IU HEALTH WHITE HOSPITAL

In Lieu of Form CMS-2552-10

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3.00

5.00

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9.00

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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: 15-1312 Worksheet S Peri od. From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: То 5/28/2019 6:19 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/28/2019 Time: 6:19 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 6. Date Received: 7. Contractor No. Contractor 10. NPR Date: 5. 1]Cost Report Status Γ

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN
 11. Contractor's Column 1 is 4: Enter

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 Δ use only (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 WHITE HOSPITAL (15-1312) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. TODD WILLIAMS (Signed) Officer or Administrator of Provider(s) CHIEF FINANCIAL OFFICER Title (Dated when report is electronically signed.) Date Title XVIII Title V Part B Title XIX Cost Center Description Part A HIT 1.00 2.00 3.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1.00 0 165, 330 134, 865 0 0 1.00 Hospi tal 0 Subprovider - IPF 2 00 2 00 С 0 C

3.00

5.00

6 00

9.00

200.00 Total

Subprovider - IRF

HOME HEALTH AGENCY I

Swing bed - SNF

Swing bed - NF

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.

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The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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97.325

262, 655

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134, 865

	AL AND HOSPITAL HEALTH CARE COMPLEX		Provi o	ler CCN: 1	5-1312	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/28/20	me Pre	epared:
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co									1.00
. 00	Street: 720 SOUTH SIXTH STREET	PO Box: State: IN	Zin Cod	0. 17040	Count					1.00
. 00	City: MONTICELLO	Component Name	CCN	e: 47960 CBSA	Provi der	ty: WHITE Date	Daymo	ent Syst	om (D	2.00
			Number	Number	Type	Certified		, 0, or		
					.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	oor triffod	V			1
		1.00	2.00	3.00	4.00	5.00	6.00		8.00	1
	Hospital and Hospital-Based Componer	1			1			1	1 2. 22	
00	Hospi tal	IU HEALTH WHITE	151312	99915	1	07/01/1966	Ν	0	0	3.00
		HOSPI TAL								
00	Subprovider - IPF									4.00
00	Subprovider - IRF									5.0
00	Subprovider - (Other)									6.0
00	Swing Beds - SNF	IU HEALTH WHITE	15Z312	99915		02/16/1990	N	0	N	7.00
		HOSPI TAL								
00	Swing Beds - NF									8.00
00	Hospital-Based SNF									9.0
0. 00	Hospital -Based NF									10.0
. 00	Hospital -Based OLTC		157514	00015		02/01/1007	NI		N	11.0
2.00	Hospital-Based HHA	HOME CARE OF WHITE COUNTY	157514	99915		03/01/1997	N	N	N	12.00
. 00	Separately Certified ASC	COUNTY								13.0
. 00	Hospi tal -Based Hospi ce									14.0
5.00	Hospital -Based Health Clinic - RHC									15.0
b. 00	Hospital -Based Health Clinic - FQHC									16.0
7.00	Hospital -Based (CMHC) I									17.0
3.00	Renal Dialysis									18.0
9.00	Other									19.00
		l	1			From:		То	:	
						1.00		2. (00	1
0. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/20	018	12/31	/2018	20.00
1.00	Type of Control (see instructions)					2				21.00
						2.00		2.0	20	1
	Innationt DDS Information				1.00	2.00		3. (00	
00	Inpatient PPS Information	currently receiving n	avments for	-				3. (00	22 0
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	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA I	Provider CC	N: 15-1312	Period: From 01/0	01/2018	Works Part	sheet S-2 I	2
					To 12/3	31/2018	5/28/	'Time Pre	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	iys M	Other ledi cai d days	
24.00	If this provider is an LDDC beenited, onter the	1.00	2.00	3.00	4.00	5.00) ()	6.00	2 24 00
	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0		0		0		24.00
					Urban/F			of Geogr 2.00	_
26.00	Enter your standard geographic classification (not wa	age) status	at the bec	inning of t		2		2.00	26.00
	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 enter the effective date of the geographic reclassifi	r rural. age) status r "2" for r	at the end ural. If ap	l of the cos		2			27.00
35.00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
					Begin	ni ng: 00		di ng: 2. 00	-
36.00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb		00			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.	r the numbe			s	0			37.00
37. 01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37.01
38.00	LE Line 07 is 1 and a the best straight and and and and								
30.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
50.00	greater than 1, subscript this line for the number of				<u> </u>			Y/N	38.00
	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii	f periods i payment a), (ii), or the mileage	djustment f (iii)? Ent requiremen	one and for low volu er in colum its in	n 1.	/N 00 I		Y/N 2. 00 N	_
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39.00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	f periods in payment au), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	one and for low volu er in colum its in 2 "Y" for ye (" for yes o	1. me 1 s r 1	00 1 1	2 XVI I	2. 00 N N	40.00
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39. 00 40. 00 45. 00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet ta accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) 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. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	f periods in payment ad), (ii), or the mileage ii)? Enter n adjustmen per 1. Ente (see inst nt for disp eption for	djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina	For low volu ter in colum ts in Y" for yes o res or "N" for te share in the ary circumst	1. me 1 s r 1 or	00 N V 1.00	2 XVI I) 2. 0	N N 1 X1 X 0 3.00	40.00
