31)		0 0. 000000 0. 00 0. 00 0. 00 0. 00	30 31 32 33 34 35
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	line 28) s line 33)(see instruc 31) d private room cost di		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30 31 32 33 34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room cost differential (line 32 minu: Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	line 28) s line 33)(see instruc 31) d private room cost di TMENTS		0 0.00000 0.00 0.00 0.00 0 3,312,307	30 31 32 33 34 35 36 37
 . 00 <li< td=""><td>Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY</td><td>line 28) s line 33)(see instruc 31) d private room cost di <u>TMENTS</u> nstructions) 8)</td><td></td><td>0 0. 000000 0. 00 0. 00 0. 00 0. 00 0</td><td>30 31 32 33 34 35 36 37 37 38</td></li<>	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an 27 minus line 36) PART 11 - HOSPITAL AND SUBPROVIDERS ONLY	line 28) s line 33)(see instruc 31) d private room cost di <u>TMENTS</u> nstructions) 8)		0 0. 000000 0. 00 0. 00 0. 00 0. 00 0	30 31 32 33 34 35 36 37 37 38

	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2016	Worksheet D-1	2552- I
					To 12/31/2016	Date/Time Pre	
			Title	XVIII	Hospi tal	5/22/2017 2:4 Cost	to pili
	Cost Center Description	Total Inpatient Costl	Total Inpatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.
8. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	681, 643	263	2, 591. 8	0 80	207, 344	43.
l. 00	CORONARY CARE UNIT	001,043	203	2, 391. 0	0 80	207, 344	43.
5.00	BURN I NTENSI VE CARE UNI T						45.
6.00	SURGI CAL INTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	, line 200)			876, 551	48
. 00	Total Program inpatient costs (sum of lines			ns)		2, 600, 650	
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	Wkst. D, sum	of Parts I and	0	50
. 00	III) Pass through costs applicable to Program inpa	atient ancillary	v services (fr	om Wkst D s	um of Parts II	0	51
	and IV)		<i>y</i> controcc (11				
2.00	Total Program excludable cost (sum of lines					0	
3.00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	0	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				<u> </u>	
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0	
. 00	Difference between adjusted inpatient operat	ing cost and tai	rget amount (I	ine 56 minus	line 53)	0	
8.00 9.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	orting period (ending 1996 u	indated and co	mounded by the	0.00	
. 00	market basket	sol thig period t		pulled and co	inpounded by the	0.00	
0. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
1.00	If line 53/54 is less than the lower of line					0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (TTHES 54 X	60), OF 1% OF	the target		
2.00	Relief payment (see instructions)					0	62
3. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ta thursunk Daar		++!		471.040	
4. 00	instructions) (title XVIII only)	ts through Decer		cost reporti	ng period (see	471, 240	64.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)						
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line d	64 plus line 6	5)(title XVII	l only). For	471, 240	66
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	porting period	0	67
	(line 12 x line 19)	0			0.1	-	
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repo	rting period	0	68
00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	coutino costs (l	lino 67 - lino	60)		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU					0	107
. 00	Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line)		(line 14 v li	no 25)			72
. 00	Medically necessary private room cost applica Total Program general inpatient routine serv						73
. 00	Capital -related cost allocated to inpatient	•			art II, column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷ lin						76
. 00 . 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:						77
. 00	Aggregate charges to beneficiaries for excess		rovi der record	s)			79
. 00	Total Program routine service costs for compa	• •			us line 79)		80
	Inpatient routine service cost per diem limi						81
. 00	Inpatient routine service cost limitation (I						82
. 00 . 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		5)				83
	Utilization review - physician compensation		ns)				85
o. 00	Total Program inpatient operating costs (sum						86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST				1	
	Total observation bed days (see instructions)				960	87
7.00 3.00	Adjusted general inpatient routine cost per	diam (11 - 07	Line 2			1, 515. 24	

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	747, 426	3, 791, 374	0. 19713	9 1, 454, 630	286, 764	90.00
91.00 Nursing School cost	0	3, 791, 374	0.00000	0 1, 454, 630	0	91.00
92.00 Allied health cost	0	3, 791, 374	0.00000	0 1, 454, 630	0	92.00
93.00 All other Medical Education	0	3, 791, 374	0. 00000			93.00

)MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre 5/22/2017 2:40	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed day			2, 554	1.
