IU HEALTH NORTH HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0161 Worksheet S Peri od. From 01/01/2017 Parts I-III AND SETTLEMENT SUMMARY 12/31/2017 Date/Time Prepared: То 5/29/2018 3:05 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/29/2018 Time: 3:05 pm use only Manually submitted cost report 2 []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH NORTH HOSPITAL (15-0161) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si aned) Officer or Administrator of Provider(s) CHIEF FINANCIAL OFFICER Title

Date

			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	-196, 438	72, 111	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-196, 438	72, 111	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.

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DAT	A I	Provi der	CCN: 1	5-0161	Period: From 01/0	1/2017	Workshe Part I	eet S-2	2
							To 12/3	1/2017		me Pre 018 9:5	pare
	1.00	2.0	00	3.	00			4.00	1		
~	Hospital and Hospital Health Care Co										
0 0	Street: 11700 NORTH MERIDIAN ST City: CARMEL	PO Box: State: IN	ı 7i	n Code: 4	16032-4	1656 Coun	ty: HAMILT()N			1.
0	orty. ortimee	Component Nam			CBSA	Provi der	- 1 ⁻		ent Syst	em (P,	2.
			Nu	umber N	umber	Туре	Certifie		r, 0, or		1
		1.00			2 00	4.00	F 00	V	XVIII	XIX	4
	Hospital and Hospital-Based Componen	1.00 t Identification	2	2.00	3.00	4.00	5.00	6.00	0 7.00	8.00	-
0	Hospi tal	IU HEALTH NORTH	15	50161 2	6900	1	12/20/200	05 N	Р	Р	3.
_		HOSPI TAL									
0	Subprovider - IPF Subprovider - IRF										4.
0	Subprovider - (Other)										6.
0	Swing Beds - SNF										7.
0	Swing Beds - NF										8.
0 00	Hospital-Based SNF Hospital-Based NF										9.
00	Hospi tal -Based OLTC										111.
00	Hospital-Based HHA										12.
00	Separately Certified ASC										13.
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.
00	Hospital -Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I										17.
00 00	Renal Dialysis Other										18.
00	Jother						Fro	m:	Tc):	17.
	1						1. (2.		1
00	Cost Reporting Period (mm/dd/yyyy)						01/01/		12/31	/2017	20.
00	Type of Control (see instructions) Inpatient PPS Information						4				21.
00	Does this facility qualify and is it	currently receivi	ng paymen	ts for di	spropo	ortionate	Y		N	1	22.
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				06(c)((2) (Pi ckl	e				
01	Did this hospital receive interim un				cost re	eporting	Y		Y	,	22
	period? Enter in column 1, "Y" for y										
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	eporting period oc	curring o	n or arte		JUEI I.					
02	Is this a newly merged hospital that						N		N	I	22.
	determined at cost report settlement or "N" for no, for the portion of th						S				
	in column 2, "Y" for yes or "N" for	1 01	•				n				
	or after October 1.					P					
03	Did this hospital receive a geograph								N	I	22.
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,			unted in	accord	ance wit	n				
00	Which method is used to determine Me			/or 25 be	elow? I	n column		3	N	I	23.
	1, enter 1 if date of admission, 2 i										
	method of identifying the days in th used in the prior cost reporting per										
	used in the piror cost reporting per		In-State	In-Stat		ut-of	Out-of	Medi ca	aid 0	ther	
			Medi cai d	Medi cai		tate	State	HMO da	5	di cai d	
		1	oaid days	eligibl unpaid			Medicaid eligible		0	lays	
				days	par	adays	unpaid				
			1.00	2.00		3. 00	4.00	5.00		5.00	
00	If this provider is an IPPS hospital		637	1, 6	13	0	216	4,	912	23	3 24.
	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	d days in column									
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in If this provider is an IRF, enter th	e in-state	0		0	o	0		0		25.
00			0		~	Ŭ	5		Ĩ		20.
00	Medicaid paid days in column 1, the	in-state									
00	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	umn 2,									
00	Medicaid paid days in column 1, the	umn 2, 3, out-of-state									

OSPI I	Financial Systems IU HEAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		TH HOSPITAL Provider C		Period: From 01/01/20		<u>u of For</u> Workshe Part I		
					o 12/31/20		Date/Ti 5/29/20		
					Urban/Rural	S	Date of	Geogr	
5.00	Enter your standard geographic classification (not wa	ne) sta	atus at the be	ninning of the	1.00	1	2.0	0	26.
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ge) sta "2" fo	atus at the en or rural. If a	d of the cost		1			27.
. 00	enter the effective date of the geographic reclassifi- If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35
					Begi nni ng 1.00	:	Endi r 2. 0	0	
00	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for number	1.00		2.0	0	36
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of perio	ds MDH status		0			37
01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)				N				37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
					Y/N 1.00		Y/N 2.0		
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil- with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii eage re)? Enter in c equirements in	olumn 1 "Y" accordance	N		N	0	39
00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. I	Enter "Y" for		Y		Y		40
	no m corumn z, for unscharges on or arter october 1.	(366)			-	V 1. 00	XVIII 2.00	XI X 3. 00	
00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	t for d	di sproporti ona	te share in ac	cordance	N	Y	N	45
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption 1	for extraordin	ary circumstan	ces	N	N	N	46
	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47 48
. 00	Is this a hospital involved in training residents in a	approve	ed GME program	s? Enter "Y"	for yes	N			56
. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont 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. II	yes o h of th ", com	r "N" for no i nis cost repor plete Workshee	n column 1. lf ting period?	column 1 Enter "Y"				57
. 00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, chapter 21, §2148? If yes,	ursemei	nt for physici	ans' services	as	Ν			58
. 00	Are costs claimed on line 100 of Worksheet A? If yes	•		, Pt. I.		Ν			59
				NAHE 413.85 Y/N	Worksheet Line #		Pass-Th Qualific Criterio	cation	
00				1.00	2.00		3.0	0	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (:			N		_			60
		Y/N	IME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3.00	4.00		5.0		
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				(). 00		0.00	
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								61
. 02	instructions) 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								61
	ACA). (see instructions) Enter the base line FTE count for primary care								61

V/R INE Direct ONE INE Direct ONE 51. 04 Enter the number of unonighted primary care/or bargery prior protoce and/or cool open in FTEst Integ. 61.0 3.00 4.00 5.00 61.0 50. Enter the number of unonighted primary care/or primary care and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 0.0.0 dt intus line 0.0.3). (see Instructions) Final state Final state 51.00 4.00 5.00 61.0 51. 100 Enter the number of LAS SEGG areant that I is being the state and/or general surgery. (see instructions) Program Name Program Code Unweighted IME FTE count Inweighted incet OME FTE count 0.00 61.0 51. 100 Df the FTEs in line 61.05. specify each new program to during the state of the program name. Instructions) Enter in column 3, the IME FTE unweighted count. Enter in column 3, the IME FTE unweighted count. Enter in column 3, the GIME FTE state of the program code. Enter in column 4. The during in the inter of the specify each expanded instructions) Enter in column 1, the program code. Enter in column 4. The during the during the during the during the down. 1.00 2.00 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0	OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017		pared:
1.00 Enter the number of unweighted primary carry/or surgery allopathic and/or ostogathic FTEs in the current cost reporting period. (see instructions). 61.0 1.00 DE Inter the difference between the baseline primary and/or general surgery FTE counts (Line primary care and/or general surgery FTE counts (Line primary care and/or general surgery FTE counts (Line primary care and/or general surgery FTE counts (Line primary care or general surgery. (see Instructions) Program Name Program Code Unweighted Unweighted FTE Count 0.00 61.0 1.100 The fTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) from each new program name. Enter in column 3, the INE FTE residents for each expanded prigram name. Enter in column 3, the INE FTE in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program code. Enter in column 4, the direct GME FTE unmelighted count. Enter in column 3, the INE FTE in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program code. Enter in column 3, the program code. Enter in column 4, the direct GME FTE unmelighted count. Enter in column 2, the program code contructions) 1.00 0.00 0.00 61.2 2.00 FTE residents that your hospital trained in this cost reporting period for which your hospital recolved (MESA PCKE from a Teaching Health Center (THC) into your hospital during in this cost reporting period for which Has your cost in for no in colum 1. If yes, complete infines de through c). 0.00 0.00 0.00 62.0<		Y/N	IME	Direct GME	IME		
1.00 Enter the number of unweighted primary carry/or surgery allopathic and/or ostogathic FTEs in the current cost reporting period. (see instructions). 61.0 1.00 DE Inter the difference between the baseline primary and/or general surgery FTE counts (Line primary care and/or general surgery FTE counts (Line primary care and/or general surgery FTE counts (Line primary care and/or general surgery FTE counts (Line primary care or general surgery. (see Instructions) Program Name Program Code Unweighted Unweighted FTE Count 0.00 61.0 1.100 The fTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) from each new program name. Enter in column 3, the INE FTE residents for each expanded prigram name. Enter in column 3, the INE FTE in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program code. Enter in column 4, the direct GME FTE unmelighted count. Enter in column 3, the INE FTE in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program code. Enter in column 3, the program code. Enter in column 4, the direct GME FTE unmelighted count. Enter in column 2, the program code contructions) 1.00 0.00 0.00 61.2 2.00 FTE residents that your hospital trained in this cost reporting period for which your hospital recolved (MESA PCKE from a Teaching Health Center (THC) into your hospital during in this cost reporting period for which Has your cost in for no in colum 1. If yes, complete infines de through c). 0.00 0.00 0.00 62.0<		1.00	2.00	3.00	4.00	5.00	-
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used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unweighted IME Unweighted IME Unweighted IME 1.10 0r the FTEs in line 61.05, specify each new program special by, if any, and the number of FTE residents for each new program name. Enter in column 2, the program special by, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program code. Enter in column 2, the program special by, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 4, the direct GME free idents for each expanded program. (see instructions) Enter in column 4, the program code. Enter in column 1, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 0.00 0.00 0.00 61.2 20.00 Enter in column 4, the direct GME instructions) Enter in column 4, the direct GME FTE unweighted count. 1.00 0.00 0.00 0.00 62.0 20.01 Enter in column 4, the direct GME FTE unweighted count. 1.00 0.00 <	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.06
ACA Provisions Affecting 0 0 0 0 0 0 0 1.00 2.00 3.00 4.00 0.00	used for cap relief and/or FTEs that are nonprimary						
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specialty, if any, and the number of FTE residents for each new program. (see instructions) Do f the FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in colum 2, the program code. Enter in column 4, the direct QME FTE unweighted count. Enter in colum 2, the program code. Enter in column 4, the direct QME FTE unweighted count. Enter in colum 2, the program code. Enter in column 4, the direct QME FTE unweighted count. 2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 2.01 Enter the number of FTE residents that totated from a Teaching Health Center (THC) into your hospital 0.00 Ce C Cost <u>Free NHSA that Charles that Carbor of FTE residents in Nonprovider Settings</u> 3.00 Has your facility trained residents in nonprovider Settings 3.00 Has your facility trained residents in Nonprovider Settings 4.00 Enter in column 1, if yes, complete lines 64 through 67. (see instructions) <u>FTE S</u> Nonprovider FTE si your cost reporting period? Enter Y" for yes or 'N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) <u>1.00</u> 2.00 3.00 0.00 0.00 0.00 0.00 0.00 0.00 0.000000 64.0 0.00 0.00 0.000000 64.0 0.00 0.00 0.000000 64.0 0.00 0.000000 64.0 0.00 0.000000 64.0 0.00 0.000000 64.0 0.00 0.000000 64.0 0.000000 64.0 0.0000000 64.0 0.000000 64.0 0.000000 64.0 0.0000000 64.0			1.00	2.00			
51.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 62.0 ACA Provisions Affecting the Heal th Resources and Services Administration (HRSA) 0.00 0.00 62.0 20.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital scattering period of HRSA THC program. (see instructions) 0.00 62.0 20.01 Enter the number of FTE residents in Nonprovider Settings 0.00 0.00 63.0 30.00 Has your facility trained residents in Nonprovider Settings Unweighted FTEs in Hospital 0.00 0.00 0.00 30.00 Has your facility trained residents in Nonprovider Settings 0.00 0.00 0.000000 64.0 44.00 Enter in column 1, if line 63 is yes, or your facility trained residents in Nonprovider SettingsThis base year is your cost reporting period for unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings 0.00 0.000 0.0000000 64.0	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE				0. 00	0.00	61. 10
ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 22.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.0 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 33.00 Has your facility trained residents in nonprovider Settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 44.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Nonprovider Site Nonprovider S	1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,				0. OC	0. 00	61.20
22.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 0.00 62.0 22.01 Enter the number of FTE residents that rotated from a Teaching Heal th Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) 0.00 62.0 22.01 Enter the number of FTE residents that rotated from a Teaching Heal th Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions) 0.00 0.00 62.0 Teaching Hospitals that Claim Residents in Nonprovider Settings May your facility trained residents in nonprovider settings during this cost reporting period? Enter N 33.00 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Prise in Residents in Nonprovider Settings Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period 0.00 9.00 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>1.00</td><td>-</td></t<>						1.00	-
your hospital received HRSA PCRE funding (see instructions) 52.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.0 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 33.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.0 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 54.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unweighted FTEs Nonprovider Site N							
during in this cost reporting period of HRSA THC program. (see instructions) Image: Construction in the second section in the second section in the second section in the base year period, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 1 the column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) 0.00 <	your hospital received HRSA PCRE funding (see instruc	tions)					
A3.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.0 "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unweighted Ratio (col. 1/ (col. 1 + col. 2)) "Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0.00 0.00 0.000000 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) 0.00 0.00 0.00 0.00 0.00 Program Name Program Code FTEs Nonprovider Site Unweighted FTEs in Hospital Ratio (col. 3/ (col. 3 + col. 4)) Ratio (col. 3/ (col. 3 + col. 4))	during in this cost reporting period of HRSA THC prog	gram. (s	see instructio			0.00	02.01
Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0	3.00 Has your facility trained residents in nonprovider se	ettings	during this c			N	63.00
Site 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 0.00 0.00 0.00 0.000000 64.00 A4.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unweighted FTEs Unweighted FTEs Ratio (col. 3/ (col. 3 + col. 4))							
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period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unweighted FTEs Unweighted FTEs Ratio (col. 3/ (col. 3 + col. 4))							
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) 0.00 0.00 0.000000 64.0 Program Name Program Code Unweighted FTEs Unweighted FTEs in Hospital Ratio (col. 3/ (col. 3 + col. 4))				inis base yea	ir is your cost r	reporting	
of (column 1 divided by (column 1 + column 2)). (see instructions) Vert (column 2) Program Name Program Code Unweighted FTEs FTEs FTEs in Nonprovider Nonprovider 4))	4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	y train -primar all non I non-pr	ned residents ry care nprovider rimary care	0.	00 0. 00	0. 000000	64.00
Program Name Program Code Unweighted Unweighted Ratio (col. 3/ (col. 3 + col. Nonprovider Site							
				FTEs Nonprovi der	FTEsin	(col. 3 + col.	
			2.00	Si te 3. 00	4.00	5.00	-

		ATA Provi der	Fr	eriod: com 01/01/2017	Worksheet S-2 Part I	
			To	12/31/2017	Date/Time Pre 5/29/2018 9:5	pared
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	позрі таї	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column						
4)). (see instructions)		I	Unweighted	Unweighted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te 1.00	2.00	3.00	-
Section 5504 of the ACA Current Y	/ear FTE Residents i	n Nonprovider Settir				
beginning on or after July 1, 201 .00 Enter in column 1 the number of u	10	•	0.00	•	0. 000000	
FTEs that trained in your hospita (column 1 divided by (column 1 +						
	Program Name	structions) Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			FTĔs Nonprovider Site 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
.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	Program Name	Program Code	FTËs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
.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	Program Name	Program Code	FTĔs Nonprovider Site 3.00	FTES in Hospi tal 4.00 0.00	(col. 3 + col. 4)) 5.00 0 0.000000	
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.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 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF.00	Program Name 1.00 2S rchiatric Facility (Program Code 2.00	FTĔs Nonprovi der Si te 3.00 0.00	FTES in Hospi tal 4.00 0.00 1.0	(col . 3 + col . 4)) 5.00 0 0.000000 0 0.0000000	-
 .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 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 100 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. .00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412. 424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) 	Program Name 1.00 1.00 2S /chiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0 0.000000 0 0.0000000	
 .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 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF.00 Is this facility an Inpatient Psychiatric Section of the ratio of column 1. Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR column 3: If column 2 is Y, indic 	Program Name 1.00 1.00 2S white facility have a sfore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y / PPS habilitation Facilit	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTĚs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col. 3 + col. 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	_

Health Financial Systems IU HEALTH NORTH HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0161 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: То 12/31/2017 5/29/2018 9:51 am 1.00 Long Term Care Hospital PPS 80.00 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Ν 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85 00 Ν 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 87 00 Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. ٧ XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for Ν Υ 90 00 ves or "N" for no in the applicable column. $|I\,s\,$ this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 Ν Ν 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Ν 92.00 93.00 Ν Ν 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the Ν Ν 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. Υ 98.01 98.01 Ν C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation Ν γ 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and Ν 98.04 Ν in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 γ 98.05 Ν column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Ν 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 Ν 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Respi ratory Physi cal Occupati onal Speech 1 00 2 00 4 00 3 00 109.00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 Ν complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi	TAL der CCN: 15-0161	Period: From 01/01/ To 12/31/	2017	Workshe Part I Date/Ti 5/29/20	et S-2 me Pre	epared:
		1.00		2. (00	1
111.00 If this facility qualifies as a CAH, did it participate in the Front Health Integration Project (FCHIP) demonstration for this cost report "Y" for yes or "N" for no in column 1. If the response to column 1 i integration prong of the FCHIP demo in which this CAH is participati Enter all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	rting period? Enter is Y, enter the ing in column 2.	r N				111.00
			1.00	2.00	3.00	1
 Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for is yes, enter the method used (A, B, or E only) in column 2. If colu 3 either "93" percent for short term hospital or "98" percent for lo psychiatric, rehabilitation and long term hospitals providers) based Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes 117.00 Is this facility legally-required to carry malpractice insurance? Enter 	umn 2 is "E", ente ong term care (inc d on the definition or "N" for no.	r in column ludes n in CMS	N N Y		0	115. 00 116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence policy? En	ter 1 if the policy	yis	1			118.00
claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losse	s	Insur	ance	
10 Odligt securts of relevanting and sold losses	1.00	2.00		3. (110.01
18.01 List amounts of malpractice premiums and paid losses:	366, 0	576	0		l	0118.01
118.02 Are malpractice premiums and paid losses reported in a cost center of	athen than the	1.00 N		2. (00	118.02
Administrative and General? If yes, submit supporting schedule list and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmles §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	ss provision in ACA 1, "Y" for yes or for the Outpatien			N		119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable of patients? Enter "Y" for yes or "N" for no.	devices charged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defined in Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", the Worksheet A line number where these taxes are included.	§1903(w)(3) of the enter in column :	e Y 2		5. ()5	122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes ar	nd "N" for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, enter the		e				126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the c in column 1 and termination date, if applicable, in column 2.	certification date					127.00
28.00 If this is a Medicare certified liver transplant center, enter the c in column 1 and termination date, if applicable, in column 2.						128.00
29.00 If this is a Medicare certified lung transplant center, enter the concolumn 1 and termination date, if applicable, in column 2.		in				129.00
 30.00 If this is a Medicare certified pancreas transplant center, enter the date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter 						130.00
date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified islet transplant center, enter the						132.00
in column 1 and termination date, if applicable, in column 2. 33.00 If this is a Medicare certified other transplant center, enter the c						133.00
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the OPO nu						134.00
and termination date, if applicable, in column 2. All Providers						1
140.00 Are there any related organization or home office costs as defined i chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and are claimed, enter in column 2 the home office chain number. (see in are claimed, enter in column 2 the home office chain number.	d home office cost	s Y		15H0)59	140. 00

	EX IDENTIFICATION DATA	NORTH HOSPITAL Provider C	CN: 15-0161				2 epared:
1.00		2.00			3.00	5/27/2010 9:	
If this facility is part of a cha	ain organization, enter		bugh 143 the	name and		of the	
home office and enter the home of							
1. 00 Name: IU HEALTH, INC	Contractor's Name	e: WPS	Contrac	ctor's Nu	mber: 0810)1	141.0
2.00 Street: 340 W. 10TH STREET 3.00 City: INDIANAPOLIS	PO Box: State:	IN	Zip Cod	10.	4620	12	142.0
S. OOJETTY. THUTANALOETS	State.	1 11	210 000		4020		145.00
						1.00	1
4.00 Are provider based physicians' co	osts included in Workshe	et A?				Y	144.0
							_
		74 11 1			1.00	2.00	1.15 0
5.00 If costs for renal services are (inpatient services only? Enter "	claimed on Wkst. A, line	e /4, are the cost	s for				145.0
no, does the dialysis facility in							
period? Enter "Y" for yes or "N			reporting				
6.00 Has the cost allocation methodol		eviously filed cos	st report?		Ν		146.0
Enter "Y" for yes or "N" for no i		ıb. 15-2, chapter	40, §4020)	f			
yes, enter the approval date (mm/	/dd/yyyy) in column 2.						_
						1.00	-
7.00 Was there a change in the statis	tical basis? Enter "V" f	for ves or "N" for				1.00 N	147.0
8.00Was there a change in the order of	of allocation? Enter "Y"	for ves or "N" f	for no.			N	147.0
9.00Was there a change to the simplin				or no.		N	149.0
	3	Part A	Part B		itle V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a prov							
or charges? Enter "Y" for yes or	"N" for no for each con			. (See 42			455 /
5.00 Hospital 6.00 Subprovider - IPF		N	N N		N N	N N	155. 0 156. 0
7. 00 Subprovider - IRF		N	N N		N	N	150.0
8. 00 SUBPROVI DER		IN IN	in in		IN IN	IN IN	158.0
9. 00 SNF		N	N		N	N	159.0
0.00 HOME HEALTH AGENCY		N	N		N	N	160. 0
1. 00 CMHC			N		Ν	N	161.0
							_
						1.00	-
Multicampus 5.00 Is this hospital part of a Multic	campus bospital that has	opo or moro com	wees in dif	Foront CR	SAc2	N	165.0
Enter "Y" for yes or "N" for no.	campus nospi tai that has				SAS?	IN	105.0
	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
6.00 If line 165 is yes, for each						0.0	0 166. 0
campus enter the name in column							
0, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1.00	
Health Information Technology (H				ent Act		1	_
						Y	167.0
7.00 Is this provider a meaningful use			10/15 Y), enter	the		0168. 0
7.00ls this provider a meaningful use 8.00lf this provider is a CAH (line ?		tionc)		or a hard	lshi n		168. 0
7.00 is this provider a meaningful use 8.00 if this provider is a CAH (line reasonable cost incurred for the	HIT assets (see instruc		r qualify fo		i sin p		100.0
7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is	HIT assets (see instruct not a meaningful user,	does this provide					
7.00 is this provider a meaningful use 8.00 if this provider is a CAH (line reasonable cost incurred for the	HIT assets (see instruc not a meaningful user,)? Enter "Y" for yes or	does this provide "N" for no. (see	instruction:	5)	enter the	9.9	9169. C
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y")	does this provide "N" for no. (see	instruction:	s) s "N"), e			99169. C
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 9.00 If this provider is a meaningful 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y")	does this provide "N" for no. (see	instruction:	s) s "N"), e <u>Be</u>	gi nni ng	Endi ng	9169.0
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 9.00 If this provider is a meaningful transition factor. (see instruction factor) 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y") ions)	does this provide "N" for no. (see and is not a CAH	instructions (line 105 is	s) s "N"), e Be	gi nni ng 1. 00	Endi ng 2. 00	9169.0
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 9.00 If this provider is a meaningful transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y") ions)	does this provide "N" for no. (see and is not a CAH	instructions (line 105 is	s) s "N"), e Be	gi nni ng	Endi ng	99169. C
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 9.00 If this provider is a meaningful transition factor. (see instruction factor) 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y") ions)	does this provide "N" for no. (see and is not a CAH	instructions (line 105 is	s) s "N"), e Be	gi nni ng 1. 00	Endi ng 2. 00	_
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 9.00 If this provider is a meaningful transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y") ions)	does this provide "N" for no. (see and is not a CAH	instructions (line 105 is	s) s "N"), e Be 04/	gi nni ng 1. 00 ⁄01/2017	Endi ng 2. 00 06/30/2017	_
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 9.00 If this provider is a meaningful transition factor. (see instruction factor) 0.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy) 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y") ions) beginning date and endi	does this provide "N" for no. (see and is not a CAH ng date for the r	instructions (line 105 is reporting	s) s "N"), e Be 04/	gi nni ng 1. 00	Endi ng 2.00 06/30/2017 2.00	_
 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line reasonable cost incurred for the 8.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 9.00 If this provider is a meaningful transition factor. (see instruction 0.00 Enter in columns 1 and 2 the EHR 	HIT assets (see instruct not a meaningful user,)? Enter "Y" for yes or user (line 167 is "Y") ions) beginning date and endi	does this provide "N" for no. (see and is not a CAH ng date for the r	instructions (line 105 is reporting	s) s "N"), e Be 04/	gi nni ng 1. 00 /01/2017 1. 00	Endi ng 2.00 06/30/2017 2.00	170. 0

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017		epared
				Y/N	<u>5/29/2018 9:5</u> Date	<u>siam</u>
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	lfor all NO re	sponses. Ente			
~ ~	Provider Organization and Operation	<u> </u>				
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.0
	reporting period: IT yes, enter the date of the change in t		Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug der or its of the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports		Y	•	02/22/2010	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	°or Compiled,	Y	A	02/22/2018	4.
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit rec	conciliation.				
				Y/N	Legal Oper.	_
				1.00	2.00	_
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	e provider is	5 N		6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		l during the	N N		7. 8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		Ν		9.
. 00	Was an approved Intern and Resident GME program initiated of	or renewed in t	he current	Ν		10.
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	roved	Ν		11.
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? If	yes, see ins	structions.	N	14.
. 00	Did total beds available change from the prior cost reporti		yes, see inst t A	tructions. Par	N t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16.
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/04/2018	Y	04/04/2018	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.

Health Financial Systems

IU HEALTH NORTH HOSPITAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems IU HEALTH NO	RTH HOSPITAL		In Lie	u of Form (MS-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet Part II Date/Time	S-2 Prepared:
					5/29/2018	9:51 am
			iption D	Y/N 1.00	Y/N 3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	Ν		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost rep	oorting period?	Ν	24.00
	Have there been new capitalized leases entered into during instructions.		0.1	5	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	the cost reporti	ng period? If	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th copy.	ne cost reportir	ng period? If	yes, submit	Ν	27.00
	Interest Expense				-	
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	entered into dur	ing the cost	reporting	Ν	28.00
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	eserve Fund)	Ν	29.00
30. 00	Has existing debt been replaced prior to its scheduled mat instructions.	turity with new	debt? If yes,	see	Ν	30.00
	Has debt been recalled before scheduled maturity without i instructions. Purchased Services	ssuance of new	debt? If yes,	see	N	31.00
+	Have changes or new agreements occurred in patient care se	ervi ces furni she	d through cor	ntractual	N	32.00
	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap	ructions.	0		N	33.00
	no, see instructions. Provider-Based Physicians		.9			
	Are services furnished at the provider facility under an a If yes, see instructions.	arrangement with	n provi der-bas	ed physi ci ans?	Ν	34.00
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		nts with the p	orovi der-based	Ν	35.00
	physicians during the cost reporting period: in yes, see i	nstructrons.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	Y Y		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	Ν		38.00
	the provider? If yes, enter in column 2 the fiscal year er If line 36 is yes, did the provider render services to oth	nd of the home o	offi ce.	N		39.00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	lf yes, see	Ν		40.00
	instructions.					
	Cost Deport Droppers Contact Information	1.	00	2.	00	
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
42.00	respectively. Enter the employer/company name of the cost report	INDIANA UNIVER	SLTY HEALTH			42.00
	preparer. Enter the telephone number and email address of the cost	317-962-1093		RUTTER@I UHEALTI	H ORG	43.00
ŦJ. 00	report preparer in columns 1 and 2, respectively.	017 702-1073				+3.00

Heal th	Financial Systems IU HEALTH	NORT	H HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider C	CCN: 15-0161	Period: From 01/01/2017	Worksheet S-2 Part II	
							pared: <u>1 am</u>
			3.	. 00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	D	IRECTOR OF G	OVERNMENT			41.00
	held by the cost report preparer in columns 1, 2, and 3,	Ρ	ROGRAMS				
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost	t					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IU HEALTH NOR	Provi der C	CN: 15-0161	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre	
					10 12/01/2017	5/29/2018 9:5	
						I/P Days / O/P	
	Comment	Washinka at A		Ded Deve		Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	120	43, 8	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)						2.00
2.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		120	43, 8	0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34.00	0		0 0.00		11.00
11.01	PEDIATRIC INTENSIVE CARE UNIT	34.01	6 23			0	11.01
11. 02 12. 00	PREMATURE INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	34. 02	23	8, 3	75 0.00	0	11.02 12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)	10.00	149	54, 3	85 0.00	-	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00 23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22.00 23.00
23.00	HOSPICE						23.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		149				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		10	1.0	20		31.00
32.00	Labor & delivery days (see instructions)		12	4, 3	50		32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.01

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017		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	
	1	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 for the portion of LDP room available beds)	7, 078	241	22, 69	91		1.0
2.00	HMO and other (see instructions)	2, 313	5, 826				2.0
8.00	HMO IPF Subprovider	0	0				3.0
I. 00	HMO IRF Subprovider	0	0				4.0
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.0
o. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	7, 078	241	22, 69	91		7.0
3.00	INTENSIVE CARE UNIT						8.0
. 00	CORONARY CARE UNIT						9.0
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT	0	0		0		11.
1. 01	PEDIATRIC INTENSIVE CARE UNIT	2	98	1, 14	16		11.
1. 02	PREMATURE INTENSIVE CARE UNIT	0	255	4, 55	58		11. (
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		958	5, 07	75		13.0
4.00	Total (see instructions)	7,080	1, 552	33, 47	0.00	791.61	14.0
5.00	CAH visits	0	0		0		15.
6. 00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF						17.
3. 00	SUBPROVIDER						18.
9.00	SKILLED NURSING FACILITY						19.
0. OO	NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						21.
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE						24.
4. 10	HOSPICE (non-distinct part)	0	0	7	76		24.
5.00	CMHC - CMHC						25.
6.00	RURAL HEALTH CLINIC						26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.
7.00	Total (sum of lines 14-26)				0.00	791.61	27.
8.00	Observation Bed Days		58	1, 96	50		28.
9.00	Ambul ance Trips	0					29.
00 .C	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	23	87	75		32.
2.01	Total ancillary labor & delivery room	-			0		32.
	outpatient days (see instructions)						1
3.00	LTCH non-covered days	0					33.
	LTCH site neutral days and discharges	0					33.

HOSPI -	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/29/2018 9:5	pared:
		Full Time		Di s	charges	0/2//2010 7.0	
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers		10.00	11.00	Patients	
1 00	Hospital Adults & Dods (columns E 6 7 and	11.00	12.00	13.00	14.00	15.00	1.00
1.00 2.00 3.00 4.00 5.00 7.00 8.00 7.00 11.00 11.01 11.02 12.00 13.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.10 25.00 26.00 26.00 28.00 29.00	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) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT PEDIATRIC INTENSIVE CARE UNIT PREMATURE INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips	0. 00 0. 00 0. 00	0	4	97 890 0 0	9, 701	1.00 2.00 3.00 4.00 5.00 6.00 7.00 7.00 11.00 11.00 11.00 11.00 11.00 11.00 12.00 13.00 14.00 15.00 16.00 15.00 16.00 21.00 22.00 23.00 24.00 24.00 24.00 25.00 26.00 26.00 27.00 28.00 29.00
30. 00 31. 00 32. 00 32. 01 33. 00	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 LTCH site neutral days and discharges				0		30.00 31.00 32.00 32.0 33.00 33.00

						rom 01/01/2017 o 12/31/2017		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
,	 PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARIES							
. 00	Total salaries (see instructions)	200.00	58, 214, 926	-832, 777	57, 382, 149	1, 685, 620. 38	34.04	1.00
. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
. 00	A Non-physician anesthetist Part		0	0	0	0.00	0.00	3.00
	В		205 447		205 447			
00	Physician-Part A - Administrative		385, 447	0	385, 447	1, 526. 20	252. 55	4.00
	Physicians - Part A - Teaching Physician and Non		0	-	-			
00	Physician-Part B		0			0.00	0.00	5.00
00	Non-physician-Part B for hospital-based RHC and FQHC services		C	0	0	0.00	0.00	6.00
00	Interns & residents (in an	21.00	C	0	0	0.00	0.00	7.00
01	approved program) Contracted interns and residents (in an approved		C	0	0	0.00	0.00	7.0
00	programs) Home office and/or related organization personnel		O	0	0	0.00	0.00	8.0
0. 00	SNF Excluded area salaries (see instructions)	44.00	0 950, 517	0 779, 067	0 1, 729, 584	0. 00 56, 949. 08		
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		1, 937, 376	0	1, 937, 376	28, 822. 28	67.22	11.0
	Care							
2.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.0
3. 00	Contract Labor: Physician-Part		1, 484, 502	0	1, 484, 502	9, 896. 68	150.00	13.0
	A - Administrative Home office and/or related orgainzation salaries and		C	0	0	0.00	0.00	14.0
	wage-related costs Home office salaries		16, 134, 623	0	16, 134, 623	363, 612. 91	44.37	14 0
4. 02	Related organization salaries		0	0	0	0.00	0.00	14.0
5.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.0
6. 00	Home office and Contract		0	0	0	0.00	0.00	16.0
}	Physicians Part A - Teaching WAGE-RELATED COSTS							-
	Wage-related costs (core) (see		13, 607, 428	0	13, 607, 428			17.0
8. 00	instructions) Wage-related costs (other)		0	0	0			18. C
9.00	(see instructions) Excluded areas		451, 625	0	451, 625			19. C
	Non-physician anesthetist Part		451, 025		451, 025			20.0
1. 00	A Non-physician anesthetist Part		C	0	0			21.0
	B Physician Part A - Administrative		C	0	0			22.0
	Physician Part A - Teaching		0	0	0			22. C
	Physician Part B Wage-related costs (RHC/FQHC)		0	0	0			23. C 24. C
	Interns & residents (in an		0	0	0			24. C
5. 50	approved program) Home office wage-related (core)		2, 633, 897	0	2, 633, 897			25.5
5. 51	Related organization		0	0	0			25.5
5. 52	wage-related (core) Home office: Physician Part A - Administrative -		O	0	о			25. 5
5. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		O	0	0			25. 5
	wage-related (core) OVERHEAD COSTS - DIRECT SALARIE	S		1	1		1	-
	Employee Benefits Department	4.00	770, 018	-571, 333	198, 685	10, 410. 36	19.09	1 26. 0

Health Financial Systems		IU HEALTH NOR	TH HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provider C		Period:	Worksheet S-3	
					From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	narod
			-			5/29/2018 9:5	
	Wkst. A Line		Recl assi fi cati			Average Hourly	
	Number	Reported	on of Salaries			Wage (col. 4 ÷	
			(from Wkst.	(col.2 ± col.		col. 5)	
			A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
28.00 Administrative & General under contract (see inst.)		385	0	38	5 3.50	110.00	28.00
29.00 Maintenance & Repairs	6.00	2, 074, 845	-5, 603	2, 069, 24	2 65, 883. 18	31. 41	29.00
30.00 Operation of Plant	7.00	1, 122, 440	0	1, 122, 44	40, 384. 41	27.79	30.00
31.00 Laundry & Linen Service	8.00	0	0		0.00	0.00	31.00
32.00 Housekeepi ng	9.00	1, 456, 151	-13, 628	1, 442, 52	3 91, 940. 88	15. 69	32.00
33.00 Housekeeping under contract		0	0		0.00	0.00	33.00
(see instructions)							
34.00 Dietary	10.00	724, 803	-9, 880	714, 92	3 40, 680. 91	17.57	34.00
35.00 Dietary under contract (see		0	0		0.00	0.00	35.00
instructions)							
36.00 Cafeteria	11.00	1, 228, 001	-4, 061	1, 223, 94	0 68, 911. 07		
37.00 Maintenance of Personnel	12.00	0	0		0.00		
38.00 Nursing Administration	13.00	2, 923, 472	-506, 981	2, 416, 49	1 67, 489. 61		
39.00 Central Services and Supply	14.00	830, 125	-6, 892	823, 23			39.00
40.00 Pharmacy	15.00	2, 422, 874	-9, 841	2, 413, 03	3 52, 068. 57	46.34	40.00
41.00 Medical Records & Medical	16.00	0	0		0.00	0.00	41.00
Records Library							
42.00 Social Service	17.00						42.00
43.00 Other General Service	18.00	211, 827	0	211, 82	7 13, 937. 32	15. 20	43.00

Heal th	Financial Systems		IU HEALTH NOR	TH HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2017 To 12/31/2017		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		58, 215, 311	-832, 777	57, 382, 53	4 1, 685, 623. 88	34.04	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		950, 517	779, 067	1, 729, 58	4 56, 949. 08	30. 37	2.00
3.00	Subtotal salaries (line 1		57, 264, 794	-1, 611, 844	55, 652, 95	0 1, 628, 674. 80	34, 17	3.00
3.00	minus line 2)		37, 204, 794	-1,011,044	55, 652, 95	0 1,020,074.00	54.17	3.00
4.00	Subtotal other wages & related		19, 556, 501	0	19, 556, 50	1 402, 331. 87	48. 61	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs (see inst.)		16, 241, 325	0	16, 241, 32	5 0.00	29. 18	5.00
6.00	Total (sum of lines 3 thru 5)		93, 062, 620	-1, 611, 844	91, 450, 77	6 2,031,006.67	45.03	6,00
7.00	Total overhead cost (see		19, 538, 628					
,.00	instructions)		17, 550, 620	1, 130, 473	10, 402, 10			,

alth Financial Systems	IU HEALIH	NORTH HOSPITAL			In Lieu of Form CMS-	
SPITAL WAGE RELATED COSTS		Provi der	CCN: 15-0		Worksheet S-3	3
				From 01/01 To 12/31	/2017 Part IV /2017 Date/Time Pro	enar
				10 12/31	5/29/2018 9:1	
					Amount	
					Reported	
					1.00	
PART IV - WAGE RELATED COSTS						4
Part A - Core List						4
RETIREMENT COST						
00 401K Employer Contributions					2, 338, 509	
DO Tax Sheltered Annuity (TSA) Emplo						2
00 Nonqualified Defined Benefit Plan		s)				D 3
00 Qualified Defined Benefit Plan Co					(2 4
PLAN ADMINISTRATIVE COSTS (Paid t	External Organization	ı)				
00 401K/TSA Plan Administration fees) 5
00 Legal /Accounting/Management Fees-						0 6
00 Employee Managed Care Program Adm	nistration Fees				(<u> </u>
HEALTH AND INSURANCE COST					,	
Health Insurance (Purchased or Se						3 C
1 Health Insurance (Self Funded wit						3 C
Health Insurance (Self Funded wit	n a Third Party Adminis	strator)			7, 417, 606	
Heal th Insurance (Purchased)						3 0
00 Prescription Drug Plan						2 9
00 Dental, Hearing and Vision Plan					250, 63	
00 Life Insurance (If employee is ow					29, 526	
00 Accident Insurance (If employee i						0 12
00 Disability Insurance (If employee					78, 050	
00 Long-Term Care Insurance (If empl	oyee is owner or benefi	ci ary)				0 14
00 'Workers' Compensation Insurance					303, 813	
00 Retirement Health Care Cost (Only	current year, not the	extraordinary a	accrual re	quired by FASB 1	06. (D 16
Non cumulative portion)						_
TAXES 00 FICA-Employers Portion Only					4, 072, 452	1 17
00 Medicare Taxes - Employers Portic	0.001.00					2 17
00 Unemployment Insurance	i oni y) 18) 19
00 State or Federal Unemployment Tax					55, 718	
OTHER	25				55,718	의 20
00 Executive Deferred Compensation ()thor Than Poti romont (Cast Poportod or	Linos 1	through 4 abovo	(500)	2 21
(instructions))		JUST Repuired OF	i i i i i i i i i i i i i i i i i i i	thi ough 4 above.	(See	7 21
00 Day Care Cost and Allowances						22
00 Tuition Reimbursement						2 = 23
00 Total Wage Related cost (Sum of I	nes 1 -23)				14, 546, 31	
Part B - Other than Core Related					14, 340, 31	4 24
. 00 OTHER WAGE RELATED COSTS (SPECIFY						25

Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-016		eri od:	Worksheet S-3	
					rom 01/01/2017	Part V	
				1	o 12/31/2017	Date/Time Pre 5/29/2018 9:5	
	Cost Center Description				Contract Labor		
					1.00	2.00	
	PART V - Contract Labor and Benefit Cost						
	Hospital and Hospital-Based Component Identi	fication:					
1.00	Total facility's contract labor and benefit				1, 937, 376	14, 546, 311	1.00
2.00	Hospi tal				1, 937, 376	14, 546, 311	2.00
3.00	Subprovider - IPF						3.00
4.00	Subprovider - IRF						4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	6.00
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF						8.00
9.00	Hospital-Based NF						9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA						11.00
12.00	Separately Certified ASC						12.00
13.00	Hospi tal -Based Hospi ce						13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
	Renal Dialysis						17.00
18.00	Other				0	0	18.00

Heal th	Financial Systems IU HEALTH NORTH H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN:	15-0161	Peri od:	Worksheet S-1	0
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by line :	202 column	8)	0. 226286	1.00
	Medicaid (see instructions for each line)				1	
2.00	Net revenue from Medicaid				4, 290, 650	
3.00	Did you receive DSH or supplemental payments from Medicaid?			: -10	N	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr		rom medica	10?		4.00
5.00 6.00	Medicaid charges	on medicalu			76, 694, 361	
7.00	Medicaid cost (line 1 times line 6)				17, 354, 860	
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	line 7 minus :	sum of lin	es 2 and 5; if	13, 064, 210	
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)			1	
9.00	Net revenue from stand-alone CHIP				C	
	Stand-allone CHIP charges				C	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (lino 11 minus	lino 0, i	f < zoro thon		
12.00	enter zero)		-			12.00
12 00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl)	C	13.00
13.00	Charges for patients covered under state or local indigent care					
14.00	10)		The udeu	TH THES 0 OF		14.00
15.00	State or local indigent care program cost (line 1 times line 14				C	
16.00		ligent care pr	ogram (lin	e 15 minus line	C	16.00
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state//	ocal india	ent care program	 ms (see	-
	instructions for each line)	r and state/it		ent care program	115 (566	
17.00	Private grants, donations, or endowment income restricted to fu	unding charity	care		C	17.00
	Government grants, appropriations or transfers for support of h				C	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent car	e programs	(sum of lines	13, 064, 210	19.00
			Jni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00		ility	5, 625, 06	5 799, 392	6, 424, 457	20.00
	(see instructions)		-,,	,	-,,	
21.00	Cost of patients approved for charity care and uninsured discou	ints (see	1, 272, 87	799, 392	2, 072, 265	21.00
~~ ~~	instructions)	66	050.04		050.010	00.00
22.00	Payments received from patients for amounts previously written charity care	off as	252, 91	8 0	252, 918	22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 019, 95	5 799, 392	1, 819, 347	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patien	nt days beyond	a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		re program	's length of	C	25.00
	stay limit					
	Total bad debt expense for the entire hospital complex (see ins				10, 615, 637	
	Medicare reimbursable bad debts for the entire hospital complex				268, 485	
	Medicare allowable bad debts for the entire hospital complex (s Non-Medicare bad debt expense (see instructions)	see instructio	115)		413, 053 10, 202, 584	
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see ins	tructions		2, 453, 270	
30.00	· · · · · · · · · · · · · · · · · · ·				4, 272, 617	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			17, 336, 827	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	IU HEALTH NORT	H HOSPITAL Provider CO	[^] N· 15-0161 P	In Lie eriod:	u of Form CMS-: Worksheet A	2552-10
RECEN				F T	rom 01/01/2017	Date/Time Pre 5/29/2018 9:5	pared: 1 am
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
1 00	GENERAL SERVICE COST CENTERS				0 221 220	0 221 220	1 1 00
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST		0 0				1.00
1.01	00102 MOB LEASED SPACE		0			1, 238, 842	1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP		0			4, 204, 212	•
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	770, 018	594, 057	1, 364, 075		11, 730, 677	
5.01	00540 NONPATI ENT TELEPHONES	0	6, 359	6, 359	-4, 169	2, 190	5.01
5.02	00550 DATA PROCESSI NG	0	8, 623				•
5.03	00560 PURCHASING RECEIVING AND STORES	0	40, 476			41, 173	•
5.04		1, 202, 917	702, 983			1, 439, 507	•
5.05	00590 OTHER ADMINI STRATI VE & GENERAL	4, 241, 956	62, 267, 523			42, 632, 225	•
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	2, 074, 845 1, 122, 440	5, 211, 507 2, 117, 803			6, 586, 024 2, 986, 145	•
8.00	00800 LAUNDRY & LINEN SERVICE	1, 122, 440	118, 329			118, 329	•
9.00	00900 HOUSEKEEPING	1, 456, 151	4, 623, 517			5, 541, 114	•
10.00	01000 DI ETARY	724, 803	588, 464			1, 133, 640	•
11.00	01100 CAFETERI A	1, 228, 001	2, 128, 356	3, 356, 357	-391, 819	2, 964, 538	11.00
13.00	01300 NURSING ADMINISTRATION	2, 923, 472	1, 267, 369	4, 190, 841			
14.00	01400 CENTRAL SERVICES & SUPPLY	830, 125	1, 581, 169				
15.00	01500 PHARMACY	2, 422, 874	3, 898, 268			2, 942, 573	
16.00	01600 MEDICAL RECORDS & LIBRARY	220 014	175, 921			174, 714	•
17.00 18.00	01700 SOCIAL SERVICE 01850 PATIENT TRANSPORTATION	328, 814 211, 827	288, 918 57, 327				•
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	211, 027	37, 327	209, 134	-38, 045	231, 109	10.00
30.00	03000 ADULTS & PEDIATRICS	12, 256, 811	9, 150, 664	21, 407, 475	-4, 804, 815	16, 602, 660	30.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0			0	1
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	855, 927	1, 031, 838	1, 887, 765	-308, 270	1, 579, 495	34.01
34.02	03402 PREMATURE INTENSIVE CARE UNIT	2, 549, 497	1, 559, 783	4, 109, 280			•
43.00	04300 NURSERY	0	0	0	1, 468, 976	1, 468, 976	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	4, 344, 377	19, 966, 838	24, 311, 215	-18, 294, 257	6, 016, 958	50.00
50.00	05100 RECOVERY ROOM	2,001,416	863, 886				
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 069, 342	3, 027, 816			4, 333, 933	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 249, 783	3, 094, 432				
56.00	05600 RADI OI SOTOPE	222, 341	277, 239			266, 199	•
60.00	06000 LABORATORY	646, 628	5, 213, 322	5, 859, 950	-90, 469		•
65.00	06500 RESPI RATORY THERAPY	1, 891, 628	753, 511			2, 016, 077	
66.00	06600 PHYSI CAL THERAPY	1, 932, 084	986, 945			2, 295, 034	•
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	475, 361 228, 899	133, 562			511, 265 247, 542	
69.00	06900 ELECTROCARDI OLOGY	292, 690	178, 431 352, 953				•
70.00	07000 ELECTROENCEPHALOGRAPHY	112, 963	374, 585				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			4, 471, 171	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		9, 161, 088	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	3, 933, 610	3, 933, 610	
75.00	07500 ASC (NON-DI STINCT PART)	0	0	-	-	0	•
75.01	07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 436, 548	2, 423, 189	3, 859, 737	-1, 979, 221	1, 880, 516	75.01
01 00	OUTPATIENT SERVICE COST CENTERS	2 150 071	1 0/1 000	4, 021, 793	740 247	2 201 444	01 00
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	2, 159, 871	1, 861, 922	4, 021, 793	-740, 347	3, 281, 446	91.00 92.00
118.0		57, 264, 409	136, 927, 885	194, 192, 294	-946, 073	193, 246, 221	118.00
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	75, 008	75, 008	0	75 008	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	, 3, 800	, 0, 000	0		192.00
	19201 OTHER NON-REI MBURSABLE	476, 928	1, 559, 664	2, 036, 592	-	1, 759, 700	
	19202 CHI LDBI RTH EDUCATI ON	193, 682	42, 440			225, 660	
	19204 PHYSI CLANS' PRI VATE OFFI CES	0	51, 118				192.04
	19205 ANSON CLINIC	279, 907	237, 506			1, 800, 048	
200.0	TOTAL (SUM OF LINES 118 through 199)	58, 214, 926	138, 893, 621	197, 108, 547	0	197, 108, 547	J200. 00

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider C	CN: 15-0161	Peri od:	Worksheet A	
					From 01/01/2017 To 12/31/2017	Date/Time Prep	
	Cost Center Description	Adjustments	Net Expenses			5/29/2018 9:51	am
	bost benter beschiptron		For Allocation				
		6.00	7.00				
	GENERAL SERVICE COST CENTERS		-	-			
00	00100 NEW CAP REL COSTS-BLDG & FIXT	-1, 320, 187					1.
01	00101 NEW CAP REL COSTS-INTEREST	-432, 595					1.
)2	00102 MOB LEASED SPACE	0					1
00	00200 NEW CAP REL COSTS-MVBLE EQUIP	308, 622					2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 371, 422					4
01	00540 NONPATI ENT TELEPHONES	0	_,				5
)2	00550 DATA PROCESSING	5, 104, 176					5
)3	00560 PURCHASING RECEIVING AND STORES	674,018					5
)4)F		1, 776, 710					5
)5	00590 OTHER ADMINISTRATIVE & GENERAL	-20, 928, 156					5
00 00	00600 MAINTENANCE & REPAIRS	-1, 732, 478					6
00	00700 OPERATION OF PLANT	-224, 137 0					7 8
00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0					9
00	01000 DI ETARY	-29, 942					10
00	01100 CAFETERIA	-1, 622, 575		1			11
00	01300 NURSING ADMINISTRATION	-323, 322					13
	01400 CENTRAL SERVICES & SUPPLY	-48, 855					14
	01500 PHARMACY	-63, 518					15
00	01600 MEDICAL RECORDS & LIBRARY	-03, 310					16
	01700 SOCIAL SERVICE	-13, 995					17
	01850 PATIENT TRANSPORTATION	-2, 168					18
00	INPATIENT ROUTINE SERVICE COST CENTERS	2,100	220, 711	1			10
00	03000 ADULTS & PEDI ATRI CS	-3, 164, 770	13, 437, 890				30
	03400 SURGI CAL I NTENSI VE CARE UNI T	0, 101, 770					34
	03401 PEDIATRIC INTENSIVE CARE UNIT	-596, 579	-				34
	03402 PREMATURE I NTENSI VE CARE UNI T	-1, 658, 892					34
00	04300 NURSERY	-36					43
	ANCILLARY SERVICE COST CENTERS						
00	05000 OPERATING ROOM	-978, 088	5, 038, 870				50
00	05100 RECOVERY ROOM	0	2, 217, 481				51
00	05200 DELIVERY ROOM & LABOR ROOM	-1, 151, 712	3, 182, 221				52
00	05400 RADI OLOGY-DI AGNOSTI C	-438, 043					54
00	05600 RADI OI SOTOPE	0					56
00	06000 LABORATORY	-30, 814	5, 738, 667				60
00	06500 RESPI RATORY THERAPY	-326					65
00	06600 PHYSI CAL THERAPY	-17, 549					66
00	06700 OCCUPATI ONAL THERAPY	0					67
	06800 SPEECH PATHOLOGY	-21, 611					68
	06900 ELECTROCARDI OLOGY	-184, 795					69
	07000 ELECTROENCEPHALOGRAPHY	-8, 718					70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0					71
	07200 I MPL. DEV. CHARGED TO PATIENT	0					72
	07300 DRUGS CHARGED TO PATIENTS	0					73
	07500 ASC (NON-DI STI NCT PART)	0	-				75
01	07501 CARDI AC CATHERI ZATI ON LABORATORY	-89, 832	1, 790, 684				75
00	OUTPATIENT SERVICE COST CENTERS	E01 440	2 750 704				01
00 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-521, 660	2, 759, 786				91 92
υU	SPECIAL PURPOSE COST CENTERS		I	1			72
3. 00		-30, 113, 249	163, 132, 972			11	118
. 00	NONREIMBURSABLE COST CENTERS	-30, 113, 249	103, 132, 972	1			110
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	75, 008			11	190
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0					190 192
	19201 OTHER NON-REIMBURSABLE	-412, 346	-				192 192
	19202 CHI LDBI RTH EDUCATI ON	-412, 340	225, 660				192
	19202 CHILDBERTH EDUCATION 19204 PHYSI CLANS' PRI VATE OFFI CES	-1, 910					192
	19205 ANSON CLINIC	-190, 401					192
00	TOTAL (SUM OF LINES 118 through 199)	170,401	1,007,047	1		!'	. /2

A - LEASI NEW CAP F FI XT 2.00 MOB LEASI S.00 3.00 NEW CAP F EQUI P 4.00 Solo 5.00 NEW CAP F EQUI P 4.00 Solo 5.00 NEW CAP F EQUI P 4.00 Solo 7.00 NEW CAP F EQUI P 1.00 TOTALS B DEPRI 1.00 NEW CAP F EQUI P 3.00 NEW CAP F 4.00 Solo 5.00 NEW CAP F 3.00 NEW CAP F 4.00 Solo 5.00 NEW CAP F 2.00 NEW CAP F 2.00 NEW CAP F 3.00 NEW CAP F 1.00 Solo 12.00 Solo 13.00 Solo 14.00 Solo 15.00 Solo 16.00 Solo 17.00 Solo 23.00 Zaoo 24.00 Solo 25.0	Cost Center 2.00 SES REL COSTS-BLDG & GED SPACE REL COSTS-MVBLE	Increases Li ne # 3.00 1.02 2.00 0.00	Sal ary 4.00 0 0 0 0 0 0 0 0 0 0 0 0	Provi der CCN: 15	From 01/	'01/2017 '31/2017 Date/	Sheet A-6 (Ti me Prepared: (2018 9: 51 am) (2018 9: 51 am) 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 2.00
A - LEASI NEW CAP F FIXT 2.00 MOB LEASI S.00 NEW CAP F EQUI P 4.00 5.00 6.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 TOTALS B - DEPRI 1.00 NEW CAP F EQUI P 3.00 14.00 TOTALS 0.00 NEW CAP F EQUI P 3.00 4.00 5.00 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 20.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00	2.00 SES REL COSTS-BLDG & SED SPACE REL COSTS-MVBLE ECI ATI ON REL COSTS-BLDG &	Li ne # 3. 00 1. 00 1. 02 2. 00 0. 00		5.00 1,847,635 1,238,842 235,173 0 0 0 0 0 0 0 0 0 0 0 0 0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 13. 00 14. 00
A - LEASI NEW CAP F FI XT 2.00 MOB LEASI S.00 3.00 NEW CAP F EOUI P 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 TOTALS B - DEPRI 1.00 NEW CAP F 2.00 13.00 14.00 TOTALS B - DEPRI 1.00 NEW CAP F EQUI P 3.00 4.00 5.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 22.00 23.00 24.00 25.00 25.00 26.00 27.00 28.00 29.00 30.00 <th>2.00 SES REL COSTS-BLDG & SED SPACE REL COSTS-MVBLE ECI ATI ON REL COSTS-BLDG &</th> <th>3.00 1.00 1.02 2.00 0.00</th> <th></th> <th>5.00 1,847,635 1,238,842 235,173 0 0 0 0 0 0 0 0 0 0 0 0 0</th> <th></th> <th></th> <th>2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 13.00 14.00</th>	2.00 SES REL COSTS-BLDG & SED SPACE REL COSTS-MVBLE ECI ATI ON REL COSTS-BLDG &	3.00 1.00 1.02 2.00 0.00		5.00 1,847,635 1,238,842 235,173 0 0 0 0 0 0 0 0 0 0 0 0 0			2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.00 13.00 14.00
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IU HEALTH NORTH HOSPITAL Provider CCN: 15-0161 Period:

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

Internet Unrevenue Other 17.00 2.09 3.00 0.00 0.00 0 18.00 0.00 0.00 0 0 17 19.00 0.00 0.00 0 0 17 19.00 0.00 0 0 0 0 17 19.00 0.00 0 0 0 0 0 17 21.00 0.00 0 0 0 0 0 17 22.00 0.00 0 0 0 0 0 17 22.00 0.00 0 0 0 0 0 17 23.00 0.00 0 0 0 0 17	RECLAS	STELCATIONS			Provider CCN: 15-0	161 Period: Worksheet A From 01/01/2017 To 12/31/2017 Date/Time F 5/29/2018 9	Prepared:
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13.00 RECOVERY ROOM 51.00 0 7,684 13 14.00 DELI VERY ROOM & LABOR ROOM 52.00 0 17,041 14 15.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3,668 15 16.00 RESPI RATORY THERAPY 65.00 0 3,431 16 17.00 PHYSI CAL THERAPY 66.00 0 4,246 17 18.00 OCCUPATI IONAL THERAPY 67.00 0 6,096 18 19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,486 21 21.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 22.00 EMERGENCY	11.00	ADULTS & PEDIATRICS	30.00	0			11.00
14.00 DELIVERY ROOM & LABOR ROOM 52.00 0 17.041 14 15.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3.668 15 16.00 RESPI RATORY THERAPY 65.00 0 3.431 16 17.00 PHYSI CAL THERAPY 66.00 0 4.226 17 18.00 OCCUPATI ONAL THERAPY 67.00 0 6.096 18 19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,979 20 21.00 CARDI AC CATHERI ZATI ON 75.01 0 262.755 21 1 BREAST CARE 0 262.755 1 22 1 BREAST CARE 1 12.05 489.252 299.302 1 1 BREAST CARE 1 14.890.810 14 1 1.00 ANSON CLI NI C 192.05 489.252 299.302 1 1 OTALS 289.815 303.373 1 1 1.00 ANSON CLI NI C 2	12.00	OPERATING ROOM	50.00	0			12.00
15.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3,668 15 16.00 RESPI RATORY THERAPY 65.00 0 3,431 16 17.00 PHYSI CAL THERAPY 66.00 0 4,246 17 18.00 OCCUPATI ONAL THERAPY 67.00 0 6,096 18 19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,486 21 1.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 1.ABORATORY - 0 262,755 22 20 1 BREAST CARE - 0 262,755 22 1 BREAST CARE - 0 262,755 1 1.00 ANSON CLI NIC - 192.05 489,252 299,302 1 1 - 192.05 289,815 303,373 1 1 1.00 ANSON CLI NIC - 289,815 303,373 1 1 1.00 EMPLOYEE BENEFI TS DEPAR							13.00
16.00 RESPIRATORY THERAPY 65.00 0 3,431 16 17.00 PHYSI CAL THERAPY 66.00 0 4,246 17 18.00 OCCUPATI ONAL THERAPY 67.00 0 6,096 18 19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,486 21 LABORATORY 91.00 0 17,933 22 21.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 LABORATORY 91.00 0 17,933 22 22 10 ANSON CLI NI C 192.05 489,252 299,302 1 1 0 0 289,815 303,373 1 1 1.00 ANSON CLI NI C 192.05 289,815 303,373 1 1 1.00 ANSON CLI NI C 192.05 289,815 303,373 1 1 1.00 ANSON CLI NI C 0 570,022 1 1 1 1.00 EMPLOYEE BENEFIT				-			14.00
17.00 PHYSI CAL THERAPY 66.00 0 4, 246 17 18.00 OCCUPATI ONAL THERAPY 67.00 0 6,096 18 19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,979 20 21.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 LABORATORY				-			15.00
18.00 OCCUPATI ONAL THERAPY 67.00 0 6,096 18 19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,979 20 21.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 LABORATORY				0			16.00
19.00 SPEECH PATHOLOGY 68.00 0 569 19 20.00 ELECTROCARDI OLOGY 69.00 0 3,979 20 21.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 LABORATORY 91.00 0 17,933 22 22.00 EMERGENCY 91.00 0 17,933 22 I BREAST CARE 0 262,755 1 1 1.00 ANSON CLINIC 192.05 489,252 299,302 1 J ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 J ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1 1.00 EMPLOYEE BENEFITS DEPARTME				0			17.00 18.00
20.00 ELECTROCARDIOLOGY 69.00 0 3,979 20 21.00 CARDIAC CATHERIZATION 75.01 0 3,486 21 22.00 EMERGENCY 91.00 0 17,933 22 1 BREAST CARE 0 262,755 1 1 1.00 ANSON CLINIC 192.05 489,252 299,302 1 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 1 1.00 ANSON CLINIC 0 570,022 1 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 570,022				0			19.00
21.00 CARDI AC CATHERI ZATI ON 75.01 0 3,486 21 LABORATORY 91.00 0 17,933 22 I BREAST CARE 0 262,755 299, 302 21 1.00 ANSON CLINIC 192.05 489,252 299, 302 1 1 J ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 1 J ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 570,022 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 570,022 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 570,02				0			20.00
LABORATORY 91.00 0 17,933 22 TOTALS 0 262,755 28 28 I - BREAST CARE 192.05 489,252 299,302 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 J - ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 I.00 ANSON CLINIC 192.05 289,815 303,373 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 570,022 1							21.00
TOTALS 0 262,755 I - BREAST CARE 1 - - - 1 1 1 1.00 ANSON_CLINIC				-	-,		
I - BREAST CARE 1.00 ANSON CLINIC 192.05 489,252 299,302 1 TOTALS 489,252 299,302 1 1 J - ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 K - ACCURED PTO 289,815 303,373 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 I.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1	22.00	EMERGENCY	91.00	0	17, 933		22.00
1.00 ANSON CLINIC 192.05 489,252 299,302 1 TOTALS 489,252 299,302 1 1 J - ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1.00 ANSON CLINIC 192.05 289,815 303,373 1 K - ACCURED PTO 289,815 303,373 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 I.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 I.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1				0	262, 755		
TOTALS 489, 252 299, 302 J - ORTHO AND SPINE CLINIC 192.05 289, 815 303, 373 1.00 ANSON CLINIC 192.05 289, 815 303, 373 K - ACCURED PTO 100 570, 022 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570, 022 1 L - BI LLABLE SUPPLIES 1 1 1 1							
J - ORTHO AND SPINE CLINIC 192.05 289,815 303,373 1 1.00 ANSON_CLINIC 192.05 289,815 303,373 1 TOTALS 289,815 303,373 1 1 K - ACCURED PTO 1 1 1 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 1 L - BILLABLE SUPPLIES 0 570,022 1 1	1.00		192.05				1.00
1.00 ANSON_CLINIC 192.05 289,815 303,373 1 TOTALS 289,815 303,373 1 1 K - ACCURED PTO 1 1 1 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 TOTALS 0 570,022 1 L - BILLABLE SUPPLIES 1 1 1				489, 252	299, 302		_
TOTALS 289, 815 303, 373 K - ACCURED PTO 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570, 022 TOTALS 0 570, 022 1 L - BILLABLE SUPPLIES 1 1	1 00		102 05	280 815	303 373		1.00
K - ACCURED PTO 570,022 1 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 TOTALS 0 570,022 1 L - BILLABLE SUPPLIES 1 1 1	1.00		172.03				1.00
1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 570,022 1 TOTALS 0 570,022 0 570,022 1 L BILLABLE SUPPLIES 0 570,022 1			<u> </u>	207,010			_
TOTALS 0 570, 022 L - BI LLABLE SUPPLI ES	1.00		4.00		570, 022		1.00
				0			
	1.00	CENTRAL SERVICES & SUPPLY	14.00		296		1.00
	2.00		71.00		4, 471, 171		2.00
PATI ENTS		PATTENIS					

IU HEALTH NORTH HOSPITAL Provider CCN: 15-0161 Period:

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

RECLASS	SEFECATIONS			Provider CCN: 15-0161	Period: From 01/01/2017	Worksheet A-6)
					To 12/31/2017	Date/Time Pre 5/29/2018 9:5	epared:
		Increases				5/29/2016 9.5	
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00			
3.00	2.00	0.00	0	0			3.00
4.00		0.00	0	0			4.00
5.00 6.00		0.00 0.00	0	0 0			5.00 6.00
7.00		0.00	Ö	0			7.00
8.00 9.00		0.00 0.00	0	0 0			8.00 9.00
10.00		0.00	0	0			10.00
11.00		0.00	o	0			11.00
12.00 13.00		0.00 0.00	0	0 0			12.00 13.00
14.00		0.00	0	0			14.00
15. 00 16. 00		0.00 0.00	0	0 0			15. 00 16. 00
17.00		0.00	0	0			17.00
	TOTALS		0	4, 471, 467			
1.00	M - NON-BILLABLE SUPPLIES PURCHASING RECEIVING AND	5.03	0	74, 939			1.00
	STORES						
2.00 3.00	CENTRAL SERVICES & SUPPLY	14.00 0.00	0	6, 412, 703 0			2.00 3.00
4.00		0.00	0	0			4.00
5.00		0.00	0	0			5.00
6.00 7.00		0.00 0.00	0	0 0			6.00 7.00
8.00		0.00	0	0			8.00
9. 00 10. 00		0.00 0.00	0	0 0			9.00 10.00
11.00		0.00	0	0			11.00
12.00		0.00	0	0			12.00
13. 00 14. 00		0.00 0.00	0	0 0			13.00 14.00
15.00		0.00	0	0			15.00
16. 00 17. 00		0.00 0.00	0	0 0			16.00 17.00
18.00		0.00	0	0			18.00
19.00		0.00	0	0			19.00
20. 00 21. 00		0.00 0.00	0	0 0			20. 00 21. 00
22.00		0.00	0	0			22.00
23. 00 24. 00		0.00 0.00	0	0 0			23.00 24.00
24.00 25.00		0.00	0	0			24.00 25.00
26.00		0.00	O	0			26.00
27.00 28.00		0.00 0.00	0	0			27.00 28.00
29.00		0.00	0	Ö			29.00
30.00			<u>0</u> 0	<u> </u>			30.00
	N - BILLABLE DRUGS		U				
1.00	NURSING ADMINISTRATION	13.00		5, 334			1.00
2.00 3.00	DRUGS CHARGED TO PATIENTS	73.00 0.00	o	3, 933, 610 0			2.00 3.00
4.00		0.00	0	0			4.00
5.00 6.00		0.00 0.00	0	0 0			5.00 6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9. 00 10. 00		0.00 0.00	0	0			9.00 10.00
11.00	L	0.00	О	0			11.00
	TOTALS O - NON-BILLABLE DRUGS		0	3, 938, 944			
1.00	PURCHASING RECEIVING AND	5.03		790			1.00
2 00	STORES PHARMACY	15.00		466 090			2 00
2.00 3.00		0.00	0	466, 989 0			2.00 3.00
4.00		0.00	0	0			4.00
5.00 6.00		0.00 0.00	0	0			5.00 6.00
7.00		0.00	0	0			7.00
8.00		0.00	0	0			8.00
9. 00 10. 00		0.00 0.00	0 0	0 0			9. 00 10. 00
	I		-1	- 1		I	

Heal th	Financial Systems		IU HEALTH NO	RTH HOSPITAL		In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS			Provider C	CN: 15-0161	Peri od:	Worksheet A-	6
						From 01/01/2017		
						To 12/31/2017	Date/Time Pr 5/29/2018 9:	epared: 51 am
		Increases					572772010 7.	
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
	TOTALS		0	467, 779				
	P - IMPLANTS							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	882				1.00
2.00	IMPL. DEV. CHARGED TO	72.00	0	9, 161, 088				2.00
	PATI ENT							
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
	TOTALS		0	9, 161, 970				
500.00	Grand Total: Increases		2, 342, 822	64, 954, 306				500.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

IU HEALTH NORTH HOSPITAL

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

Provider CCN: 15-0161

 Period:
 Worksheet A-6

 From 01/01/2017
 Date/Time Prepared:

 To
 12/31/2017
 Date/Time Prepared:

						5/29/2018 9:	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - LEASES	7.00	8.00	9.00	10.00		
1.00	OTHER ADMINI STRATI VE &	5.05	0	2, 306, 360	10		1.00
	GENERAL		-	, ,			
2.00	MAINTENANCE & REPAIRS	6.00	0	14, 835	10		2.00
3.00	OPERATION OF PLANT	7.00	0	7, 735	10		3.00
4.00 5.00	CAFETERIA NURSING ADMINISTRATION	11.00 13.00	0	384 106, 415	0		4.00
5.00 6.00	ADULTS & PEDIATRICS	30.00	0	47, 610	-		6.00
7.00	PEDIATRIC INTENSIVE CARE	34.01	0	271	0		7.00
	UNI T						
8.00	PREMATURE INTENSIVE CARE	34.02	0	5, 186	0		8.00
9.00	UNIT OPERATING ROOM	50.00	o	195, 818	o		0.00
9.00 10.00	RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	209, 955	0		9.00 10.00
11.00	RESPI RATORY THERAPY	65.00	0	15, 526	-		11.00
12.00	PHYSI CAL THERAPY	66.00	0	192, 260			12.00
13.00	OTHER NON-REIMBURSABLE	192.01	0	182, 035	0		13.00
14.00	ANSON CLINIC	1 <u>92.</u> 05	0	3 <u>7, 2</u> 60			14.00
	TOTALS		0	3, 321, 650			
1.00	B - DEPRECIATION NONPATIENT TELEPHONES	5.01		4, 169	9		1.00
2.00	DATA PROCESSING	5.02		7, 135			2.00
3.00	PURCHASI NG RECEI VI NG AND	5.02		18, 049			3.00
0.00	STORES	0100		10,017			0.00
4.00	ADMI TTI NG	5.04		224, 824			4.00
5.00	OTHER ADMINISTRATIVE &	5.05		7, 573, 131			5.00
(00	GENERAL	(004.044			6.00
6.00 7.00	MAINTENANCE & REPAIRS OPERATION OF PLANT	6.00 7.00		224, 364 35, 468			6.00 7.00
7.00 8.00	HOUSEKEEPI NG	9.00		94, 720			8.00
9.00	DI ETARY	10.00		1, 793			9.00
10.00	CAFETERIA	11.00		22, 561			10.00
11.00	NURSING ADMINISTRATION	13.00		48, 399			11.00
12.00	CENTRAL SERVICES & SUPPLY	14.00		123, 876			12.00
13.00	PHARMACY	15.00		23, 162			13.00
14.00	MEDI CAL RECORDS & LI BRARY	16.00		1, 207			14.00
15.00 16.00	SOCI AL SERVI CE ADULTS & PEDI ATRI CS	17.00 30.00		338 183, 249			15.00 16.00
17.00	PEDIATRIC INTENSIVE CARE	34.01		28, 171			17.00
17.00	UNI T	54.01		20, 171			17.00
18.00	PREMATURE INTENSIVE CARE	34.02		46, 316	-		18.00
	UNIT						
19.00	OPERATING ROOM	50.00		1, 307, 023			19.00
20. 00 21. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00		37, 342 117, 960			20.00
21.00	RADI OLOGY-DI AGNOSTI C	54.00		821, 866			21.00
23.00	RADI OI SOTOPE	56.00		125			23.00
24.00	LABORATORY	60.00		1, 657			24.00
25.00	RESPI RATORY THERAPY	65.00		48, 256			25.00
26.00	PHYSI CAL THERAPY	66.00		26, 784			26.00
27.00	OCCUPATIONAL THERAPY	67.00		736			27.00
28. 00 29. 00	SPEECH PATHOLOGY	68.00		1, 337			28.00
29.00 30.00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00		90, 255 29, 577			29.00 30.00
31.00	CARDI AC CATHERI ZATI ON	75.01		192, 888			31.00
51.00	LABORATORY	, 5. 01		1,2,000			
32.00	EMERGENCY	91.00		53, 234			32.00
33.00	OTHER NON-REIMBURSABLE	192.01		2, 930			33.00
34.00	PHYSICIANS' PRIVATE OFFICES	192.04		49, 183			34.00
35.00	ANSON CLINIC	<u> </u>		10, 548			35.00
	TOTALS C - EMPLOYEE BENEFITS		0	11, 452, 633			-
1.00	ADMI TTI NG	5.04	0	232, 799	0		1.00
2.00	OTHER ADMINISTRATIVE &	5.05	0	368, 434			2.00
	GENERAL		J				
3.00	MAINTENANCE & REPAIRS	6.00	0	359, 323	0		3.00
4.00	OPERATION OF PLANT	7.00	0	210, 864			4.00
5.00	HOUSEKEEPING	9.00	0	432, 255			5.00
6.00		10.00	0	170, 942			6.00
7.00 8.00	CAFETERIA NURSING ADMINISTRATION	11.00 13.00	0	368, 019 639, 875	-		7.00 8.00
8.00 9.00	CENTRAL SERVICES & SUPPLY	13.00	0	639, 875 197, 240			9.00
9.00 10.00	PHARMACY	14.00	0	319, 980			10.00
11.00	SOCI AL SERVI CE	17.00	0				11.00
			9		, ol		,

Health Financial Systems RECLASSIFICATIONS

IU HEALTH NORTH HOSPITAL Provider CCN: 15-0161

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2017

							te/Time Prepared:
		Decreases				5/	29/2018 9:51 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
12.00	PATIENT TRANSPORTATION	18.00	0	38, 045			12.00
13.00 14.00	ADULTS & PEDIATRICS PEDIATRIC INTENSIVE CARE	30.00 34.01	0	2, 286, 026 224, 549			13.00 14.00
14.00	UNIT	54.01	0	224, 349			14.00
15.00	PREMATURE INTENSIVE CARE	34.02	0	552, 616	0		15.00
	UNIT						
16.00	OPERATING ROOM RECOVERY ROOM	50.00	0	744, 213			16.00
17.00 18.00	DELIVERY ROOM & LABOR ROOM	51.00 52.00	0	368, 067 577, 100			17.00 18.00
19.00	RADI OLOGY-DI AGNOSTI C	54.00	0	549, 637			19.00
20.00	RADI OI SOTOPE	56.00	0	28, 528			20.00
21.00	LABORATORY	60.00	0	82, 791	(21.00
22.00	RESPI RATORY THERAPY	65.00	0	367, 220			22.00
23.00	PHYSICAL THERAPY	66.00	0	353, 689			23.00
24.00 25.00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	0	91, 620 44, 642			24.00 25.00
26.00	ELECTROCARDI OLOGY	69.00	0	45, 568			26.00
27.00	ELECTROENCEPHALOGRAPHY	70.00	0	12, 473			27.00
28.00	CARDI AC CATHERI ZATI ON	75.01	0	206, 997	(28.00
~~ ~~	LABORATORY						
29.00	EMERGENCY	91.00	0	313, 021			29.00 30.00
30. 00 31. 00	OTHER NON-REIMBURSABLE CHILDBIRTH EDUCATION	192.01 192.02	0	91, 923 16, 999			30.00
32.00	ANSON CLINIC	192.02	0	51, 138			32.00
	TOTALS		0	10, 408, 325		-	
	D - INTEREST				1	1	
1.00	OTHER ADMINISTRATIVE &	5.05	0	13, 624, 572	11		1.00
	GENERAL	+	— — — ₀	13, 624, 572		-	
	E - LABOR AND DELIVERY		U_	13, 024, 372			
1.00	DELIVERY ROOM & LABOR ROOM	52.00	265, 311	29, 569	()	1.00
2.00		0.00	0	0			2.00
	TOTALS		265, 311	29, 569			
1.00	F - MARKETING ADMITTING	5.04		2, 478			1.00
2.00	OTHER ADMINISTRATIVE &	5.04		3, 750			2.00
2.00	GENERAL	0100		0,,00			21.00
3.00	DI ETARY	10.00		103			3.00
4.00	SOCIAL SERVICE	17.00		26			4.00
5.00 6.00	ADULTS & PEDIATRICS PHYSICAL THERAPY	30.00 66.00		53 127			5.00 6.00
0.00	TOTALS	00.00	— — — d				0.00
	G - NURSERY	L	<u> </u>	0,007		1	
1.00	ADULTS & PEDIATRICS		<u>1, 298, 4</u> 44	<u>147, 7</u> 66)	1.00
	TOTALS		1, 298, 444	147, 766			
1.00	H - FMLA EMPLOYEE BENEFITS DEPARTMENT	4.00	1, 311	0	0	ป	1.00
2.00	OTHER ADMINISTRATIVE &	5.05	5, 536	0			2.00
	GENERAL		-,	-			
3.00	MAINTENANCE & REPAIRS	6.00	5, 603	0			3.00
4.00	HOUSEKEEPING	9.00	13, 628	0			4.00
5.00 6.00	DI ETARY CAFETERI A	10.00 11.00	9, 880 4, 061	0			5.00 6.00
7.00	NURSING ADMINI STRATI ON	13.00	17, 729	0			7.00
8.00	CENTRAL SERVICES & SUPPLY	14.00	6, 892	0			8.00
9.00	PHARMACY	15.00	9, 841	0	0		9.00
10.00	SOCI AL SERVI CE	17.00	2, 738	0			10.00
11.00	ADULTS & PEDIATRICS	30.00	92, 901	0			11.00
12.00 13.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	24, 502	0 0			12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	7, 684 17, 041	0			13.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 668	0			14.00
16.00	RESPI RATORY THERAPY	65.00	3, 431	0			16.00
17.00	PHYSI CAL THERAPY	66.00	4, 246	0			17.00
18.00	OCCUPATIONAL THERAPY	67.00	6, 096	0			18.00
19.00		68.00 69.00	569 3, 979	0 0			19.00
20. 00 21. 00	ELECTROCARDI OLOGY CARDI AC CATHERI ZATI ON	69.00 75.01	3, 979	0			20.00 21.00
21.00	LABORATORY	, 3. 01	5, 400	0			21.00
22.00	EMERGENCY	<u>91.</u> 00	1 <u>7, 9</u> 33	0)	22.00
	TOTALS		262, 755	0	1		