39. 00 40. 00 45. 00 46. 00 47. 00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet 1 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment 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 Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment	f periods in payment ar), (ii), or the mileage ii)? Enter n adjustmen ber 1. Ente . (see inst nt for disp eption for t. L, Pt. I capital? Ei	djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst	For low volu er in colum its in 2 "Y" for yes o ves or "N" for e share in a ry circumsta C L-1, Pt.	1. me 1 s r 1 or accordance ances I through for no.	00 N N 1. 00 N	2 XVI I D 2. 00	N N 1 XIX 0 3.00	40. 00 45. 00 47. 00
39.00 40.00 45.00 46.00 47.00 48.00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer 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 Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in	f periods in payment ac), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst csee inst nt for disp eption for t. L, Pt. I capital? Ei t? Enter "	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina il and Wkst nter "Y for Y" for yes	Fone and For low volu ter in colum tts in P "Y" for yes res or "N" for te share in try circumst C L-1, Pt. or "N" for	1. me 1 s r 1 or accordance ances 1 through for no. no.	00 J V 1. 00 N N N	2 XVII) 2.0 N N N	2.00 N 1 XIX 0 3.00 N N N	40. 00 45. 00 46. 00 48. 00
39. 00 40. 00 45. 00 46. 00 47. 00 48. 00 56. 00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet the accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting 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 "N	f periods in payment ac (ii), or the mileage i)? Enter n adjustmen per 1. Enter (see inst (see inst at for disp eption for t. L, Pt. I capital? Ei t? Enter " approved G period during r yes or "N th of this of Y", completer	djustment f (iii)? Ent requiremer in column 2 t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes WE programs ng which re " for no in cost report e Worksheet	Fone and For low volu ter in colum ter in colum ts in "Y" for yes o res or "N" for e share in try circumst. L-1, Pt. yes or "N" or "N" for ? Enter "Y esidents in column 1. ting period?	1. me 1. me 1 s r 1 or accordance ances I through for no. no. " for yes approved I f col umn Enter "Y	00 J V 1. 00 N N N N N 1	2 XVII) 2.0 N N N	2.00 N 1 XIX 0 3.00 N N N	40. 00 40. 00 45. 00 46. 00 46. 00 48. 00 56. 00
39. 00 40. 00 45. 00 46. 00 47. 00 48. 00 56. 00 57. 00	greater than 1, subscript this line for the number of enter subsequent dates. Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet faccordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment 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 Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in 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	f periods in payment aa), (ii), or the mileage ii)? Enter n adjustmen ber 1. Enter . (see inst . (see inst) . (see inst . (see inst . (see inst) . (see inst) . (se	djustment f (iii)? Ent requiremen in column 2 t? Enter "Y r"Y" for y ructions) roportionat extraordina II and Wkst hter "Y for Y" for yes ME programs ng which re 'for no in cost report e Worksheet cost physicia	For low volu er in colum ets in 2 "Y" for yes wes or "N" for es share in ary circumst. L-1, Pt. yes or "N" or "N" for sidents in a column 1. ing period? E-4. If co	1. me 1. n 1. s 1. r 1. r 2. n 1. n 2. n	00 J V 1. 00 N N N N N 1	2 XVII) 2.0 N N N	2.00 N 1 XIX 0 3.00 N N N	40.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ТА	Provider C		eriod: rom 01/01/2018 p 12/31/2018	Date/Time Pre	pared
		I	NAHE 413.85 Y/N	Worksheet A Line #	5/28/2019 6:1 Pass-Through Qual i fi cati on Cri teri on Code	
			1.00	2.00	3.00	
0.00 Are you claiming nursing and allied health education			N			60.
any programs that meet the criteria under §413.85? (Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	-
Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N	2.00	3.00	0.00		61.
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.
instructions) 02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61.
and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for						61.
 determining compliance with the 75% test. (see instructions) 04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the 						61.
current cost reporting period. (see instructions). 1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
 61.04 minus line 61.03). (see instructions) .06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	(1
 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 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. 				0.00		
Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
					1.00	
ACA Provisions Affecting the Health Resources and Ser .00 Enter the number of FTE residents that your hospital				od for which	0.00	62
your hospital received HRSA PCRE funding (see instruction of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) 1 Teachi	ng Health Cen	ter (THC) into		0.00	
Teaching Hospitals that Claim Residents in Nonprovide .00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Setti ettings	ings during this c	ost reporting p		N	63.
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00 is your cost r	3.00 reporting	
 period that begins on or after July 1, 2009 and befor 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 resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see 	re June y train -priman all nor l non-pr n column	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0. 00	-		64.

SPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Provider	Fr	eriod: com 01/01/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/28/2019 6:1	pared 9 pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	4))	
	1.00	2.00	3.00	4.00	5.00	1
.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)						
			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/	
			Nonprovi der	Hospi tal	(cor. 1 + cor. 2))	
			Si te	•		
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settir	ngsEffective fo	or cost reporti	ing periods	
Enter in column 2 the number of		rovider settings. rv.care resident				
Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 -	unweighted non-prima tal. Enter in column	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
FTEs that trained in your hospin (column 1 divided by (column 1 -	unweighted non-prima tal. Enter in column ⊢column 2)). (see in:	ry care resident 3 the ratio of structions)	FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospit (column 1 divided by (column 1 - column 1 divided by (column 1 - column 1 divided by (column 1 - column 2, the program code. 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	unweighted non-prima tal. Enter in column column 2)). (see in: Program Name 1.00	ry care resident 3 the ratio of structions) Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
FTEs that trained in your hospit (column 1 divided by (column 1 - column 1 divided by (column 1 - column 1 divided by (column 1 - column 2) (column 1 divided by (column 1 - column 2) (column 2) the program code and 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	unweighted non-prima tal. Enter in column column 2)). (see in: Program Name 1.00	ry care resident 3 the ratio of structions) Program Code	FTEs Nonprovi der Si te 3.00	FTES in Hospi tal 4.00 0.00	(col. 3 + col. 4)) 5.00 0 0.000000	-
FTEs that trained in your hospit (column 1 divided by (column 1 - column 1 divided by (column 1 - expression of the second secon	unweighted non-prima tal. Enter in column column 2)). (see in: Program Name 1.00	ry care resident 3 the ratio of structions) Program Code	FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0 0.000000	-
FTEs that trained in your hospit (column 1 divided by (column 1 - column 1 divided by (column 1 - expression of the second of the second your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	unweighted non-prima tal. Enter in column column 2)). (see in Program Name 1.00	ry care resident 3 the ratio of structions) Program Code 2.00	FTĚs 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 0.000000 0 2.00 3.00	- 67. (
FTEs that trained in your hospit (column 1 divided by (column 1 - (column 1 divided by (column 1 -) (column 2 divided by column 3 (column 2, the program code. 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)	unweighted non-prima tal. Enter in column column 2)). (see in: Program Name 1.00 1.00 2.00 2.00 3.00 3.00 4.00 2.00 3.00 3.00 5.20	ry care resident 3 the ratio of structions) 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 stain an IPF subp ning program in t yes or "N" for n s in a new teach yes or "N" for n	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 0.000000 0 2.00 3.00	70. (
FTEs that trained in your hospit (column 1 divided by (column 1 - (column 1 divided by (column 1 -) .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) .00 Inpatient Psychiatric Facility I 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) .00 Inpatient Psychiatric Facility I 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) .00 Inpatient Psychiatric Facility I column 1: Did recent cost report filed on or to 42 CFR 412. 424(d)(1)(iii)(c)) C program in accordance with 42 Cf Column 3: If column 2 is Y, inditication	unweighted non-prima tal. Enter in column column 2)). (see in: Program Name 1.00 1.00 1.00 2.00 2.00 2.00 3.00 3.00 4.00 5.00 5.00 5.00 5.00 5.00 5.00 5	ry care resident 3 the ratio of structions) 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	FTËs Nonprovi der Si te 3.00 0.00 rtain an IPF subp ning program in t yes or "N" for n s cost reporting	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	_