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		sivata room dave	2, 186 0	2. 3.
00	do not complete this line.	iys). Ti you nave oniy pi	Tvate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation b			1, 226	4.
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	311	5.
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				_
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	r 31 of the cost	57	7.
00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)			11	
00	Total inpatient days including private room days applicable t newborn days)	o the Program (excluding	g swing-bed and	11	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		com days) arter	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	12
. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)	-	
. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14 15
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31 (of the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18
. 00	reporting period	s through December 21 a	f the cost	137.32	10
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through beceniber st o	the cost	137.32	19
. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ls)		3, 791, 374	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	2	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportio	an ported (Line 6	0	23
. 00	x line 18)	ST OF THE COST TEPOLIT	ig period (Title 8	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	7, 827	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
. 00	x line 20)			0	25
	Total swing-bed cost (see instructions)	(1:22 01 2:22 1:22 0()		479,067	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 26)		3, 312, 307	27
. 00	General inpatient routine service charges (excluding swing-be	d and observation bed cl	narges)	0	28
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	30 31
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		LT UNS)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	-		0	36
7.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 312, 307	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		-		
	Adjusted general inpatient routine service cost per diem (see	-		1, 515. 24	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			16, 668 0	39 40
	J J J J J J J J J J J J J J J J J J J			-	

	h Financial Systems IU HEALTH WHITE HOSPITAL JTATION OF INPATIENT OPERATING COST Provider	- CCN: 15-1312	In Lie Period:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2016 To 12/31/2016		
	Cost Center Description Total Inpatient Cost Inpatient Da 1.00 2.00	itle XIX Average Per aysDiem (col. 1 col. 2) 3.00		Cost Program Cost (col. 3 x col. 4) 5.00	
42.00		0 0.	0 00		42.00
43.00	Intensive Care Type Inpatient Hospital Units	263 2, 591.	30 0	0	43.00
44.00		203 2, 371.	0	0	44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00					46.00
47.00	O OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47.00
	· · · · · · · · · · · · · · · · · · ·			1.00	
48.00	5 1 5			15, 970	
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instruct PASS THROUGH COST ADJUSTMENTS	tions)		32, 638	49.00
50.00		rom Wkst. D, sur	n of Parts I and	0	50.00
51.00	5 11 5 1	(from Wkst. D, s	sum of Parts II	0	51.00
52.00	and IV)) Total Program excludable cost (sum of lines 50 and 51)			0	52.00
53.00	5	physician anestl	netist, and	0	
	medical education costs (line 49 minus line 52)				
54.00	TARGET AMOUNT AND LIMIT COMPUTATION			0	54.00
55.00	5 5			0.00	
56.00				0	
57.00	3 1 1 5 5	(line 56 minus	line 53)	0	
58.00 59.00		undated and c	ampounded by the	0 0.00	
57.00	market basket	, upuateu anu cu	shipounded by the	0.00	39.00
60.00				0.00	
61.00				0	61.00
	which operating costs (line 53) are less than expected costs (lines 54 amount (line 56), otherwise enter zero (see instructions)	x 60), 01 1% 0	the target		
62.00				0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST) Medicare swing-bed SNF inpatient routine costs through December 31 of 1	the cost reporti	na period (See	0	64.00
04.00	instructions) (title XVIII only)		lig per lou (see	0	04.00
65.00	5 1	e cost reporting	g period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line)		L only) For	0	66.00
00.00	CAH (see instructions)		r only). Tor	0	00.00
67.00) Title V or XIX swing-bed NF inpatient routine costs through December 3	1 of the cost re	eporting period	0	67.00
68.00	(line 12 x line 19)	of the east ron	arting pariod	0	60.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 ((line 13 x line 20)	of the cost rep	bring period	0	68.00