EELLASSET LATIONS Provider COL: 15 0161 Provider COL: 15 0161 <th< th=""><th></th><th>Financial Systems SIFICATIONS</th><th></th><th>IU HEALTH NOR</th><th></th><th>CON: 15 0161</th><th>In Lieu of Form CM Period: Worksheet A</th><th></th></th<>		Financial Systems SIFICATIONS		IU HEALTH NOR		CON: 15 0161	In Lieu of Form CM Period: Worksheet A	
Operation Decrements Other	RECEAS	SHIGAHONS				CON. 13-0101	From 01/01/2017 To 12/31/2017 Date/Time F	repared:
0 0.00 7.00 8.00 9.00 10.00 1.00 Unset CARF CARF 13.00 7.00 9.00 10.00 1.00 Unset CARF CARF 13.00 7.00 10.00 10.00 1.00 Unset CARF CARF 10.00 10.00 10.00 10.00 1.00 Unset CARF CARF 10.00 10.00 10.00 10.00 Unset CARF 10.00 10.00 10.00 10.00 10.00 Unset CARF 10.00 5.00.00 5.00.00 10.00 10.00 Trans Unset CarF 10.00 5.00 10.00 10.00 Trans State State 10.00 3.00 5.90 0 10.00 1.00 State State 10.00 5.00 5.90 0 10.00 10.00 1.00 State State 10.00 10.00 10.00 10.00 10.00 10.00 10.00 1.00 State State 10.00 10.00 10.00			Decreases				072772010	
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100 DEPENDING_BOM 50.00 296.810 503.273 0 11.00 TALKER DEPTIN				489, 202	299, 302			_
IDIALS IDIALS <thidials< th=""> <thidials< t<="" td=""><td>1.00</td><td></td><td>50,00</td><td>289, 815</td><td>303.373</td><td>3</td><td>0</td><td>1.00</td></thidials<></thidials<>	1.00		50,00	289, 815	303.373	3	0	1.00
1.00 EPLCVPCE EREFITS DEPARTMENT 4.00 570.022 0								
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L. BULLARIE SUPPLIES L. BULQUESTING RECEIVING AND PURCHASTING RECEIVING AND PURCH	1.00		4.00				0	1.00
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3.00 PULSERCEPTING 9.00 3.2 0 4.00 4.00 DETARY 10.00 6.125 0 4.00 5.00 PARARACY 15.00 6.125 0 5.00 10.00 5.00 10.00 5.00 10.00 5.00 10.00 110.00 10.00 10.00 10.00 10.00 10.00 <td></td> <td>1</td> <td></td> <td></td> <td>56, 983</td> <td></td> <td></td> <td>1</td>		1			56, 983			1
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LABORATORY 91.0 12,179 0 17.00 M- ADR-BILLABLE SUPPLIES - - 1,00 - 1,00 - 1,00 - 1,00 - 1,00 - 1,00 - 1,00 - 1,00 - 1,00 - 1,00 - 0,00 0,4,471,467 0 0 2,00 0 0,00		1 1					0	
17.00 ENERGENCY 91.00 12.179 0 17.00 M - NON-BILLABLE SUPPLIES 0 4.471.467 0 1.00 1.00 ENPLOYEE EBLET TO SUPPARTMENT 4.00 0 1.420 0 2.00 2.00 ADMI TTI NG TS DEPARTMENT 4.00 0 1.420 0 3.00 3.00 OTHER ADMINISTRATIVE & 5.04 0 0 4.471.467 0 0 4.471.467 0 0 4.471.467 0 0 1.00 2.00 3.00 0 0 0.00 0 1.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 0.00 0 </td <td>16.00</td> <td></td> <td>75.01</td> <td></td> <td>746, 584</td> <td>Ļ</td> <td>0</td> <td>16.00</td>	16.00		75.01		746, 584	Ļ	0	16.00
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10.00 PHARMACY 15.00 0 64,756 0 10.00 11.00 ADULTS & PEDIATRIC INTENSIVE CARE 34.01 0 55,279 0 12.00 UNIT 0 FEMATURE INTENSIVE CARE 34.01 0 55,279 0 12.00 UNIT 0 FEMATURE INTENSIVE CARE 34.02 0 148,207 0 13.00 UNIT 0 RECOVERV ROOM 51.00 0 219,113 0 14.00 15.00 RECOVERV ROOM 51.00 0 710,304 17.00 16.00 16.00 DELIVERY ROOM S2.00 0 460,660 17.00 18.00 17.00 18.00 17.00 18.00 19.00 20.00 19.00 20.00 19.00 20.00 20.00 19.452 0 20.00 22.00 22.00 22.00 22.00 22.00 22.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 23.00 24.00 25.00		1					0	1
11.00 ADULTS & PEDIATRI CS 30.00 0 996, 497 0 11.00 12.00 PEDIATRI C INTENSIVE CARE 34.01 0 55, 279 0 12.00 13.00 PREMATURE INTENSIVE CARE 34.02 0 148, 207 0 13.00 14.00 OPERATING ROOM 50.00 0 3, 568, 377 0 14.00 15.00 RECOVERY ROOM 51.00 0 219, 113 0 15.00 16.00 DELIVERY ROOM & LABOR ROOM 52.00 0 460, 660 0 16.00 17.00 RADIOLOGY-DIAGNOSTIC 54.00 0 170, 304 0 17.00 18.00 LABORATORY 66.00 0 5802 0 19.00 20.00 RESPIRATORY THERAPY 65.00 0 19.00 22.00 22.00 21.00 PHYSICAL THERAPY 67.00 0 5.302 0 22.00 23.00 SPECH PATHOLOGY 68.00 0 2.977 0 23.00 24.00 LECTROCARDIALDAGRAPHY 70.00 0 2.377 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>0</td> <td>1</td>				-			0	1
12.00 PEDI ATRIC I INTENSI VE CARE 34.01 0 55, 279 0 12.00 13.00 PREMATURE INTENSI VE CARE 34.02 0 148, 207 0 13.00 14.00 OPERATIUR ROM 50.00 0 3, 568, 377 0 14.00 15.00 RECOVERY ROM 51.00 0 219, 113 0 15.00 16.00 DELI VERY ROM & LABOR ROM 52.00 0 460, 660 0 17.00 17.00 RADI OLSGYDE 56.00 0 170, 00 842 0 18.00 18.00 RADI OLSGYDEY 65.00 0 191, 452 0 20.00 21.00 PHYSI CAL THERAPY 66.00 0 5, 302 0 21.00 22.00 COLPATI ONAL THERAPY 67.00 0 5, 302 0 22.00 23.00 SPEECH PATHOLOGY 68.00 0 22.97 23.00 24.00 25.00 LECTROENCEPHALOGRAPHY 70.00 0 16, 316 0 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
UNIT 13.00 PREMATURE INTENSIVE CARE 34.02 0 148,207 0 13.00 14.00 OPERATING ROOM 50.00 0 3,568,377 0 14.00 15.00 RECOVERY ROOM 51.00 0 219,113 0 15.00 16.00 16.00 DELIVERY ROOM & LABOR ROOM 52.00 0 460,660 0 16.00 17.00 RADI OLGCY-DI AGNOSTIC 54.00 0 170,304 0 18.00 18.00 RADI OLSCY-DI AGNOSTIC 54.00 0 5802 0 19.00 20.00 LABORATORY 60.00 0 5,802 0 19.00 21.00 PHYSI CAL THERAPY 66.00 0 5302 0 21.00 22.00 OCCUPATI ONAL THERAPY 66.00 0 2.397 0 24.00 23.00 SPECH PATHOLOGY 68.00 0 2.397 0 24.00 24.00 ELECTROCARDIAC CATHERIZATI ON 75.01 0 10				°,			0	
UNIT Image: Constant of the second seco		UNI T						
14.00 OPERATING ROOM 50.00 0 3,568,377 0 14.00 15.00 RECOVERY ROOM 51.00 0 219,113 0 15.00 16.00 DELIVERY ROOM & LABOR ROOM 52.00 0 460,660 0 16.00 17.00 RADI OLOGY-DI AGNOSTI C 54.00 0 170,304 0 17.00 18.00 RADI OLOGY-DI AGNOSTI C 56.00 0 842 0 18.00 19.00 LABORATORY 60.00 0 5.802 0 19.00 20.00 RESPI RATORY THERAPY 66.00 0 5.302 0 21.00 22.00 CCUPATI ONAL THERAPY 66.00 0 22.00 23.00 22.00 23.00 SPEECH PATHOLOGY 68.00 0 22.192 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROCARDI OLOGY 69.00 0 27.00 24.00 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104,571	13.00		34.02	0	148, 207	7	0	13.00
15.00 RECOVERY ROOM 51.00 0 219,113 0 15.00 16.00 DELIVERY ROOM & LABOR ROOM 52.00 0 460.660 0 16.00 17.00 RADI 0LOGY-DI AGNOSTI C 54.00 0 170.0304 0 170.00 18.00 RADI 0LOGY-DI AGNOSTI C 54.00 0 842 0 18.00 19.00 LABORATORY 60.00 0 5.802 0 19.00 20.00 RESPI RATORY THERAPY 66.00 0 191.452 0 20.00 21.00 PHYSI CAL THERAPY 67.00 0 5.302 0 21.00 23.00 SPECH PATHOLOGY 68.00 0 22.90 23.00 24.00 25.00 24.00 24.00 25.00 ELECTROCARDI OLOGY 69.00 0 27.97 0 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 30.00 29.00 3.00 <t< td=""><td>14 00</td><td></td><td>F0 00</td><td></td><td>2 540 277</td><td>,</td><td></td><td>14.00</td></t<>	14 00		F0 00		2 540 277	,		14.00
16.00 DELIVERY ROOM & LABOR ROOM 52.00 0 460,660 0 16.00 17.00 RADI OLOGY-DI AGNOSTI C 54.00 0 170,304 0 17.00 18.00 RADI OLOGY-DI AGNOSTI C 56.00 0 842 0 18.00 19.00 LABORATORY 60.00 0 5.802 0 19.00 20.00 RESPI RATORY THERAPY 65.00 0 19.452 0 20.00 21.00 PHYSI CAL THERAPY 66.00 0 50,650 0 22.00 22.00 22.00 OCUPATI ONAL THERAPY 67.00 0 5,302 0 22.00 23.00 24.00 ELECTROCARDI OLOGY 68.00 0 2,397 0 23.00 25.00 ELECTRORACPHALCGARAPHY 70.00 0 16,316 0 25.00 26.00 26.00 CARDI AC CATHERIZATI ON 75.01 0 104,571 0 26.00 27.00 EMERGENCY 91.00 0 272,065 0 27.00 28.00 29.00 OHYSI C				-				
17.00 RADI OLOGY-DI AGNOSTI C 54.00 0 170,304 0 17.00 18.00 RADI OLSOTOPE 56.00 0 842 0 18.00 19.00 LABORATORY 60.00 0 5,802 0 19.00 20.00 RESPI RATORY THERAPY 66.00 0 19.452 0 20.00 21.00 PHYSI CAL THERAPY 66.00 0 50,650 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 5,302 0 22.00 23.00 SPECH PATHOLOGY 68.00 0 22.97 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 104,571 0 26.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 104,571 0 26.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 27.00 28.00 29.00 29.00 PHYSI CI ANS' PRI VATE OFFI CES 192.04 0 25		1		-			0	
19.00 LABORATORY 60.00 0 5,802 0 19.00 20.00 RESPI RATORY THERAPY 65.00 0 191,452 0 20.00 21.00 PHYSI CAL THERAPY 66.00 0 55,302 0 22.00 22.00 OCCUPATI ONAL THERAPY 66.00 0 5,302 0 22.00 23.00 SPEECH PATHOLOGY 68.00 0 22,192 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16,316 0 26.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104,571 0 26.00 28.00 OHERE NON-REI MBURSABLE 192.01 0 4 0 29.00 29.00 PHYSI CI ANS' PRI VATE OFFICES 192.04 25 0 29.00 29.00 30.00 TOTALS 0 6,487,642 1 30.00 2.00 30.00 SOCI AL SERVICE 17.00 7,463 0 2.00<		1		0			0	
20.00 RESPI RATORY THERAPY 65.00 0 191,452 0 20.00 21.00 PHYSI CAL THERAPY 66.00 0 50,650 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 5,302 0 22.00 23.00 SPEECH PATHOLOGY 68.00 0 22,192 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16,316 0 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104,571 0 26.00 27.00 EMERGENCY 91.00 0 272,065 0 28.00 29.00 OTHER NON-REI MBURSABLE 192.01 0 4 0 28.00 29.00 PHYSI CI ANS' PRI VATE OFFI CES 192.04 0 25 0 30.00 30.00 ANSON CLI NIC	18.00	RADI OI SOTOPE	56.00	0	842	2	0	18.00
21.00 PHYSI CAL THERAPY 66.00 0 50,650 0 21.00 22.00 OCCUPATI ONAL THERAPY 67.00 0 5,302 0 22.00 23.00 SPEECH PATHOLOGY 68.00 0 22,192 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16,316 0 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104,571 0 26.00 27.00 EMERGENCY 91.00 0 272,065 0 28.00 29.00 OTHER NON-REI MBURSABLE 192.01 0 4 0 28.00 29.00 PHYSI CI ANS' PRI VATE OFFI CES 192.04 0 25 0 30.00 30.00 ANSON CLINIC 192.05 0 6.487, 642 0 29.00 30.00 SOCI AL SERVI CE 17.00 7, 463 0 2.00 30.00 PREMATURE INTENSI VE CARE 34.02 113 0 3.00				0			0	
22.00 OCCUPATI ONAL THERAPY 67.00 0 5,302 0 22.00 23.00 SPEECH PATHOLOGY 68.00 0 22,192 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16,316 0 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104,571 0 26.00 27.00 EMERGENCY 91.00 0 272,065 0 28.00 27.00 EMERGENCY 91.00 0 272,065 0 29.00 28.00 OTHER NON-REI MBURSABLE 192.01 0 4 0 28.00 29.00 PHYSI CI ANS' PRI VATE OFFI CES 192.04 0 25 0 29.00 30.00 ANSON CLI NI C 192.05 0 161 0 2.00 2.00 30.00 SOCI AL SERVI CE 17.00 3,431,535 0 1.00 2.00 3.00 PREMATURE I NTENSI VE CARE 34.02 113				0			0	
23.00 SPEECH PATHOLOGY 68.00 0 22, 192 0 23.00 24.00 ELECTROCARDI OLOGY 69.00 0 2, 397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16, 316 0 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104, 571 0 26.00 27.00 EMERGENCY 91.00 0 272, 065 0 27.00 28.00 OTHER NON-REI MBURSABLE 192.01 0 4 0 28.00 29.00 PHYSI CI ANS' PRI VATE OFFI CES 192.04 0 25 0 29.00 30.00 ANSON CLI NIC 192.05 0 161 0 30.00 70.00 Soci AL SERVI CE 17.00 3, 431, 535 0 1.00 2.00 Soci AL SERVI CE 17.00 7, 463 0 2.00 30.00 PREMATURE INTENSI VE CARE 34.02 113 0 3.00 4.00 OPERATI NG ROOM 50.00 156, 711 0 4.00				0				
24.00 ELECTROCARDIOLOGY 69.00 0 2,397 0 24.00 25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16,316 0 25.00 26.00 CARDIAC CATHERIZATION 75.01 0 104,571 0 26.00 27.00 EMERGENCY 91.00 0 272,065 0 27.00 28.00 OTHER NON-REIMBURSABLE 192.01 0 4 0 28.00 29.00 PHYSICIANS' PRIVATE OFFICES 192.04 0 25 0 29.00 30.00 ANSON CLINIC		1					0	
25.00 ELECTROENCEPHALOGRAPHY 70.00 0 16,316 0 25.00 26.00 CARDI AC CATHERI ZATI ON 75.01 0 104,571 0 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 27.00 EMERGENCY 91.00 0 272,065 0 27.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 30.00 4.00 29.00 30.00 4.01 28.00 29.00 30.00 30.00 4.01 30.00 29.00 30.00 30.00 30.00 4.01 4.00 30.00 30.00 30.00 30.00 30.00 4.01 4.00 30.00 4.01 4.00		1		o			ō	
LABORATORY 91.00 0 272,065 0 27.00 EMERGENCY 91.00 0 272,065 0 27.00 28.00 28.00 28.00 28.00 29.00 PHYSICIANS' PRIVATE OFFICES 192.01 0 4 0 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 30.00 100 6,487,642 100 29.00 29.00 30.00 100 1.00 1.00 29.00 30.00 1.00 29.00 3.431,535 0 1.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00	25.00	ELECTROENCEPHALOGRAPHY	70.00	o			0	25.00
27.00 EMERGENCY 91.00 0 272,065 0 27.00 28.00 OTHER NON-REIMBURSABLE 192.01 0 4 0 28.00 29.00 PHYSI CLANS' PRI VATE OFFICES 192.04 0 25 0 29.00 30.00 ANSON CLINIC 192.05 0 161 0 30.00 TOTALS 0 6,487,642 0 2.00 30.00 1.00 PHARMACY 15.00 3,431,535 0 1.00 2.00 SOCI AL SERVI CE 17.00 7,463 0 2.00 3.00 PREMATURE INTENSI VE CARE 34.02 113 0 3.00 UNIT 100 50.00 156,711 0 4.00	26.00		75.01	0	104, 571		0	26.00
28.00 OTHER NON-REIMBURSABLE 192.01 0 4 0 28.00 29.00 29.00 PHYSICIANS' PRIVATE OFFICES 192.04 0 25 0 29.00 29.00 29.00 30.00 40500 21.01 0 40.0 25 0 29.00 30.00	27 00		01 00		272 0/5		0	27 00
29.00 PHYSI CI ANS' PRI VATE OFFICES 192.04 0 25 0 20.00 30.00 30.00 ANSON_CLINIC 192.05 0 161 0 30.00 TOTALS 0 6,487,642 0 30.00 30.00 N - BILLABLE DRUGS		1		-	212, U05 ۸		0	
30.00 ANSON_CLINIC 192.05 161 30.00		1			25		ō	
N - BI LLABLE DRUGS 1.00 PHARMACY 15.00 3,431,535 0 1.00 2.00 SOCI AL SERVI CE 17.00 7,463 0 2.00 3.00 PREMATURE INTENSI VE CARE 34.02 113 0 3.00 4.00 OPERATI NG ROOM 50.00 156,711 0 4.00				0			Ō	
1.00 PHARMACY 15.00 3,431,535 0 1.00 2.00 SOCI AL SERVI CE 17.00 7,463 0 2.00 3.00 PREMATURE INTENSIVE CARE 34.02 113 0 3.00 UNI T 50.00 156,711 0 4.00 4.00		TOTALS		0	6, 487, 642			
2.00 SOCI AL SERVICE 17.00 7,463 0 2.00 3.00 PREMATURE INTENSIVE CARE 34.02 113 0 3.00 3.00 4.00 OPERATING ROOM 50.00 156,711 0 4.00 4.00								
3. 00 PREMATURE INTENSIVE CARE 34. 02 113 0 3. 00 4. 00 OPERATING ROOM 50. 00 156, 711 0 4. 00		1 1						
UNIT 00 0PERATING ROOM 50.00 156, 711 0 4.00		1						1
4.00 OPERATING ROOM 50.00 156,711 0 4.00	5.00		54.02		113		~	5.00
5. 00 DELI VERY ROOM & LABOR ROOM 52. 00 3, 444 0 5. 00		OPERATING ROOM						
	5.00	DELIVERY ROOM & LABOR ROOM	52.00		3, 444	ł	0	5.00

ρερί δς	SIFICATIONS			Provider (CCN: 15-0161	Peri od:	Worksheet A-6
(LULA)					50N. 13-0101	From 01/01/2017 To 12/31/2017	Date/Time Prepare 5/29/2018 9:51 a
		Decreases					
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	· .	
	6.00	7.00	8.00	9.00	10.00		
6.00	RADI OLOGY-DI AGNOSTI C	54.00		126, 322		0	6
7.00	RADI OI SOTOPE	56.00		191, 003		0	7
B. 00	RESPI RATORY THERAPY	65.00		22		0	8
9.00	ELECTROCARDI OLOGY	69.00		6, 480)	0	9
10. 00	CARDIAC CATHERIZATION LABORATORY	75.01		15, 848		0	10
11.00	EMERGENCY	91.00		3	1	0	11
	TOTALS			3, 938, 944		1	
	0 - NON-BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		40, 296	,	0	1
2.00	NURSING ADMINISTRATION	13.00		. 89		0	2
3.00	ADULTS & PEDIATRICS	30.00		116, 458		0	3
4.00	PREMATURE INTENSIVE CARE	34.02		9, 161		0	4
1.00	UNI T	01.02		, 101			
5.00	OPERATING ROOM	50.00		98, 956		0	5
6.00	RECOVERY ROOM	51.00		23, 283		0	6
7.00	DELIVERY ROOM & LABOR ROOM	52.00		34, 876		0	7
B. 00	RADI OLOGY-DI AGNOSTI C	54.00		23, 756		0	8
9.00	RADI OI SOTOPE	56.00		12, 310		0	9
10.00	LABORATORY	60.00		219		0	10
11.00	RESPI RATORY THERAPY	65.00		2, 657		0	11
12.00	PHYSI CAL THERAPY	66.00		2,037		0	12
13.00	ELECTROENCEPHALOGRAPHY	70.00		27		0	13
14.00	CARDI AC CATHERI ZATI ON	75. 01		17, 372		0	13
	LABORATORY						
15.00	EMERGENCY	<u>91.</u> 00	— — — ₀	8 <u>8, 2</u> 27		0	15
			U	467, 779			
1 00	P - IMPLANTS CENTRAL SERVICES & SUPPLY	14.00	0	1 110		0	1
1.00			0	1, 118		0	1
2.00	ADULTS & PEDIATRICS	30.00	0	281		0	2
3.00	OPERATING ROOM	50.00	0	8, 376, 269			3
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	63		0	4
5.00	RADI OI SOTOPE	56.00	0	56		0	5
6.00	PHYSI CAL THERAPY	66.00	0	54		0	6
7.00	SPEECH PATHOLOGY	68.00	0	86, 626		0	7
8.00	ELECTROENCEPHALOGRAPHY	70.00	0	924		0	8
9.00	CARDIAC CATHERIZATION	75.01	0	694, 961		0	9
10.00	LABORATORY	04.00					
10.00	EMERGENCY	91.00		<u>1, 618</u>		Q	10
	TOTALS		0	9, 161, 970	1		

Heal th	Financial Systems	IU HEALTH NOR	TH HOSPITAL			In Lie	u of Form CMS-:	2552-10
	ILIATION OF CAPITAL COSTS CENTERS	10 112/12/11 1101	Provi der CO	CN: 15-0161	Pe	ri od:	Worksheet A-7	
RECONC				. 10 0101		om 01/01/2017		
					То	12/31/2017		pared:
							5/29/2018 9:5	1 am
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
	1	1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	0	0		0	0	0	
2.00	Land Improvements	11, 942, 223	0		0	0	0	
3.00	Buildings and Fixtures	148, 862, 711	0		0	0	82, 822	3.00
4.00	Building Improvements	11, 308, 147	82, 822		0	82, 822	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	103, 314, 548	2, 370, 096		0	2, 370, 096	10, 369, 782	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	275, 427, 629	2, 452, 918		0	2, 452, 918	10, 452, 604	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	275, 427, 629	2, 452, 918		0	2, 452, 918	10, 452, 604	10.00
		Endi ng Bal ance					· · · · ·	
		5	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	11, 942, 223	0					2.00
3.00	Buildings and Fixtures	148, 779, 889	0					3.00
4.00	Building Improvements	11, 390, 969	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	95, 314, 862	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	267, 427, 943	0					8.00
9.00	Reconciling Items		0					9.00
10.00	Total (line 8 minus line 9)	267, 427, 943	0					10.00
10.00		201, 121, 140	0					1 .0.00

Health Financial Systems	IU HEALTH NOR	TH_HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2017 To 12/31/2017		pared:
		SL	IMMARY OF CAP	ITAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1.00
1.01 NEW CAP REL COSTS-INTEREST	0	0		0 0	0	1.01
1.02 MOB LEASED SPACE	0	0		0 0	0	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum				
	Capi tal -Relate					
	d Costs (see	through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01 NEW CAP REL COSTS-INTEREST	0	0				1.01
1.02 MOB LEASED SPACE	0	0				1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	l O	0				3.00

Heal th	Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 9:5	
		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 CI			T	-		
1.00 1.01 1.02	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-INTEREST MOB LEASED SPACE	172, 113, 081 0 0		172, 113, 08	1 0. 643587 0 0. 000000 0 0. 000000	0 0 0	1. 00 1. 01 1. 02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	95, 314, 862	C	95, 314, 86		0	2.00
3.00	Total (sum of lines 1-2)	267, 427, 943		267, 427, 94		0	3.00
			TION OF OTHER (SUMMARY C		
	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 CI	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	C		0 6, 163, 407	1, 847, 635	1.00
1.01	NEW CAP REL COSTS-INTEREST	0	C		97, 344	0	1.01
1.02	MOB LEASED SPACE	0)	0 0	1, 238, 842	1.02
2.00 3.00	NEW CAP REL COSTS-MVBLE EQUIP	0			0 4, 277, 661	235, 173	2.00
3.00	Total (sum of lines 1-2)	0	, ,	JMMARY OF CAPI	0 <u>10, 538, 412</u>	3, 321, 650	3.00
			30	JININART OF CAPT	TAL		
	Cost Center Description	Interest	Insurance (see instructions)	instructions)	Capital-Relate d Costs (see instructions)	through 14)	
		11.00	12.00	13.00	14.00	15.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	1		1		0.011.010	1 00
1.00 1.01	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-INTEREST	0	-			8,011,042	1. 00 1. 01
1.01	MOB LEASED SPACE	13, 094, 633		1		13, 191, 977 1, 238, 842	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP					4, 512, 834	2.00
3.00	Total (sum of lines 1-2)	13, 094, 633			0 0	26, 954, 695	3.00
				ļ.	· · · · ·	,, 0,01	

DJUST	MENTS TO EXPENSES			Provider CCN: 15-0161	Period: From 01/01/2017	Worksheet A-8	
					To 12/31/2017	Date/Time Prep 5/29/2018 9:5	pared 1 am
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter	1.00		NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1. 0
01	2) Investment income - NEW CAP REL COSTS-INTEREST (chapter 2)	В	-529, 939	NEW CAP REL COSTS-INTEREST	1.01	11	1. (
02	Investment income - MOB LEASED SPACE (chapter 2)		0	MOB LEASED SPACE	1.02	0	1. (
00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
00	2) Investment income - other (chapter 2)		0		0.00	0	3. (
00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.0
00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.0
00	Rental of provider space by suppliers (chapter 8)		C		0.00	0	6. (
00	Telephone services (pay stations excluded) (chapter		C		0.00	0	7. C
00	21) Television and radio service (chapter 21)		C		0.00	о	8. (
00 . 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 - 10, 496, 039		0.00	0	
	adjustment Sale of scrap, waste, etc.	N 0 2	10, 170, 007		0.00		11.0
. 00	(chapter 23) Related organization	A-8-1	5, 499, 492				12.0
	transactions (chapter 10) Laundry and linen service		0, ,		0.00		13. (
. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-1, 565, 671 0	CAFETERI A	11.00 0.00	0	
. 00	and others Sale of medical and surgical		O		0.00		16.
	supplies to other than patients	_					
	Sale of drugs to other than patients	В		PHARMACY	15.00		17.
	Sale of medical records and abstracts		0		0.00		18.0
. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. (
	Vending machines Income from imposition of		0		0.00 0.00	0	
. 00	interest, finance or penalty charges (chapter 21)		Q		0.00	0	22. (
. 00	overpayments and borrowings to repay Medicare overpayments		U		0.00	0	22.1
. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. (
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.
. 00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114.00		25. (
. 00	(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26. (
. 01	COSTS-BLDG & FIXT Depreciation - NEW CAP REL		C	FIXT NEW CAP REL COSTS-INTEREST	1.01	0	26. (
. 02	COSTS-INTEREST Depreciation - MOB LEASED		O	MOB LEASED SPACE	1.02	0	26.
. 00			C	NEW CAP REL COSTS-MVBLE	2.00	о	27.
	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	EQUIP *** Cost Center Deleted ***			28. (
9.00	Physicians' assistant		C	1	0.00	0	29.

<u>Heal th</u>	Financial Systems		IU HEALTH NOR	TH_HOSPITAL	In Lie	eu of Form CMS-2	<u>2552-1</u> 0
	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
				Expense Classification on			i am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33.00	MI SCELLANEOUS I NCOME	В	-470	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
	MI SCELLANEOUS I NCOME	В	-560, 627	OTHER ADMI NI STRATI VE & GENERAL	5.05	0	33. 01
	MI SCELLANEOUS I NCOME	В		MAINTENANCE & REPAIRS	6.00		
	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7.00		33.03
	MI SCELLANEOUS I NCOME	BB			10.00		33.04 33.05
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION ADULTS & PEDIATRICS	13.00 30.00		33.05
	MI SCELLANEOUS I NCOME	B		SPEECH PATHOLOGY	68.00		33.07
	INTERCOMPANY REVENUE	A		OTHER NON-REIMBURSABLE	192.01		33.08
	INTERCOMPANY REVENUE	A		PHYSICIANS' PRIVATE OFFICES	192.04		33.09
33.10	INTERCOMPANY REVENUE	A	-190, 401	ANSON CLINIC	192.05	0	33.10
	SHARED EMPLOYEE	В		EMPLOYEE BENEFITS DEPARTMENT			33. 11
33. 12 33. 13	SHARED EMPLOYEE SHARED EMPLOYEE	B B		ADMI TTI NG OTHER ADMI NI STRATI VE &	5.04 5.05		33. 12 33. 13
33. 14	SHARED EMPLOYEE	В		GENERAL MAINTENANCE & REPAIRS	6.00		
	SHARED EMPLOYEE	B B		OPERATION OF PLANT	7.00		33. 15 33. 16
33.16	SHARED EMPLOYEE SHARED EMPLOYEE	В		DI ETARY CAFETERI A	10.00		33.16
		B		NURSING ADMINISTRATION	13.00		33.17
	SHARED EMPLOYEE	B		CENTRAL SERVICES & SUPPLY	14.00		33.19
33.20	SHARED EMPLOYEE	В		SOCIAL SERVICE	17.00		33.20
33. 21	SHARED EMPLOYEE	В	-111, 317	OPERATING ROOM	50.00	0	33. 21
33. 22	SHARED EMPLOYEE	В		LABORATORY	60.00		33. 22
33.23	SHARED EMPLOYEE	В		PHYSICAL THERAPY	66.00		33.23
33. 24	SHARED EMPLOYEE	В		CARDIAC CATHERIZATION LABORATORY	75.01		33. 24
	SHARED EMPLOYEE FISHERS RADIOLOGY START UP COST AMOR	B A		EMERGENCY RADI OLOGY-DI AGNOSTI C	91.00 54.00		
33. 27	EMPLOYEE BENEFITS	A	-10, 463, 100	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 27
33. 28	ACCURED PTO	A	-570, 022	EMPLOYEE BENEFITS DEPARTMENT	4.00		33. 28
	HAF FEES	В		OTHER ADMI NI STRATI VE & GENERAL	5.05		
33. 30 33. 31	MARKETI NG MARKETI NG	A A		ADMI TTI NG OTHER ADMI NI STRATI VE & GENERAL	5. 04 5. 05		
33.32	MARKETI NG	A	-103	DI ETARY	10.00	0	33. 32
	MARKETING	A		SOCIAL SERVICE	17.00		
	MARKETING	A		ADULTS & PEDIATRICS	30.00		
		A		PHYSICAL THERAPY	66.00		
	TELEPHONE EQUI PMENT	A			5.04		33.37
	TELEPHONE EQUI PMENT TELEPHONE EQUI PMENT	A A		PHARMACY PATI ENT TRANSPORTATI ON	15.00 18.00		33.38 33.39
	TELEPHONE EQUIPMENT	A		ADULTS & PEDIATRICS	30.00		
	TELEPHONE EQUIPMENT	A		DELIVERY ROOM & LABOR ROOM	52.00		33.40
	TELEPHONE EQUI PMENT	A		RADI OLOGY-DI AGNOSTI C	54.00		
	TELEPHONE EQUI PMENT	A		RESPI RATORY THERAPY	65.00		
	TELEPHONE EQUIPMENT	A		PHYSICAL THERAPY	66.00		
33.45 33.46	UNWONTED SITUATIONS UNWONTED SITUATIONS	A A		ADMITTING OTHER ADMINISTRATIVE &	5.04 5.05		
33. 47 33. 48	UNWONTED SITUATIONS UNWONTED SITUATIONS	A A		GENERAL ADULTS & PEDIATRICS PEDIATRIC INTENSIVE CARE	30.00 34.01		
33. 48 33. 49	UNWONTED SITUATIONS	A		UNIT NURSERY	43.00		
	PHYSICIAN MALPRACTICE INS	A		OTHER ADMINISTRATIVE &	5. 05		
				GENERAL			

Health Financial Systems		IU HEALTH NOR	TH HOSPI TAL	In Lie	u of Form CMS-:	2552-10
ADJUSTMENTS TO EXPENSES			Peri od:	Worksheet A-8		
				From 01/01/2017	Data (Tima Dua	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	pared: 1 am
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49)		-30, 717, 906				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Health Financial Systems IU HEALTH NORTH HOSPITAL In Li					eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0161	Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared
					5/29/2018 9:5	
	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	
	A. COSTS INCURRED AND ADJUST					
	HOME OFFICE COSTS:					
1.00		NEW CAP REL COSTS-BLDG & FIX		514, 527	1, 834, 714	1.00
2.00			HOME OFFICE ALLOCATION	13, 721, 916	13, 624, 572	2.00
3.00			HOME OFFICE ALLOCATION	308, 622	0	3.00
3.01		EMPLOYEE BENEFITS DEPARTMENT		8, 977, 928	146, 791	3.01
3.02			HOME OFFICE ALLOCATION	5, 104, 176	0	3.02
3.03		PURCHASING RECEIVING AND STO		674, 018	0	3.03
3.04			HOME OFFICE ALLOCATION	1, 972, 053	27, 610	3.04
3.05		OTHER ADMINISTRATIVE & GENER		16, 544, 942	26, 668, 122	3.05
3.06			HOME OFFICE ALLOCATION	85, 777	102, 658	3.06
3.07			SHARED SERVICES	196, 532	196, 532	3.07
3.08			SHARED SERVICES	3, 247, 040	3, 247, 040	3.08
3.09			SHARED SERVICES	620, 017	620, 017	3.09
3.10			SHARED SERVICES	670, 674	670, 674	3.10
3.11			SHARED SERVICES	387, 341	387, 341	3.11
3.12			SHARED SERVICES	1, 076, 426	1, 076, 426	3.12
3.13	54.00	RADI OLOGY-DI AGNOSTI C	SHARED SERVICES	492, 524	492, 524	3.13
3.14	60.00	LABORATORY	SHARED SERVICES	4, 591, 554	4, 591, 554	3.14
3.15	66.00	PHYSI CAL THERAPY	SHARED SERVICES	10, 643	10, 643	3.15
3.16	69.00	ELECTROCARDI OLOGY	SHARED SERVICES	184, 795	184, 795	3.16
3.17	70.00	ELECTROENCEPHALOGRAPHY	SHARED SERVICES	268, 068	268, 068	3.17
3.18	75.01	CARDIAC CATHERIZATION LABORA	SHARED SERVICES	162, 992	162, 992	3. 18
3.19	91.00	EMERGENCY	SHARED SERVICES	491, 038	491, 038	3.19
3.20	192.01	OTHER NON-REIMBURSABLE	SHARED SERVICES	206, 547	206, 547	3.20
4.00	192.05	ANSON CLINIC	SHARED SERVICES	39,000	39,000	4.00
5.00	TOTALS (sum of lines 1-4).			60, 549, 150	55, 049, 658	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.