Heal th	Financial Systems IU HEALTH WHIT	TE HOSPITAL		In Lie	u of Form CMS	5-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1312	Period: From 01/01/2018	Worksheet S Part I	-2
				To 12/31/2018	Date/Time P	
					<u> 5/28/2019_6</u> ;	19 pm
					1.00	
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	<u>no</u>		N	80.00
	Is this a LTCH co-located within another hospital for part of			g period? Enter	N	81.00
	"Y" for yes and "N" for no.		•			_
05 00	TEFRA Providers			on "N" for no	N	
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (exclude				IN IN	85.00 86.00
	§413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
	Is this hospital an extended neoplastic disease care hospita	al classified	under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XIX	
				1.00	2.00	_
	Title V and XIX Services				[
	Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
	is this hospital reimbursed for title V and/or XIX through t	the cost repor	t either in	N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the appl	icable column	I.			
	Are title XIX NF patients occupying title XVIII SNF beds (du		ion)? (see		N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applica Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93.00
	"Y" for yes or "N" for no in the applicable column.					
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n.	0.00	0.00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96.00
	applicable column.					07.00
	If line 96 is "Y", enter the reduction percentage in the app Does title V or XIX follow Medicare (title XVIII) for the ir			0.00 N	0. 00 Y	97.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" f			IN IN		70.00
	column 1 for title V, and in column 2 for title XIX.	-				
	Does title V or XIX follow Medicare (title XVIII) for the re			. N	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti title XIX.	tie v, and in				
98.02	Does title V or XIX follow Medicare (title XVIII) for the ca			N	Y	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes o	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 a crit	tical access h	ospital (CAH)	N	N	98.03
	reimbursed 101% of inpatient services cost? Enter "Y" for ye			1		
	for title V, and in column 2 for title XIX.	not mburgood 10	10 of	N	N	00.04
	Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no ir			N	N	98.04
	in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) and add ba				Y	98.05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c column 2 for title XIX.		itiev, and i	1		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost			N	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column	n 1 for title	V, and in			
	column 2 for title XIX. Rural Providers					_
	Does this hospital qualify as a CAH?			Y		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-	inclusive met	hod of paymen	t N		106.00
107 00	for outpatient services? (see instructions) If this facility qualifies as a CAH, is it eligible for cost	reimbursemen	t for L&R	N		107.00
	training programs? Enter "Y" for yes or "N" for no in column					107.00
	yes, the GME elimination is not made on Wkst. B, Pt. I, col.	25 and the p	rogram is cos	t		
108 00	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the	CRNA fee sche	dule? See 42	N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	onna ree sene	ddre: 300 42	N N		100.00
		Physi cal	Occupati ona		Respi ratory	/
109.00	If this hospital qualifies as a CAH or a cost provider, are	1.00 N	2.00 N	3.00 N	4.00 N	109.00
107.00	therapy services provided by outside supplier? Enter "Y"	i v				107.00
	for yes or "N" for no for each therapy.					
					1.00	_
	Did this hospital participate in the Rural Community Hospita				N 1.00	110.00
	Demonstration) for the current cost reporting period? Enter "					
	complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	KSNEET E-2, I	ines 200 thro	uyn ∠15, as		
	on the second				1	1