69.00		ine 68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/II		<u>,</u>		1 70 00
70.00 71.00	5 5 5 5		1		70.00
72.00		110 2)			72.00
73.00	5 51 11 6 1				73.00
74.00 75.00	5 5 1		Dort II column		74.00
75.00	 Capital-related cost allocated to inpatient routine service costs (from 26, line 45) 	III WULKSHEEL D, I	art II, CUIUMM		75.00
7/ 00) Per diem capital-related costs (line 75 ÷ line 2)				76.00
76.00	o				77.00
77.00) Inpatient routine service cost (line 74 minus line 77)	anda)			78.00
77. 00 78. 00					/9 nn
77.00 78.00 79.00	Aggregate charges to beneficiaries for excess costs (from provider reco		nus line 79)		
77.00 78.00 79.00 80.00 81.00	Aggregate charges to beneficiaries for excess costs (from provider reco Total Program routine service costs for comparison to the cost limitati Inpatient routine service cost per diem limitation		nus line 79)		80.00 81.00
77.00 78.00 79.00 80.00 81.00 82.00	Aggregate charges to beneficiaries for excess costs (from provider reco Total Program routine service costs for comparison to the cost limitati Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81)		nus line 79)		80.00 81.00 82.00
77.00 78.00 79.00 80.00 81.00 82.00 83.00	Aggregate charges to beneficiaries for excess costs (from provider reco Total Program routine service costs for comparison to the cost limitati Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		nus line 79)		80.00 81.00 82.00 83.00
77.00 78.00 79.00 80.00 81.00 82.00	Aggregate charges to beneficiaries for excess costs (from provider reco Total Program routine service costs for comparison to the cost limitati Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions) Program inpatient ancillary services (see instructions)	· · · · · · · · · · · · · · · · · · ·	nus line 79)		79.00 80.00 81.00 82.00 83.00 84.00 85.00
77.00 78.00 79.00 80.00 81.00 82.00 83.00 84.00	 Aggregate charges to beneficiaries for excess costs (from provider record Total Program routine service costs for comparison to the cost limitation Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) 	· · · · · · · · · · · · · · · · · · ·	nus line 79)		80.00 81.00 82.00 83.00 84.00
$\begin{array}{c} 77.\ 00\\ 78.\ 00\\ 79.\ 00\\ 80.\ 00\\ 81.\ 00\\ 82.\ 00\\ 83.\ 00\\ 84.\ 00\\ 85.\ 00\\ 86.\ 00\\ \end{array}$	 Aggregate charges to beneficiaries for excess costs (from provider records) Aggregate charges to beneficiaries for comparison to the cost limitation Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 	· · · · · · · · · · · · · · · · · · ·	nus line 79)	040	80.00 81.00 82.00 83.00 84.00 85.00 86.00
$\begin{array}{c} 77.\ 00\\ 78.\ 00\\ 79.\ 00\\ 80.\ 00\\ 81.\ 00\\ 82.\ 00\\ 83.\ 00\\ 84.\ 00\\ 85.\ 00\\ \end{array}$	 Aggregate charges to beneficiaries for excess costs (from provider recorder) Aggregate charges to beneficiaries for excess costs (from provider recorder) Total Program routine service costs for comparison to the cost limitation Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine services (see instructions) Program inpatient ancillary services (see instructions) Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 	· · · · · · · · · · · · · · · · · · ·	nus line 79)	960 1, 515. 24	80. 00 81. 00 82. 00 83. 00 84. 00 85. 00 86. 00 87. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	747, 426	3, 791, 374	0. 19713	9 1, 454, 630	286, 764	90.00
91.00 Nursing School cost	0	3, 791, 374	0.00000	0 1, 454, 630	0	91.00
92.00 Allied health cost	0	3, 791, 374	0.00000	0 1, 454, 630	0	92.00
93.00 All other Medical Education	0	3, 791, 374	0.00000	1, 454, 630	0	93.00

Health Financial Systems	IU HEALTH WHITE HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre	
				5/22/2017 2:4	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 ADULTS & PEDI ATRI CS			1 440 001		30.00
30. 00 03000 ADDETS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT			1, 440, 801 282, 882		30.00
43. 00 04300 NURSERY			202, 002		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 44859	79 17, 760	7,967	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 19730			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 20675			•
56. 00 05600 RADI OI SOTOPE		0. 1138			•
57. 00 05700 CT SCAN		0. 10797			•
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 21706			
60. 00 06000 LABORATORY		0. 28358	579, 395	164, 305	60.00
66. 00 06600 PHYSI CAL THERAPY		0. 59907	124, 489	74, 578	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 68820	43, 306	29, 803	67.00