			Related Organization(s) and/		
					1
					1
					1
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownership		Ownershi p	1
1.00	2.00	3.00	4.00	5.00	
 B INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME OFFLCE			

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	0.00 I U HEALTH 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	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 HEA	ALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared: 5/29/2018 9:51 am

					5/29/20	018 9:51 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTMENT	S REQUIRED AS A RESULT OF TRA	SACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO					
1.00	-1, 320, 187	9				1.00
2.00	97, 344					2.00
3.00	308, 622	9				3.00
3.01	8, 831, 137	0				3. 01
3.02	5, 104, 176	0				3. 02
3.03	674, 018	0				3. 03
3.04	1, 944, 443	0				3.04
3.05	-10, 123, 180	0				3.05
3.06	-16, 881	0				3.06
3.07	0	0				3. 07
3.08	0	0				3. 08
3.09	0	0				3.09
3.10	0	0				3. 10
3.11	0	0				3. 11
3.12	0	0				3. 12
3.13	0	0				3. 13
3.14	0	0				3. 14
3.15	0	0				3. 15
3.16	0	0				3. 16
3.17	0	0				3. 17
3.18	0	0				3. 18
3.19	0	0				3. 19
3.20	0	0				3. 20
4.00	0	0				4.00
5.00	5, 499, 492					5.00

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

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

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

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

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

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

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

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

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

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

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

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

In Lieu of Form CMS-2552-10

	Financial Syste		IU HEALIH NU	RTH HUSPITAL		In Lie	EU OT FORM CMS-	
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period:	Worksheet A-8	3-2
						rom 01/01/2017		
						To 12/31/2017		
			T 1 1		D 11		5/29/2018 9:5	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	124, 354	124, 354	0	211, 500	0	1.00
2.00	5.05	OTHER ADMINISTRATIVE &	1, 874, 225	1, 874, 225	0	211, 500	0	2.00
		GENERAL						
3.00	30, 00	ADULTS & PEDIATRICS	3, 156, 890	3, 156, 890	0	179,000	0	3.00
4.00		PEDIATRIC INTENSIVE CARE	596, 542					4.00
1.00	01.01	UNI T	0,0,012	0,0,012	0	107,700	Ŭ	1.00
5.00	24.02	PREMATURE INTENSIVE CARE	1, 658, 892	1, 658, 892	0	169, 700	0	5.00
5.00	54. UZ	UNIT	1, 030, 072	1,030,072	0	109,700	0	5.00
(00	F0.00	OPERATING ROOM	0// 771	0// 771	0	244 400		(00
6.00			866, 771	866, 771	0	,		6.00
7.00		DELIVERY ROOM & LABOR ROOM	1, 151, 416			237, 100		7.00
8.00		RADI OLOGY-DI AGNOSTI C	443, 448			,		8.00
9.00	69.00	ELECTROCARDI OLOGY	184, 795	184, 795	0	197, 500	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	8, 718	8, 718	0	211, 500	0	10.00
11.00	91.00	EMERGENCY	429, 988	429, 988	0	211, 500	0	11.00
200.00			10, 496, 039	10, 496, 039	0		0	200.00
200100	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WRSt. A LINC #	I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
		ruentiriei	L11111 L				Insurance	
				Limit	Continuing	Share of col.	Insurance	
	4 00	2.00	0.00	0.00	Education	12	44.00	
1.00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	1.00
1.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	-	-	0	1.00
2.00	5.05	OTHER ADMINISTRATIVE &	0	0	0	0	0	2.00
		GENERAL						
3.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	34.01	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	4.00
		UNI T						
5.00	34 02	PREMATURE INTENSIVE CARE	0	0	0	0	0	5.00
0.00	01.02	UNI T	0	j ő	0	0	Ŭ	0.00
6.00	50.00	OPERATING ROOM	0	0	0	0	0	6.00
7.00		DELIVERY ROOM & LABOR ROOM	0	0	0	-	-	7.00
			0	0	0	-	0	
8.00		RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	8.00
9.00		ELECTROCARDI OLOGY	0	0		0	0	9.00
10.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	10.00
11.00	91.00	EMERGENCY	0	0	0	0	0	11.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
		r dontri i r di	Share of col.		Di Sal i Gilance			
			14					
	1.00	2.00	15. 00	16.00	17.00	18.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	15.00	10.00	17.00	124, 354		1.00
			0	0	0			
2.00	5.05	OTHER ADMINISTRATIVE &	0	0	0	1, 874, 225		2.00
		GENERAL						
3.00		ADULTS & PEDIATRICS	0	0	0			3.00
4.00	34.01	PEDIATRIC INTENSIVE CARE	0	0	0	596, 542		4.00
		UNI T						
5.00	34.02	PREMATURE INTENSIVE CARE	0	0	0	1, 658, 892		5.00
		UNI T						
6.00	50 00	OPERATING ROOM	n	0	0	866, 771		6.00
7.00		DELIVERY ROOM & LABOR ROOM		0				7.00
			0		-			
8.00		RADI OLOGY-DI AGNOSTI C		0		443, 448		8.00
9.00		ELECTROCARDI OLOGY	0	0	-	184, 795		9.00
10.00		ELECTROENCEPHALOGRAPHY	0	0		8, 718		10.00
11.00	91.00	EMERGENCY	0			429, 988		11.00
200.00			0	0	0	10, 496, 039		200.00

Cost Center Description Net Expenses for Cost Al location (from Wkst A col. 7) New INTEREST For Cost Al location (from Wkst A col. 7) New INTEREST MOB LEASED SPACE New MW EQUI 0 1.00 1.01 1.02 2.00 0 0.100 New CAP REL COSTS-BLDG & FIXT 8,011,042 8,011,042 1.01 1.28,842 0 0 1,238,842 0 0 1,238,842 4,55 4,55 4,55 4,55 5,05 6,01 0,52 0 <th>e Prepared: 8 9:51 am</th>	e Prepared: 8 9:51 am
Cost Center Description Net Expenses for Cost (from Wkst A col. 7) NEW BLDG & FIXT NEW INTEREST MOB LEASED SPACE NEW MV EQUI 1.00 00100 NEW CAP REL COST CENTERS 0 1.00 1.01 1.02 2.00 0 00100 NEW CAP REL COSTS-BLDG & FIXT 8,011,042 8,011,042 0 1.3,191,977 1.3,191,977 1.3,191,977 1.3,191,977 1.3,191,977 0 1.3,191,977 0 1.238,842 0 0 0 4,51 2.00 00200 NEW CAP REL COSTS-INTEREST 1,238,842 0 0 0 1,238,842 4,51 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 9,359,255 13,138 21,634 11,010 0	BLE
First First SPACE EQUI All ocation (from Wkst A col. 7) 0 1.00 1.01 1.02 2.00 0 0.0100 NEW CAP REL COST CENTERS 0 1.00 1.01 1.02 2.00 1.01 00100 NEW CAP REL COSTS - BLDG & FIXT 8,011,042 8,011,042 13,191,977 12,238,842 0 0 1,238,842 4,51 2.00 00200 NEW CAP REL COSTS - NUBLE EQUI P 4,512,834 - 4,51 4,512,834 - 4,51 - <	
First First SPACE EQUI All ocation (from Wkst A col. 7) 0 1.00 1.01 1.02 2.00 0 0.0100 NEW CAP REL COST CENTERS 0 1.00 1.01 1.02 2.00 1.01 00100 NEW CAP REL COSTS - BLDG & FIXT 8,011,042 8,011,042 13,191,977 12,238,842 0 0 1,238,842 4,51 2.00 00200 NEW CAP REL COSTS - NUBLE EQUI P 4,512,834 - 4,51 4,512,834 - 4,51 - <	
Image: Control of the service cost centers (from Wkst A col. 7) 0 1.00 1.01 1.02 2.00 0 0 1.00 1.01 1.02 2.00 0 0 1.00 1.01 1.02 2.00 0 0 1.00 1.01 1.02 2.00 0 0 1.01 1.02 2.00 0 0 1.01 1.02 2.00 0 0 1.3, 191, 977 0 13, 191, 977 1.02 00120 MB LEASED SPACE 1, 238, 842 0 0 0 2.00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4, 512, 834 4, 51 4, 51 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 9, 359, 255 13, 138 21, 634 11, 010 5.01 00550 DATA PROCESSI NG 5, 105, 664 112, 512 185, 277 5, 249 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 715, 191 209, 060 344, 263 2, 659 22 6.00 00600 MAI NTENARCY	
Col. 7) Col. 7) <t< td=""><td></td></t<>	
O 1.00 1.01 1.02 2.00 1.00 00100 NEW CAP REL COSTS -BLDG & FIXT 8,011,042 8,011,042 13,191,977 13,191,977 13,191,977 13,191,977 13,191,977 13,191,977 13,191,977 1,238,842 0 0 1,238,842 4,51 2.00 00200 NEW CAP REL COSTS-INTEREST 13,191,977 0 13,191,977 0 1,238,842 4,51 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 9,359,255 13,138 21,634 11,010 0 0 5.01 00540 NONPATI ENT TELEPHONES 2,190 0 0 0 0 0 5.02 00550 DATA PROCESSI NG 5,105,664 112,512 185,277 5,249 2 0	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 8,011,042 8,011,042 8,011,042 1.01 00101 NEW CAP REL COSTS-INTEREST 13,191,977 0 13,191,977 0 1.02 00102 MOB LEASED SPACE 1,238,842 0 0 1,238,842 2.00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4,512,834 4,51 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 9,359,255 13,138 21,634 11,010 5.01 00540 NONPATI ENT TELEPHONES 2,190 0 0 0 5.02 00550 DATA PROCESSI NG 5,105,664 112,512 185,277 5,249 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 715,191 209,060 344,263 2,659 2 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 21,704,069 87,585 144,229 297,302 15 6.00 006000 MAI NTENANCE & REPAI RS 4,853,546 116,337 191,575 0 16 7.00 00700 PERATIO N OF PLANT 2,762,008 1,293,993 2,	
1. 01 00101 NEW CAP REL COSTS-INTEREST 13, 191, 977 0 13, 191, 977 1, 238, 842 0 0 1, 238, 842 0 0 1, 238, 842 4, 51 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4, 512, 834 4, 51 4, 51 4, 51 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 9, 359, 255 13, 138 21, 634 11, 010 0 <t< td=""><td>1.00</td></t<>	1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUI P 4, 512, 834 4, 512, 834 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 9, 359, 255 13, 138 21, 634 11, 010 5.01 00540 NONPATI ENT TELEPHONES 2, 190 0 0 0 5.02 00550 DATA PROCESSI NG 5, 105, 664 112, 512 185, 277 5, 249 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 715, 191 209, 060 344, 263 2, 659 2 5.04 00570 ADMI TTI NG 3, 216, 217 70, 900 116, 753 0 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 21, 704, 069 87, 585 144, 229 297, 302 15 6.00 00600 MAI NTENANCE & REPAI RS 4, 853, 546 116, 337 191, 575 0 16 7.00 00700 OPERATI ON OF PLANT 2, 762, 008 1, 293, 993 2, 130, 849 26, 535 4 8.00 0800 LAUNDRY & LI NEN SERVI CE 118, 329 0 0 0 0 0 0 0 0 0 <td>1.01</td>	1.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 9, 359, 255 13, 138 21, 634 11, 010 5.01 00540 NONPATI ENT TELEPHONES 2, 190 0 0 0 5.02 00550 DATA PROCESSI NG 5, 105, 664 112, 512 185, 277 5, 249 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 715, 191 209, 060 344, 263 2, 659 2 5.04 00570 ADMI TTI NG 3, 216, 217 70, 900 116, 753 0 0 6.00 00600 MAI NTENANCE & GENERAL 21, 704, 069 87, 585 144, 229 297, 302 18 7.00 00700 OPERATI ON OF PLANT 2, 762, 008 1, 293, 993 2, 130, 849 26, 535 4 8.00 00800 LAUNDRY & LI NEN SERVICE 118, 329 0 0 0 0 9.00 09000 HOUSEKEEPI NG 5, 541, 114 106, 636 175, 601 4, 266 13 10.00 01000 DI ETARY 1, 341, 963 311, 742 513, 352 0 3 13.00 <	1.02
5.01 00540 NONPATI ENT TELEPHONES 2,190 0 0 0 5.02 00550 DATA PROCESSI NG 5,105,664 112,512 185,277 5,249 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 715,191 209,060 344,263 2,659 2 5.04 00570 ADMI TTI NG 3,216,217 70,900 116,753 0 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 21,704,069 87,585 144,229 297,302 15 6.00 00600 MAI NTENANCE & REPAI RS 4,853,546 116,337 191,575 0 16 7.00 00700 OPERATI ON OF PLANT 2,762,008 1,293,993 2,130,849 26,535 26 8.00 00800 LAUNDRY & LI NEN SERVICE 118,329 0 0 0 0 0 9.00 00900 HOUSEKEEPI NG 5,541,114 106,636 175,601 4,266 13 10.00 01000 DI ETARY 1,103,698 47,636 78,444 0 13 0 13 0 1300<	2,834 2.00 1,029 4.00
5.03 00560 PURCHASI NG RECEI VI NG AND STORES 715, 191 209, 060 344, 263 2, 659 2 5.04 00570 ADMI TTI NG 3, 216, 217 70, 900 116, 753 0 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 21, 704, 069 87, 585 144, 229 297, 302 15 6.00 00600 MAI NTENANCE & REPAI RS 4, 853, 546 116, 337 191, 575 0 16 7.00 00700 OPERATI ON OF PLANT 2, 762, 008 1, 293, 993 2, 130, 849 26, 535 26 8.00 00800 LAUNDRY & LI NEN SERVI CE 118, 329 0	5, 658 5. 01
5.04 00570 ADMI TTI NG 3, 216, 217 70, 900 116, 753 0 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 21, 704, 069 87, 585 144, 229 297, 302 15 6.00 00600 MAI NTENANCE & REPAI RS 4, 853, 546 116, 337 191, 575 0 16 7.00 00700 OPERATI ON OF PLANT 2, 762, 008 1, 293, 993 2, 130, 849 26, 535 4 8.00 00800 LAUNDRY & LI NEN SERVI CE 118, 329 0	9,683 5.02
5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 21,704,069 87,585 144,229 297,302 15 6.00 00600 MAI NTENANCE & REPAI RS 4,853,546 116,337 191,575 0 16 7.00 00700 OPERATI ON OF PLANT 2,762,008 1,293,993 2,130,849 26,535 26 8.00 00800 LAUNDRY & LI NEN SERVI CE 118,329 0 <td< td=""><td>4, 496 5. 03 1, 582 5. 04</td></td<>	4, 496 5. 03 1, 582 5. 04
7.00 00700 OPERATI ON OF PLANT 2,762,008 1,293,993 2,130,849 26,535 44 8.00 00800 LAUNDRY & LINEN SERVICE 118,329 0	2, 201 5. 05
8.00 00800 LAUNDRY & LINEN SERVICE 118,329 0 0 0 9.00 00900 HOUSEKEEPING 5,541,114 106,636 175,601 4,266 13 10.00 01000 DI ETARY 1,103,698 47,636 78,444 0 11.00 01100 CAFETERI A 1,341,963 311,742 513,352 0 31 13.00 01300 NURSI NG ADMI NI STRATI ON 2,286,603 46,084 75,888 0 1 14.00 01400 CENTRAL SERVICES & SUPPLY 8,453,204 319,262 525,737 0 16 15.00 01500 PHARMACY 2,879,055 115,838 190,754 0 15	3, 763 6. 00
9.00 00900 HOUSEKEEPING 5, 541, 114 106, 636 175, 601 4, 266 133 10.00 01000 DI ETARY 1, 103, 698 47, 636 78, 444 0 11.00 01100 CAFETERI A 1, 341, 963 311, 742 513, 352 0 33 13.00 01300 NURSI NG ADMI NI STRATI ON 2, 286, 603 46, 084 75, 888 0 1 14.00 01400 CENTRAL SERVICES & SUPPLY 8, 453, 204 319, 262 525, 737 0 16 15.00 01500 PHARMACY 2, 879, 055 115, 838 190, 754 0 15	5, 403 7. 00 0 8. 00
11. 0001100CAFETERIA1, 341, 963311, 742513, 352033113. 0001300NURSI NG ADMI NI STRATI ON2, 286, 60346, 08475, 8880114. 0001400CENTRAL SERVI CES & SUPPLY8, 453, 204319, 262525, 73701615. 0001500PHARMACY2, 879, 055115, 838190, 754015	1,435 9.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 2, 286, 603 46, 084 75, 888 0 1 14. 00 01400 CENTRAL SERVI CES & SUPPLY 8, 453, 204 319, 262 525, 737 0 16 15. 00 01500 PHARMACY 2, 879, 055 115, 838 190, 754 0 15	2,433 10.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 8, 453, 204 319, 262 525, 737 0 16 15. 00 01500 PHARMACY 2, 879, 055 115, 838 190, 754 0 15	5, 352 11. 00 1, 977 13. 00
	1, 304 14. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 174, 714 20, 233 33, 319 0	1, 167 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 174, 714 20, 233 33, 319 0 17. 00 01700 SOCI AL SERVI CE 534, 178 11, 586 19, 078 0	1,638 16.00 459 17.00
18. 00 01850 PATIENT TRANSPORTATION 228, 941 0 0 0	0 18.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 13, 437, 890 1, 537, 645 2, 532, 072 0 30	5, 844 30. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT	0 34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 982, 916 142, 945 235, 392 0 2	7, 146 34. 01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 1, 688, 553 393, 987 648, 788 6, 800 3 43. 00 04300 NURSERY 1, 468, 940 186, 276 306, 746 0	9, 946 34. 02 4, 609 43. 00
ANCI LLARY SERVI CE COST CENTERS	43.00
50. 00 OPERATI NG ROOM 5, 038, 870 847, 233 1, 395, 158 0 1, 89	9, 582 50. 00
	4, 490 51. 00 3, 005 52. 00
	2, 165 54. 00
56. 00 05600 RADI 0I SOTOPE 266, 199 23, 060 37, 974 0	170 56.00
60. 00 06000 LABORATORY 5, 738, 667 168, 888 278, 113 0 65. 00 06500 RESPI RATORY 100, 751 33, 112 54, 527 0 75	2, 249 60. 00 6, 050 65. 00
	4, 215 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 511, 265 0 0 0	999 67.00
68. 00 06800 SPEECH PATHOLOGY 225, 931 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 316, 148 46, 472 76, 527 0 23	1,815 68.00 9,321 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 419, 513 15, 632 25, 742 0	1, 569 70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 4, 471, 171 0 0 0	0 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 9, 161, 088 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 933, 610 0 0 0 0	0 72.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0	0 75.00
	1, 457 75. 01
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 2,759,786 251,836 414,704 0 8	2, 983 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	92.00
SPECIAL PURPOSE COST CENTERS	7 105 110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 163, 132, 972 7, 863, 902 12, 949, 678 1, 206, 836 4, 47 NONREI MBURSABLE COST CENTERS	7 <u>, 195</u> 118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 75, 008 38, 637 63, 625 0	0 190. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0	0 192.00
192. 01 0THER NON-REI MBURSABLE 1, 347, 354 10, 514 17, 314 32, 006 192. 02 CHI LDBI RTH EDUCATI ON 225, 660 0 0 0 0	< u//liu/) //*
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES 0 97, 989 161, 360 0	3, 977 192. 01 0 192. 02
	0 192. 02 2, 271 192. 04
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0	0 192. 02 2, 271 192. 04 9, 391 192. 05
202.00 TOTAL (sum lines 118 through 201) 166, 390, 641 8, 011, 042 13, 191, 977 1, 238, 842 4, 51	0 192. 02 2, 271 192. 04

Heal th	Financial Systems	IU HEALTH NORT	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/29/2018 9:5	pared: 1 am
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND STORES	ADMI TTI NG	
		4.00	5.01	5.02	5.03	5.04	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST						1.00 1.01
1.01	00102 MOB LEASED SPACE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 406, 066					4.00
5.01	00540 NONPATI ENT TELEPHONES	0	7, 848				5.01
5.02	00550 DATA PROCESSI NG	0	0	5, 418, 38	5		5.02
5.03	00560 PURCHASING RECEIVING AND STORES	0	0		0 1, 295, 669		5.03
5.04	00570 ADMI TTI NG	197, 867	161	110, 96		3, 714, 840	•
5.05	00590 OTHER ADMINI STRATI VE & GENERAL	696, 844	270	186, 72		0	5.05
6.00	00600 MAINTENANCE & REPAIRS	340, 368	311	214, 80		0	6.00
7.00	00700 OPERATION OF PLANT	184, 629	191	131, 71		0	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 237, 279	0 434	299, 78		0	8.00 9.00
10.00	01000 DI ETARY	117, 597	192	132, 66		0	10.00
11.00	01100 CAFETERIA	201, 325	325	224, 70		0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	397, 486	319	220, 09		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	135, 413	202	139, 38	2 24, 757	0	14.00
15.00	01500 PHARMACY	396, 917	246	169, 76	8 4, 091	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	53, 636	46	31, 87		0	17.00
18.00	01850 PATIENT TRANSPORTATION	34, 843	66	45, 44	3 0	0	18.00
30.00	03000 ADULTS & PEDIATRICS	1, 827, 535	1, 608	1, 110, 64	4 62, 950	332, 476	30.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	1, 027, 335	1,000		0 02, 930	0352,470	34.00
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	140, 791	Ő	6		28, 507	34.01
34.02	03402 PREMATURE INTENSIVE CARE UNIT	419, 364	3	2, 23	8 9, 362	101, 549	34.02
43.00	04300 NURSERY	216, 949	193	132, 93	8 0	44, 962	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	662, 901	595	410, 82		806, 786	1
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	327, 947 458, 429	269 387	185, 63 267, 23		150, 005 211, 633	•
52.00	05400 RADI OLOGY-DI AGNOSTI C	438, 429 533, 950	482	332,88		254, 866	
56.00	05600 RADI OI SOTOPE	36, 573	26	17, 77		38, 312	•
60.00	06000 LABORATORY	106, 363	203	139, 85		246, 538	
65.00	06500 RESPI RATORY THERAPY	310, 588	165	113, 67	6 12, 094	51, 087	65.00
66.00	06600 PHYSI CAL THERAPY	317, 108	260	179, 26		47, 043	•
67.00	06700 OCCUPATIONAL THERAPY	77, 189	59	40, 83		16,008	•
68.00	06800 SPEECH PATHOLOGY	37, 558	28	19, 60		6, 468	•
69.00 70.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	47, 490 18, 581	38 14	26, 52 9, 36		58, 549 15, 126	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 301	0		0 282, 448	100, 469	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 578, 723	376, 735	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	253, 244	
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75.01	07501 CARDI AC CATHERI ZATI ON LABORATORY	235, 723	181	124, 73	1 6, 606	167, 376	75.01
01 00	OUTPATIENT SERVICE COST CENTERS	050.005	0.07	044.74	(47.407	407 404	01.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	352, 325	307	211, 61	6 17, 187	407, 101	91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		9, 121, 568	7, 581	5, 233, 62	8 1, 295, 657	3, 714, 840	118.00
	NONREI MBURSABLE COST CENTERS				· · · ·		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19201 OTHER NON-REI MBURSABLE	78, 449	83	57, 31			192.01
	19202 CHI LDBI RTH EDUCATI ON	31, 859	24	16, 68			192.02
	19204 PHYSI CLANS' PRI VATE OFFI CES 19205 ANSON CLINIC	0 174, 190	0 160	110, 75	0 2 9 10		192. 04 192. 05
200.00		174, 190	100	110,75	/	0	200.00
200.00		О	о		o o	0	201.00
202.00		9, 406, 066	7, 848	5, 418, 38	5 1, 295, 669		

COST	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS		Provider C	1	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/29/2018 9:5	pared:
	Cost Center Description	Subtotal	OTHER ADMI NI STRATI VE & GENERAL	MAI NTENANCE 8 REPAI RS	OPERATION OF	LAUNDRY & LINEN SERVICE	
		5A. 04	5.05	6.00	7.00	8.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01	00102 MOB LEASED SPACE						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00540 NONPATI ENT TELEPHONES						5.01
5.02	00550 DATA PROCESSI NG						5.02
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04	00570 ADMI TTI NG						5.04
5.05	00590 OTHER ADMINISTRATIVE & GENERAL	23, 269, 288	23, 269, 288				5.05
6.00	00600 MAI NTENANCE & REPAI RS	5, 887, 135	957, 154	6, 844, 28	9		6.00
7.00	00700 OPERATION OF PLANT	6, 575, 327					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	118, 329			0 0	137, 567	8.00
9.00	00900 HOUSEKEEPI NG	6, 497, 283				0	
10.00		1, 483, 096				0	•
11.00		2, 628, 819				0	11.00
13.00		3, 038, 635				0	13.00
14.00 15.00		9, 759, 261	1, 586, 700			638	14.00
16.00		3, 907, 836 229, 904				0	•
17.00		650, 861	105, 820			0	17.00
18.00		309, 293			0 0	0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0077270	00,200		<u> </u>		1 .0.00
30.00		21, 148, 664	3, 438, 481	1, 421, 88	2 2, 225, 816	79, 291	1 30. 00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0 0	0	34.00
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	1, 561, 257	253, 835	132, 18	4 206, 921	0	34.01
34.02		3, 310, 590	538, 249	364, 32	6 570, 316	5, 819	
43.00		2, 361, 613	383, 960	172, 25	2 269, 644	5, 043	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00		11, 287, 363					50.00
51.00		3, 387, 187				7,662	
52.00 54.00		5, 688, 939				12 027	52.00 54.00
56.00		6, 816, 213 420, 137				12, 937 0	56.00
60.00		6, 681, 244				235	60.00
65.00		2, 667, 050				11	65.00
66.00		3, 395, 236				1, 048	
67.00		646, 686			0 0	0	67.00
68.00		292, 804			0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	811, 216	131, 891	42, 97	3 67, 271	0	69.00
70.00		546, 568			5 22, 629	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 854, 088	789, 197		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENT	10, 116, 546			0 0	0	
73.00		4, 186, 854	680, 715		0 0	0	
75.00		0	0		0 0	0	
75.01		3, 173, 187	515, 909	264, 28	2 413, 708	5, 677	75.01
01 00	OUTPATIENT SERVICE COST CENTERS O9100 EMERGENCY	4, 497, 845	731, 278	232, 87	7 364, 546	12, 272	1 01 00
91.00		4,497,043	/31,2/0	232,07	7 304, 340	12, 272	91.00 92.00
72.00	SPECIAL PURPOSE COST CENTERS	0		1			72.00
118.0		162, 206, 354	22, 588, 990	6, 708, 22	6 8, 627, 953	137, 567	1118.00
	NONREI MBURSABLE COST CENTERS						
190.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	177, 270	28, 821	35, 72	9 55, 930	0	190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		192.00
	1 19201 OTHER NON-REI MBURSABLE	1, 547, 010	251, 519	9, 72	2 15, 219		192. 01
	2 19202 CHI LDBI RTH EDUCATI ON	274, 228			0 0		192. 02
	4 19204 PHYSI CLANS' PRI VATE OFFI CES	261, 622	42, 536	90, 61	2 141, 843		192. 04
	5 19205 ANSON CLINIC	1, 924, 157	312, 837		0 0	0	192. 05
200.0		0					200.00
	0 Negative Cost Centers	0			0 0	0	201.00
201.0 202.0		166, 390, 641	23, 269, 288	6, 844, 28	8, 840, 945		

Health Financial Systems	IU HEALTH NORT	H HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/29/2018 9:5	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVICE 0.00000 MOUSEFEEDINC	7 206 606					$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ \end{array}$
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01000 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE 18. 00 01850 PATI ENT TRANSPORTATI ON	7, 806, 606 61, 970 405, 548 59, 951 415, 331 150, 695 26, 322 15, 072 0	1, 899, 200 0 0 0 0 0 0 0 0	4, 201, 305 224, 600 142, 235 173, 243 0 32, 531 46, 374	3, 926, 543 0 0 0 0 0 0 0	12, 661, 539 41, 022 0 0 0	9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	2,000,335	1, 726, 275	1, 133, 383	1, 936, 079	631, 262	30.00
34.00 0.3400 SURGI CAL I NTENSI VE CARE UNI T 34.01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 34.02 03402 PREMATURE I NTENSI VE CARE UNI T 43.00 04300 NURSERY NURSERY NURSERY	2, 000, 333 0 185, 959 512, 541 242, 329	1, 728, 273 0 48, 673 0 0	1, 133, 383 0 69 2, 284 135, 660	0 0 125 4, 010	031,282 0 35,018 93,886 0	34.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OLOGY-DI AGNOSTI C 56. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY 65. 00 06500 RESPI RATORY 66. 00 06600 PHYSI CAL THERAPY 66. 00 06600 SPEECH PATHOLOGY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 072001 IMPL DEV.	$\begin{array}{c} 1,\ 102,\ 173\\ 215,\ 045\\ 701,\ 361\\ 439,\ 538\\ 30,\ 000\\ 219,\ 709\\ 43,\ 076\\ 8,\ 029\\ 0\\ 0\\ 60,\ 456\\ 20,\ 336\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	0 1, 339 99, 353 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	272, 704 339, 704 18, 134 142, 720 116, 003 182, 933 41, 667 20, 003 27, 063	342, 103 378, 068 55, 764 94, 736 0 94, 736 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 260, 499 138, 804 291, 819 107, 884 533 3, 675 121, 281 32, 086 3, 359 14, 058 1, 518 10, 336 2, 832, 402 5, 803, 384	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ \end{array}$
73.00 07300 DRUGS CHARGED TO PATIENTS	О	0	C	0	0	73.00
75. 00 07500 ASC (NON-DI STINCT PART) 75. 01 07501 CARDIAC CATHERIZATION LABORATORY OUTPATIENT SERVICE COST CENTERS	0 371, 798	0 11, 726	C 127, 285	0 0 150, 250	0 66, 244	
91. 00 92. 00 92. 00 92. 01 92. 01 92	327, 616	11, 834	215, 948	278, 194	172, 348	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	7, 615, 190	1, 899, 200	4, 012, 765	3, 878, 924	12, 661, 418	118.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 192.01 19201 192.01 19201 0THER NON-REI MBURSABLE 192.02 19202 CHI LDBI RTH EDUCATI ON 192.05 19204 PHYSI CI ANS' PRI VATE OFFI CES 192.04 19204 CHI LDBI RTH EDUCATI ON 192.05 ANSON CLI NI C	50, 264 0 13, 678 0 127, 474 0	0 0 0 0 0	0 58, 486 17, 027 0 113, 027	0 0 0 0 7 6, 015 0 0	0 3 0 16	190. 00 192. 00 192. 01 192. 02 192. 04 192. 05
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 7, 806, 606	0 1, 899, 200	C	0 0		200. 00 201. 00 202. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH NORT		CN: 15-0161	In Lie Period:	u of Form CMS- Worksheet B	2552-10
CUST	LLUCATION - GENERAL SERVICE COSTS		Provider C	1	From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/29/2018 9:5	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICI	SERVICE PATIENT TRANSPORTATION	Subtotal	
		15.00	16.00	17.00	18.00	24.00	
1 00	GENERAL SERVICE COST CENTERS			1			1 1 00
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 12.\ 00\\ 10.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\ 00\\ 10.\ 00\ 00\ 00\ 00\ 00\ 00\ 0$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	5, 182, 954 0 0	341, 604 C	831, 768			$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 16.\ 00\\ 17.\ 00\\ 10.\ 00\ 00\\ 00\ 00\\ 0.\ 00\ 00\\ 0.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\$
18.00	01850 PATIENT TRANSPORTATION	0	C				18.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	138, 408	30, 584	563, 89	7 275, 216	36, 749, 573	30.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	00,001 (0	0	1
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	0	2, 622			2, 469, 042	
34. 02 43. 00	03402 PREMATURE INTENSIVE CARE UNIT 04300 NURSERY	10, 888 0	9, 341 4, 136			5, 590, 805 3, 996, 395	
101 00	ANCI LLARY SERVI CE COST CENTERS		1,100			0, , , 0, 0, 0	
50.00	05000 OPERATING ROOM	117,607	74, 102			19, 518, 420	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	27, 671 41, 449	13, 799 19, 467			5, 265, 896 9, 697, 053	
54.00	05400 RADI OLOGY-DI AGNOSTI C	28, 233	23, 444		0 0	9, 733, 440	
56.00	05600 RADI OI SOTOPE	14, 630	3, 524	ļ (0 0	609, 971	56.00
60.00	06000 LABORATORY	260	22, 678		0 0	8, 652, 169	
65.00		3, 158	4, 699		0 0	3, 467, 450	1
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	109 0	4, 327 1, 473		0 0	4, 190, 420 798, 326	1
68.00	06800 SPEECH PATHOLOGY	0	595			375, 065	
69.00	06900 ELECTROCARDI OLOGY	0	5, 386		0 0	1, 147, 774	
70.00	07000 ELECTROENCEPHALOGRAPHY	32	1, 391		0 0	714, 162	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 242	2 (0 0	8, 484, 929	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	34, 655		0 0	17, 599, 374	
	07300 DRUGS CHARGED TO PATIENTS	4, 675, 007	23, 295		0	9, 565, 871	
75.00 75.01	07500 ASC (NON-DI STI NCT PART) 07501 CARDI AC CATHERI ZATI ON LABORATORY	20, 646	0 15, 396			0 5, 136, 108	
75.01	OUTPATIENT SERVICE COST CENTERS	20, 040	15, 570	<u>/</u>	0	3, 130, 100	/ 0.01
91.00	09100 EMERGENCY	104, 856	37, 448	3 (0 0	6, 987, 062	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	5, 182, 954	341, 604	831, 768	405, 953	160, 749, 305	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	348, 014	190 00
	19200 PHYSI CLANS' PRI VATE OFFICES	o	(192.00
	19201 OTHER NON-REI MBURSABLE	Ő	C		o o	1, 895, 637	
192.02	19202 CHI LDBI RTH EDUCATI ON	О	C		0 0	341, 855	192.02
	19204 PHYSI CLANS' PRI VATE OFFI CES	0	C) (0 0	664, 103	
	19205 ANSON CLINIC	0	C		0 0	2, 391, 727	
200.00 201.00		_	r				200.00 201.00
201.00		5, 182, 954	341, 604	831, 768	405, 953		
202.00		5, 102, 754	541,004	1 031,700	403, 933	100, 370, 041	1202.00

Heal th	Financial Systems	IU HEALTH NOR	TH HOSPITAL		I	n Lieu of Form CM	S-2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0161	Period: From 01/01	Worksheet B	
					To 12/31		repared:
	Cost Center Description	Intern &	Total			372772010 7	
		Residents Cost & Post					
		Stepdown					
		Adjustments 25.00	26.00				
	GENERAL SERVICE COST CENTERS	23.00	20.00				
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
1.01 1.02	00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG						5. 01 5. 02
5.02	00560 PURCHASING RECEIVING AND STORES						5.02
5.04	00570 ADMI TTI NG						5.04
5.05	00590 OTHER ADMINISTRATIVE & GENERAL						5.05
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION						11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00 18.00	01700 SOCIAL SERVICE 01850 PATIENT TRANSPORTATION						17.00 18.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	36, 749, 573				30.00
34. 00 34. 01	03400 SURGI CAL INTENSI VE CARE UNI T 03401 PEDI ATRI CINTENSI VE CARE UNI T	0	0 2, 469, 042				34.00 34.01
	03402 PREMATURE I NTENSI VE CARE UNI T	0	5, 590, 805				34.02
43.00	04300 NURSERY	0	3, 996, 395				43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	19, 518, 420				50.00
51.00	05100 RECOVERY ROOM	0	5, 265, 896				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	9, 697, 053				52.00
54.00 56.00	05400 RADI OLOGY-DI AGNOSTI C 05600 RADI OI SOTOPE	0	9, 733, 440 609, 971				54.00 56.00
60.00	06000 LABORATORY	0	8, 652, 169				60.00
65.00	06500 RESPI RATORY THERAPY	0	3, 467, 450				65.00
66.00	06600 PHYSI CAL THERAPY	0	4, 190, 420				66.00 67.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	798, 326 375, 065				68.00
	06900 ELECTROCARDI OLOGY	0	1, 147, 774				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	714, 162				70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	8, 484, 929 17, 599, 374				71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	9, 565, 871				73.00
	07500 ASC (NON-DISTINCT PART)	0	0				75.00
75.01	07501 CARDIAC CATHERIZATION LABORATORY OUTPATIENT SERVICE COST CENTERS	0	5, 136, 108				75.01
91.00	09100 EMERGENCY	0	6, 987, 062				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	160, 749, 305				118.00
118.00	NONREIMBURSABLE COST CENTERS	0	160, 749, 305				118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	348, 014				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1 005 (67				192.00
	19201 OTHER NON-REIMBURSABLE 19202 CHI LDBI RTH EDUCATI ON	0	1, 895, 637 341, 855				192. 01 192. 02
	19204 PHYSI CLANS' PRI VATE OFFI CES	0	664, 103				192.02
	19205 ANSON CLINIC	0	2, 391, 727				192.05
200.00 201.00		0	0				200. 00 201. 00
201.00		0	166, 390, 641				201.00
		-					

	ici al Systems DF CAPI TAL RELATED COSTS	IU HEALTH NOR	Provider C	CN: 15-0161	Period:	u of Form CMS-: Worksheet B	2002-1
					rom 01/01/2017	Part II	norod.
					Го 12/31/2017	Date/Time Pre 5/29/2018 9:5	
				CAPITAL RE	ELATED COSTS		
	Cost Center Description	Directly	NEW BLDG &	NEW INTEREST	MOB LEASED	NEW MVBLE	
		Assigned New	FLXT		SPACE	EQUI P	
		Capi tal					
		Related Costs 0	1.00	1.01	1.02	2.00	
GENER	AL SERVICE COST CENTERS	, <u> </u>				2100	
	NEW CAP REL COSTS-BLDG & FIXT						1.00
	NEW CAP REL COSTS-INTEREST MOB LEASED SPACE						1.01
	NEW CAP REL COSTS-MVBLE EQUIP						2.00
	EMPLOYEE BENEFITS DEPARTMENT	0	13, 138	21, 63	4 11, 010	1, 029	4.00
	NONPATI ENT TELEPHONES	0	0	(0 0	5, 658	
	DATA PROCESSING	0	112, 512			9, 683	5.0
	PURCHASING RECEIVING AND STORES	0	209, 060 70, 900			24, 496 1, 582	5.03 5.04
	OTHER ADMINISTRATIVE & GENERAL	0	87, 585			152, 201	5.05
	MAINTENANCE & REPAIRS	0	116, 337			163, 763	
	OPERATION OF PLANT	0	1, 293, 993			45, 403	
	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	0 106, 636		0 0 1 4, 266	0 131, 435	8.00 9.00
	DI ETARY	0	47, 636			2, 433	
	CAFETERIA	0	311, 742			35, 352	11.00
	NURSING ADMINISTRATION	0	46, 084			11, 977	13.00
	CENTRAL SERVICES & SUPPLY	0	319, 262			161, 304	14.00
	PHARMACY MEDICAL RECORDS & LIBRARY	0	115, 838 20, 233			151, 167 1, 638	
	SOCIAL SERVICE	0	11, 586			459	
	PATIENT TRANSPORTATION	0	0		0 0	0	•
	I ENT ROUTI NE SERVI CE COST CENTERS	-1			-1 -1		
	ADULTS & PEDIATRICS SURGICAL INTENSIVE CARE UNIT	0	1, 537, 645		2 0	305, 844 0	30.00
	PEDIATRIC INTENSIVE CARE UNIT	0	142, 945			27, 146	
	PREMATURE INTENSIVE CARE UNIT	0	393, 987			39, 946	•
	NURSERY	0	186, 276	306, 74	6 0	4, 609	43.00
	LARY SERVICE COST CENTERS	0	847, 233	1, 395, 15	3 0	1, 899, 582	50.00
	RECOVERY ROOM	0	165, 304			1, 899, 582	•
	DELIVERY ROOM & LABOR ROOM	0	539, 131			113,005	
	RADI OLOGY-DI AGNOSTI C	0	337, 869			582, 165	54.00
	RADIOISOTOPE	0	23, 060			170	
	LABORATORY RESPI RATORY THERAPY	0	168, 888 33, 112			2, 249 76, 050	
	PHYSI CAL THERAPY	0	6, 172			14, 215	
	OCCUPATIONAL THERAPY	0	0		0 0	999	67.00
	SPEECH PATHOLOGY	0	0		0 0		68.00
		0	46, 472			239, 321	
	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	15, 632	25, 74		41, 569 0	
	IMPL. DEV. CHARGED TO PATIENT	0	0			0	
	DRUGS CHARGED TO PATIENTS	0	0) (0 0	0	
	ASC (NON-DISTINCT PART)	0	0	(0 0	0	75.00
	CARDIAC CATHERIZATION LABORATORY	0	285, 798	470, 63	1 0	91, 457	75.01
91.00 09100		0	251, 836	414, 70	4 0	82, 983	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0	201,000			02,700	92.00
	AL PURPOSE COST CENTERS				· · · · ·		
	SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 863, 902	12, 949, 67	3 1, 206, 836	4, 477, 195	118.00
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38, 637	63, 62	5 0	0	190. 00
	PHYSICIANS' PRIVATE OFFICES	0	30, 037 0	03, 02			190.00
	OTHER NON-REI MBURSABLE	0	10, 514	17, 31	4 32, 006		192.0
	CHILDBIRTH EDUCATION	0	0		0 0		192. 0
	PHYSICIANS' PRIVATE OFFICES	0	97, 989	161, 36	0		192.04
192.05 19205 200.00	ANSON CLINIC Cross Foot Adjustments	0	0	"	ן ע	29, 391	192. 0 200. 0
200.00	Negative Cost Centers		0		0 0	0	200.0
	TOTAL (sum lines 118 through 201)	0	8, 011, 042	13, 191, 97	1, 238, 842	4, 512, 834	