lealth Financial Systems IU HEALTH WHITE HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN:	15-1312	Period: From 01/0		u of For Workshe Part I Date/Ti 5/28/20	et S-2 me Pre	2 epared:
			1.0	00	2.0	00	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colu integration prong of the FCHIP demo in which this CAH is parti Enter all that apply: "A" for Ambulance services; "B" for addi for tele-health services.	reporting per umn 1 is Y, en cipating in co	riod? Enter ter the plumn 2.	. 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 " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers) Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for 117.00 Is this facility legally-required to carry malpractice insuran	f column 2 is for long term based on the or yes or "N" t	"E", enter care (incl definition for no.	in column udes in CMS			0	115. 00 116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence polic		2		1			118.00
claim-made. Enter 2 if the policy is occurrence.					lacur		
		Premiums	Loss	65	Insur	ance	
	-	1.00	2.0)0	3. (00	-
118.01 List amounts of malpractice premiums and paid losses:		39, 1	67	0		(0 118. 01
			1.0	0	2. (00	
118.02 Are malpractice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul 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 H §3121 and applicable amendments? (see instructions) Enter in c "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2, "Y" for yes or "N" for no.	e listing cos darmless provis column 1, "Y" n ifies for the	t centers sion in ACA for yes or Outpatient			N		119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no.	able devices o	charged to	Y				121.00
122.00 Does the cost report contain healthcare related taxes as defin Act?Enter "Y" for yes or "N" for no in column 1. If column 1 i the Worksheet A line number where these taxes are included.	ned in §1903(w) s "Y", enter i)(3) of the n column 2	Y		5. (00	122.00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" fo	orno.lf	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2.		cation date					126. 00
27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	the certifica						127.0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter			n				128. 0 129. 0
column 1 and termination date, if applicable, in column 2. 30.00 f this is a Medicare certified pancreas transplant center, en	nter the certin						130. 0
date in column 1 and termination date, if applicable, in colum 31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	enter the cer	ti fi cati on					131.0
32.00 If this is a Medicare certified islet transplant center, in column 1 and termination date, if applicable, in column 2.		ation date					132. 0
33.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2.							133. 0
34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	OPO number in	column 1					134. 0
All Providers 40.00 Are there any related organization or home office costs as def chapter 10? Enter "Y" for yes or "N" for no in column 1. If ye			Y		15H)59	140. 00