68.00 06800 SPEECH PATHOLOGY		0. 66442	17, 038	11, 320	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 05046	50 107, 822	5, 441	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 38814	10 5, 184	2, 012	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 23148	39 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 29233	37 1, 034, 178	302, 328	73.00
76. 00 03020 CARDI OPULMONARY		0. 93759	241, 658	226, 577	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 68134		0	90.00
91. 00 09100 EMERGENCY		0. 28478			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 38282			
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 55470			
200.00 Total (sum of lines 50-94 and 96-98)			2, 518, 120	876, 551	
201.00 Less PBP Clinic Laboratory Services-Prog	ram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)		I	2, 518, 120		202.00

Health Financial Systems	IU HEALTH WHITE HO	SPI TAL			In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	P	rovider CO	CN: 15-1312	Peri		Worksheet D-3	
					n 01/01/2016		
	G	omponent (CCN: 15-Z312	То	12/31/2016	Date/Time Pre 5/22/2017 2:40	pared:
		Title	XVIII	Swi n	g Beds - SNF		o pili
Cost Center Description			Ratio of Cos		Inpatient	Inpati ent	
			To Charges			Program Costs	
					Charges	(col. 1 x col.	
					Ũ	2)	
			1.00		2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS					0		30.00
31.00 03100 INTENSIVE CARE UNIT					0		31.00
43.00 04300 NURSERY							43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM			0. 4485	99	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.0000	00	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 1973	01	3, 628	716	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C			0. 2067	56	0	0	55.00
56. 00 05600 RADI 0I SOTOPE			0. 1138	16	3, 156	359	56.00
57.00 05700 CT SCAN			0. 1079	79	4, 781	516	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 2170	61	0	0	58.00
60. 00 06000 LABORATORY			0. 2835	81	62, 197	17, 638	60.00
66. 00 06600 PHYSI CAL THERAPY			0. 5990	77	95, 254	57, 064	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 6882	06	52, 638	36, 226	67.00
68.00 06800 SPEECH PATHOLOGY			0. 6644	22	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 0504	60	2, 190	111	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 3881	40	275	107	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 2314	89	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 2923	37	184, 238	53, 860	73.00
76. 00 03020 CARDI OPULMONARY			0. 9375	95	44, 552	41, 772	76.00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C			0. 6813	41	0	0	90.00
91.00 09100 EMERGENCY			0. 2847	82	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 3828	21	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)			0. 5547	09	0	0	92.01
200.00 Total (sum of lines 50-94 and 96-98)					452, 909	208, 369	
201.00 Less PBP Clinic Laboratory Services-Prog	gram only charges (line 61)			0		201.00
202.00 Net Charges (line 200 minus line 201)					452, 909		202.00

Health Financial Systems IU HEALTH WHITE	E HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1312	Peri od:	Worksheet D-3	
			From 01/01/2016 To 12/31/2016		narod
			10 12/31/2010	5/22/2017 2:4	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10.554	1	
30. 00 O3000 ADULTS & PEDIATRICS			18, 551		30.00
31. 00 03100 I NTENSI VE CARE UNI T			C		31.00
43.00 04300 NURSERY			C)	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0. 4485	20	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 4485			50.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1973			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2067			55.00
56. 00 05600 RADI OLOGI - THERAPEOTIC		0. 1138			56.00
57. 00 05700 CT SCAN		0. 1079		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2170			
60. 00 06000 LABORATORY		0. 2835			
66. 00 06600 PHYSI CAL THERAPY		0. 5990			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 68820			67.00
68. 00 06800 SPEECH PATHOLOGY		0.66442			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 0504			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3881			
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 2314			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2923		5, 791	73.00
76. 00 03020 CARDI OPULMONARY		0. 9375	2,068	1, 939	76.00
OUTPATIENT SERVICE COST CENTERS		•			1
90. 00 09000 CLINIC		0. 6813	41 C	0 0	90.00
91. 00 09100 EMERGENCY		0. 2847	32 9, 556	2, 721	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 38282	21 C	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 55470)9 C	0	92.01