East Center Description Subtotal ENVEXPE ENVEXPENT PMICHAP TELEMPORT PMICHAP FTELEMPORT PMICHAPSING RECEVING 005 PMICHAPSING SUBJ 1.000 00100 INE® CAP REL COST SENUES & FIXI 1.000 5.02 5.03	Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	IU HEALTH NORT	Provi der CC		Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/29/2018 9:5	pared:
ENERGIAL SLEWICE COST CENTER B 24 4.00 5.01 5.02 5.03 1.00 GOTOR INER CAP REL COST SELDE A FIXT 1.00	Cost Center Description	Subtotal	BENEFITS			PURCHASING RECEIVING AND	
1.00 DOTOQ MEN CAP REL COSTS-HUEL & FIXT 1.00 1.00 DOTOQ MUN CAP REL COSTS-HUELES TO FUELS 1.00 1.00 DOTOQ MUN CAP REL COSTS-HUELES TO FUELS 1.00 0.00 DOSCIM CAP REL COSTS-HUELES TO FUELS 1.00 0.00 DOSCIM CAP RECOSTS-HUELES TO FUELS 0.00 0.00 DOSCIM CAP REL COSTS-HUELES 5.6 0.00 DOSCIM CAP REL COSTS-HUELES 5.6 0.00 DOSCIM CAP REL COSTS-HUELES 5.0 1.00 DISCIM CAP REL COSTS-HUELES 1.0 1.00 DISCIM CAP REL COSTS		2A		5.01	5.02		
1.01 00101 NEW CAP. REL COSTS-INTEREST 1.0 2.00 00200 NEW CAP BEL COSTS-WALE EQUIP 1.0 2.00 00200 NEW CAP. REL COSTS-WALE EQUIP 4.0 5.01 00200 NEW CAP. REL COSTS-WALE EQUIP 5.68 0 5.01 00200 NEW CAP. REL COSTO S000 TOP 5.04 0 5.01 00200 NEW CAP. REL S011 STATUE S011 S							
1.20 00102 JUBS LEASED SPACE 1.00 0.00							1.00
2.00 DOZDO INP. CAP. PRIL COSTS-WARE EQUIP							•
4.00 00400 DPLOVE BUNFT IS DEPARIMENT 40, 811 4.0 5.01 00500 NORWATENT TELEPHONES 5, 668 5.0 5.02 00500 DATA PROCESSING 312, 721 0 0 0 0 5.0 5.03 00500 DATA PROCESSING 312, 721 0 0 0 5.0 5.04 00570 ADMITTI KG ENRITIES 5.0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
5.01 005-00 NORMAT LET TELEPHONES 5.08 5.0 5.0		44 011	44 011				
5.02 00550 DATA PROCESSING 312, 721 0				5 65	8		•
5.02 00500 PURCHASING RECEIVING AND STORES 5.08, 100, 400570 00500 016 6.4078 5.05, 5.05 5.04 00570, 01HER ARMINISTRATI VE & GENERAL 681, 317 3.470 1795 10, 777 2.95, 7.00 000000 00FRATION OF PLANT 3.466, 780 010 138 7.602 1 7.00 0 <			-				5.02
5.05 005900 OTHER ADMINISTRATIVE & GENERAL. 681.317 3.470 1075 10.777 29 5.05 0.000000 OPERATION OF PLANT 3.496,780 919 138 7.602 1 7.00 0.000000 OUTOD OFERATION OF PLANT 3.496,780 919 138 7.602 1 7.00 0.000000 OUSEXEEPI NG 417,673 1.181 313 17,302 327 9.00 0.010000 DETAWY 128,513 586 139 7.657 192 10.00 0.01000 DETAWY 128,513 586 139 7.657 192 10.00 0.11500 DETAWN INSTRATIVN 133,494 1,677 2.98 1.763 1.799 230 12,703 18.01 13.00 130.01 130,94 1.979 230 12,703 11.83 15.01 1.73 4.77 7.623 10.01 15.01 1.746 1.777 7.653 10.01 1.730 1.73 1.77 1.655 <td< td=""><td></td><td></td><td>-</td><td></td><td></td><td>580, 478</td><td>•</td></td<>			-			580, 478	•
6.00 000000 MAINTERNANCE & REPAIRS 471, 675 1.095 224 12, 397 2.881 6.0 8.00 000800 LAUNDRY & LINEN SERVICE 0	5. 04 00570 ADMI TTI NG		985	11	6 6, 404		•
7.00 00700 OPERATION OF PLANT 3.496 780 919 138 7.602 1 7.00 00 0 00	5. 05 00590 OTHER ADMINI STRATI VE & GENERAL	681, 317	3, 470	19	95 10, 777	29	5.05
8.00 002800 LAUNDRY & LINEN SERVICE 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>2, 881</td> <td>6.00</td>						2, 881	6.00
9.00 00900 HOUSEKEEPI NG 417, 938 1, 181 313 17, 302 327 9.0 11.00 01000 LETARY 128, 513 586 139 7, 657 192 10.0 11.00 01000 LETARY 1018 15 CATE ON 133, 94 1, 979 233 12, 969 24 11.0 13.00 01300 UNESING ADMINISTRATION 133, 949 1, 979 233 12, 969 24 11.0 13.00 01300 UNESING ADMINISTRATION 133, 949 1, 979 233 12, 969 24 11.0 13.00 01300 UNESING ADMINISTRATION 133, 949 1, 979 233 12, 969 24 11.0 10.00 0100 UNESING ADMINISTRATION 133, 949 1, 979 233 12, 969 24 11.0 10.00 0100 UNESING ADMINISTRATION 133, 949 1, 979 233 12, 969 14 141 1, 922 14.0 10.00 0100 UNESING AL SERVICE S & SUPPLY 1, 0.06, 303 6, 674 146 8, 044 11, 922 14.0 15.00 01500 PARMACY 51 128 267 33 1, 840 0 17.0 10.00 1700 0105 CIAL SERVICE COST CENTERS		3, 496, 780					7.00
10.00 01000 DICARY 128.513 556 139 7.657 192 10.0 13.00 01300 NURSING ADMINISTRATION 133.949 1.979 230 12.703 83 13.0 14.00 01400 CENTRAL SERVICES & SUPPLY 1.006, 303 674 146 8.044 11.092 14.0 15.00 01500 PHARMACY 457.759 1.976 177 9.798 1.833 15.0 16.00 0160.00 DISOD PHILENT RANSPORTATION 0 17.3 477 2.622 0 16.0 10.00 0180.00 DUSTS APENDRATATION 0 17.3 477 2.622 0 10.0 0.00 03000 AURITENT REANSPORTATION 0 9.077 1.158 64.000 28.203 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 30.0 43.0 30.0 43.0 30.0 43.0 30.0 43.0		0	-				8.00
11.00 01100 CAFETERIA 860,446 1,002 235 12,969 24 11.0 13.00 01300 (NRS) MG ADMINISTRATION 133,949 1,979 220 12,703 83 13.0 14.00 01400 (ENTRAL SERVICES & SUPPLY 1,006,303 674 146 8,044 11.002 14.00 15.00 01500 (MEDICAL RECORDS & LIBRARY 55,190 0 0 0 16.00 173 47 2,627 33 1,840 17.0 18.00<							•
13: 00 01300 NURSI RG ADMI NI STRATI ON 133, 949 1, 979 230 12, 703 88 13, 0 14: 00 01400 (CENTRAL SERVICES & SUPPLY 1, 006, 030 674 146 8, 044 11, 092 14, 00 15: 00 01500 (PHARMACY 457, 759 1, 976 177 9, 798 1, 833 15, 00 16: 00 01600 (SCI AL SERVICE 31, 123 267 33 1, 840 0 17, 00 0 17, 00 0 17, 00 0 17, 00 0							•
14. 00 01400_CENTRAL_SERVICES_8_SUPPLY 1,006,303 674 14.6 8,044 11,092 14.0 15. 00 01500_PHARMACY 457,759 1,976 177 9,798 18.33 15.00 16. 00 01600_MEDICAL_RECORDS_&LIBRARY 55,190 0							•
15:00 01500 PHARMACY 457,759 1,976 177 9,798 1,833 15.00 10:00 01000 SOCIAL SERVICE 31,123 267 33 1,840 01 15.00 10:00 01000 SOCIAL SERVICE 31,123 267 33 1,840 01 17.00 10:00 01500 PATENT ENT RENSPORTATION 0 173 477 2,623 00 3300 00:00 03000 SURGICAL INTENSIVE CARE UNIT 405,453 701 0 4 1,565 34.00 04:01 03401 PEDIATRIC INTENSIVE CARE UNIT 405,453 701 0 4 1,565 34.00 04:02 03400 SURGICAL INTENSIVE CARE UNIT 1,056,9521 2,088 2 129 4,119 3,01 429 23,710 100,992 50.00 04300 INREERY 00 5000 DEECORT ROOM 422,004 1,633 194 10.714 6,201 51.00 51.00 51.00 51.00 51.00 51.00 51.01 54.00 54.00 54.00 54.00 56.00 50.00 66.00 66.00 66.00							•
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30: 00 03000 ADULTS & PEDIATRIC S 4.375,561 9,077 1,158 64,100 28,203 30.0 34: 00 3400 OSKRGICAL INTENSIVE CARE UNIT 405,483 701 0 4 1,565 34.0 34: 00 3400 PEDIATRIC INTENSIVE CARE UNIT 1,089,521 2,088 2 129 4,195 34.0 34: 00 04300 NURSERY 497,631 1,080 139 7,673 0 43.0 ANCILLARY SERVICE COST CENTERS		0	173	4	2, 623	0	18.00
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34. 02 03402 PREMATURE INTENSIVE CARE UNIT 1,089,521 2,088 2 129 4,195 34. 0 43. 00 04300 NURSERY 497,631 1,080 139 7,673 0 34. 0 43. 00 05000 DEPARTI NG ROM 4,141,973 3,01 429 23,710 100,992 50. 0 50. 00 DECOVERY ROM 4492,004 1,633 194 10,714 6,201 51. 0 52. 00 DEL VERY ROM & LABOR ROM 1,539,936 2,283 279 15,423 13,038 52. 00 54. 00 OKOO RADI OLOSTOPE 61,204 182 19 1,026 24 56. 0 56. 00 OS600 RESPI RATORY THERAPY 163,689 1,546 119 6,551 5.418 65. 0 50. 00 OS600 RESPI RATORY THERAPY 570,877 1,579 187 1,331 68. 69. 0 64. 00 OCOLOPATI ONAL THERAPY 570,877 1,579 187 1,331 68 69. 0 0.00 OR500 RESPI RATORY THERAPY 362,320 236 28 1,531 68 <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td>•</td>			-				•
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ANCILLARY SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS ANCILLARY SERVICE COST CENTERS State State St				13			•
50. 00 05000 0FERATING ROOM 4, 141, 973 3, 301 429 23, 710 100, 992 50, 00 51. 00 05100 RECOVERY ROOM 492, 004 1, 633 194 10, 714 6, 201 51, 00 52. 00 D5200 DELI VERY ROOM & LABOR ROOM 1, 539, 936 2, 283 279 15, 423 13, 038 52, 00 54. 00 D5600 RADI 010CV-DI AGNOSTI C 1, 789, 100 2, 659 348 19, 213 4, 820 54, 00 60. 00 O6000 RABORTORY 449, 250 530 146 8, 072 164 60, 00 66. 00 O6500 RESPI RATORY THERAPY 163, 689 1, 546 119 6, 561 5, 418 65, 00 67. 00 06700 CUPATI ONAL, THERAPY 999 384 433 2, 357 150 67, 00 69. 00 O6900 ELECTROCARDIOLOGY 3, 62, 320 236 28 1, 531 68, 69, 00 70. 00 OT000 MEDICALSUPPLIES CHARGED TO PATI ENTS <td></td> <td>1777001</td> <td>1,000</td> <td></td> <td>,,,,,,,</td> <td></td> <td>10100</td>		1777001	1,000		,,,,,,,		10100
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72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 259, 268 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 73.00 07300 ASC (NON-DI STINCT PART) 0 0 0 0 73.00 75.01 07501 CARDIAC CATHERIZATION LABORATORY 847,886 1,174 130 7,199 2,960 75.00 0100 D9100 EMERGENCY 847,886 1,174 130 7,199 2,960 75.00 75.00 749,523 1,754 221 12,213 7,700 91.00 92.00 0BEDS (NON-DI STINCT PART) 0 92.00 0BERVATI ON BEDS (NON-DI STINCT PART) 91.00 92.00 92.01 92.01 92.02 92.02 0BEDS (NON-DI STINCT PART) 91.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 9		82, 943	93	1	0 540		
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75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 847,886 1,174 130 7,199 2,960 75.00 0UTPATI ENT SERVICE COST CENTERS 749,523 1,754 221 12,213 7,700 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 92.00 9200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 92.00 0SERVATI ON BEDS (NON-DI STINCT PART) 92.00 92.00 0SERVATI ON BEDS (NON-DI STINCT PART) 92.00 92.00 0SERVATI ON BEDS (NON-DI STINCT PART) 92.00 92.00 18.00 118.00 92.00 SECI AL PURPOSE COST CENTERS 92.00 192.00 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
75. 01 07501 CARDIAC CATHERIZATION LABORATORY 847,886 1,174 130 7,199 2,960 75. 0 0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 749,523 1,754 221 12,213 7,700 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 9200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 9200 00000 CIFT, FLOWER COST CENTERS 91.00 92.00 9200 SUBTOTALS (SUM OF LINES 1 through 117) 26,497,611 45,394 5,465 302,058 580,472 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 102,262 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.01 192.01 19201 OTHER NON-REI MBURSABLE 63,811 391 660 3,308 0 192.0 192.02 19202 CHI LDBI RTH EDUCATION 0 159 <		0	0				
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 749,523 1,754 221 12,213 7,700 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 10.00 92.00 92.01 92.01 12,213 7,700 91.01 92.01 SPECI AL PURPOSE COST CENTERS 5 5 302,058 580,472 118.00 118.00 SUBTOTALS (SUM OF LI NES 1 through 117) 26,497,611 45,394 5,465 302,058 580,472 118.00 NONREI IMBURSABLE COST CENTERS 0 0 0 0 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 102,262 0 0 0 190.00 192.00 192.01 192.01 01HER NON-REI MBURSABLE 63,811 391 660 3,308 0 192.00 192.01 192.02 192.02 192.04 192.04 192.04 192.04 192.04 192.04 192.04 192.04 192.05 192.05 192.05 192.02 192.05 192.02 <td></td> <td>847 886</td> <td>1 174</td> <td></td> <td></td> <td></td> <td>•</td>		847 886	1 174				•
91.00 09100 EMERGENCY 749, 523 1, 754 221 12, 213 7, 700 91.00 92.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 26, 497, 611 45, 394 5, 465 302, 058 580, 472 118.00 NONREL MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 102, 262 0 0 0 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.01 0THER NON-REI MBURSABLE 63, 811 391 60 3, 308 0 192.0 192.02 192.02 192.02 192.02 192.02 192.04 192.04 192.04 192.05 192.05 192.05 192.05 192.05 192.05 192.02 192.02 192.02 192.02 192.02 192.04 192.04 192.04 192.05 192.05 192.05 192.05 192.02		047,000	1, 174	13	7,177	2, 900	75.01
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 26,497,611 45,394 5,465 302,058 580,472 118.00 NONREI MBURSABLE COST CENTERS 118.00 NONREI MBURSABLE COST CENTERS 100.00 0 0 1900.00 0 0 190.00 192.00 190.00 FT, FLOWER, COFFEE SHOP & CANTEEN 102,262 0 0 0 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 192.01 19201 OTHER NON-REI MBURSABLE 63,811 391 60 3,308 0 192.00 192.02 19202 CHI LDBI RTH EDUCATI ON 0 159 17 963 0 192.00 192.02 19205 ANSON CLI NIC 29,391 867 116 6,392 5		749, 523	1, 754	22	12, 213	7,700	91.00
SUBTOTALS (SUM OF LINES 1 through 117) 26, 497, 611 45, 394 5, 465 302, 058 580, 472 118. 00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 102, 262 0 0 0 190.00 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 192.01 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 0 159 17 963 0 192.00 192.02 192.04 192.04 192.04 19204 PHYSI CI ANS' PRI VATE OFFI CES 261, 620 0 0 192.04 <td></td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>		1					92.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 102,262 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 19200 OTHER NON-REI MBURSABLE 63,811 391 60 3,308 0 192.0 192.02 19202 CHI LDBI RTH EDUCATI ON 0 159 17 963 0 192.0 192.04 19204 PHYSI CI ANS' PRI VATE OFFI CES 261,620 0 0 1 192.0 192.05 19205 ANSON CLI NI C 29,391 867 116 6,392 5 192.0 192.05 0 0 0 0 200.00 200.00 200.00 200.00 200.00 200.00 0 0 0 200.00]
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 102, 262 0 0 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 192.01 19200 IPHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 192.01 19202 ITHER NON-REI MBURSABLE 63,811 391 60 3,308 0 192.0 192.02 19202 CHI LDBI RTH EDUCATION 0 159 17 963 0 192.0 192.04 19204 PHYSICIANS' PRIVATE OFFICES 261,620 0 0 1 192.0 192.05 19205 ANSON CLINIC 29,391 867 116 6,392 5 192.0 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 201.00 0 0 0 0 200.00		26, 497, 611	45, 394	5, 46	5 302, 058	580, 472	118.00
192.00 19200 PHYSICLANS' PRIVATE OFFICES 0 0 0 0 192.00 192.01 19201 OTHER NON-RELMBURSABLE 63,811 391 60 3,308 0 192.0 192.02 19202 CHILDBIRTH EDUCATION 0 159 17 963 0 192.0 192.04 19204 PHYSICLANS' PRIVATE OFFICES 261,620 0 0 0 192.0 192.05 19205 ANSON CLINIC 29,391 867 116 6,392 5 192.0 192.0 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 0 0 0 0 0 200.00			-1		-	-	
192.01 19201 OTHER NON-REI MBURSABLE 63,811 391 60 3,308 0 192.0 192.02 19202 CHI LDBI RTH EDUCATI ON 0 159 17 963 0 192.0 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 261,620 0 0 0 1 192.0 192.05 19205 ANSON CLI NI C 29,391 867 116 6,392 5 192.0 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		102, 262					•
192.02 CHILDBIRTH EDUCATION 0 159 17 963 0 192.02 192.04 19204 PHYSICIANS' PRIVATE OFFICES 261,620 0 0 0 1 192.02 192.05 19205 ANSON CLINIC 29,391 867 116 6,392 5 192.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			-		-		•
192.04 19204 PHYSI CLANS' PRIVATE OFFICES 261,620 0 0 1 192.02 192.05 19205 ANSON CLINIC 29,391 867 116 6,392 5 192.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		63, 811					
192.05 19205 ANSON CLINIC 29,391 867 116 6,392 5 192.02 200.00 Cross Foot Adjustments 0 0 200.00 200.00 200.00 200.00 200.00 0 0 200.0		261 620					
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0							
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		1 1	207		5,572	0	200.00
202.00 TOTAL (sum Lines 118 through 201) 26.954.695 46.811 5.658 312.721 580.478/202.00	201.00 Negative Cost Centers	0	0		0 0		201.00
	202.00 TOTAL (sum lines 118 through 201)	26, 954, 695	46, 811	5,65	312, 721	580, 478	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	IU HEALTH NOF	Provider C		Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet B Part II Date/Time Pre	pared:
Cost Center Description	ADMI TTI NG	OTHER ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF	5/29/2018 9:5 LAUNDRY & LINEN SERVICE	1 am
	5.04	5.05	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS		1	1			
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYCE BENEFITS DEPARTMENT 5.01 00540 NONPATIENT TELEPHONES 5.02 00550 DATA PROCESSING 5.03 00560 PURCHASING RECEIVING AND STORES 5.04 00570 ADMITTING 5.05 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION	196, 918 C C C C C C C C C C C C C C C C C C C	695, 788 28, 623 31, 969	517, 49 90, 47 7, 45 3, 33 21, 79	3 3, 627, 882 0 0 6 63, 342 1 28, 296 6 185, 175	575 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 2. \ 00\\ 4. \ 00\\ 5. \ 01\\ 5. \ 02\\ 5. \ 03\\ 5. \ 04\\ 5. \ 05\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ \end{array}$
14. 00 01400 CENTRAL SERVICES & SUPPLY	C	47,450			3	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	C C C		1, 41	5 12, 019	0 0 0	15.00 16.00 17.00
18.00 01850 PATIENT TRANSPORTATION	C	1, 504		0 0	0	18.00
30. 00 03000 ADULTS & PEDI ATRI CS 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 34. 02 03402 PREMATURE I NTENSI VE CARE UNI T	17, 613 C 1, 51C 5, 379	0 0 7, 591 16, 096	9, 99 27, 54	0 0 4 84, 910 7 234, 029	332 0 0 24	30.00 34.00 34.01 34.02
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	2, 382	11, 482	13, 02	4 110, 649	21	43.00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 56.00 05600 RADI OLOGY-DI AGNOSTI C 56.00 06600 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	42, 867 7, 946 11, 211 13, 501 2, 030 13, 060 2, 706 2, 492 848 343	16, 469 27, 660 33, 140 2, 043 32, 484 12, 967 16, 508 3, 144	11, 55 37, 69 23, 62 1, 61 11, 80 2, 31 43	8 98, 191 5 320, 245 3 200, 695 2 13, 698 8 100, 320 5 19, 669	29 32 0 54 0 1 0 4 0 0	50.00 51.00 52.00 54.00 60.00 65.00 65.00 66.00 67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 102	3, 944	3, 24		0	69.00
70. 0007000ELECTROENCEPHALOGRAPHY71. 0007100MEDI CAL SUPPLIES CHARGED TO PATI ENTS72. 0007200I MPL. DEV. CHARGED TO PATI ENT73. 0007300DRUGS CHARGED TO PATI ENTS75. 0007500ASC (NON-DI STI NCT PART)75. 0107501CATHERI ZATI ON LABORATORY	801 5, 322 19, 957 13, 415 C 8, 867	23, 601 49, 187 20, 356		0 0 0 0 0 0 0 0	0 0 0 0 0 24	70.00 71.00 72.00 73.00 75.00 75.01
OUTPATIENT SERVICE COST CENTERS		-				
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS	21, 566	21, 869	17, 60	8 149, 591	51	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	196, 918	1				118.00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICLANS' PRIVATE OFFICES 192.01 19201 OTHER NON-REIMBURSABLE 192.02 19202 CHILDBIRTH EDUCATION 192.04 19204 PHYSICLANS' PRIVATE OFFICES 192.05 19205 ANSON CLINIC 200.00 Cross Foot Adjustments		862 0 7, 522 1, 333 1, 272 9, 355	73 6, 85	0 0 5 6, 245 0 0	0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 04 192. 05 200. 00
200.00Cross Foot Adjustments201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	C 196, 918	0 C 695, 788	517, 49	0 0 5 3, 627, 882	0	200. 00 201. 00 202. 00

Health Financial Systems	IU HEALTH NORT	H HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	1	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/29/2018 9:5	pared: 1 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS						1.00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-NVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	539, 449 4, 282 28, 024 4, 143 28, 700 10, 413	180, 207 0 0 0 0	60, 00 38, 00 46, 28	6 258, 463 1 0 5 0	1, 352, 378 4, 382	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	1, 819 1, 041	0		0 1 0	0	
18. 00 01850 PATIENT TRANSPORTATION	1, 041	0			0	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 34. 00 03400 SURGI CAL INTENSI VE CARE UNI T 34. 01 03401 PEDI ATRI C INTENSI VE CARE UNI T	138, 227 0 12, 850	163, 799 0 4, 618	1	0 0 8 8	67, 425 0 3, 740	34. 00 34. 01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	35, 417	0			10, 028 0	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	16, 745	0	36, 24	4 15, 408	0	43.00
50. 00 05000 OPERATI NG ROOM	76, 162	0	112,00	5 26, 693	241, 444	50.00
51.00 05100 RECOVERY ROOM	14, 860	127				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	48, 465	9, 427	72,85		31, 169	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	30, 373 2, 073	0			11, 523 57	
60. 00 06000 LABORATORY	15, 182	0	.,		393	•
65.00 06500 RESPIRATORY THERAPY	2, 977	0			12, 954	
66. 00 06600 PHYSI CAL THERAPY	555	0			3, 427	
67.00 06700 OCCUPATI ONAL THERAPY	0	0			359	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 4, 178	0	5, 34 7, 23		1, 502 162	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 405	0			1, 104	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	302, 528	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	619, 859	
73. 00 07300 DRUGS CHARGED TO PATIENTS 75. 00 07500 ASC (NON-DISTINCT PART)	0	0			0	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	25, 692	1, 113	34, 00	6 9, 890	7,075	
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	22, 639	1, 123	57, 69	4 18, 312	18, 408	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	526, 222	180, 207	1, 072, 08	255, 328	1, 352, 365	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	3, 473	0		0 0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	3,473	0		0 0		190.00
192. 01 19201 OTHER NON-REI MBURSABLE	945	0	15, 62	-		192.01
192. 02 19202 CHI LDBI RTH EDUCATI ON	0	0	4, 54		0	192. 02
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	8, 809	0	00.10	0 0		192.04
192.05 19205 ANSON CLINIC 200.00 Cross Foot Adjustments	0	0	30, 19	7 2, 739	11	192.05 200.00
201.00 Negative Cost Centers	0	0		0 0	0	200.00
202.00 TOTAL (sum lines 118 through 201)	539, 449	180, 207	1, 122, 45	2 258, 463		

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH NORT	Provider C		eriod:	u of Form CMS- Worksheet B	2002-10
					rom 01/01/2017 o 12/31/2017	Part II Date/Time Pre 5/29/2018 9:5	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	SERVI CE PATI ENT TRANSPORTATI ON	Subtotal	
		15.00	16.00	17.00	18.00	24.00	
1 00	GENERAL SERVICE COST CENTERS			1	1		1 1 00
11. 00 13. 00 14. 00 15. 00 16. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICE & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	628, 530 0 0	71, 561 C				$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
	01850 PATIENT TRANSPORTATION	0	0				17.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
	03000 ADULTS & PEDIATRICS 03400 SURGICAL INTENSIVE CARE UNIT	16, 785 0	6, 422 0	1		6, 490, 430 0	1
	03401 PEDI ATRI C I NTENSI VE CARE UNI T	0	551		-	535, 960	1
	03402 PREMATURE INTENSIVE CARE UNIT	1, 320	1, 961			1, 438, 223	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	868	8, 165	2, 538	724, 049	43.00
	05000 OPERATI NG ROOM	14, 262	15, 391		0	5, 416, 631	50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 356 5, 027	2, 897 4, 088		-	754, 139 2, 163, 690	
	05400 RADI OLOGY-DI AGNOSTI C	3, 424	4,088			2, 103, 890	
	05600 RADI OI SOTOPE	1, 774	740			91, 327	1
	06000 LABORATORY	32	4, 762		-	680, 570	
		383	987			263, 283	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	13 0	909 309			661, 302 19, 725	
	06800 SPEECH PATHOLOGY	0	125			19, 723	
	06900 ELECTROCARDI OLOGY	0	1, 131		-	414, 784	
	07000 ELECTROENCEPHALOGRAPHY	4	292		0	103, 242	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 941	1	0	459, 935	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	7, 277		-	955, 548	
	07300 DRUGS CHARGED TO PATIENTS	566, 930	4, 891	1	-	605, 592	
	07500 ASC (NON-DI STI NCT PART) 07501 CARDI AC CATHERI ZATI ON LABORATORY	2, 504	0 3, 233	-		0 1, 156, 928	
75.01	OUTPATIENT SERVICE COST CENTERS	2, 304	5,233		<u> </u>	1, 130, 920	/ / 3. 01
91.00	09100 EMERGENCY	12, 716	7, 863	0	0	1, 120, 851	91.00
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) SPECI AL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	628, 530	71, 561	53, 851	16, 737	26, 300, 553	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			132, 249	
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0				192.00
100 01	19201 OTHER NON-REI MBURSABLE	0	0	0	-		192.01
	19202 CHI LDBI RTH EDUCATI ON	0	C	0	0		192.02
192.02		~	~		~	22/ 7/2	102 04
192. 02 192. 04	19204 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	-	336, 760	
192. 02 192. 04 192. 05	19204 PHYSI CI ANS' PRI VATE OFFI CES 19205 ANSON CLI NI C	0 0	C	0	-	79, 073	192.05
192. 02 192. 04	19204 PHYSICIANS' PRIVATE OFFICES 19205 ANSON CLINIC Cross Foot Adjustments	0 0 0	c c c	-	-	79, 073 0	

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH NOR	Provider CC	N· 15_0161	Period: In Lieu of Fo	rm CMS-2552-10
ALLUUF	THON OF CAFILIAE KELATED CUSIS			. 10-0101	From 01/01/2017 Part I To 12/31/2017 Date/T	I
	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total			
		25.00	26.00			
1.00 1.01 1.02 2.00 4.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					1.00 1.01 1.02 2.00 4.00
5.01 5.02 5.03 5.04 5.05 6.00	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG AND STORES 00570 ADMI TTI NG 00590 OTHER ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS					5. 01 5. 02 5. 03 5. 04 5. 05 6. 00
0.00 7.00 8.00 9.00 10.00 11.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA					7.00 8.00 9.00 10.00 11.00
13.00 14.00 15.00 16.00 17.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE					13. 00 14. 00 15. 00 16. 00 17. 00
18.00	01850 PATIENT TRANSPORTATION					18.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 34.00	03000 ADULTS & PEDIATRICS 03400 SURGICAL INTENSIVE CARE UNIT	0	6, 490, 430 0			30.00 34.00
34.00	03401 PEDIATRIC INTENSIVE CARE UNIT	0	535, 960			34.00
34.02	03402 PREMATURE INTENSIVE CARE UNIT	0	1, 438, 223			34.02
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	724, 049			43.00
50.00	05000 OPERATI NG ROOM	0	5, 416, 631			50.00
51.00	05100 RECOVERY ROOM	0	754, 139			51.00
52.00 54.00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	2, 163, 690 2, 231, 825			52.00 54.00
56.00	05600 RADI OLOGI - DI AGNOSTI C	0	2, 231, 825 91, 327			56.00
60.00	06000 LABORATORY	0	680, 570			60.00
65.00		0	263, 283			65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	661, 302 19, 725			66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	12, 519			68.00
69.00	06900 ELECTROCARDI OLOGY	0	414, 784			69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103, 242 459, 935			70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	459, 935 955, 548			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	605, 592			73.00
	07500 ASC (NON-DI STI NCT PART)	0	0			75.00
75.01	07501 CARDI AC CATHERI ZATI ON LABORATORY OUTPATI ENT SERVICE COST CENTERS	0	1, 156, 928			75. 01
91.00	09100 EMERGENCY	0	1, 120, 851			91.00
92.00		0	1, 120, 001			92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	26, 300, 553			118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	132, 249			190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
	19201 OTHER NON-REI MBURSABLE	0	98, 643			192.01
	2 19202 CHI LDBI RTH EDUCATI ON 19204 PHYSI CI ANS' PRI VATE OFFI CES	0	7, 417 336, 760			192. 02 192. 04
	19204 PHISICIANS PRIVATE OFFICES	0	79, 073			192.04
200.00	Cross Foot Adjustments	0	0			200.00
201.00		0	0			201.00
202.00	TOTAL (sum lines 118 through 201)	0	26, 954, 695			202. (

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH NOR	RTH HOSPITAL Provider CO		eri od:	u of Form CMS-2 Worksheet B-1	
			T	rom 01/01/2017 p 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		CAPI TAL REI	LATED COSTS		372772010 7.3	
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW INTEREST (SQUARE FEET)	MOB LEASED SPACE (MOB SQ FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	1.00	1.01	1.02	2.00	4.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	433, 546					1.00
1. 0100101NEW CAP REL COSTS-INTEREST1. 0200102MOB LEASED SPACE2. 0000200NEW CAP REL COSTS-MVBLE EQUIP4. 0000400EMPLOYEE BENEFITS DEPARTMENT5. 0100540NONPATI ENT TELEPHONES	0 0 711 0	433, 546 0 711	89, 452 795	3, 325, 178 758 4, 169	57, 183, 464 0	1. 01 1. 02 2. 00 4. 00 5. 01
5. 02 00550 DATA PROCESSI NG 5. 03 00560 PURCHASI NG RECEI VI NG AND STORES 5. 04 00570 ADMI TTI NG	6, 089 11, 314	6, 089 11, 314	379 192	7, 135 18, 049	0	
5. 05 00590 OTHER ADMINI STRATI VE & GENERAL	3, 837 4, 740			1, 166 112, 146	1, 202, 917 4, 236, 420	
6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	6, 296 70, 029 0	6, 296 70, 029	0 1, 916	120, 665 33, 454 0	2, 069, 242 1, 122, 440 0	6.00
9.00 00900 HOUSEKEEPI NG	5, 771			96, 845	1, 442, 523	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	2, 578 16, 871			1, 793 26, 048	714, 923 1, 223, 940	
13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 494			8, 825	2, 416, 491	
14.00 01400 CENTRAL SERVICES & SUPPLY	17, 278			118, 853	823, 233	
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	6, 269 1, 095			111, 384 1, 207	2, 413, 033 0	15.00 16.00
17. 00 01700 SOCIAL SERVICE	627			338	326, 076	
18. 00 01850 PATI ENT TRANSPORTATI ON	0	0	0	0	211, 827	18.00
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	83, 215	83, 215	0	225, 354	11, 110, 294	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	03,213			223, 334	0	34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	7, 736			20, 002	855, 927	
34. 02 03402 PREMATURE I NTENSI VE CARE UNI T	21, 322			29, 433	2, 549, 497	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	10, 081	10, 081	0	3, 396	1, 318, 927	43.00
50. 00 05000 OPERATI NG ROOM	45, 851	45, 851	0	1, 399, 665	4, 030, 060	50.00
51.00 05100 RECOVERY ROOM	8, 946			40, 150	1, 993, 732	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	29, 177 18, 285			83, 265 428, 955	2, 786, 990 3, 246, 115	
56. 00 05600 RADI OLOGI DI AGNOSTI O	1, 248			125	222, 341	
60. 00 06000 LABORATORY	9, 140			1, 657	646, 628	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 792 334			56, 036 10, 474	1, 888, 197 1, 927, 838	
67. 00 06700 OCCUPATI ONAL THERAPY	0			736		
68.00 06800 SPEECH PATHOLOGY	0	0	0	1, 337	228, 330	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 515			176, 338	288, 711	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	846			30, 629 0	112, 963 0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	-	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	-	0	0	0	
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0 15, 467	, o	0	0 67, 388	0 1, 433, 062	75.00 75.01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	13, 629	13, 629	0	61, 144	2, 141, 938	91.00 92.00
SPECIAL PURPOSE COST CENTERS						72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	425, 583	425, 583	87, 141	3, 298, 919	55, 453, 880	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 091	2, 091	0	0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0		0	0		192.00
192.01 19201 OTHER NON-REI MBURSABLE	569	569	2, 311	2, 930	476, 928	
192. 02 19202 CHI LDBI RTH EDUCATI ON 192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	0 5, 303	0 5, 303	0	0 1, 673	193, 682	192. 02 192. 04
192. 05 19205 ANSON CLINIC	0, 303	0, 303	0	21, 656	1, 058, 974	
200.00 Cross Foot Adjustments						200. 00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	0 011 040	12 101 07	1 220 042	1 610 004	0 404 044	201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	8, 011, 042	13, 191, 977	1, 238, 842	4, 512, 834	9, 406, 066	202.00
203.00 204.00 Part II)	18. 477952	30. 428091	13. 849238	1. 357171	0. 164489 46, 811	203. 00 204. 00
205.00 Unit cost multiplier (Wkst. B, Part					0. 000819	205. 00
11)						I

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider C	Provider CCN: 15-0161		Worksheet B-1	
			From O To 12		Date/Time Pre 5/29/2018 9:5	pared:
Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW INTEREST (SQUARE FEET)	MOB LEASED SPACE (MOB SQ FEET	NEW MVBLE EQUI P) (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	
	1.00	1.01	1.02	2.00	4.00	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	- STATISTICAL BASIS	IU HEALTH NOR	Provider C		ri od:	of Form CMS-2 Worksheet B-1	
					om 01/01/2017	Date/Time Pre	
					12/31/2017	5/29/2018 9:5	
Cos	t Center Description	NONPATI ENT	DATA	PURCHASI NG		Reconciliation	
		TELEPHONES (FTEs)	PROCESSING (FTEs)	RECEI VI NG AND STORES	(GROSS CHARGES)		
		(FIES)	(FIES)	(COSTED	CHARGES)		
				REQUISITIONS)			
		5.01	5.02	5.03	5.04	5A. 05	
	SERVICE COST CENTERS						
	/ CAP REL COSTS-BLDG & FIXT / CAP REL COSTS-INTEREST						1
	LEASED SPACE						
	CAP REL COSTS-MVBLE EQUIP						2
	LOYEE BENEFITS DEPARTMENT						4
	IPATI ENT TELEPHONES	79, 887					5
00550 DAT	A PROCESSING	0	79, 887				5
	CHASING RECEIVING AND STORES	0	0	20, 510, 375			5
00570 ADN		1,636	1,636		710, 382, 571		5
	IER ADMI NI STRATI VE & GENERAL NTENANCE & REPAI RS	2,753	2, 753		0	-23, 269, 288 0	
	RATION OF PLANT	3, 167 1, 942	3, 167 1, 942	101, 806 31	0	0	
	NDRY & LINEN SERVICE	0	1, 742	0	0	0	
	ISEKEEPING	4, 420	4, 420	11, 547	0	0	
00 01000 DI E	TARY	1, 956	1, 956	6, 788	0	0	10
00 01100 CAF	ETERI A	3, 313	3, 313	855	0	0	11
	SING ADMINISTRATION	3, 245	3, 245		0	0	
	ITRAL SERVICES & SUPPLY	2,055	2,055		0	0	
00 01500 PHA		2, 503	2, 503	64, 756	0	0	
	II CAL RECORDS & LI BRARY	0 470	0 470	0	0 O	0	
	TENT TRANSPORTATION	470 670	470 670	-	0	0	
	ROUTINE SERVICE COST CENTERS	070	070		0	0	
	ILTS & PEDIATRICS	16, 375	16, 375	996, 497	63, 583, 168	0	30
00 03400 SUR	GICAL INTENSIVE CARE UNIT	0	0	0	0	0	34
	IATRIC INTENSIVE CARE UNIT	1	1	55, 279	5, 451, 790	0	
	MATURE INTENSIVE CARE UNIT	33	33		19, 420, 332	0	
00 04300 NUR		1, 960	1, 960	0	8, 598, 535	0	43
	SERVICE COST CENTERS	6,057	6, 057	3, 568, 377	154, 242, 825	0	50
	OVERY ROOM	2,737	2, 737		28, 687, 122	0	
	IVERY ROOM & LABOR ROOM	3, 940	3, 940		40, 472, 921	0	
	I OLOGY-DI AGNOSTI C	4, 908	4, 908		48, 740, 936	0	
00 05600 RAD	I OI SOTOPE	262	262	842	7, 326, 803	0	56
00 06000 LAB		2, 062	2, 062	5, 802	47, 148, 215	0	
	PIRATORY THERAPY	1, 676	1, 676		9, 769, 944	0	
	SICAL THERAPY	2,643	2, 643		8, 996, 600	0	
	CUPATIONAL THERAPY	602 289	602	5, 302	3, 061, 338 1, 236, 924	0	
	ECH PATHOLOGY CTROCARDI OLOGY	289 391	289 391		1, 236, 924	0	
	CTROENCEPHALOGRAPHY	138	138		2, 892, 741	-	70
	I CAL SUPPLIES CHARGED TO PATIENTS	0	0		19, 213, 790	0	
	PL. DEV. CHARGED TO PATIENT	0	0	9, 161, 088	72, 047, 300	0	
	IGS CHARGED TO PATIENTS	0	0	0	48, 430, 624	0	
	(NON-DISTINCT PART)	0	0	0	0	0	
	DI AC CATHERI ZATI ON LABORATORY	1, 839	1, 839	104, 571	32, 009, 186	0	75
	NT SERVICE COST CENTERS	2 120	2 120	272.045	77 054 44 2	0	
00 09100 EME	ERVATION BEDS (NON-DISTINCT PART)	3, 120	3, 120	272, 065	77, 854, 462	0	91
	PURPOSE COST CENTERS						72
	STOTALS (SUM OF LINES 1 through 117)	77, 163	77, 163	20, 510, 185	710, 382, 571	-23, 269, 288	118
	JRSABLE COST CENTERS	· · ·	· · · · · · · · · · · · · · · · · · ·				
	T, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190
	SICIANS' PRIVATE OFFICES	0	0	0	0		192
	IER NON-REI MBURSABLE	845	845		0		192
	LDBIRTH EDUCATION 'SICIANS' PRIVATE OFFICES	246	246	25	0		192 192
2. 05 19205 ANS		1, 633	1, 633				192
	ss Foot Adjustments	1, 000	1, 000	101	0	0	200
	ative Cost Centers						201
	it to be allocated (per Wkst. B,	7, 848	5, 418, 385	1, 295, 669	3, 714, 840		202
Par	tl)						
	t cost multiplier (Wkst. B, Part I)	0. 098239	67.825616		0.005229		203
	t to be allocated (per Wkst. B,	5, 658	312, 721	580, 478	196, 918		204
	t II)	0.070005		0,000000	0 000077		005
5.00 Uni)	t cost multiplier (Wkst. B, Part	0. 070825	3. 914542	0. 028302	0.000277		205
	E adjustment amount to be allocated						206
	er Wkst. B-2)						1200