	IU HEALTH X IDENTIFICATION DATA	Provider CC	CN: 15-1312	Period: From 01/01/201 To 12/31/201		-2 repared:
1.00		2.00		3.00		
If this facility is part of a cha				name and address	s of the	
home office and enter the home of				tors o Numbers 00	101	111 0
41.00 Name: INDIANA UNIVERSITY HEALTH 42.00 Street: 340 WEST 10TH STREET	Contractor's Name PO Box:	9: WPS	Contract	tor's Number: 08	101	141.0
43. 00 City: INDIANAPOLIS	State:	IN	Zip Code	. 46'	202	142.0
S. OOPERTY. THURANALOETS	jstate.	1 11		. 40.	202	145.0
					1.00	_
14.00 Are provider based physicians' co	sts included in Workshe	et A?			Y	144.0
				1.00	2.00	
45.00 If costs for renal services are c						145. C
inpatient services only? Enter "Y						
no, does the dialysis facility in period? Enter "Y" for yes or "N"	for no in column 2	tion for this cost	reporting			
46.00 Has the cost allocation methodolog		wiously filed cost	t roport?	N		146.0
Enter "Y" for yes or "N" for no i						140.0
yes, enter the approval date (mm/		\sim 10 z , onapter z				
				I		
					1.00	
17.00 Was there a change in the statist					N	147.0
18.00Was there a change in the order o					Ν	148.0
19.00Was there a change to the simplif	ed cost finding method				N	149. C
		Part A	Part B	Title V	Title XIX	_
		1.00	2.00	3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or						
55.00 Hospital	N FOR NO FOR EACH COM	N	N	<u>(See 42 CFR 94</u> N	<u>N N</u>	155. 0
56. 00 Subprovi der – I PF		N	N N	N	N	156.0
57. 00 Subprovider - IRF		N	N N	N	N	157.0
58. OO SUBPROVI DER						158.0
59. 00 SNF		N	N	N	N	159. C
50.00 HOME HEALTH AGENCY		N	N N	N	N	160. C
51.00 CMHC			N	N	N	161.0
					1.00	
Multicampus				CDCA-O	N	1/5 0
55.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that nas	s one or more campu	uses in diffe	erent CBSAS?	N	165. C
LITTER I TOT YES OF IN TOT HO.			State Zi		FTE/Campus	_
	Name	County		n Code CBSA		
	Name 0	<u>County</u> 1.00		p Code CBSA 3.00 4.00		-
56.00 fline 165 is yes, for each	Name O	<u>County</u> 1.00	2.00	p Code CBSA 3.00 4.00	5.00	 00166.0
66.00 If line 165 is yes, for each campus enter the name in column					5.00	00 166. 0
campus enter the name in column O, county in column 1, state in					5.00	00 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,					5.00	00 166. (
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					5.00	00 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,					5.00	00 166. (
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					5.00	00 166. 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)	0	1.00	2.00	3.00 4.00	5.00	00 166. 0
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI	0 T) incentive in the Ame	1.00 erican Recovery and	2.00	3.00 4.00	5.00	_
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	0 T) incentive in the Amer r under §1886(n)? Ente	1.00 erican Recovery and er "Y" for yes or "	2.00 d Reinvestme	3.00 4.00 nt Act	5.00 0.0	167. 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) Health Information Technology (HI 57.00 Is this provider a meaningful use	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea	1.00 erican Recovery and er "Y" for yes or " aningful user (line	2.00 d Reinvestme	3.00 4.00 nt Act	5.00 0.0	167. 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) Health Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 58.01 If this provider is a CAH and is 10	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user,	1.00 erican Recovery and er "Y" for yes or " aningful user (line tions) does this provider	d Reinvestme 'N" for no. e 167 is "Y";	<u>3.00</u> 4.00 <u>nt Act</u>), enter the r a hardship	5.00 0.0	167. (0168. (
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) Health Information Technology (HI 57.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the 1 58.01 If this provider is a CAH and is 1 exception under §413.70(a)(6)(ii)	0 T) incentive in the Ame r under §1886(n)? Ente 25 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or	1.00 erican Recovery and er "Y" for yes or " aningful user (line tions) does this provider "N" for no. (see i	2.00 d Reinvestme "N" for no. e 167 is "Y"; r qualify for nstructions;	<u>3.00</u> 4.00 <u>nt Act</u>), enter the r a hardship	5.00 0.0	167. (0168. (168. (
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) Health Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 for this provider is a CAH and is i exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	1.00 erican Recovery and er "Y" for yes or " aningful user (line tions) does this provider "N" for no. (see i	2.00 d Reinvestme "N" for no. e 167 is "Y"; r qualify for nstructions;	<u>3.00</u> 4.00 <u>nt Act</u>), enter the r a hardship	5.00 0.0	167. (0168. (168. (