200.00 Total (sum of lines 50-94 and 96-98)			52, 899	15, 970	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		C		201.00
202.00 Net Charges (line 200 minus line 201)			52, 899		202.00

CALCUL	Financial Systems IU HEALTH WHITE HOSPITAL In Lie ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-1312 Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
	Title XVIII Hospital	5/22/2017 2:40 Cost	6 pm
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	7, 133, 798	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00 4.00	PPS payments Outlier payment (see instructions)	0	3.00 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0	8.00 9.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	7, 133, 798	
	COMPUTATION OF LESSER OF COST OR CHARGES	1 1	
12 00	Reasonable charges Ancillary service charges	0	12.00
12.00 13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	12.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17 00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19.00
~~ ~~	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	7, 205, 136	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT	0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)	61, 037	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	4, 314, 150	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	2, 829, 949	27.00
28.00	instructions)	0	28.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50) ESRD direct medical education costs (from Wkst. E-4, line 36)	0	28.00
30.00	Subtotal (sum of lines 27 through 29)	2, 829, 949	
	Primary payer payments	573	
32.00	Subtotal (line 30 minus line 31)	2, 829, 376	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	580, 182	
	Adjusted reimbursable bad debts (see instructions)	377, 118	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	569, 438	
37.00	Subtotal (see instructions)	3, 206, 494	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	38.00 39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	3, 206, 494	1
40. 01 41. 00	Sequestration adjustment (see instructions) Interim payments	64, 130 2, 982, 262	
	Tentative settlement (for contractors use only)	2, 902, 202	42.00
43.00	Balance due provider/program (see instructions)	160, 102	1
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR		1
~~ ~~	Original outlier amount (see instructions)	0	90.00
90.00			
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)	0	71.00
91.00	Utilier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	91.00 92.00 93.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider 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, write "NONE" or enter a zero		2, 319, 60	0	2, 982, 262 0	1.00
3.00	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) Program to Provider					3.00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3. 99 3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			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)		2, 319, 60	09	2, 982, 262	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
E E 0	Provider to Program			0		E E 2
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 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)				1/0 100	6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		E4 4	0	160, 102 0	6. 01 6. 02
6.02 7.00	Total Medicare program liability (see instructions)		56, 62 2, 262, 98		3, 142, 364	6.02 7.00
			2,202,7	Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor	(1.00	2.00	8.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Component (CN: 15-1312 CCN: 15-Z312	Period: From 01/01/201 To 12/31/201		
					5/22/2017 2:4	l6 pm
			XVIII	Swing Beds - SN		
		Inpatien	t Part A	Pa	nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		736, 2		0	1.0
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					1
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. (
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	-				
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
04				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
50 51				0	0	
52				0	0	
53				0	0	
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
~ ~	3. 50-3. 98)		70/ 0			
00	Total interim payments (sum of lines 1, 2, and 3.99)		736, 2	15	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		I			
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01 02	TENTATI VE TO PROVIDER			0	0	
02				0	0	
00	Provider to Program	L		0	0	
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	5.
52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER			0	0	6.