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	pared: 1 am
Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	Reconciliation	
	TELEPHONES	PROCESSI NG	RECEIVING AND) (GROSS		
	(FTEs)	(FTEs)	STORES	CHARGES)		
			(COSTED	, , , , , , , , , , , , , , , , , , ,		
			REQUISITIONS)	1		
	5.01	5.02	5.03	5. 04	5A. 05	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems LOCATION – STATISTICAL BASIS	IU HEALTH NOR	Provi der C	Fi	eriod: com 01/01/2017	Worksheet B-1	
					5 12/31/2017	Date/Time Pre 5/29/2018 9:5	pare 1 am
	Cost Center Description	OTHER ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	
		5. 05	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS		I	1			
. 01 . 02 . 02 . 00 . 00 . 01 . 02 . 03 . 03 . 02 . 03 . 03 . 04 . 05 . 00 . 00 . 00 <td>00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE 00200 NEW CAP REL COSTS-INTEREST 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE</td> <td>143, 121, 353 5, 887, 135 6, 575, 327 118, 329 6, 497, 283 1, 483, 096 2, 628, 819 3, 038, 635 9, 759, 261 3, 907, 836 229, 904 650, 861</td> <td>400, 559 70, 029 0 5, 771 2, 578 16, 871 2, 494 17, 278 6, 269</td> <td>330, 530 0 5, 771 2, 578 16, 871 2, 494 17, 278 6, 269</td> <td>261, 639 0 0 0 1, 214 13 0 0</td> <td>324, 759 2, 578 16, 871 2, 494 17, 278 6, 269 1, 095 627</td> <td>10. 11. 13. 14. 15.</td>	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE 00200 NEW CAP REL COSTS-INTEREST 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSING 00560 PURCHASING RECEIVING AND STORES 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	143, 121, 353 5, 887, 135 6, 575, 327 118, 329 6, 497, 283 1, 483, 096 2, 628, 819 3, 038, 635 9, 759, 261 3, 907, 836 229, 904 650, 861	400, 559 70, 029 0 5, 771 2, 578 16, 871 2, 494 17, 278 6, 269	330, 530 0 5, 771 2, 578 16, 871 2, 494 17, 278 6, 269	261, 639 0 0 0 1, 214 13 0 0	324, 759 2, 578 16, 871 2, 494 17, 278 6, 269 1, 095 627	10. 11. 13. 14. 15.
	01850 PATIENT TRANSPORTATION	309, 293		0	0	0	18.
	INPATIENT ROUTINE SERVICE COST CENTERS	T	·	· · · · · · ·		· · · · · · · · · · · · · · · · · · ·	
4.00 4.01 4.02 3.00	03000 ADULTS & PEDIATRICS 03400 SURGICAL INTENSIVE CARE UNIT 03401 PEDIATRIC INTENSIVE CARE UNIT 03402 PREMATURE INTENSIVE CARE UNIT 04300 NURSERY	21, 148, 664 0 1, 561, 257 3, 310, 590 2, 361, 613	21, 322	0	150, 802 0 0 11, 067 9, 591	83, 215 0 7, 736 21, 322 10, 081	
	ANCI LLARY SERVICE COST CENTERS	11 007 0/0	45.051	45.051	10 175	45.051	
	05000 OPERATING ROOM 05100 RECOVERY ROOM	11, 287, 363 3, 387, 187		45, 851 8, 946	13, 175 14, 573	45, 851 8, 946	
	05200 DELIVERY ROOM & LABOR ROOM	5, 688, 939			0	29, 177	
	05400 RADI OLOGY-DI AGNOSTI C	6, 816, 213			24, 605	18, 285	
	05600 RADI OI SOTOPE	420, 137	1, 248		0	1, 248	
	06000 LABORATORY 06500 RESPI RATORY THERAPY	6, 681, 244 2, 667, 050			447 21	9, 140 1, 792	
	06600 PHYSI CAL THERAPY	3, 395, 236	334	334	1, 993		66
. 00	06700 OCCUPATI ONAL THERAPY	646, 686		0	0	0	67
	06800 SPEECH PATHOLOGY	292, 804			0	0	
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	811, 216			0	2, 515	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	546, 568 4, 854, 088		846 0	0	846 0	
	07200 IMPL. DEV. CHARGED TO PATIENT	10, 116, 546		0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	4, 186, 854	0	0	0	0	73
	07500 ASC (NON-DI STINCT PART) 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0 15, 467	15 467	0 10, 797	0 15 467	75
	DUTPATIENT SERVICE COST CENTERS	3, 173, 187	15,407	15, 467	10, 797	15, 467	1 / 3
	09100 EMERGENCY	4, 497, 845	13, 629	13, 629	23, 341	13, 629	91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
8.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	138, 937, 066	392, 596	322, 567	261, 639	316, 796	1119
-	VONREI MBURSABLE COST CENTERS	130, 737, 000	572, 570	522, 507	201,037	510,770	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	177, 270	2, 091	2, 091	0	2, 091	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192
	19201 OTHER NON-REIMBURSABLE 19202 CHILDBIRTH EDUCATION	1, 547, 010 274, 228		569	0	569	192
	19204 PHYSI CLANS' PRI VATE OFFI CES	261, 622		5, 303	0	5, 303	
	19205 ANSON CLINIC	1, 924, 157		0	0	0	192
0.00	Cross Foot Adjustments						200
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	23, 269, 288	6, 844, 289	8, 840, 945	137, 567	7, 806, 606	201
∠.00	Part I)	23, 207, 288	0, 044, 289	0, 040, 945	137,307	7,000,000	202
3.00 4.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 162584 695, 788			0. 525789 575		
5.00	Unit cost multiplier (Wkst. B, Part	0. 004862	1. 291932	10. 975954	0. 002198	1. 661075	205
06.00	<pre>II) NAHE adjustment amount to be allocated (per Wkst. B-2)</pre>						206

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
	_			To 12/31/2017	Date/Time Pre 5/29/2018 9:5	pared: 1 am
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	ADMI NI STRATI VE	REPAI RS	PLANT	LINEN SERVICE	(SQUARE	
	& GENERAL	(SQUARE	(SQUARE	(POUNDS OF	FEET)	
	(ACCUM.	FEET)	FEET)	LAUNDRY)		
	COST)					
	5.05	6.00	7.00	8.00	9.00	
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Finan	cial Systems ION - STATISTICAL BASIS	IU HEALTH NORT	H HOSPITAL Provider C	CN: 15-0161 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
COST NELCON					rom 01/01/2017	Date/Time Pre 5/29/2018 9:5	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	. ,	NURSI NG ADMI NI STRATI ON (NURSI NG FTES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI SI TI ONS)	PHARMACY (COSTED REQUIS.)	
OFNED		10.00	11.00	13.00	14.00	15.00	
$\begin{array}{c ccccc} 1. & 00 & 00100 \\ 1. & 01 & 00101 \\ 1. & 02 & 00102 \\ 2. & 00 & 00200 \\ 4. & 00 & 00400 \\ 5. & 01 & 00540 \\ 5. & 02 & 00550 \\ 5. & 03 & 00560 \\ 5. & 04 & 00570 \\ 5. & 05 & 00590 \\ 6. & 00 & 00600 \\ 7. & 00 & 00700 \\ 8. & 00 & 00800 \\ 9. & 00 & 00900 \\ 10. & 00 & 0000 \\ 10. & 00 & 0$	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-INTEREST MOB LEASED SPACE NEW CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES DATA PROCESSING PURCHASING RECEIVING AND STORES ADMITTING OTHER ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY SOCIAL SERVICE PATIENT TRANSPORTATION	70, 938 0 0 0 0 0 0 0 0 0 0	60, 700 3, 245 2, 055 2, 503 0 470 670	31, 334 0 0 0 0 0 0	19, 987, 231 64, 756 0 0	4, 361, 004 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 18.\ 00\\ 1$
30.00 03000 34.00 03400 34.01 03401 34.02 03402 43.00 04300	ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS SURGICAL INTENSIVE CARE UNIT PEDIATRIC INTENSIVE CARE UNIT PREMATURE INTENSIVE CARE UNIT NURSERY	64, 479 0 1, 818 0 0	16, 375 0 1 33 1, 960	0 1 32	0 55, 279 148, 207	116, 458 0 0 9, 161 0	34.00 34.01 34.02
50.00 05000 51.00 05100 52.00 05200 54.00 05400 56.00 05600	_ARY SERVICE COST CENTERS OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC RADIOISOTOPE LABORATORY	0 50 3, 711 0 0	6, 057 2, 737 3, 940 4, 908 262 2, 062	2, 730 3, 017 445 0	219, 113 460, 660 170, 304 842	98, 956 23, 283 34, 876 23, 756 12, 310 219	51.00 52.00 54.00 56.00
65.00 06500 66.00 06600 67.00 06700 68.00 06800 69.00 06900	RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		1, 676 2, 643 602 289 391 138	0 0 0 0 0	191, 452 50, 650 5, 302 22, 192 2, 397	2, 657 92 0 0 0 27	65.00 66.00 67.00 68.00 69.00
72.00 07200 73.00 07300 75.00 07500 75.01 07501	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS ASC (NON-DISTINCT PART) CARDIAC CATHERIZATION LABORATORY TIENT SERVICE COST CENTERS	0 0 0 438	0 0 0 0 1, 839	000000000000000000000000000000000000000	9, 161, 088 0 0	0 0 3, 933, 610 0 17, 372	72.00 73.00 75.00
91.00 09100 92.00 09200	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	442	3, 120	2, 220	272, 065	88, 227	91.00 92.00
118.00 NONREI	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	70, 938	57, 976	30, 954	19, 987, 041		
192.00 19200 192.01 19201 192.02 19202 192.04 19204 192.05 19205 200.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES OTHER NON-REIMBURSABLE CHILDBIRTH EDUCATION PHYSICIANS' PRIVATE OFFICES ANSON CLINIC Cross Foot Adjustments	0 0 0 0 0	0 0 845 246 0 1,633	0 0 48 0	0 4 0 25	0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 04 192. 05 200. 00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	1, 899, 200	4, 201, 305	3, 926, 543	12, 661, 539	5, 182, 954	201. 00 202. 00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	26. 772675 180, 207	69. 214250 1, 122, 452			1. 188477 628, 530	
	Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2)	2. 540345	18. 491796	8. 248644	0. 067662	0. 144125	205. 00 206. 00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
				o 12/31/2017	Date/Time Pre 5/29/2018 9:5	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
	(MEALS SERVED)	(FTEs)	ADMI NI STRATI ON	I SERVICES &	(COSTED	
	. ,			SUPPLY	REQUIS.)	
			(NURSI NG	(COSTED	,	
			FTEs)	REQUISITIONS)		
	10.00	11.00	13.00	14.00	15.00	
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Health Financ	ial Systems ON - STATISTICAL BASIS	IU HEALTH NOR	TH HOSPITAL	CN: 15-0161	In Lie Period:	u of Form CMS-25 Worksheet B-1	52-10
					From 01/01/2017 To 12/31/2017	Date/Time Prepa	ared:
				OTHER GENERAL		5/29/2018 9:51	
				SERVI CE	-		
(Cost Center Description	MEDICAL RECORDS &	SOCI AL SERVI CE	PATIENT	N		
		LI BRARY	(TOTAL PATIENT				
		(GROSS	DAYS)	(TOTAL PATIEN	IT		
		CHARGES) 16.00	17.00	DAYS) 18.00	-		
	L SERVICE COST CENTERS			1			1 00
	NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-INTEREST						1.00 1.01
	MOB LEASED SPACE						1.02
	NEW CAP REL COSTS-MVBLE EQUIP						2.00
	EMPLOYEE BENEFITS DEPARTMENT NONPATIENT TELEPHONES						4.00 5.01
	DATA PROCESSING						5.02
	PURCHASING RECEIVING AND STORES						5.03
	ADMITTING DTHER ADMINISTRATIVE & GENERAL						5.04 5.05
6.00 00600 1	MAINTENANCE & REPAIRS						6.00
	DPERATION OF PLANT _AUNDRY & LINEN SERVICE						7.00 8.00
	HOUSEKEEPING						8.00 9.00
	DI ETARY						10.00
	CAFETERIA NURSING ADMINISTRATION						11. 00 13. 00
	CENTRAL SERVICES & SUPPLY						14.00
	PHARMACY						15.00
	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE	710, 382, 571 0	33, 470				16. 00 17. 00
	PATIENT TRANSPORTATION	0	0		0		18.00
	ENT ROUTINE SERVICE COST CENTERS	(2 502 1/0	22 (01	22.40	1		20.00
	ADULTS & PEDIATRICS SURGICAL INTENSIVE CARE UNIT	63, 583, 168 0	22, 691 0		0		30. 00 34. 00
	PEDIATRIC INTENSIVE CARE UNIT	5, 451, 790	1, 146		-		34.01
1 1	PREMATURE INTENSIVE CARE UNIT	19, 420, 332	4, 558				34.02
	NURSERY ARY SERVICE COST CENTERS	8, 598, 535	5, 075	5, 07	0		43.00
	DPERATI NG ROOM	154, 242, 825	0		0		50.00
	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	28, 687, 122 40, 472, 921	0		0		51.00 52.00
	RADI OLOGY-DI AGNOSTI C	48, 740, 936	0		0		54.00
	RADI OI SOTOPE	7, 326, 803	0		0		56.00
1 1	LABORATORY RESPI RATORY THERAPY	47, 148, 215 9, 769, 944	0		0		60. 00 65. 00
66.00 06600 F	PHYSI CAL THERAPY	8, 996, 600	0		0		66.00
		3,061,338		1	0		67.00
	SPEECH PATHOLOGY ELECTROCARDI OLOGY	1, 236, 924 11, 197, 015			0		68.00 69.00
	ELECTROENCEPHALOGRAPHY	2, 892, 741	0		0		70.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 213, 790 72, 047, 300			0		71.00 72.00
	DRUGS CHARGED TO PATIENTS	48, 430, 624			0		73.00
	ASC (NON-DI STI NCT PART)	0	0		0		75.00
	CARDIAC CATHERIZATION LABORATORY	32, 009, 186	0		0		75. 01
91.00 09100 E	EMERGENCY	77, 854, 462	0		0		91.00
	DBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SUBTOTALS (SUM OF LINES 1 through 117)	710, 382, 571	33, 470	33, 47	0	1.	18.00
	MBURSABLE COST CENTERS						~ ~ ~
	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0			0		90.00 92.00
192.01 19201 (OTHER NON-REIMBURSABLE	0	0		0	10	92. 01
	CHILDBIRTH EDUCATION	0	0		0		92. 02 92. 04
192.04 19204 19204	PHYSICIANS' PRIVATE OFFICES ANSON CLINIC	0			0		92.04 92.05
200.00	Cross Foot Adjustments	Ū				20	00.00
1 1	Negative Cost Centers Cost to be allocated (per What B	211 204	021 7/0	10E 0E	3		01. 00 02. 00
	Cost to be allocated (per Wkst. B, Part I)	341, 604	831, 768	405, 95	13	20	UZ. UU
203.00 l	Jnit cost multiplier (Wkst. B, Part I)	0. 000481	24. 851150				03.00
	Cost to be allocated (per Wkst. B, Part II)	71, 561	53, 851	16, 73	57	20	04.00
205.00	Jnit cost multiplier (Wkst. B, Part	0. 000101	1. 608933	0. 50006	0	20	05.00
)		I		I	I	

Health Financial Systems	IU HEALTH NO	RTH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2017	Worksheet B-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	pared: 1 am
			OTHER GENERAL	-		
			SERVI CE			
Cost Center Description	MEDI CAL	SOCI AL SERVICE	PATI ENT			
	RECORDS &		TRANSPORTATI 0	N		
	LI BRARY	(TOTAL PATIENT				
	(GROSS	DAYS)	(TOTAL PATIEN	Т		
	CHARGES)		DAYS)			
	16.00	17.00	18.00			
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017		pared: 1 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	36, 749, 573		36, 749, 5	73 0	36, 749, 573	30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	2, 469, 042		2, 469, 04	12 0	2, 469, 042	34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT	5, 590, 805		5, 590, 80	05 0	5, 590, 805	34.02
43. 00 04300 NURSERY	3, 996, 395		3, 996, 39	95 0	3, 996, 395	43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	19, 518, 420		19, 518, 42		17/010/120	
51.00 05100 RECOVERY ROOM	5, 265, 896		5, 265, 89		5, 265, 896	
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 697, 053		9, 697, 0		9, 697, 053	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 733, 440		9, 733, 44		9, 733, 440	
56. 00 05600 RADI OI SOTOPE	609, 971		609, 9		609, 971	
60. 00 06000 LABORATORY	8, 652, 169		8, 652, 16		8, 652, 169	
65. 00 06500 RESPI RATORY THERAPY	3, 467, 450		-,		3, 467, 450	
66. 00 06600 PHYSI CAL THERAPY	4, 190, 420		4, 190, 42	20 0	4, 190, 420	66.00
67.00 06700 OCCUPATI ONAL THERAPY	798, 326	0	798, 32	26 0	798, 326	
68.00 06800 SPEECH PATHOLOGY	375, 065	0	375, 00	5 0	375, 065	
69. 00 06900 ELECTROCARDI OLOGY	1, 147, 774		1, 147, 7	74 0	1, 147, 774	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	714, 162		714, 10	62 0	714, 162	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 484, 929		8, 484, 92	29 0	8, 484, 929	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	17, 599, 374		17, 599, 3	74 0	17, 599, 374	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 565, 871		9, 565, 8	71 0	9, 565, 871	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	5, 136, 108		5, 136, 10	0 8	5, 136, 108	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	6, 987, 062		6, 987, 00	52 0	6, 987, 062	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 921, 948		2, 921, 94	18	2, 921, 948	92.00
200.00 Subtotal (see instructions)	163, 671, 253	0	163, 671, 25	53 0	163, 671, 253	200.00
201.00 Less Observation Beds	2, 921, 948		2, 921, 94	18	2, 921, 948	201.00
202.00 Total (see instructions)	160, 749, 305	0	160, 749, 30	05 0	160, 749, 305	202.00

Health Financial Systems	IU HEALTH NORT	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017		epared: 51 am
	-	Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				1		
30. 00 03000 ADULTS & PEDI ATRI CS	57, 263, 368		57, 263, 3			30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	5, 451, 790		5, 451, 7			34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	19, 420, 332		19, 420, 3			34.02
43. 00 04300 NURSERY	8, 598, 535		8, 598, 5	35		43.00
ANCILLARY SERVICE COST CENTERS			1	- 1		
50. 00 05000 OPERATI NG ROOM	66, 576, 603	87, 666, 222				
51.00 05100 RECOVERY ROOM	7, 833, 654	20, 853, 468			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 505, 571	6, 967, 350			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	9, 139, 560	39, 601, 376			0.00000	
56. 00 05600 RADI OI SOTOPE	813, 283	6, 513, 520			0.00000	
60. 00 06000 LABORATORY	19, 108, 834	28, 039, 381			0.00000	
65. 00 06500 RESPI RATORY THERAPY	6, 783, 541	2, 986, 403			0.00000	
66. 00 06600 PHYSI CAL THERAPY	3, 810, 497	5, 186, 103			0.00000	
67.00 06700 OCCUPATI ONAL THERAPY	1, 930, 408	1, 130, 930			0.00000	
68.00 06800 SPEECH PATHOLOGY	382, 799	854, 125			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	3, 703, 475	7, 493, 540			0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	780, 241	2, 112, 500			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 391, 741	10, 822, 049			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	51, 692, 961	20, 354, 339			0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 723, 166	14, 707, 458			0.00000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0. 000000		
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	13, 216, 496	18, 792, 690	32, 009, 1	36 0. 160457	0.00000	75.01
OUTPATIENT SERVICE COST CENTERS						_
91.00 09100 EMERGENCY	13, 470, 967	64, 383, 495				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	282, 822	6, 036, 978			0.00000	
200.00 Subtotal (see instructions)	365, 880, 644	344, 501, 927	710, 382, 5	71		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	365, 880, 644	344, 501, 927	710, 382, 5	71		202.00

Health Financial Systems	IU HEALTH NORTH	I HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prep 5/29/2018 9:51	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT					34.01
34. 02 03402 PREMATURE I NTENSI VE CARE UNI T					34.02
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·				
50. 00 05000 OPERATI NG ROOM	0. 126543				50.00
51.00 05100 RECOVERY ROOM	0. 183563				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 239594				52.00
54, 00 05400 RADI OLOGY-DI AGNOSTI C	0, 199697				54.00
56. 00 05600 RADI 0I SOTOPE	0. 083252				56.00
60, 00 06000 LABORATORY	0. 183510				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 354910				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 465778				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 260777				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 303224				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 102507				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 246881				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 441606				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 244275				72.00
73. 00 07200 DRUGS CHARGED TO PATTENT	0. 197517				73.00
75.00 07500 ASC (NON-DI STINCT PART)	0. 000000				75.00
					75.00 75.01
	0. 160457				/5.01
	0.000745				01 00
91.00 09100 EMERGENCY	0.089745				91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 462348				92.00
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 NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 9:5	pared: 1 am
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	36, 749, 573		36, 749, 57	3 0	36, 749, 573	
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	2, 469, 042		2, 469, 04	2 0	2, 469, 042	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	5, 590, 805		5, 590, 80	05 0	5, 590, 805	34.02
43. 00 04300 NURSERY	3, 996, 395		3, 996, 39	5 0	3, 996, 395	43.00
ANCI LLARY SERVI CE COST CENTERS			-			
50.00 05000 OPERATI NG ROOM	19, 518, 420		19, 518, 42	0 0	19, 518, 420	50.00
51.00 05100 RECOVERY ROOM	5, 265, 896		5, 265, 89	6 0	5, 265, 896	
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 697, 053		9, 697, 05	3 0	9, 697, 053	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 733, 440		9, 733, 44	0 0	9, 733, 440	54.00
56. 00 05600 RADI OI SOTOPE	609, 971		609, 97	1 0	609, 971	56.00
60. 00 06000 LABORATORY	8, 652, 169		8, 652, 16	9 0	8, 652, 169	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 467, 450	0	3, 467, 45	0 0	3, 467, 450	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 190, 420	0	4, 190, 42	0 0	4, 190, 420	66.00
67.00 06700 OCCUPATI ONAL THERAPY	798, 326	0	798, 32	6 0	798, 326	67.00
68.00 06800 SPEECH PATHOLOGY	375, 065	0	375, 06	5 0	375, 065	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 147, 774		1, 147, 77	4 0	1, 147, 774	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	714, 162		714, 16	2 0	714, 162	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 484, 929		8, 484, 92	9 0	8, 484, 929	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	17, 599, 374		17, 599, 37	4 0	17, 599, 374	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 565, 871		9, 565, 87	1 0	9, 565, 871	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	5, 136, 108		5, 136, 10	0 8	5, 136, 108	75.01
OUTPATIENT SERVICE COST CENTERS			•			
91.00 09100 EMERGENCY	6, 987, 062		6, 987, 06	2 0	6, 987, 062	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 921, 948		2, 921, 94	8	2, 921, 948	92.00
200.00 Subtotal (see instructions)	163, 671, 253	0	163, 671, 25	3 0	163, 671, 253	200.00
201.00 Less Observation Beds	2, 921, 948		2, 921, 94	8	2, 921, 948	201.00
202.00 Total (see instructions)	160, 749, 305		160, 749, 30	05 0	160, 749, 305	