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) Health Information Technology (HI 57.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1) reasonable cost incurred for the 1 58.01 If this provider is a CAH and is 1 exception under §413.70(a)(6)(ii)	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	1.00 erican Recovery and er "Y" for yes or " aningful user (line tions) does this provider "N" for no. (see i	2.00 d Reinvestme "N" for no. e 167 is "Y"; r qualify for nstructions;	<u>3.00</u> 4.00 <u>nt Act</u>), enter the r a hardship "N"), enter the	5.00 0.0 1.00 Y	167. (0168. (168. (
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) Health Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 1 for this provider is a CAH and is i exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	1.00 erican Recovery and er "Y" for yes or " aningful user (line tions) does this provider "N" for no. (see i	2.00 d Reinvestme "N" for no. e 167 is "Y"; r qualify for nstructions;	3.00 4.00 nt Act), enter the r a hardship "N"), enter the Beginning	5.00 0.0 1.00 Y e 0.0 Endi ng	167. (0168. (168. (
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) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 58.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful to transition factor. (see instruction	0 T) incentive in the Ame r under §1886(n)? Ente 55 is "Y") and is a mea HIT assets (see instruction not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 erican Recovery and er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (2.00 d Reinvestme 'N" for no. a 167 is "Y"; r qualify for nstructions; (line 105 is	3.00 4.00 nt Act), enter the r a hardship "N"), enter the Beginning 1.00	5.00 0.0 1.00 Y e 0.0 Endi ng 2.00	167. (0168. (168. (00 169. (
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) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the seception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	0 T) incentive in the Ame r under §1886(n)? Ente 55 is "Y") and is a mea HIT assets (see instruction not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 erican Recovery and er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (2.00 d Reinvestme 'N" for no. a 167 is "Y"; r qualify for nstructions; (line 105 is	3.00 4.00 nt Act), enter the r a hardship "N"), enter the Beginning	5.00 0.0 1.00 Y e 0.0 Endi ng	167. (0168. (168. (00169. (
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) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 58.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful to transition factor. (see instruction	0 T) incentive in the Ame r under §1886(n)? Ente 55 is "Y") and is a mea HIT assets (see instruction not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 erican Recovery and er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (2.00 d Reinvestme 'N" for no. a 167 is "Y"; r qualify for nstructions; (line 105 is	3.00 4.00 nt Act), enter the r a hardship "N"), enter the Beginning 1.00	5.00 0.0 1.00 Y e 0.0 Endi ng 2.00	167. (0168. (168. (00169. (
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) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the seception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	0 T) incentive in the Ame r under §1886(n)? Ente 55 is "Y") and is a mea HIT assets (see instruction not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") ons)	1.00 erican Recovery and er "Y" for yes or " aningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (2.00 d Reinvestme 'N" for no. a 167 is "Y"; r qualify for nstructions; (line 105 is	3.00 4.00 nt Act), enter the r a hardship "N"), enter the Beginning 1.00	5.00 0.0 1.00 Y e 0.0 Endi ng 2.00	167. (0168. (168. (
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) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the seception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HIT assets (see instruc not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) peginning date and endi	1.00 erican Recovery and er "Y" for yes or " aningful user (line tions) does this provider "N" for no. (see i and is not a CAH (ng date for the re	d Reinvestme N" for no. e 167 is "Y"; qualify for nstructions; (line 105 is eporting	3.00 4.00 nt Act), enter the r a hardship "N"), enter the Begi nni ng 1.00 01/01/2018	5.00 0.0 1.00 Y 2.00 03/31/2018 2.00	167. (0168. (168. (00169. (
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) Heal th Information Technology (HI 57.00 Is this provider a meaningful use 58.00 If this provider is a CAH (line 11 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	0 T) incentive in the Ame r under §1886(n)? Ente D5 is "Y") and is a mea HT assets (see instruct not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) peginning date and endi vider have any days for	1.00 erican Recovery and er "Y" for yes or " nningful user (line ctions) does this provider "N" for no. (see i and is not a CAH (ng date for the re	d Reinvestme 'N" for no. e 167 is "Y") - qualify for nstructions (line 105 is eporting	3.00 4.00 nt Act), enter the a hardship "N"), enter the Beginning 1.00 01/01/2018 1.00	5.00 0.0 1.00 Y 2.00 03/31/2018 2.00	167. (0168. (168. (000169. (170. (