02	SETTLEMENT TO PROGRAM		66, 3	-	0	
00	Total Medicare program liability (see instructions)		669, 8		0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-2	2552-10			
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1312 Period: From 01/01/2016							
To 12/31/2016 Da								
	5/22/20							
		Title XVIII	Hospi tal	Cost				
				1.00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS							
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION							
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14	540 1, 081	1.00 2.00			
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12							
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2							
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12							
	5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200							
6.00	6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20							
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I	0	7.00			
	line 168							
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00			
9.00	Sequestration adjustment amount (see instructions)			0	9.00			
10.00								
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			0	30.00			
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)							
31.00	31.00 Other Adjustment (specify)							
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)	0	32.00			

	Financial Systems IU HEALTH WHIT ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1312	Peri od:	u of Form CMS-2 Worksheet E-2	
ALCOL	ATTON OF RELIMBORGEMENT SETTLEMENT SWING BEDS		From 01/01/2016	WORKSHEET 2	
		Component CCN: 15-Z312	To 12/31/2016	Date/Time Pre 5/22/2017 2:4	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
. 00	Inpatient routine services - swing bed-SNF (see instructions		475, 952	0	
. 00	Inpatient routine services - swing bed-NF (see instructions)				2.
. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa		210, 453	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see i				
. 00	Per diem cost for interns and residents not in approved teac	ching program (see		0.00	4.
	instructions)				
. 00	Program days		311	0	
. 00	Interns and residents not in approved teaching program (see			0	
00	Utilization review - physician compensation - SNF optional m	nethod only	0		7.
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		686, 405	0	
00	Primary payer payments (see instructions)		0	0	
D. 00	Subtotal (line 8 minus line 9)		686, 405	0	
1.00	Deductibles billed to program patients (exclude amounts appl professional services)	icable to physician	0	0	11.
2.00	Subtotal (line 10 minus line 11)		686, 405	0	12.
3.00	Coinsurance billed to program patients (from provider record for physician professional services)	ds) (excl ude coi nsurance	3, 059	0	13.
1.00	80% of Part B costs (line 12 x 80%)			0	14.
i. 00	Subtotal (enter the lesser of line 12 minus line 13, or line	e 14)	683, 346	0	15
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
. 50	Pioneer ACO demonstration payment adjustment (see instruction	ons)	0	0	16
. 55	410A RURAL DEMONSTRATION PROJECT		0		16
. 00	Allowable bad debts (see instructions)		312	0	17
. 01	Adjusted reimbursable bad debts (see instructions)		203	0	
. 00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)	0	0	18
. 00	Total (see instructions)		683, 549	0	19
. 01	Sequestration adjustment (see instructions)		13, 671	0	19
. 00	Interim payments		736, 215	0	20
. 00	Tentative settlement (for contractor use only)		0	0	1
2.00	Balance due provider/program (line 19 minus lines 19.01, 20,		-66, 337	0	22
3.00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub. 15-2,	0	0	23.
	chapter 1, §115.2				

		TE HOSPITAL		u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Peri od:	Worksheet E-3	
			From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narodi
			10 12/31/2010	5/22/2017 2:4	
		Title XVIII	Hospi tal	Cost	0 p
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COST	RETMBURSEMENT		
1.00	Inpatient services			2, 600, 650	
2.00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		0	
3.00 4.00	Organ acquisition Subtotal (sum of lines 1 through 3)			0	
4.00 5.00	· · · · · · · · · · · · · · · · · · ·			2, 600, 650	
5.00 6.00	Primary payer payments Total cost (line 4 less line 5). For CAH (see instructions)			3, 364 2, 623, 293	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES)		2,023,243	0.00