Health Financial Systems	IU HEALTH NORT	TH HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017		epared: 51 am
	-	Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	57, 263, 368		57, 263, 3			30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	5, 451, 790		5, 451, 7			34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	19, 420, 332		19, 420, 3			34.02
43. 00 04300 NURSERY	8, 598, 535		8, 598, 5	35		43.00
ANCI LLARY SERVICE COST CENTERS			r			
50. 00 05000 OPERATI NG ROOM	66, 576, 603	87, 666, 222				
51.00 05100 RECOVERY ROOM	7, 833, 654	20, 853, 468				
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 505, 571	6, 967, 350			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 139, 560	39, 601, 376			0. 000000	
56. 00 05600 RADI OI SOTOPE	813, 283	6, 513, 520				
60. 00 06000 LABORATORY	19, 108, 834	28, 039, 381				
65. 00 06500 RESPI RATORY THERAPY	6, 783, 541	2, 986, 403				
66. 00 06600 PHYSI CAL THERAPY	3, 810, 497	5, 186, 103				
67.00 06700 OCCUPATI ONAL THERAPY	1, 930, 408	1, 130, 930				
68.00 06800 SPEECH PATHOLOGY	382, 799	854, 125				
69. 00 06900 ELECTROCARDI OLOGY	3, 703, 475	7, 493, 540			0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	780, 241	2, 112, 500			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 391, 741	10, 822, 049	19, 213, 7	0. 441606	0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	51, 692, 961	20, 354, 339				
73.00 07300 DRUGS CHARGED TO PATIENTS	33, 723, 166	14, 707, 458	48, 430, 6		0.00000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000		
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	13, 216, 496	18, 792, 690	32, 009, 1	36 0. 160457	0. 000000	75.01
OUTPATIENT SERVICE COST CENTERS			_			
91.00 09100 EMERGENCY	13, 470, 967	64, 383, 495	77, 854, 4	52 0. 089745	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	282, 822	6, 036, 978	6, 319, 8	0. 462348	0.00000	92.00
200.00 Subtotal (see instructions)	365, 880, 644	344, 501, 927	710, 382, 5	71		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	365, 880, 644	344, 501, 927	710, 382, 5	71		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0161 Period: To 12/31/2017 Worksheet C Part I Date/Time Prepared: 5/29/2018 (9:51 am Cost Center Description PPS Inpatient Ratio Title XIX Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 30.00 34.00 34.00 34.00 034000 SURGI CAL INTENSIVE CARE UNIT 34.00 34.00 34.00 34.00 034000 NURSERY 34.00 34.00 34.00 350.00 05000 RECOVERY ROM 0.126543 51.00 34.00 360.00 05000 OPERATING ROM 0.138563 51.00 51.00 50.00 055000 RECOVERY ROM 0.138563 51.00 52.00 50.00 055000 RECOVERY ROM 0.333252 56.00 56.00 60.00 06000 APPTIONAL THERAPY 0.345910 66.00 66.00 60.00 06000 OPERATING ROMEPHAPY 0.33224 67.00 67.00 61.00 06000 RADORAD ROMEY 0.333224 66.00 66.00 60.00 06000 RECOR	Health Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lieu	u of Form CMS-:	2552-10
Cost Center Description PPS Inpatient Ratio Nation 11.00 11.00 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 34.00 34.00 34.00 34.01 34.01 34.01 34.01 34.01 34.01 34.01 34.01 34.01 34.01 34.01 34.01 34.02 34.02 34.02 34.02 34.02 34.02 34.01 34.01 34.02 34.02 34.02 34.02 35.00 05000 DEPEATING ROOM 0.126543 50.00 05200 DELIVERY ROOM 0.138563 51.00 05400 RADIO LOGY-DI AGNOSTI C 0.199697 56.00 05600 RADIO ISOTOPE 0.083252 60.00 06000 LABORATORY 0.183510 60.00 06600 PHYSI CAL THERAPY 0.465778 60.00 06600 SPEECH PATHOLOGY 0.303224 60.00 06600 SPEECH PATHOLOGY 0.303224 60.00 06600 SPEECH PATHOLOGY	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/29/2018 9:5	
Ratio Ratio 11.00 <			Title XIX	Hospi tal	PPS	
30.00 3000 ADULTS & PEDIATRICS 30.00 34.00 3300 DEDIATRIC INTENSIVE CARE UNIT 34.00 34.01 3010 PEDIATRIC INTENSIVE CARE UNIT 34.01 34.00 3300 DEDIATRIC INTENSIVE CARE UNIT 34.01 34.00 34.00 MACILLARY SERVICE COST CENTERS 34.02 350.00 D5000 DPENATING COST CENTERS 50.00 50.00 D5000 DELIVERY ROOM 0.126543 50.00 51.00 D5000 DELIVERY ROOM 0.138563 50.00 52.00 D5200 DELIVERY ROOM 0.138563 50.00 54.00 D5400 RADI OLOGY-DI AGNOSTIC 0.19697 54.00 56.00 D6000 LABORATORY 0.183510 60.00 66.00 D6000 LABORATORY 0.183510 60.00 66.00 D6000 CCUPATI ONAL THERAPY 0.260777 65.00 66.00 D6000 ELECTROCARDI OLOGY 0.202507 67.00 67.00 D6700 DECLECTROCARDI OLOGY 0.202507 69.00 70.00 OT000 ELECTROCARDI OLOGY 0.246881 70.00 7	Cost Center Description	Ratio				
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 34.00 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 34.01 34.00 04300 NURSERY 34.01 43.00 04300 NURSERY 43.00 ANCLLARY SERVICE COST CENTERS 50.00 05000 PERATING ROOM 0.126543 50.00 05000 RECOVERY ROOM 0.133563 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.329594 52.00 54.00 05600 RADI OLOGY-DI AGNOSTI C 0.199697 54.00 56.00 05000 RESPI RATORY THERAPY 0.354910 66.00 65.00 06500 RSPI RATORY THERAPY 0.354910 66.00 66.00 06500 PESPI RATORY THERAPY 0.460778 67.00 67.00 06000 LECTROCARD ILOGY 0.33224 68.00 69.00 06000 ELECTROCARD ILOGY 0.102507 70.00 70.00 70.00 ELECTROCARDED TO PATI ENTS 0.441606 71.00 71.00 07100 NEULARY SERVICE 0.197517 73.00 <td>INPATIENT ROUTINE SERVICE COST CENTERS</td> <td>· · · · ·</td> <td></td> <td></td> <td></td> <td></td>	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·				
34.01 03401 PEDI ATRI C INTENSI VE CARE UNI T 34.01 34.02 03402 PREMATURE INTENSI VE CARE UNI T 34.02 33.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.126543 50.00 50.00 05100 RECOVERY ROOM 0.183563 51.00 52.00 05200 DELI VERY ROOM & 0.183563 52.00 54.00 05400 RADI OLGGY-DI AGNOSTI C 0.199697 54.00 54.00 05600 RADI OLGGY-DI AGNOSTI C 0.199697 56.00 65.00 06000 LABORATORY 0.83252 56.00 65.00 06000 PARTORY THERAPY 0.354910 66.00 66.00 06000 PESPI RATORY THERAPY 0.260777 67.00 67.00 06000 PLECTROCARDI PHAY 0.2465778 68.00 69.00 06900 ELECTROCARDI OLGGY 0.303224 68.00 69.00 06000 PLECTROEARGED TO PATI ENTS 0.41606 71.00 71.00 DTOLMED LAC SUPPHI ES CHARGED TO PATI ENTS 0.44	30. 00 03000 ADULTS & PEDI ATRI CS					30.00
34.01 03401 PEDI ATRI C INTENSI VE CARE UNI T 34.01 34.02 03402 PREMATURE INTENSI VE CARE UNI T 34.02 33.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.126543 50.00 51.00 05100 RECOVERY ROOM 0.183563 51.00 52.00 05200 DELI VERY ROOM & 0.183510 52.00 54.00 05400 RADI OLGGY-DI AGNOSTI C 0.199697 54.00 56.00 05600 RADI OLGGY-DI AGNOSTI C 0.199697 56.00 66.00 06000 LABORATORY 0.183510 60.00 65.00 06000 PESPI RATORY THERAPY 0.354910 65.00 66.00 06000 PESPI RATORY THERAPY 0.260777 67.00 67.00 06000 PELECTROCARDI OLGGY 0.303224 68.00 69.00 06900 ELECTROCARDI OLGGY ADI PATI ENTS 0.41606 71.00 71.00 07000 ELECTROCARDE TO PATI ENTS 0.41606 71.00 72.00 7300 DRUSC CHARGED TO PATI E	34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 43.00 50.00 05000 0PERATING ROOM 0.126543 51.00 05000 0PERATING ROOM 0.133563 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.239594 52.00 05400 RADIOLOGY-01AGNOSTI C 0.199697 54.00 05600 RADIOLOGY-01AGNOSTI C 0.199697 56.00 06500 RADIOLAGNOSTI C 0.83252 56.00 06500 RADIOLAGNATORY 0.1354910 65.00 06600 PHYSI CAL THERAPY 0.465778 66.00 06600 PHYSI CAL THERAPY 0.262077 68.00 06800 SPECH PATHOLOGY 0.303224 69.00 06800 PECCH PATHOLOGY 0.303224 69.00 1000 ELECTROCARDIOLOGY 0.303224 69.00 IMPL AEV, CHARGED TO PATI ENTS 0.441606 71.00 71.00 DOTIOD MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.441606 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.441606 73.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td>34.01</td>						34.01
ANCI LLARY SERVICE COST CENTERS 50:00 05000 OPERATI NG ROM 0.126543 50.00 51:00 05100 RECOVERY ROM 0.183563 51.00 52:00 05200 DELI VERY ROM & LABOR ROM 0.239594 52.00 54:00 05400 RADI 0LOGY-DI AGNOSTI C 0.199697 54.00 56:00 05600 RADI 0LOGY-DI AGNOSTI C 0.183510 60.00 60:00 06000 LABORATORY 0.183510 60.00 65:00 06500 RESPI RATORY THERAPY 0.354910 65.00 66:00 06600 PHYSI CAL THERAPY 0.260777 66.00 66:00 06600 SPEECH PATHOLOGY 0.303224 68.00 69:00 G6900 ELECTROCARDI OLOGY 0.303224 68.00 69:00 OF000 CEUPATI ONAL THERAPY 0.246581 70.00 0:00 07000 ELECTROCARDI OLOGY 0.246281 71.00 70:00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.441606 71.00 71:00 07300 DRUGS CHARGED TO PATI ENTS 0.197517 73.00 73.00 70:00 07500 ASC	34. 02 03402 PREMATURE INTENSIVE CARE UNIT					34.02
50.00 05000 0PERATING ROOM 0.126543 50.00 51.00 05100 RECOVERY ROOM 0.183563 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.239594 52.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.199697 54.00 56.00 05600 RADI 0LOGY-DI AGNOSTI C 0.199697 54.00 50.00 06600 LABORATORY 0.183510 65.00 60.00 06500 RESPI RATORY THERAPY 0.183510 65.00 66.00 06600 PHYSI CAL THERAPY 0.364910 65.00 66.00 06600 PHYSI CAL THERAPY 0.260777 67.00 67.00 06700 OCUPATI ONAL THERAPY 0.260777 67.00 68.00 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCACPHALOGRAPHY 0.246881 70.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.441606 71.00 72.00 07200 I MPL, DEV. CHARGED TO PATIENTS 0.197517 72.00 73.00 07300 RUGS CHARGED TO PATIENTS 0.160457 75.01 0107501 CARDI AC CATHERIZATION LABORATORY 0.160457 75.01 <td>43. 00 04300 NURSERY</td> <td></td> <td></td> <td></td> <td></td> <td>43.00</td>	43. 00 04300 NURSERY					43.00
51.00 05100 RECOVERY ROOM 0.183563 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.239594 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.199697 54.00 66.00 05600 RADI OLOGY-DI AGNOSTI C 0.083252 56.00 60.00 06000 LABORATORY 0.183510 60.00 65.00 06600 PHYSI CAL THERAPY 0.465778 66.00 66.00 06600 PHYSI CAL THERAPY 0.260777 67.00 68.00 06900 ELECTROCARD IOLOGY 0.303224 68.00 69.00 06900 ELECTROCARD IOLOGY 0.246881 70.00 70.00 07000 ELECTROCARD IOLOGY 0.244275 71.00 71.00 MDI OL DEV. CHARGED TO PATI ENTS 0.441606 71.00 73.00 07300 RRUGS CHARGED TO PATI ENTS 0.1002507 75.00 75.00 07500 ASC (NON-DI STI NCT PART) 0.000000 73.00 73.00 74.00 MUTATI ENT SERVICE COST CENTERS 91.00 73.00 73.00 73.00 91.00 <td>ANCILLARY SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td>	ANCILLARY SERVICE COST CENTERS					
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.239594 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.199697 54.00 56.00 05600 RADI OLOGY-DI AGNOSTI C 0.083252 56.00 60.00 06000 LABORATORY 0.133510 60.00 65.00 06500 RESPI RATORY THERAPY 0.354910 65.00 66.00 06600 PHYSI CAL THERAPY 0.465778 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.260777 67.00 68.00 6800 SPEECH PATHOLOGY 0.102507 68.00 69.00 06900 ELECTROCARDI OLOGY 0.102507 69.00 70.00 07000 ELECTROCARDI OLOGY 0.246881 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.441606 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.197517 73.00 73.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 0.160457 75.01 017PATI ENT SERVICE COST CENTERS 0.000000 75.01 75.01 91.00 <td>50.00 05000 OPERATI NG ROOM</td> <td>0. 126543</td> <td></td> <td></td> <td></td> <td>50.00</td>	50.00 05000 OPERATI NG ROOM	0. 126543				50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 0. 199697 54.00 56.00 05600 RADI OI SOTOPE 0. 083252 56.00 60.00 06000 LABORATORY 0. 183510 60.00 65.00 06500 RESPI RATORY THERAPY 0. 354910 65.00 66.00 06600 PHYSI CAL THERAPY 0. 465778 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 260777 67.00 68.00 06800 SPEECH PATHOLOGY 0. 303224 68.00 69.00 ELECTROCARDI OLOGY 0. 102507 70.00 70.00 71.00 07000 ELECTROCERCEPHALOGRAPHY 0. 246881 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 441606 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0. 197517 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 197517 73.00 75.01 07501 CARDI AC CATHERIZATI ON LABORATORY 0. 160457 75.01 0UTPATI ENT SERVICE COST CENTERS 91.00 92.00 92200 09200 0BSERVATI O	51.00 05100 RECOVERY ROOM	0. 183563				51.00
56.00 05600 RADI 0I SOTOPE 0.083252 56.00 60.00 06000 LABORATORY 0.183510 60.00 65.00 06500 RESPI RATORY THERAPY 0.354910 65.00 66.00 06600 PHYSI CAL THERAPY 0.465778 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.260777 67.00 68.00 06800 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCARDI OLOGY 0.102507 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.441606 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.441606 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.197517 73.00 75.01 07501 CARDI AC CATHERIZATION LABORATORY 0.160457 75.01 0UTPATI ENT SERVICE COST CENTERS 0.089745 91.00 91.00 09100 EMERGENCY 0.462348 91.00 920.00 092000 BSERVATI ON BEDS (NON-DI STI NCT PAR	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 239594				52.00
60.00 06000 LABORATORY 0.183510 60.00 65.00 06500 RESPI RATORY THERAPY 0.354910 65.00 66.00 06600 PHYSI CAL THERAPY 0.465778 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.260777 67.00 68.00 06800 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCARDI OLOGY 0.102507 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.246881 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.441606 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATI ENT 0.244275 72.00 73.00 07300 RUGS CHARGED TO PATI ENT 0.244275 73.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 0.160457 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 0.160457 75.01 01700 FUENT ENT SERVICE COST CENTERS 91.00 92.00 92.00 095200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.462348 92.00	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 199697				54.00
65.00 06500 RESPI RATORY THERAPY 0.354910 65.00 66.00 06600 PHYSI CAL THERAPY 0.465778 66.00 67.00 0CCUPATI ONAL THERAPY 0.260777 67.00 68.00 06800 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCARDI OLOGY 0.102507 69.00 70.00 07000 ELECTROCARDI OLOGY 0.246881 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.441606 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.197517 72.00 75.00 07500 (ASC (NON-DI STI NCT PART) 0.000000 75.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 0.160457 75.01 0100 DIPONE EMERGENCY 0.089745 91.00 91.00 09100 EMERGENCY 0.462348 92.00 920.00 Subtotal (see instructions) 200.00 201.00 201.00 <td>56. 00 05600 RADI OI SOTOPE</td> <td>0. 083252</td> <td></td> <td></td> <td></td> <td>56.00</td>	56. 00 05600 RADI OI SOTOPE	0. 083252				56.00
66.00 06600 PHYSI CAL THERAPY 0.465778 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.260777 67.00 68.00 06800 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCARDI OLOGY 0.102507 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.246881 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.197517 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.197517 73.00 75.01 07501 CATHERI ZATI ON LABORATORY 0.160457 75.01 017501 CATHERI ZATI ON LABORATORY 0.089745 91.00 91.00 09100 EMERGENCY 0.089745 92.00 920.00 Subtotal (see instructions) 200.00 201.00 200.00	60. 00 06000 LABORATORY	0. 183510				60.00
67.00 06700 0CCUPATIONAL THERAPY 0.260777 67.00 68.00 06800 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCARDIOLOGY 0.102507 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.246881 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.2424275 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.197517 73.00 75.01 07501 CATHERIZATION LABORATORY 0.160457 75.01 001704 EMERGENCY 0.089745 91.00 91.00 09200 DSERVATION BEDS (NON-DI STINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 462348 200.00 201.00	65. 00 06500 RESPI RATORY THERAPY	0. 354910				65.00
68.00 06800 SPEECH PATHOLOGY 0.303224 68.00 69.00 06900 ELECTROCARDIOLOGY 0.102507 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.246881 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.244275 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.107517 73.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 75.01 07501 CARDIAC CATHERIZATION LABORATORY 0.160457 75.01 01TPATIENT SERVICE COST CENTERS 91.00 92.00 92.00 92.00 92.00 0958ERVATION BEDS (NON-DI STINCT PART) 0.462348 92.00 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00	66. 00 06600 PHYSI CAL THERAPY	0. 465778				66.00
69.00 06900 ELECTROCARDI OLOGY 0.102507 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.246881 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.242275 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.197517 73.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 0.160457 75.00 75.01 07500 DSERVATI ON BEDS (NON-DI STINCT PART) 0.489745 91.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 446348 200.00 201.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 260777				67.00
70.00 07000 ELECTROENCEPHALOGRAPHY 0.246881 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.244275 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.197517 73.00 75.01 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 75.01 07501 CARDI AC CATHERIZATION LABORATORY 0.160457 75.01 91.00 OPSERVATION BEDS (NON-DI STINCT PART) 0.462348 91.00 920.00 Subtotal (see instructions) 462348 200.00 201.00 Less Observation Beds 201.00 201.00	68.00 06800 SPEECH PATHOLOGY	0. 303224				68.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.441606 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.244275 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.197517 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 75.01 07501 CARDIAC CATHERIZATION LABORATORY 0.160457 75.01 91.00 09100 EMERGENCY 0.089745 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	69.00 06900 ELECTROCARDI OLOGY	0. 102507				69.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.244275 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.197517 73.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 75.01 07501 CATHERIZATION LABORATORY 0.160457 75.01 01100 EMERGENCY 0.089745 91.00 92.00 095ERVATION BEDS (NON-DI STINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 200.00 201.00	70.00 07000 ELECTROENCEPHALOGRAPHY	0. 246881				70.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.197517 73.00 75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 75.01 07501 CARDIAC CATHERIZATION LABORATORY 0.160457 75.01 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.089745 91.00 92.00 095ERVATION BEDS (NON-DI STINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 200.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 441606				71.00
75.00 07500 ASC (NON-DI STINCT PART) 0.000000 75.00 75.01 07501 CARDI AC CATHERI ZATION LABORATORY 0.160457 75.01 0UTPATI ENT SERVICE COST CENTERS 0.089745 91.00 92.00 92.00 09SERVATION BEDS (NON-DI STINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 200.00 201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 244275				72.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY 0.160457 75. 01 0UTPATI ENT SERVICE COST CENTERS 0000 09100 EMERGENCY 0.089745 91. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 462348 92. 00 92. 00 200. 00 200. 00 200. 00 201. 00 <td>73.00 07300 DRUGS CHARGED TO PATIENTS</td> <td>0. 197517</td> <td></td> <td></td> <td></td> <td>73.00</td>	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 197517				73.00
OUTPATI ENT SERVICE COST CENTERS 91.00 91.00 91.00 91.00 91.00 91.00 92.00	75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
OUTPATI ENT SERVICE COST CENTERS 91.00 91.00 91.00 91.00 91.00 91.00 92.00	75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 160457				75.01
91.00 09100 EMERGENCY 0.089745 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.462348 92.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00						
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00		0. 089745				91.00
201.00 Less Observation Beds 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 462348				92.00
201.00 Less Observation Beds 201.00	200.00 Subtotal (see instructions)					200.00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds					
	202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider C		Period: From 01/01/2017	Worksheet C Part II	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost		t Capital	Operating Cost	
	(Wkst. B, Part				Reducti on	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	19, 518, 420	5, 416, 631			0	50.00
51.00 05100 RECOVERY ROOM	5, 265, 896	754, 139			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 697, 053	2, 163, 690			0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 733, 440	2, 231, 825			0	54.00
56. 00 05600 RADI OI SOTOPE	609, 971	91, 327			0	56.00
60. 00 06000 LABORATORY	8, 652, 169	680, 570			0	60.00
65. 00 06500 RESPI RATORY THERAPY	3, 467, 450	263, 283			0	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 190, 420	661, 302		8 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	798, 326	19, 725	778, 60	01 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	375, 065	12, 519	362, 54	6 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 147, 774	414, 784	732, 99	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	714, 162	103, 242	610, 92	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 484, 929	459, 935	8, 024, 99	4 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	17, 599, 374	955, 548	16, 643, 82	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 565, 871	605, 592	8, 960, 27	9 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	5, 136, 108	1, 156, 928	3, 979, 18	0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	6, 987, 062	1, 120, 851	5, 866, 21	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 921, 948	516, 051	2, 405, 89	7 0	0	92.00
200.00 Subtotal (sum of lines 50 thru 199)	114, 865, 438	17, 627, 942	97, 237, 49	6 0	0	200. 00
201.00 Less Observation Beds	2, 921, 948	516, 051		7 0	0	201.00
202.00 Total (line 200 minus line 201)	111, 943, 490	17, 111, 891			0	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA	TIOS NET OF	Provider C	CN: 15-0161	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 01/01/2017	Part II	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	epared: 51 am
·		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
·	Capital and	(Worksheet C,	Cost to Char	je		
	Operating Cost					
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS	·					
50.00 05000 OPERATING ROOM	19, 518, 420	154, 242, 825				50.00
51.00 05100 RECOVERY ROOM	5, 265, 896	28, 687, 122				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 697, 053	40, 472, 921	0. 2395	94		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 733, 440	48, 740, 936	0. 1996	97		54.00
56. 00 05600 RADI OI SOTOPE	609, 971	7, 326, 803				56.00
60. 00 06000 LABORATORY	8, 652, 169	47, 148, 215	0. 1835	10		60.00
65. 00 06500 RESPI RATORY THERAPY	3, 467, 450	9, 769, 944				65.00
66. 00 06600 PHYSI CAL THERAPY	4, 190, 420	8, 996, 600				66.00
67.00 06700 OCCUPATI ONAL THERAPY	798, 326	3, 061, 338	0. 2607	77		67.00
68.00 06800 SPEECH PATHOLOGY	375, 065	1, 236, 924	0. 3032	24		68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 147, 774	11, 197, 015	0. 10250)7		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	714, 162	2, 892, 741	0. 2468	31		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 484, 929	19, 213, 790	0.4416	06		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	17, 599, 374	72,047,300	0. 2442	75		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	9, 565, 871	48, 430, 624	0. 1975	17		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	00		75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	5, 136, 108	32, 009, 186	0. 1604	57		75.01
OUTPATIENT SERVICE COST CENTERS			_			
91.00 09100 EMERGENCY	6, 987, 062	77, 854, 462	0. 0897	45		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 921, 948	6, 319, 800	0.4623	18		92.00
200.00 Subtotal (sum of lines 50 thru 199)	114, 865, 438	619, 648, 546				200.00
201.00 Less Observation Beds	2, 921, 948	0				201.00
202.00 Total (line 200 minus line 201)	111, 943, 490	619, 648, 546				202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPI	TAL COSTS	Provider C	F	Period: From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/29/2018 9:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Swing Bed Adjustment	Reduced Capi tal	Total Patient Days	Per Diem (col. 3 / col. 4)	
	(from Wkst. B,	-	Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 490, 430	0	6, 490, 430	24, 651	263.29	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0		(0 0	0.00	34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	535, 960		535, 960	0 1, 146	467.68	34.01
34.02 PREMATURE INTENSIVE CARE UNIT	1, 438, 223		1, 438, 223	3 4, 558	315.54	34.02
43.00 NURSERY	724, 049		724, 049	9 5, 075	142.67	43.00
200.00 Total (lines 30 through 199)	9, 188, 662		9, 188, 662	2 35, 430		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	-			
	6.00	7.00			-	
INPATIENT ROUTINE SERVICE COST CENTERS			1			-
30.00 ADULTS & PEDIATRICS	7,078	1, 863, 567				30.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	2	935				34.01
34.02 PREMATURE INTENSIVE CARE UNIT	0	0				34.02
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	7,080	1, 864, 502	2			200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2017	Worksheet D Part II Date (Time Due	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	E 444 404	454 040 005	0.00544	0 04 077 040	050.475	50.00
50. 00 05000 OPERATING ROOM	5, 416, 631					
51.00 05100 RECOVERY ROOM	754, 139					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 163, 690					
54. 00 05400 RADI OLOGY-DI AGNOSTI C 56. 00 05600 RADI OI SOTOPE	2, 231, 825				168, 175 6, 060	
60. 00 06000 LABORATORY	91, 327 680, 570					60.00
65. 00 06500 RESPIRATORY THERAPY	263, 283					
66. 00 06600 PHYSI CAL THERAPY	661, 302			-		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	19, 725					
68. 00 06800 SPEECH PATHOLOGY	12, 519					
69. 00 06900 ELECTROCARDI OLOGY	414, 784					
70. 00 07000 ELECTROENCEPHALOGRAPHY	103, 242					
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	459, 935					
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	955, 548					
73.00 07300 DRUGS CHARGED TO PATIENTS	605, 592					73.00
75.00 07500 ASC (NON-DI STINCT PART)	0				0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 156, 928	32, 009, 186	0. 03614	4 5, 796, 154	209, 496	75.01
OUTPATIENT SERVICE COST CENTERS		· · · · ·			· · · · ·	
91.00 09100 EMERGENCY	1, 120, 851	77, 854, 462	0.01439	7 6, 072, 147	87, 421	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	516, 051	6, 319, 800	0. 08165	6 102, 780	8, 393	92.00
200.00 Total (lines 50 through 199)	17, 627, 942	619, 648, 546	1	92, 952, 675	2, 258, 872	200. 00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	Period: rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 9:5	pared: 1 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments		Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I		1			
30. 00 03000 ADULTS & PEDI ATRI CS 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	C	-	0	
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	0	C	0	0	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0	0		0	0	34.02
43. 00 04300 NURSERY	0	0	()	0	0	43.00
200.00 Total (lines 30 through 199)	0	0	()	0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,			0 5	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS		•	•			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	24, 651	0.00	7, 078	30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	C	0.00	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT		0	1, 146	0.00	2	34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT		0	4, 558	0.00	0	34.02
43. 00 04300 NURSERY		0	5, 075	0.00	0	43.00
200.00 Total (lines 30 through 199)		0	35, 430		7, 080	200.00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0					34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT	0					34.02
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	0					34.02 43.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title	2 XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician			I Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
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	54.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0		0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS	1	I				
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00 Total (lines 50 through 199)	0	I 0	1	0 0	0	200. 00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	S Provider C	1	Period: From 01/01/2017 Fo 12/31/2017		pared: 1 am	
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges		
	Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.		
		4)	col. 2, 3 and	8)	7)		
			4)				
	4.00	5.00	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	() 154, 242, 825			
51.00 05100 RECOVERY ROOM	0	0	(28, 687, 122	0.000000		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(40, 472, 921			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(48, 740, 936	0.000000	54.00	
56. 00 05600 RADI OI SOTOPE	0	0	(7, 326, 803			
60. 00 06000 LABORATORY	0	0	(0 47, 148, 215	0. 000000	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0	(9, 769, 944	0. 000000	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0	(8, 996, 600	0. 000000	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0	(3, 061, 338	0. 000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	(1, 236, 924	0.000000	68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 11, 197, 015	0.000000	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		2, 892, 741	0. 000000	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		19, 213, 790	0. 000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72, 047, 300	0. 000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		48, 430, 624	0. 000000	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(0 0	0. 000000	75.00	
75.01 07501 CARDIAC CATHERIZATION LABORATORY	0	0	(32, 009, 186	0. 000000	75.01	
OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY	0	0	(77, 854, 462	0.000000	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(6, 319, 800	0. 000000	92.00	
200.00 Total (lines 50 through 199)	0	0	(619, 648, 546		200. 00	

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-0161	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	24, 266, 043		0 12, 813, 058		50.00
51.00 05100 RECOVERY ROOM	0. 000000	2, 865, 086		0 3, 110, 204	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	114, 113		0 17, 997		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 672, 740		0 7, 016, 724	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 000000	486, 191		0 2, 207, 883	0	56.00
60. 00 06000 LABORATORY	0. 000000	5, 994, 099		0 2, 462, 118	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 289, 269		0 824, 353	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 643, 089		0 37, 261	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	886, 689		0 11, 361	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	188, 896		0 2,352	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 665, 848		0 3, 075, 850	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	288, 289		0 147, 249	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 097, 431		0 2, 844, 415	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	24, 025, 215		0 5, 249, 630	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	10, 498, 596		0 2, 606, 980	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0. 000000	5, 796, 154		0 6, 073, 521	0	75.01
OUTPATIENT SERVICE COST CENTERS	· · · · ·	i				
91.00 09100 EMERGENCY	0.000000	6,072,147		0 10, 238, 449	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	102, 780		0 836, 595		92.00
200.00 Total (lines 50 through 199)		92, 952, 675		0 59, 576, 000		200.00
-						

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 9:5	pared: 1 am
		Title	XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 126543			0 0	1, 621, 403	
51.00 05100 RECOVERY ROOM	0. 183563			0 0	570, 918	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 239594			0 0	4, 312	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 199697			0 0	1, 401, 219	
56. 00 05600 RADI OI SOTOPE	0. 083252	2, 207, 883		0 0	183, 811	56.00
60. 00 06000 LABORATORY	0. 183510	2, 462, 118		0 0	451, 823	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 354910	824, 353		0 0	292, 571	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 465778	37, 261		0 0	17, 355	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 260777	11, 361		0 0	2, 963	67.00
68.00 06800 SPEECH PATHOLOGY	0. 303224	2, 352		0 0	713	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 102507	3, 075, 850		0 0	315, 296	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 246881	147, 249		0 0	36, 353	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 441606	2, 844, 415		0 0	1, 256, 111	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 244275	5, 249, 630		0 0	1, 282, 353	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 197517	2, 606, 980		0 45, 348	514, 923	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75.01 07501 CARDIAC CATHERIZATION LABORATORY	0. 160457	6, 073, 521		0 0	974, 539	75.01
OUTPATIENT SERVICE COST CENTERS		•	•			
91.00 09100 EMERGENCY	0. 089745	10, 238, 449	1	0 0	918, 850	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 462348	836, 595		0 0	386, 798	92.00
200.00 Subtotal (see instructions)		59, 576, 000		0 45, 348	10, 232, 311	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		59, 576, 000	1	0 45, 348	10, 232, 311	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0161	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 9:5	
		Title	XVIII	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						_
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
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
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	8, 957				73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0				75.01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	8, 957				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	8, 957				202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 1 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 490, 430	0	6, 490, 43	0 24, 651	263.29	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
34. 01 PEDIATRIC INTENSIVE CARE UNIT	535, 960		535, 96	0 1, 146	467.68	34.01
34.02 PREMATURE INTENSIVE CARE UNIT	1, 438, 223		1, 438, 22	3 4, 558	315.54	34.02
43.00 NURSERY	724, 049		724, 04	9 5, 075	142.67	43.00
200.00 Total (lines 30 through 199)	9, 188, 662		9, 188, 66	2 35, 430		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	241	63, 453	5			30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	98	45, 833				34.01
34.02 PREMATURE INTENSIVE CARE UNIT	255	80, 463				34.02
43.00 NURSERY	958	136, 678				43.00
200.00 Total (lines 30 through 199)	1, 552	326, 427	/			200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2017	Worksheet D Part II	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	r	-	1	- F		
50.00 05000 OPERATING ROOM	5, 416, 631					50.00
51.00 05100 RECOVERY ROOM	754, 139					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 163, 690					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 231, 825	48, 740, 936	0. 04579			54.00
56. 00 05600 RADI 0I SOTOPE	91, 327	7, 326, 803	0. 01246	5 8, 936	111	56.00
60. 00 06000 LABORATORY	680, 570	47, 148, 215	0. 01443	5 311, 752	4, 500	60.00
65. 00 06500 RESPI RATORY THERAPY	263, 283	9, 769, 944	0. 02694	8 484, 915	13, 067	65.00
66. 00 06600 PHYSI CAL THERAPY	661, 302	8, 996, 600	0. 07350	6 40, 793	2, 999	66.00
67.00 06700 OCCUPATI ONAL THERAPY	19, 725	3, 061, 338	0. 00644	3 25, 101	162	67.00
68.00 06800 SPEECH PATHOLOGY	12, 519	1, 236, 924	0. 01012	8, 324	84	68.00
69. 00 06900 ELECTROCARDI OLOGY	414, 784	11, 197, 015	0. 03704	4 48, 381	1, 792	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	103, 242	2, 892, 741	0. 03569	0 23, 328	833	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	459, 935	19, 213, 790	0. 02393	8 39, 383	943	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	955, 548	72, 047, 300	0. 01326	3 7, 949	105	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	605, 592	48, 430, 624	0. 01250	4 534, 093	6, 678	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 156, 928	32, 009, 186	0. 03614	4 92, 524	3, 344	75.01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	1, 120, 851	77, 854, 462				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	516, 051	6, 319, 800	0. 08165	6 7, 944	649	92.00
200.00 Total (lines 50 through 199)	17, 627, 942	619, 648, 546	1	2, 307, 019	58, 433	200. 00

Health Financial Systems	IU HEALTH NOF	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	TS Provider C	F	Period: From 01/01/2017 To 12/31/2017		pared: 1 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Post-Stepdown Adjustments		Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2/1	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT				-	0	
34. 01 03401 PEDIATRI C INTENSI VE CARE UNI T	0				0	1
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0				0	
43. 00 04300 NURSERY	0				0	
	0				-	200.00
200.00 Total (lines 30 through 199) Cost Center Description	Swing-Bed	Total Costs	Tatal Dationt	Per Diem (col.	Inpati ent	200.00
COST Center Description	Adjustment	(sum of cols.	Days	$5 \div col.$ 6)	Program Days	
	Amount (see	1 through 3,	Days	5 - 001. 0)	Frogram Days	
	instructions)	minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	24, 651	0.00	241	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0		24,03			
34. 01 03400 PEDIATRIC INTENSIVE CARE UNIT			1, 146			
34. 02 03402 PREMATURE INTENSIVE CARE UNIT			4, 558			
43. 00 04300 NURSERY			5,075			
						200.00
	I npati ent	0	35, 430	л Л	1, 552	200.00
Cost Center Description						
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col. 8)</u> 9.00	-				
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
						20.00
	0					30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0					34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0					34.02
43.00 04300 NURSERY	0	1				43.00
200.00 Total (lines 30 through 199)	0	1				200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017		
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Ti †I	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician			I Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			·			
50. 00 05000 OPERATI NG ROOM	0	C)	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C)	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0	C)	0 0	0	56.00
60. 00 06000 LABORATORY	0	C)	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C)	0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	C)	0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS	r	-		-		
91.00 09100 EMERGENCY	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00 Total (lines 50 through 199)	0	C	P	0 0	0	200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	6 Provider C	1	Period: From 01/01/2017 Fo 12/31/2017		pared: 1 am	
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
	Medi cal	(sum of col 1		(from Wkst. C,			
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.		
		4)	col. 2, 3 and	8)	7)		
			4)				
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS			1	1	-		
50.00 05000 OPERATI NG ROOM	0	0		154, 242, 825			
51.00 05100 RECOVERY ROOM	0	0		28, 687, 122			
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		40, 472, 921			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 48, 740, 936		•	
56. 00 05600 RADI OI SOTOPE	0	0		7, 326, 803			
60. 00 06000 LABORATORY	0	0	(0 47, 148, 215	0.000000	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0	(9, 769, 944	0.000000	65.00	
66. 00 06600 PHYSI CAL THERAPY	0	0	(8, 996, 600			
67.00 06700 OCCUPATI ONAL THERAPY	0	0	(3, 061, 338	0. 000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	(1, 236, 924	0. 000000	68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0 11, 197, 015	0. 000000	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	(2, 892, 741	0.000000	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(19, 213, 790	0.000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(72, 047, 300	0.000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		48, 430, 624	0. 000000	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	75.00	
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0	0		32, 009, 186	0.000000	75.01	
OUTPATIENT SERVICE COST CENTERS						1	
91.00 09100 EMERGENCY	0	0	(77, 854, 462	0.000000	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(6, 319, 800	0. 000000	92.00	
200.00 Total (lines 50 through 199)	0	0	(619, 648, 546		200. 00	
· · ·					•		

Health Financial Systems	IU HEALTH NORTH	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 9:5	pared: 1 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0.000000	215, 469		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0.000000	37, 215		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	123, 411		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	119, 138		0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0.000000	8, 936		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	311, 752		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	484, 915		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	40, 793		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	25, 101		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	8, 324		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	48, 381		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000	23, 328		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	39, 383		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	7, 949		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	534, 093		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0, 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0.000000	92, 524		0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS	I		1	· ·		
91.00 09100 EMERGENCY	0,000000	178, 363		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	7, 944		0 0	0	92.00
200.00 Total (lines 50 through 199)		2, 307, 019		0 0	0	200.00
	· ·		•			•

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 9:5	pared: 1 am
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	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. 126543	0	543, 50	55 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 183563	0	193, 90	03 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 239594	0	22, 50	09 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 199697	0	293, 00	0 0	0	54.00
56. 00 05600 RADI OI SOTOPE	0. 083252	0	18, 8	59 0	0	56.00
60. 00 06000 LABORATORY	0. 183510	0	366, 8	57 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 354910	0	56, 4		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 465778	0	56, 8	79 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 260777	0	35, 8	70 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 303224	0	55, 6	53 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 102507	0	42, 59	91 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 246881	0	108, 9	54 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 441606	0	35, 78	35 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 244275	0	180, 3	12 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 197517	0	121, 7	15 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0. 160457	0	117, 9	19 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0. 089745	0	979, 4	32 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 462348	0	155, 0	76 0	0	
200.00 Subtotal (see instructions)		0	3, 385, 3	47 0	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	3, 385, 34	47 O	0	202.00

Heal th	Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 9:5	
			Ti tl	e XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				_
F0 00	ANCI LLARY SERVICE COST CENTERS	(0.704					50.00
	05000 OPERATING ROOM	68, 784					50.00
	05100 RECOVERY ROOM	35, 593					51.00
	05200 DELIVERY ROOM & LABOR ROOM	5, 393	0				52.00
	05400 RADI OLOGY-DI AGNOSTI C	58, 511	0				54.00
56.00	05600 RADI OI SOTOPE	1, 571	0				56.00
60.00	06000 LABORATORY	67, 322					60.00
65.00	06500 RESPI RATORY THERAPY	20, 023					65.00
66.00	06600 PHYSI CAL THERAPY	26, 493					66.00
67.00	06700 OCCUPATI ONAL THERAPY	9, 354					67.00
	06800 SPEECH PATHOLOGY	16, 878					68.00
	06900 ELECTROCARDI OLOGY	4, 366					69.00
	07000 ELECTROENCEPHALOGRAPHY	26, 899					70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 803					71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	44, 046	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	24, 041	0				73.00
	07500 ASC (NON-DISTINCT PART)	0	0				75.00
75.01	07501 CARDI AC CATHERI ZATI ON LABORATORY	18, 926	0				75.01
	OUTPATIENT SERVICE COST CENTERS	1					
	09100 EMERGENCY	87, 899		•			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	71, 699					92.00
200.00		603, 601	0				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	603, 601	0				202.00

	Financial Systems IU HEALTH NORTH ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0161	Period: From 01/01/2017	Worksheet D-1	
		T: 11 - 20/111	To 12/31/2017	Date/Time Prep 5/29/2018 9:5	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			24.451	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			24, 651 24, 651	1
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	red days)		22, 691	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5.			
00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through Decembe	[~] 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roc	om days) after December :	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (excluding	has bed and	7, 078	9
	newborn days)	0 .			
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII c	only (including private i	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
	through December 31 of the cost reporting period	5 . 51	5 /		
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 (of the cost	0.00	17
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of [.]	the cost	0.00	20
00	reporting period	`		0/ 7/0 570	
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	36, 749, 573 0	
	5 x line 17)		0 1 1		
00	Swing-bed cost applicable to SNF type services after December x line 18)	31 OF THE COST REPORTED	ig period (The 6	0	23
00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		36, 749, 573	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed cl	narges)	0	28
. 00	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	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nue line 33) (coo instru	stions)	0. 00 0. 00	
	Average per diem private room cost differential (line 34 x li			0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)	· · · · · · · · ·		0	36
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTERENTIAL (LINE	36, 749, 573	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			1, 490. 79	38
	Program general inpatient routine service cost (line 9 x line	-		10, 551, 812	
	Medically necessary private room cost applicable to the Progr	-		0,001,012	

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST		HOSPITAL Provider CC	CN: 15-0161	Peri od:	wof Form CMS- Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
Cost center bescription	Inpatient CostIn				(col. 3 x col.	
	1.00	2.00	<u>col. 2)</u> 3.00	4.00	4)	
42.00 NURSERY (title V & XIX only)	0	2.00	0. 0			42.0
Intensive Care Type Inpatient Hospital Units						1
43.00 INTENSIVE CARE UNIT 44.00 CORONARY CARE UNIT						43.0
45. 00 BURN INTENSIVE CARE UNIT						45.0
46.00 SURGI CAL I NTENSI VE CARE UNI T	0	0	0.0		-	
46.01 PEDIATRIC INTENSIVE CARE UNIT 46.02 PREMATURE INTENSIVE CARE UNIT	2, 469, 042 5, 590, 805	1, 146 4, 558	2, 154. 4 1, 226. 5		4, 309 0	
47.00 OTHER SPECIAL CARE (SPECIFY)	-, ,					47.0
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wks	t. D-3, col. 3,	line 200)			18, 083, 932	48.0
49.00 Total Program inpatient costs (sum of lines 4	1 through 48)(se	e instruction	ns)		28, 640, 053	49.0
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program inpa	tient routine se	ervices (from	Wkst. D. sum	of Parts L and	1, 864, 502	50.0
51.00 Pass through costs applicable to Program inpa and IV)	itient ancillary	services (fro	om Wkst. D, s	sum of Parts II	2, 258, 872	51.0
52.00 Total Program excludable cost (sum of lines 5					4, 123, 374	
53.00 Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		ited, non-phys	sician anesth	etist, and	24, 516, 679	53.0
TARGET AMOUNT AND LIMIT COMPUTATION	12)					
54.00 Program di scharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0.00	
57.00 Difference between adjusted inpatient operati	ng cost and targ	jet amount (li	ine 56 minus	line 53)	0	57.0
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost rep	orting period er	ding 1006 u	ndated and co	mounded by the	0.00	
market basket	or tring period er	laring 1990, a		inpounded by the	0.00	39.0
60.00 Lesser of lines 53/54 or 55 from prior year of 61.00 If line 53/54 is less than the lower of lines				the amount by	0.00	
which operating costs (line 53) are less than					0	01.0
amount (line 56), otherwise enter zero (see i	nstructions)			-		100
62.00 Relief payment (see instructions)63.00 Allowable Inpatient cost plus incentive payment	ent (see instruct	ions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Decemb	er 31 of the	cost reporti	ng period (See	0	64.0
65.00 Medicare swing-bed SNF inpatient routine cost	s after December	31 of the co	ost reporting	period (See	0	65.0
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routir	ne costs (line 64	nlus line 6	5)(title XVII	Lonly) For	0	66.0
CAH (see instructions)		·		5.		
67.00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through D	ecember 31 o	f the cost re	porting period	0	67.0
68.00 Title V or XIX swing-bed NF inpatient routine	e costs after Dec	ember 31 of	the cost repo	orting period	0	68.0
(line 13 x line 20)			(0)			
69.00 Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.0
70.00 Skilled nursing facility/other nursing facili	ty/ICF/IID routi	ne service co	ost (line 37)			70.0
71.00 Adjusted general inpatient routine service co 72.00 Program routine service cost (line 9 x line 7		ie /U÷line 2	2)			71.0
73.00 Medically necessary private room cost applica	ble to Program (ne 35)			73.0
74.00 Total Program general inpatient routine servi 75.00 Capital-related cost allocated to inpatient r	•		nrksheet R [Part II column		74.0
26, line 45)	Satine service C	Josta (TEUMEWO	UN KONEEL D, F	artir, corunni		75.0
76.00 Per diem capital related costs (line 75 ÷ lin						76.0
77.00 Program capital-related costs (line 9 x line 78.00 Inpatient routine service cost (line 74 minus						77.0
79.00 Aggregate charges to beneficiaries for excess	costs (from pro		· · · · · · · · · · · · · · · · · · ·			79.0
80.00 Total Program routine service costs for compa 81.00 Inpatient routine service cost per diem limit		π limitation	(line 78 mir	ius Line 79)		80. 0 81. 0
82.00 Inpatient routine service cost limitation (li						82.0
83.00 Reasonable inpatient routine service costs (s						83.0
84.00 Program inpatient ancillary services (see ins 85.00 Utilization review - physician compensation (;)				84. 0 85. 0
86.00 Total Program inpatient operating costs (sum	of lines 83 thro					86.0
PART IV - COMPUTATION OF OBSERVATION BED PASS 87.00 Total observation bed days (see instructions)					1, 960	87.0
88.00 Adjusted general inpatient routine cost per c		ine 2)			1, 490. 79	

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	6, 490, 430	36, 749, 573	0. 17661	2 2, 921, 948	516, 051	90.00
91.00 Nursing School cost	0	36, 749, 573	0.00000	2, 921, 948	0	91.00
92.00 Allied health cost	0	36, 749, 573	0.00000	2, 921, 948	0	92.00
93.00 All other Medical Education	0	36, 749, 573	0.00000			93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre 5/29/2018 9:5	pare
		Title XIX	Hospi tal	PPS	
	Cost Center Description		-	1.00	<u> </u>
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		24, 651	1.
00	Inpatient days (including private room days and swing bed days Inpatient days (including private room days, excluding swing-l			24, 651	
00	Private room days (excluding swing-bed and observation bed day	ys). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		22, 691	4.
00	Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December	21 of the cost	0	6.
00	reporting period (if calendar year, enter 0 on this line)	ull days) al tel December	ST OF THE COST	0	0.
00	Total swing-bed NF type inpatient days (including private room	m days) through Decembe	r 31 of the cost	0	7.
00	reporting period Total swing-bed NF type inpatient days (including private roor	m davs) after December :	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	g swing-bed and	241	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		room days)	0	10.
. 00	through December 31 of the cost reporting period (see instruct			0	1.1.1
. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er		room days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		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
. 00	after December 31 of the cost reporting period (if calendar ye			0	''
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	1
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			5, 075 958	
	SWING BED ADJUSTMENT			,,,,,	
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18
~~~	reporting period			0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 o	r the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions	s)		36, 749, 573	21
	Swing-bed cost applicable to SNF type services through December		ting period (line	00,717,070	
00	5 x line 17)	21 of the east reporting	an partial (line (	0	1 22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	ST OF THE COST TEPOLIT	ig period (Trile 8	0	23
. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost report	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reportin	n period (line 8	0	25
	x line 20)		5 p	-	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 36, 749, 573	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			30, 749, 575	21
	General inpatient routine service charges (excluding swing-bed	d and observation bed c	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
. 00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00 0.00	
. 00	Average per diem private room cost differential (line 34 x lin	, ,	/	0.00	35
. 00 . 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost d	fferential (line	0 36, 749, 573	
. 00	27 minus line 36)	and private room cost d	inerentiar (IINe	30, 149, 313	³
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 490. 79	38
	Program general inpatient routine service cost per diem (see	-		359, 280	
	Medically necessary private room cost applicable to the Progra			0	
( )( )	Total Program general inpatient routine service cost (line 39	+ IINE 40)		359, 280	1 41

MPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-0161 F	eriod:	Worksheet D-1	2552
				rom 01/01/2017 o 12/31/2017	Date/Time Pre	
			e XIX	Hospi tal	5/29/2018 9:5 PPS	1 a
Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient CostI	npatient Days			(col. 3 x col.	
	1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	-
00 NURSERY (title V & XIX only)	1.00	2.00				42
Intensive Care Type Inpatient Hospita		0,070		,	1 1011010	1
00 INTENSIVE CARE UNIT						43
00 CORONARY CARE UNIT						44
00 BURN INTENSIVE CARE UNIT 00 SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	45
01 PEDIATRIC INTENSIVE CARE UNIT	2, 469, 042	1, 146			-	
02 PREMATURE I NTENSI VE CARE UNI T	5, 590, 805	4, 558				
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	-
00 Program inpatient ancillary service of	cost (Wkst D-3 col 3	Line 200)			1.00 515,653	48
00 Total Program inpatient costs (sum of			ns)		2, 153, 249	
PASS THROUGH COST ADJUSTMENTS	<b></b>					
00 Pass through costs applicable to Prog	gram inpatient routine s	ervices (from	Wkst. D, sum	of Parts I and	326, 427	50
<ul><li>00 Pass through costs applicable to Proc</li></ul>	aram inpationt ancillary	, convicos (fr	om Wkst D su	m of Darte II	58, 433	51
and IV)	gram inpatrent anci i al y	Services (II	um wikat. D, Su		50,433	
00 Total Program excludable cost (sum of	Flines 50 and 51)				384, 860	52
00 Total Program inpatient operating cos		ated, non-phy	sician anesthe	tist, and	1, 768, 389	53
medical education costs (line 49 minu TARGET AMOUNT AND LIMIT COMPUTATION	us line 52)					
00 Program di scharges					0	54
00 Target amount per discharge					0.00	55
00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient	t operating cost and tar	get amount (I	ine 56 minus I	ine 53)	0	
<ul><li>00 Bonus payment (see instructions)</li><li>00 Lesser of lines 53/54 or 55 from the</li></ul>	cost reporting period e	nding 1996 u	ndated and com	nounded by the		
market basket	cost reporting period c	and ing 1770, d		pounded by the	0.00	
00 Lesser of lines 53/54 or 55 from pric					0.00	
.00 If line 53/54 is less than the lower					0	61
which operating costs (line 53) are l amount (line 56), otherwise enter zer		Girnes 54 x	60), OF 1% OF	the target		
00 Relief payment (see instructions)					0	62
00 Allowable Inpatient cost plus incenti		tions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED C						
00 Medicare swing-bed SNF inpatient rout instructions)(title XVIII only)	tine costs through Decem	iber 31 of the	cost reportin	g period (see	0	64
00 Medicare swing-bed SNF inpatient rout	tine costs after Decembe	er 31 of the c	ost reporting	period (See	0	65
instructions)(title XVIII only)						
00 Total Medicare swing-bed SNF inpatier	nt routine costs (line 6	64 plus line 6	5)(title XVIII	only). For	0	66
CAH (see instructions) OO Title V or XIX swing-bed NF inpatient	t routine costs through	December 31 o	f the cost ren	orting period	0	67
(line 12 x line 19)				or tring period	0	0,
00 Title V or XIX swing-bed NF inpatient	t routine costs after De	ecember 31 of	the cost repor	ting period	0	68
(line 13 x line 20)	ationt routing goets (1	ing (7 . ling	(0)			1
00 Total title V or XIX swing-bed NF inp PART III - SKILLED NURSING FACILITY,					0	69
00 Skilled nursing facility/other nursing						70
00 Adjusted general inpatient routine se		ne 70 ÷ line	2)			71
00 Program routine service cost (line 9		(line 14 ''	no 25)			72
00 Medically necessary private room cost 00 Total Program general inpatient routi			ne 35)			73
00 Capital -related cost allocated to in			orksheet B. Pa	rt II, column		75
26, line 45)						
00 Per diem capital-related costs (line						76
00 Program capital-related costs (line 0 00 Inpatient routine service cost (line	· · · · · ·					77
00 Inpatient routine service cost (line 00 Aggregate charges to beneficiaries for		ovider record	s)			79
00 Total Program routine service costs 1				s line 79)		80
00 Inpatient routine service cost per di						81
00 Inpatient routine service cost limita	•					82
<ul><li>00 Reasonable inpatient routine service</li><li>00 Program inpatient ancillary services</li></ul>		5)				83
00 Utilization review - physician comper	•	is)				84
00 Total Program inpatient operating cos						86
PART IV - COMPUTATION OF OBSERVATION	BED PASS THROUGH COST				1	
00 Total observation bed days (see instr		Line 2			1, 960 1, 490. 79	
.00 Adjusted general inpatient routine co		1100 21			1 /0/ 70	1 22

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	6, 490, 430	36, 749, 573	0. 17661.	2 2, 921, 948	516, 051	90.00
91.00 Nursing School cost	0	36, 749, 573	0.00000	2, 921, 948	0	91.00
92.00 Allied health cost	0	36, 749, 573	0.00000	2, 921, 948	0	92.00
93.00 All other Medical Education	0	36, 749, 573	0.00000	2, 921, 948	0	93.00

Health Financial Systems	IU HEALTH NORTH HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0161	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	nared
				5/29/2018 9:5	
	Ti tl o	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		1	18, 195, 629		30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT			11, 604		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT			0		34.02
43.00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS		-		-	
50.00 O5000 OPERATI NG ROOM		0. 1265			1
51.00 05100 RECOVERY ROOM		0. 1835			1
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2395			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1996			1
56. 00 05600 RADI OI SOTOPE		0.0832			
60. 00 06000 LABORATORY		0. 1835			1
65. 00 06500 RESPI RATORY THERAPY		0.3549			1
66. 00 06600 PHYSI CAL THERAPY		0.4657			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2607			1
68. 00 06800 SPEECH PATHOLOGY		0. 3032			
69. 00 06900 ELECTROCARDI OLOGY		0. 1025			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.2468			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 4416			
72.00 07200 TMPL. DEV. CHARGED TO PATTENT 73.00 07300 DRUGS CHARGED TO PATTENTS					
73.00 07300 DRUGS CHARGED TO PATTENTS 75.00 07500 ASC (NON-DISTINCT PART)		0. 1975			1
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY		0. 0000		0 930, 033	
OUTPATIENT SERVICE COST CENTERS		0. 1804	57 5, 790, 154	930, 033	75.01
91. 00 09100 EMERGENCY		0.0897	45 6, 072, 147	544, 945	91 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4623			92.00
200.00 Total (sum of lines 50 through 94 and 9	96 through 98)	0. 1020	92, 952, 675		
201.00 Less PBP Clinic Laboratory Services-Pro			.2, .32, 0,0	,,	201.00
202.00 Net charges (line 200 minus line 201)	5 · · · · j ····· <u>5 · · · · · · · · · · · · · · · </u>		92, 952, 675		202.00

Health Financial Systems IU HEALTH NORT	H HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0161	Period:	Worksheet D-3	3
			From 01/01/2017 To 12/31/2017		nared
			10 12/31/2017	5/29/2018 9:5	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			667, 474		30,00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T			007,171		34.00
34. 01   03401 PEDI ATRI C I NTENSI VE CARE UNI T			778, 081		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT			773, 166		34.02
43. 00 04300 NURSERY			164, 999		43.00
ANCI LLARY SERVI CE COST CENTERS		•	·		1
50. 00 05000 OPERATI NG ROOM		0. 1265	43 215, 469	27, 266	50.00
51.00 05100 RECOVERY ROOM		0. 1835	53 37, 215	6, 831	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2395	94 123, 411	29, 569	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1996			
56. 00 05600 RADI 0I SOTOPE		0. 0832			
60. 00 06000 LABORATORY		0. 1835			
65. 00 06500 RESPI RATORY THERAPY		0. 3549			
66. 00 06600 PHYSI CAL THERAPY		0. 4657			
67.00 06700 OCCUPATI ONAL THERAPY		0. 2607		6, 546	
68.00 06800 SPEECH PATHOLOGY		0. 3032			
69.00 06900 ELECTROCARDI OLOGY		0. 10250			1
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 2468			1
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.4416			1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2442			1
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1975			
75.00 07500 ASC (NON-DI STI NCT PART)		0.0000		0	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY OUTPATI ENT SERVI CE COST CENTERS		0. 1604	57 92, 524	14, 846	75.01
91. 00 09100 EMERGENCY		0.0897	45 178, 363	16 007	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4623			92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0. +025	2, 307, 019		
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		2,007,017	010,000	200.00
202.00 Net charges (line 200 minus line 201)			2, 307, 019		202.00

LCUL	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0161	Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/29/2018 9:5	pared
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
00 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	0 12, 867, 312	
02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	4, 038, 883	1.0
03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1.0
04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	or discharges occurring	on or after	0	1.0
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			766, 176 0	1
02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	
00 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo Indirect Medical Education Adjustment	rting period (see instru	uctions)	0 155. 42	
00	FTE count for all opathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	t recent cost reporting	period ending on	0.00	5.0
00	FTE count for allopathic and osteopathic programs which meet for new programs in accordance with 42 CFR 413.79(e)	the criteria for an add	on to the cap	0.00	6.
00 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under cost report straddles July 1, 2011 then see instructions.			0.00 0.00	
00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.
01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.
02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.
. 00 . 00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recou	ds	0.00 0.00	
	Current year allowable FTE (see instructions)			0.00	
. 00 . 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Se	otember 30, 1997,	0.00 0.00	
. 00	Sum of Lines 12 through 14 divided by 3.			0.00	15.
. 00	Adjustment for residents in initial years of the program			0.00	
	Adjustment for residents displaced by program or hospital clo	sure		0.00	
. 00 . 00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4	<b>\</b>		0.00 0.000000	
	Prior year resident to bed ratio (see instructions)	).		0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	
	IME payment adjustment - Managed Care (see instructions)			0	22.
. 00	Indirect Medical Education Adjustment for the Add-on for § 42. Number of additional allopathic and osteopathic IME FTE resid		CFR 412.105	0.00	23.
	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	
	If the amount on line 24 is greater than -0-, then enter the instructions)	lower of line 23 or line	e 24 (see	0.00	
00 00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	
	IME add-on adjustment amount - Managed Care (see instructions	)		0	
	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0			0	29.
0.0	Disproportionate Share Adjustment				1
	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instruc	ctions)	1.68	
	Percentage of Medicaid patient days (see instructions)			21.55	
	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	)		23.23 8.38	
	Disproportionate share adjustment (see instructions)	)		8.38 354,185	

			From 01/01/2017 To 12/31/2017	Date/Time Pre	
			Hocni tal	5/29/2018 9:5 PPS	<u>1 am</u>
		Title XVIII	Hospital Prior to 10/1		
			1.00	2.00	
	Uncompensated Care Adjustment				1
	Total uncompensated care amount (see instructions)		5, 977, 483, 147		
	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter	r zoro on this line) (soo	0. 000163980 980, 185	0. 000193208 1, 307, 377	
5.02	instructions)		<i>7</i> 00, 105	1, 307, 377	35.0
5. 03	Pro rata share of the hospital uncompensated care payment amou	unt (see instructions)	733, 124	329, 531	35.0
	Total uncompensated care (sum of columns 1 and 2 on line 35.03		1, 062, 655		36. (
	Additional payment for high percentage of ESRD beneficiary dis				
	Total Medicare discharges on Worksheet S-3, Part I excluding (	discharges for MS-DRGs	0		40.
	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 68	83 684 an 685 (see	0		41.
	instructions)		0		<b>– – – – –</b>
	Total ESRD Medicare covered and paid discharges excluding MS-I	DRGs 652, 682, 683, 684	0		41.
	an 685. (see instructions)				
	Divide line 41 by line 40 (if less than 10%, you do not qualit		0.00		42.
	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682 instructions)	2, 683, 684 an 685. (see	0		43.
	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44.
	days)		01 000000		
5.00	Average weekly cost for dialysis treatments (see instructions)	)	0.00		45.
	Total additional payment (line 45 times line 44 times line 41.	. 01)	0		46.
	Subtotal (see instructions)	mall mumal bassitals	19, 089, 211		47.
8.00	Hospital specific payments (to be completed by SCH and MDH, sr only. (see instructions)	mail rural nospitals	0		48.
				Amount	
				1.00	
	Total payment for inpatient operating costs (see instructions)			19, 089, 211	
	Payment for inpatient program capital (from Wkst. L, Pt. I and			1, 686, 310	
	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, lin			0	51. 52.
	Nursing and Allied Health Managed Care payment			0	
	Special add-on payments for new technologies			2, 071	54.
4. 01	Islet isolation add-on payment			0	54.
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 64	-		0	
	Cost of physicians' services in a teaching hospital (see intru			0	56.
	Routine service other pass through costs (from Wkst. D, Pt. II		rough 35).	0	57.
	Ancillary service other pass through costs from Wkst. D, Pt. I Total (sum of amounts on lines 49 through 58)	IV, COL. II II ne 200)		0 20, 777, 592	58. 59.
	Primary payer payments			6, 737	
	Total amount payable for program beneficiaries (line 59 minus	line 60)		20, 770, 855	
	Deductibles billed to program beneficiaries	-		1, 859, 284	
	Coinsurance billed to program beneficiaries			79, 289	
	Allowable bad debts (see instructions)			143, 521	
	Adjusted reimbursable bad debts (see instructions)	ructions)		93, 289	
	Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)		28, 180 18, 925, 571	66. 67.
	Credits received from manufacturers for replaced devices for a	applicable to MS-DRGs (se	e instructions)	18, 925, 571	
	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see i	nstructions)	0	
	Demonstration payment adjustment amount before sequestration			0	
1	SCH or MDH volume decrease adjustment (contractor use only)	ructions)		0	
1	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)			0	70.
	HSP bonus payment HRR adjustment amount (see instructions)			0	
	Bundled Model 1 discount amount (see instructions)			0	
U. 72					
	HVBP payment adjustment amount (see instructions)			33, 375	70.

ALCUL	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0161	Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/29/2018 9:5	pareo
		Title	e XVIII	Hospi tal	PPS	i am
				′ (yyyy)	Amount	
				0	1.00	
0.96	Low volume adjustment for federal fiscal year (yyyy) (Enter ir	n column O		0	0	70.
	the corresponding federal year for the period prior to 10/1)			-	-	
D. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter ir	n column O		0	0	70.
	the corresponding federal year for the period ending on or aft			-		
D. 98	Low Volume Payment-3	,			0	70.
0. 99	HAC adjustment amount (see instructions)				208, 109	70.
1.00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			18, 750, 837	71.
1. 01	Sequestration adjustment (see instructions)	,			375, 017	71.
1. 02	Demonstration payment adjustment amount after sequestration				0	
2.00	Interim payments				18, 572, 258	72.
3.00	Tentative settlement (for contractor use only)				0	73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			-196, 438	74.
	73)					
5.00	Protested amounts (nonallowable cost report items) in accordar	nce with			253, 917	75.
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0. 00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see inst	ructions)			0	90.
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
. 00	Operating outlier reconciliation adjustment amount (see instru	uctions)	1		0	92
. 00	Capital outlier reconciliation adjustment amount (see instruct	ions)			0	93
. 00	The rate used to calculate the time value of money (see instru	uctions)			0.00	94
. 00	Time value of money for operating expenses (see instructions)				0	95
b. 00	Time value of money for capital related expenses (see instruct	ions)			0	96
	The value of money for capital related expenses (see fisting)					
5.00			1	Prior to 10/1	On/After 10/1	
				Prior to 10/1 1.00	0n/After 10/1 2.00	
	HSP Bonus Payment Amount		1	1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)		1		2.00	100.
0.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment		1	1.00	2.00	100
0. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			1.00 0 0.0000000000	2.00 0 0.000000000	100 101
0. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions			1.00	2.00 0 0.000000000	100 101
0.00 1.00 2.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment			1.00 0 0.0000000000 0	2.00 0 0.000000000 0	100 101 102
)0. 00 )1. 00 )2. 00 )3. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	5)		1.00 0 0.000000000 0 0.0000	2.00 0 0.000000000 0 0.0000	100 101 102 103
0. 00 1. 00 2. 00 3. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	s)		1.00 0 0.0000000000 0	2.00 0 0.000000000 0 0.0000	100 101 102
0. 00 1. 00 2. 00 3. 00 4. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr	;) ration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104
0.00 1.00 2.00 3.00 4.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per	;) ration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104
0. 00 1. 00 2. 00 3. 00 4. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	;) ration) Adju		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104
0.00 1.00 2.00 3.00 4.00 0.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	s) ration) Adju riod under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200
0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	s) ration) Adju riod under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200 201
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)	s) ration) Adju riod under t		1.00 0 0.000000000 0 0.0000	2.00 0.000000000 0 0.0000 0 0.0000 0	100 101 102 103 104 200 201 201
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) ration) Adju riod under t a 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 201
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) ration) Adju riod under t a 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 201
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	s) ration) Adju riod under t a 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 202 203
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	s) ration) Adju riod under t a 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 202 203 203
0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HIR adjustment factor (see instructions) HIR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) ration) Adju riod under t a 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 202 203 203 204 204
0. 00 1. 00 2. 00 3. 00 4. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) ration) Adju riod under t a 49)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 202 203 203
2. 00 1. 00 2. 00 3. 00 4. 00 5. 00 5. 00 5. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) ration) Adju riod under t e 49) first year	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0 0.0000 0	100 101 102 103 104 200 201 202 203 203 204 205 206
1. 00 2. 00 3. 00 4. 00 5. 00 4. 00 5. 00 5. 00 7. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	s) ration) Adju riod under t e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100 101 102 103 104 200 201 202 203 203 204 205 206 207
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare inpatient routine cost cap (line 202 times line 204) Medicare to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	s) ration) Adju riod under t e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100 101 102 103 104 200 201 202 203 204 205 206 206 207 208
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment for HSP Bonus Payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions)	s) ration) Adju riod under t e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.0000000000 0.0000 0.0000 0	100 101 102 103 104 200 201 202 203 204 205 206 206 207 208 209
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	s) ration) Adju riod under t e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVR adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) ration) Adju riod under t e 49) first year ructions)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0 0.0000 0	100 101 102 103 104 200 203 203 204 205 206 207 208 209 210
D. 00         1. 00         2. 00         3. 00         4. 00         D. 00         1. 00         2. 00         3. 00         4. 00         5. 00         6. 00         7. 00         8. 00         9. 00         D. 00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) ration) Adju riod under t e 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.00000000000000000000000000000000	100 101 102 103 104 200 201 202 203 203 204 205 206 207 208 209 210 211
0.00 1.00 2.00 3.00 4.00 0.00 1.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A INPS payments (from line 208)	s) ration) Adju riod under t e 49) first year ructions) line 59)	the 21st	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100 101 102 103 104 200 201 202 203 204 205 206 207 208 209 210 211
0.00 1.00 2.00 3.00 4.00 0.00 1.00 2.00 3.00 4.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	HSP Bonus Payment Amount HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) ation) Adju ation under t a 49) first year fuctions) line 59) 211)	of the curre	1.00 0.000000000 0 0.0000 0	2.00 0.000000000 0.0000 0.0000 0	100 101 102 103 104 200 201 203 203 204 205 206 207 208 209 210 211

	Financial Systems LUME CALCULATION EXHIBIT 4		IU HEALTH NORT	Provider CC		Period:	u of Form CMS-2 Worksheet E	
						From 01/01/2017 To 12/31/2017	Part A Exhibi Date/Time Prep 5/29/2018 9:5	pared
				Title	XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
	DDC amounts other then outlies	0	1.00	2.00	3.00	4.00	5.00	1
. 00 . 01	DRG amounts other than outlier payments DRG amounts other than outlier		12, 867, 312	0			0 12, 867, 312	
. 01	payments for discharges occurring prior to October 1	1.01	12,007,312	0	12, 007, 31.	2	12,007,312	1.
. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	4, 038, 883	0		4, 038, 883	4, 038, 883	1.
. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	(	D	0	1.
. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1.
. 00	Outlier payments for discharges (see instructions)	2.00	766, 176	0	531, 10	1 235, 076	766, 177	2.
. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(	0 0	0	2.
3.00	Operating outlier reconciliation	2.01	0	0		0 0	0	
1.00	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0		0 0	0	4.
. 00	Amount from Worksheet E, Part	21.00	0.000000	0. 000000	0.00000	0. 000000		5.
. 00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	
. 00	instructions) IME payment adjustment for	22.00	0	0		5 0 D 0	0	
	managed care (see instructions)	intmont for the	Add on for Co	tion 400 of t				
. 00	Indirect Medical Education Adju IME payment adjustment factor	27.00	0. 000000	0. 000000		0.00000		7.
00	(see instructions) IME adjustment (see	28.00	0.000000	0.000000			0	
01	instructions) IME payment adjustment add on	28.01	0	0		0 0	0	
	for managed care (see instructions)			_			_	
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0			0	
01	Total IME payment for managed care (sum of lines 6.01 and 8.01) Disproportionate Share Adjustme	29.01	0					9.
0. 00	Allowable disproportionate share percentage (see	33.00	0. 0838	0. 0838	0. 083	3 0. 0838		10.
1. 00	instructions) Disproportionate share adjustment (see instructions)	34.00	354, 185	0	269, 570	0 84, 615	354, 185	11.
1. 01	Uncompensated care payments	36.00	1, 062, 655	0	549, 84	4 403, 486	953, 330	11.
2. 00	Additional payment for high per Total ESRD additional payment	rcentage of ESP 46.00	RD beneficiary o 0	li scharges 0	(	0 0	0	12.
3. 00	(see instructions) Subtotal (see instructions)	47.00	19, 089, 211	0	14, 327, 15	1 4, 762, 060	19, 089, 211	12
4.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0	14, 327, 13	0		13.
5. 00	(see instructions) Total payment for inpatient operating costs (see	49.00	19, 089, 211	0	14, 327, 15 ⁻	1 4, 762, 060	19, 089, 211	15.
6. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50.00	1, 686, 310	0	1, 283, 850	402, 460	1, 686, 310	16.
7.00	if applicable) Special add-on payments for new technologies	54.00	2, 071	0	2, 07	1 0	2, 071	
7. 01 7. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17. 17.

	Financial Systems		IU HEALTH NOR				u of Form CMS-2	2552-1
LOW VO	LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2017 To 12/31/2017	5/29/2018 9:5	pared:
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.00
10 00	SUBTOTAL			0	15, 613, 07	2 5, 164, 520	20, 777, 592	10 00
17.00		W/S L, line	(Amounts from L)		13, 013, 01	2 3, 104, 320	20, 111, 372	17.00
		0	1.00	2.00	3.00	4,00	5,00	
20.00	Capital DRG other than outlier	1.00	1, 371, 072					20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0			0 0		
21.00	Capital DRG outlier payments	2.00	249, 289	0	191, 66	1 57, 628	249, 289	21.0
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	0	21.0
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.000	0 0.0000		22. 0
23. 00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0481	0. 0481	0. 048	1 0.0481		24.0
25. 00	Disproportionate share adjustment (see instructions)	11.00	65, 949	0	50, 12	4 15, 825	65, 949	25. 0
26.00	Total prospective capital payments (see instructions)	12.00	1, 686, 310	0	1, 283, 85	0 402, 460	1, 686, 310	26.00
		W/S E, Part A						
		line	Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor	70.0/			0.00000	0 0. 000000		27.0
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96				0	0	28.0
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Ν					100. 00

HOSPI	FAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Prep 5/29/2018 9:5	pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12, 867, 312			12, 867, 312	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	4, 038, 883		4, 038, 883		1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	766, 176	531, 10	235, 076	766, 176	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2. 01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.00000	0.00000		5.00
	(see instructions)				_		
6.00	IME payment adjustment (see instructions)	22.00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22.01	0		0 0	0	6. 01
7.00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0. 000000		0. 000000		7.00
7.00	instructions)	27.00	0.000000	0.00000	0.00000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9. 01
10.00	Disproportionate Share Adjustment	00.00	0.0000	0.000	0.0000		10.00
10.00	Allowable disproportionate share percentage	33.00	0. 0838	0. 083	0. 0838		10.00
11. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	354, 185	269, 57	84, 615	354, 185	11.00
11.01	Uncompensated care payments	36.00	1, 062, 655	733, 12	329, 531	1, 062, 655	11.01
	Additional payment for high percentage of ESF	D beneficiary					
12.00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
13.00		47.00	19, 089, 211	14, 401, 10			
14.00	and MDH, small rural hospitals only.) (see	48.00	0		0 0	0	14. OC
15.00	instructions) Total payment for inpatient operating costs (see instructions)	49.00	19, 089, 211	14, 401, 10	4, 688, 105	19, 089, 211	15.00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 686, 310	1, 283, 85	402, 460	1, 686, 310	16.00
17.00	Special add-on payments for new technologies	54.00	2, 071	2, 07	/1 0	2, 071	17.00
17.01	Net organ acquisition cost						17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0		18.00
19.00	SUBTOTAL			15, 687, 02	5, 090, 565	20, 777, 592	1 10 00

	Financial Systems	IU HEALTH NOR				u of Form CMS-	2552-10
HOSPI	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet E Part A Exhibi Date/Time Pre 5/29/2018 9:5	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1, 371, 072	1, 042, 00	329, 007	1, 371, 072	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	249, 289	191, 60	51 57, 628	249, 289	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0481	0.048	0. 0481		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	65, 949	50, 12	15, 825	65, 949	25.00
26. 00	Total prospective capital payments (see instructions)	12.00	1, 686, 310	1, 283, 8	402, 460	1, 686, 310	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0		0	0	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	33, 375	11, 40	21, 971	33, 375	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70.94	0		0 0	0	31.00
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	instructions)	70. 99		156, 98	34 51, 125	208, 109	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

	Financial Systems IU HEALTH NORTH H ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0161	Peri od:	worksheet E	
			From 01/01/2017 To 12/31/2017		
		Title XVIII	Hospi tal	5/29/2018 9:5 PPS	1 am
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			8, 957	
2.00 3.00	Medical and other services reimbursed under OPPS (see instruction OPPS payments	ons)		10, 232, 311 8, 017, 420	
1. 00	Outlier payment (see instructions)			236, 078	
l. 01	Outlier reconciliation amount (see instructions)			0	
6.00 6.00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	tions)		0.000	
. 00 . 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
3. 00	Transitional corridor payment (see instructions)			0	
0.00 0.00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	V, col. 13, line 200		0	
1.00	Total cost (sum of lines 1 and 10) (see instructions)			8,957	
	COMPUTATION OF LESSER OF COST OR CHARGES				
2.00	Reasonable charges Ancillary service charges			45, 348	1 12 (
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13)			45, 348	14. (
5.00	Customary charges Aggregate amount actually collected from patients liable for pa	avmont for convicos on	a chargo basi s	0	15. 0
6.00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)	1 5	5		
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000 45,348	
9.00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ne 11) (see	36, 391	
	instructions)				
20.00	Excess of reasonable cost over customary charges (complete only instructions)	y if line 11 exceeds li	ne 18) (see	0	20.
21.00	Lesser of cost or charges (see instructions)			8, 957	21. (
	Interns and residents (see instructions)			0	
23.00 24.00	Cost of physicians' services in a teaching hospital (see instru- Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0 8, 253, 498	
4.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0,233,470	
25.00	Deductibles and coinsurance (for CAH, see instructions)	<b>0</b>		0	
26.00 27.00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			1, 435, 762 6, 826, 693	
7.00	instructions)			0,020,070	27.0
28.00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0	
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 6, 826, 693	
31.00	Primary payer payments			1, 846	
32.00	Subtotal (line 30 minus line 31)	-0)		6, 824, 847	32. (
3 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	-5)		0	33.
4.00	Allowable bad debts (see instructions)			269, 532	
35.00	Adjusted reimbursable bad debts (see instructions)			175, 196	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	uctions)		129, 474 7, 000, 043	
	MSP-LCC reconciliation amount from PS&R			25	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50 9.97	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	39. 39.
39.97 39.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ed devices (see instru	ctions)	15, 900	
39.99	RECOVERY OF ACCELERATED DEPRECIATION	<b>,</b>		0	39.
0.00	Subtotal (see instructions)			7, 000, 018	
0.01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			140,000	
1.00	Interim payments			6, 787, 907	41. (
2.00	Tentative settlement (for contractors use only)			0	
4.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2	chapter 1.	72, 111 2, 825	
	§115. 2			2, 323	]
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90. ( 91. (
	[Outlier reconciliation adjustment amount (see instructions)				
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	92. (

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2017 Fo 12/31/2017	Worksheet E-1 Part I Date/Time Prep 5/29/2018 9:51	
		Title	XVIII	Hospi tal	PPS	
		I npati ent	Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		18, 572, 25	3	6, 787, 907	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		(	כ	0	2.00
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)					3.00
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			C	0	3. 01
3.02					0	3. 02
3.03					0	3. 03 3. 04
3.04 3.05					0	3.04
3.05	Provider to Program	<u> </u>		<u> </u>	0	3.00
3.50	ADJUSTMENTS TO PROGRAM		(	D	0	3.50
3.51			(	D	0	3.51
3.52				C	0	3.52
3.53				C	0	3.53
3.54				D	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		(	C	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		18, 572, 25	3	6, 787, 907	4.00
	appropriate)					
5.00	TO BE COMPLETED BY CONTRACTOR					E O
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
F 01	Program to Provider TENTATIVE TO PROVIDER	1			0	F 01
5.01 5.02	TENTATIVE TO PROVIDER				0	5. 01 5. 02
5.02					0	5.02
0.00	Provider to Program	1 1				0.00
5.50	TENTATI VE TO PROGRAM		(	D	0	5.50
5.51				C	0	5. 51
5.52				D	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)		(	כ	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		(	D	72, 111	6. 01
6. 02	SETTLEMENT TO PROGRAM		196, 43	з	0	6. 02
7.00	Total Medicare program liability (see instructions)		18, 375, 82		6, 860, 018	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

Heal th	Financial Systems IU HEALTH NOF	RTH HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0161	Period: From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI	ON			-
1.00	Total hospital discharges as defined in AARA §4102 from Wks		- 14		1.00
	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,				2.00
	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0.12			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of	f certified HIT technology	Wkst. S-2, Pt. I		7.00
	line 168				
	Calculation of the HIT incentive payment (see instructions)	)			8.00
	Sequestration adjustment amount (see instructions)				9.00
	Calculation of the HIT incentive payment after sequestration	on (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)		>		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	a line 31) (see instruction	ns <i>)</i>		32.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2017 Fo 12/31/2017	Worksheet G Date/Time Pre 5/29/2018 9:5	pare 1 am
		General Fund	Specific Purpose Fund		Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	305, 912, 333		0 0	0	1.
00	Temporary investments	0		0 0	0	2.
00	Notes receivable	0		0 0	0	
00	Accounts receivable	32, 629, 960		5	0	
00	Other receivable	-5, 108, 468		-	0	
00	Allowances for uncollectible notes and accounts receivable Inventory	0		5	0	6.
00 00	Prepaid expenses	2, 545, 613 1, 087, 256		-	0	7. 8.
00	Other current assets	1,007,230		5	0	9
. 00	Due from other funds	0		-	0	10
	Total current assets (sum of lines 1-10)	337, 066, 694		0 0		
	FI XED ASSETS					1
. 00	Land	0	(	0 0	0	12.
. 00	Land improvements	11, 942, 223	(	0 0	0	13.
. 00	Accumulated depreciation	-9, 620, 081	(	0 0	0	14
. 00	Bui I di ngs	169, 447, 524		0 0	0	15
	Accumulated depreciation	-49, 425, 803		5	0	16
	Leasehold improvements	82, 821	(	-	0	17
	Accumulated depreciation	-15, 874	(	-	0	18
	Fixed equipment	0		5	0	19
	Accumulated depreciation	12 242		-	0	20
	Automobiles and trucks	13, 243			0	21
	Accumulated depreciation Major movable equipment	95, 175, 975		-		23
	Accumulated depreciation	-85, 662, 209		5	0	24
	Mi nor equi pment depreci abl e	-03, 002, 207		5	0	25
	Accumul ated depreciation	0		5	0	26
	HIT designated Assets	0		5	0	27
	Accumulated depreciation	0		0 0	0	
	Mi nor equipment-nondepreciable	0	(	0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	131, 937, 819	(	0 0	0	30
	OTHER ASSETS					
	Investments	0		-	0	31
	Deposits on Leases	0		-	0	32
. 00	Due from owners/officers	0		-	0	33
	Other assets	1, 375, 206		-	0	34
	Total other assets (sum of lines 31-34)	1, 375, 206		0 0	0	35
. 00	Total assets (sum of lines 11, 30, and 35)	470, 379, 719	(	0 0	0	36
00	CURRENT LI ABI LI TI ES	11 445 (00		0 0	0	1 27
	Accounts payable Salaries, wages, and fees payable	11, 445, 680 5, 431, 282			0	37
	Payroll taxes payable	5,451,202			0	
	Notes and Loans payable (short term)	200, 253, 189			0	
	Deferred income	241, 985		0 0	0	
	Accel erated payments	0		-	-	42
	Due to other funds	0		0 0	0	
	Other current liabilities	2, 152, 825		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	219, 524, 961	(	0 0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0		
. 00	Notes payable	0		0 0	0	47
	Unsecured Loans	0		0 0	0	
	Other long term liabilities	7,072,883		-	0	
	Total long term liabilities (sum of lines 46 thru 49)	7,072,883		0 0	0	
. 00	Total liabilities (sum of lines 45 and 50)	226, 597, 844	[(	0 0	0	51
00	CAPITAL ACCOUNTS	242 701 075				1 6 2
	General fund balance Specific purpose fund	243, 781, 875				52
. 00 . 00	Donor created - endowment fund balance - restricted		'		1	54
. 00	Donor created - endowment fund balance - restricted			0	1	55
. 00	Governing body created - endowment fund balance			0	1	56
. 00	Plant fund balance - invested in plant			0	0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ŭ	_
. 00	Total fund balances (sum of lines 52 thru 58)	243, 781, 875		0 0	0	59

Heal th	Financial Systems	IU HEALTH NORT	H HOSPITAL			In Lie	eu of Form CMS	-25	552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0161		eriod: com 01/01/2017 o 12/31/2017	Worksheet G- Date/Time Pr 5/29/2018 9:	ер	
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fun	d	
1 00		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) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) GOODWILL ROUNDING Total deductions (sum of lines 12-17)	0 0 0 0 0 0 1, 700, 000 3 0 0 0 0 0 0	201, 216, 785 44, 265, 093 245, 481, 878 0 245, 481, 878 1, 700, 003		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0		0 0 0 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	Fund balance at end of period per balance sheet (line 11 minus line 18)		243, 781, 875			0			19.00
		Endowment Fund	PI 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) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		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) GOODWILL 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

STATE	Financial Systems IU HEALTH NO IENT OF PATIENT REVENUES AND OPERATING EXPENSES		CN: 15 0141		workshoot C 2	
STATEN	IENI OF PAILENI KEVENUES AND OPERALING EXPENSES	Provider C	UN: 15-0161	Period: From 01/01/2017 To 12/31/2017		pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		65, 861, 9	03	65, 861, 903	
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		(5.0(1.0)	~~	(5.0(1.00)	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		65, 861, 9	J3	65, 861, 903	10.00
11.00	Intensive Care Type Inpatient Hospital Services		1			11.00
12.00	CORONARY CARE UNIT					12.00
12.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T			0	0	•
14.00	PEDIATRIC INTENSIVE CARE UNIT		5, 451, 7	0	5, 451, 790	
14.01	PREMATURE I NTENSI VE CARE UNI T		19, 420, 3		19, 420, 332	•
15.00	OTHER SPECIAL CARE (SPECIFY)		17, 120, 0	52	17, 120, 002	15.00
16.00	Total intensive care type inpatient hospital services (sur	m of lines	24, 872, 1	22	24, 872, 122	•
17 00	11-15)	d 1()	90, 734, 0	ог	00 724 025	17.00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and Ancillary services	u 16)			90, 734, 025 535, 474, 284	•
18.00	Outpatient services		261, 392, 8 13, 753, 7			•
20.00	RURAL HEALTH CLINIC		13,753,7	0 10, 420, 473		20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		
21.00	HOME HEALTH AGENCY			0 0	0	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27.00	PHYSI CI AN REVENUE			0 155, 941	155, 941	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer colu	mn 3 to Wkst.	365, 880, 6	44 344, 657, 868	710, 538, 512	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		-		-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			197, 108, 547		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00	Tatal additions (our of line- 20.25)			0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00 37.00
37.00 38.00	DEDUCT (SPECI FY)			0		37.00
38.00 39.00				0		38.00
39.00 40.00				0		40.00
40.00				0		40.00
41.00	Total deductions (sum of lines 37-41)			0		41.00
43.00	Total operating expenses (sum of lines 29 and 36 minus lin	ne 42)(transfer		197, 108, 547		43.00
						1 70.00

Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0161	Peri od:	Worksheet G-3	
				From 01/01/2017 To 12/31/2017	Date/Time Pre	arod
				10 12/31/2017	5/29/2018 9:5	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Par				710, 538, 512	1.00
2.00	Less contractual allowances and discounts or	n patients' account	ts		473, 575, 741	2.00
3.00	Net patient revenues (line 1 minus line 2)				236, 962, 771	3.00
4.00	Less total operating expenses (from Wkst. G-		13)		197, 108, 547	4.00
5.00	Net income from service to patients (line 3	minus line 4)			39, 854, 224	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellane	eous communication	servi ces		0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gue	ests			0	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical su		nan patrents		0	16.00
17.00	Revenue from sale of drugs to other than par				0	17.00
18.00	Revenue from sale of medical records and abs				0	18.00
19.00		,			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	and canteen			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MI SCELLANEOUS I NCOME				4, 410, 869	
25.00	Total other income (sum of lines 6-24)				4, 410, 869	
	Total (line 5 plus line 25)				44, 265, 093	
	OTHER EXPENSES (SPECIFY) Total other expenses (sum of line 27 and sub	acarinta)			0	27.00 28.00
	Net income (or loss) for the period (line 20				0 44, 265, 093	
29.00		5 minus IIIle 28)		I	44, 200, 093	29.00

ALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0161	Period: From 01/01/2017	Worksheet L Parts I-III	
			To 12/31/2017	Date/Time Pre 5/29/2018 9:5	
		Title XVIII	Hospi tal	PPS	
PART I - FULLY PROSPECTIVE METHOD				1.00	
CAPITAL FEDERAL AMOUNT					1
.00 Capital DRG other than outlier				1, 371, 072	1 1.
01 Model 4 BPCI Capital DRG other tha	n outlier			1, 0, 1, 0, 2	1.
00 Capital DRG outlier payments				249, 289	2.
01 Model 4 BPCI Capital DRG outlier p	avments			0	2.
00 Total inpatient days divided by nu		porting period (see inst	ructions)	80. 19	
00 Number of interns & residents (see	3	P		0.00	
00 Indirect medical education percent				0.00	5.
00 Indirect medical education adjustm		sum of lines 1 and 1.01	, columns 1 and	0	6.
1.01) (see instructions)					
00 Percentage of SSI recipient patier 30) (see instructions)	it days to Medicare Part A pa	atient days (Worksheet E	E, part A line	1.68	7.
00 Percentage of Medicaid patient day	is to total days (see instru	ctions)		21.55	8
00 Sum of lines 7 and 8				23.23	9.
.00 Allowable disproportionate share p	5 .	)		4.81	
.00 Disproportionate share adjustment				65, 949	
2.00 Total prospective capital payments	; (see instructions)			1, 686, 310	12.
				1.00	
PART II - PAYMENT UNDER REASONABLE	COST			1.00	
00 Program inpatient routine capital				0	1 1.
00 Program inpatient ancillary capita				0	2
00 Total inpatient program capital co	•			0	3.
00 Capital cost payment factor (see i				0	4.
00 Total inpatient program capital co	<i>,</i>			0	
				1.00	
PART III - COMPUTATION OF EXCEPTIO	N PAYMENTS			1.00	
00 Program inpatient capital costs (s				0	1.
00 Program inpatient capital costs for	or extraordinary circumstance	es (see instructions)		0	2
00 Net program inpatient capital cost	s (line 1 minus line 2)			0	3
00 Applicable exception percentage (s				0.00	
00 Capital cost for comparison to pay				0	5
00 Percentage adjustment for extraord	5	<i>,</i>		0.00	
00 Adjustment to capital minimum paym		circumstances (line 2 ×	(line 6)	0	7.
00 Capital minimum payment level (lir				0	
00 Current year capital payments (fro				0	
				0	10.
		apital payment (from pri	or year	0	11.
.00 Carryover of accumulated capital m Worksheet L, Part III, line 14)	1 5			_	
.00 Carryover of accumulated capital m Worksheet L, Part III, line 14) 2.00 Net comparison of capital minimum	payment level to capital page	yments (line 10 plus lir		0	
<ol> <li>Carryover of accumulated capital m Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum</li> <li>Current year exception payment (if</li> </ol>	payment level to capital par fline 12 is positive, enter	yments (line 10 plus lir the amount on this line	e)	0	13
<ul> <li>.00 Carryover of accumulated capital m Worksheet L, Part III, line 14)</li> <li>2.00 Net comparison of capital minimum Current year exception payment (if Carryover of accumulated capital m</li> </ul>	payment level to capital pay fline 12 is positive, enter ninimum payment level over ca	yments (line 10 plus lir the amount on this line	e)	-	13
<ul> <li>1.00 Carryover of accumulated capital m Worksheet L, Part III, line 14)</li> <li>2.00 Net comparison of capital minimum</li> <li>3.00 Current year exception payment (if 1.00 Carryover of accumulated capital m (if line 12 is negative, enter the</li> </ul>	payment level to capital par fline 12 is positive, enter ninimum payment level over ca a amount on this line)	yments (line 10 plus lin the amount on this line apital payment for the f	e)	0	13. 14.
<ol> <li>Carryover of accumulated capital m Worksheet L, Part III, line 14)</li> <li>Net comparison of capital minimum</li> <li>Current year exception payment (if Carryover of accumulated capital m</li> </ol>	payment level to capital pay fline 12 is positive, enter ninimum payment level over ca amount on this line) and capital payment (see ins	yments (line 10 plus lin the amount on this line apital payment for the f	e)	0	13 14 15