	Reasonable charges				1
7.00	Routi ne servi ce charges			0	7.00
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				1
11.00	Aggregate amount actually collected from patients liable for	or payment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable	for payment for services of	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13	3(e)	-		
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13.00
14.00	Total customary charges (see instructions)		0		
15.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	15.00
4	instructions)			0	1.00
16.00	Excess of reasonable cost over customary charges (complete	only IT line 6 exceeds lin	ie 14) (see	0	16.00
17.00	instructions) Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17.00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00
18.00	Direct graduate medical education payments (from Worksheet	F-4 line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 623, 293	
20.00	Deductibles (exclude professional component)			324, 548	
21.00	Excess reasonable cost (from line 16)			0	
22.00	Subtotal (line 19 minus line 20 and 21)			2, 298, 745	22.00
23.00	Coinsurance			0	
24.00	Subtotal (line 22 minus line 23)			2, 298, 745	24.00
25.00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		16, 033	25.00
26.00	Adjusted reimbursable bad debts (see instructions)			10, 421	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		13, 601	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 309, 166	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructi	i ons)		0	
29.99	Recovery of Accel erated Depreciation			0	
30.00	Subtotal (see instructions)			2, 309, 166	
30.01	Sequestration adjustment (see instructions)			46, 183	
	Interim payments			2, 319, 609	
32.00	Tentative settlement (for contractor use only)	1		0	
33.00 34.00	Balance due provider/program (line 30 minus lines 30.01, 3		chaptor 1	-56, 626	
	Protested amounts (nonallowable cost report items) in accord	ruance with UMS Pub. 15-2,	chapter I,	250, 773	34.00

MCRI F32 - 10. 5. 160. 2

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2016	Worksheet G	
ly)	ype accounting records, comprete the deneral rund cordinin	_		To 12/31/2016	Date/Time Pre 5/22/2017 2:4	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	19, 466, 840	(0 0	0	1 -
00	Temporary investments	0		o o	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	2, 319, 830		0 0	0	
00	Other receivable	908, 355		0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	274, 032			0	
00	Prepaid expenses	118, 848			0	
00	Other current assets	0		0	0	
00	Due from other funds			0	0	
00	Total current assets (sum of lines 1-10)	23, 087, 905		o o	0	1
	FIXED ASSETS		1			
00	Land	972, 779		0 0	0	
. 00	Land improvements	122, 178		0 0	0	
00	Accumulated depreciation	-61, 854			0	1
00	Buildings Accumulated depreciation	30, 187, 561 -4, 110, 223			0	
. 00	Leasehold improvements	-+, 110, 223 0			0	
. 00	Accumulated depreciation			0 0	0	
. 00	Fixed equipment	0		o o	0	10
. 00	Accumulated depreciation	C	(0 0	0	20
. 00	Automobiles and trucks	0		0 0	0	-
. 00	Accumulated depreciation	0		0 0	0	
. 00	Major movable equipment	7,679,675		0 0	0	
. 00 . 00	Accumulated depreciation Minor equipment depreciable	-4, 140, 388			0	
. 00	Accumulated depreciation				0	
	HIT designated Assets			0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	Mi nor equi pment-nondepreci abl e	0		0 0	0	20
. 00	Total fixed assets (sum of lines 12-29)	30, 649, 728		0 0	0	30
	OTHER ASSETS			-		
00	Investments	315, 844			0	
. 00	Deposits on leases Due from owners/officers				0	
. 00	Other assets			0	0	
. 00	Total other assets (sum of lines 31-34)	315, 844		0	0	-
. 00	Total assets (sum of lines 11, 30, and 35)	54, 053, 477		0 0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	612, 256		0 0	0	
. 00	Salaries, wages, and fees payable	688, 564		0 0	0	
. 00 . 00	Payroll taxes payable Notes and Loans payable (short term)	39, 551 560, 000			0	
	Deferred income	500,000			0	
. 00	Accel erated payments			5	0	4
. 00	Due to other funds	1, 999, 506		o o	0	
. 00	Other current liabilities	C	(0 0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	3, 899, 877		0 0	0	4
~~	LONG TERM LIABILITIES					1.
. 00 . 00	Mortgage payable Notes payable	21, 525, 000			0	
. 00	Unsecured Loans	21, 525, 000			0	
. 00	Other long term liabilities	399, 626		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	21, 924, 626		0 0	0	
00	Total liabilities (sum of lines 45 and 50)	25, 824, 503	(0 0	0	51
	CAPI TAL ACCOUNTS		1			1
00	General fund balance	28, 228, 974				5
00	Specific purpose fund		(5
00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
. 00	Governing body created - endowment fund balance - unrestricted			0		50
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ũ	
. 00	Total fund balances (sum of lines 52 thru 58)	28, 228, 974		0 0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	54, 053, 477		ס ור	0	60

Heal th	Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1312	Period: From 01/01/2016 To 12/31/2016	Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1 00	Fund halanass at baginning of pariod	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET INTERCOMPANY TRANSACTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17)	37, 957 0 0 0 0 0 0 1 0 0 0 0 0	24, 381, 462 3, 809, 556 28, 191, 018 37, 957 28, 228, 975 1			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28, 228, 974		0		19.00
		Endowment Fund	Pl ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET INTERCOMPANY TRANSACTIONS	0	000000000000000000000000000000000000000		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	HOSPITAL Provider C	CN: 15-1312		In Lie riod:	Worksheet G-2	
				Fro To	om 01/01/2016 12/31/2016	Parts I & II Date/Time Pre 5/22/2017 2:4	
	Cost Center Description		Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						_
	General Inpatient Routine Services						1 4 44
1.00	Hospi tal		2, 699, 4	28		2, 699, 428	
2.00	SUBPROVIDER - IPF						2.00
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER						3.00
4.00 5.00	Subprovider Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			0		0	7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 699, 4	28		2, 699, 428	
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT		399, 3	48		399, 348	11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	399, 3	48		399, 348	16. 00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 098, 7		44 000 400	3, 098, 776	
18.00	Ancillary services		4, 340, 9		41,080,100	45, 421, 007	
19.00 20.00	Outpatient services		316, 6	28 0	22, 696, 344 0	23, 012, 972 0	
20.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
21.00	HOME HEALTH AGENCY			U	0	0	
22.00	AMBULANCE SERVICES				0	0	23.00
24.00	CMHC						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPICE						26.00
27.00	PHYSI CI AN REVENUE			0	3, 337	3, 337	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	7, 756, 3	11	63, 779, 781	71, 536, 092	28.00
	G-3, line 1)						
	PART II – OPERATING EXPENSES		1		1		
29.00	Operating expenses (per Wkst. A, column 3, line 200)				23, 655, 638		29.00
30.00	ADD (SPECI FY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0 0			33.00
34.00 35.00				0			34.00
36.00	Total additions (sum of lines 30-35)			U	0		36.00
37.00	DEDUCT (SPECIFY)			0	0		37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4.	2)(transfer			23, 655, 638		43.00
	to Wkst. G-3, line 4)						

Heal th	Financial Systems IU HEALTH	WHITE HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-131		Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	pared [.]
			10 12/01/2010	5/22/2017 2:4	6 pm
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3			71, 536, 092	1.00
2.00	Less contractual allowances and discounts on patients' a	accounts		44, 883, 838	
3.00	Net patient revenues (line 1 minus line 2)			26, 652, 254	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II,			23, 655, 638	
5.00	Net income from service to patients (line 3 minus line 4	4)		2, 996, 616	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communic	cation services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00 13.00	Parking lot receipts			0	12.00 13.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			-	14.00
16.00	Revenue from rental of living quarters Revenue from sale of medical and surgical supplies to ot	har than notionts		0	16.00
17.00	Revenue from sale of drugs to other than patients	their than patrents		0	
17.00	Revenue from sale of medical records and abstracts			0	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
20.00	Rental of vending machines			0	20.00
21.00	Rental of hospital space			0	22.00
22.00	Governmental appropriations			0	
23.00	MI SCELLANEOUS I NCOME			812, 940	
24.00	Total other income (sum of lines 6-24)			812, 940	
26.00	Total (line 5 plus line 25)			3, 809, 556	
20.00	OTHER EXPENSES (SPECIFY)			3, 809, 550	27.00
27.00	Total other expenses (sum of line 27 and subscripts)			0	27.00
	Net income (or loss) for the period (line 26 minus line	28)		3, 809, 556	
27.00	not moome (or ross) for the period (rine 20 minus rine	20)		3,007,000	27.00