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2018 Part II Date/Time Prepared: То 12/31/2018 5/28/2019 6:19 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7 00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν 16.00 Ν If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/03/2019 γ 04/03/2019 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this

Ν

19.00

Ν

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

Heal th	Financial Systems IU HEALTH WH	ITE HOSPITAL		In Lie	eu of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period:	Worksheet S	
				rom 01/01/2018		
			1	o 12/31/2018	Date/Time P 5/28/2019 6	
		Descri	i pti on	Y/N	Y/N	
)	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.00
	Report data for Other? Describe the other adjustments:					
		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	N		N		21.00
	records? If yes, see instructions.					
					1.00	
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPI UNILUKENS N	USPITALS)			
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense		als made durin	a the cost	N	23.00
23.00	reporting period? If yes, see instructions.			ig the cost	IN IN	23.00
24.00	Were new leases and/or amendments to existing leases enter	ed into durina	this cost repo	orting period?	N	24.00
211.00	If yes, see instructions	ou meo uu mg	tin o ocot i opo	i ting porrour		200
25.00	Have there been new capitalized leases entered into during	the cost repor	ting period? I	f yes, see	N	25.00
	instructions.		0.1	5		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost reporti	ng period? If	yes, see	N	26.00
	instructions.					
27.00	Has the provider's capitalization policy changed during the	e cost reportin	ng period? If y	ves, submit	N	27.00
	copy.					_
~~ ~~	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost r	reporting	N	28.00
20.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	hand funda (Da	ht Comilion Doo	arria Fund)	N	29.00
29.00	treated as a funded depreciation account? If yes, see inst		bt service kes	erve Fund)	IN IN	29.00
30. 00	Has existing debt been replaced prior to its scheduled mat		debt2 If ves	500	N	30, 00
50.00	instructions.	unity with new	debt: 11 yes,	366	IN IN	30.00
31.00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If ves	See	N	31.00
01100	instructions.		dob ti 11 joo,	000		01100
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	rvi ces furni she	d through cont	ractual	N	32.00
	arrangements with suppliers of services? If yes, see instru					
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainin	ig to competiti	ve bidding? If		33.00
	no, see instructions.					_
24.00	Provi der-Based Physi ci ans			al altration of the	V V	- 24.00
34.00	Are services furnished at the provider facility under an a	rrangement with	provider-base	ed physicians?	Y	34.00
25 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agroomon	te with the pr	ovidor bacod	N	35.00
55.00	physicians during the cost reporting period? If yes, see in		its with the pi	ovider-based	IN IN	33.00
	physicialis during the cost reporting period. If yes, see h			Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		37.00
	If yes, see instructions.					
38.00	If line 36 is yes , was the fiscal year end of the home of			Ν		38.00
	the provider? If yes, enter in column 2 the fiscal year en					
39.00	If line 36 is yes, did the provider render services to oth	er chain compon	ents? If yes,	N		39.00
	see instructions.					
40.00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
	instructions.				l	
		1	00	2	00	
	Cost Report Preparer Contact Information	1.	00	Ζ.	00	
41 00	Enter the first name, last name and the title/position	RHONDA		UTTER		41.00
- I. UU	held by the cost report preparer in columns 1, 2, and 3,					⁴ 1.00
	respectively.					
42,00	Enter the employer/company name of the cost report	INDIANA UNIVER	SITY HEALTH			42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost	317. 962. 1093		RUTTER@I UHEALT	H. ORG	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems	U HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-:	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTI	ONNAI RE	Provi der	CCN: 15-1312	Period: From 01/01/2018	Worksheet S-2 Part II	
					To 12/31/2018		pared: 9 pm
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/p	osition 0	GOVERNMENT P	ROGRAMS DI RECTO	R		41.00
	held by the cost report preparer in columns 1,	2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost rep	ort					42.00
	preparer.						
43.00	Enter the telephone number and email address of	the cost					43.00
	report preparer in columns 1 and 2, respectivel	у.					

	Financial Systems	IU HEALTH WHIT				u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	:N: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prep 5/28/2019 6:19	
						I/P Days / O/P 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 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	25	9, 1	41, 568. 00	0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 1	41, 568. 00	0 0	6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY		25	9, 1.	25 41, 568. 00	0 0	14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
21.00 22.00 23.00 24.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	101.00				0	21.00 22.00 23.00 24.00
24. 10 25. 00 26. 00	HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89. 00	25 0		0	0	26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and di scharges						33. 00 33. 01

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 01/01/2018 To 12/31/2018		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00 2.00 3.00	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	1, 147 198 0	7 113 0		2		1.00 2.00 3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	319	0		9		5.00
5.00	Hospital Adults & Peds. Swing Bed NF		0				6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 466	7	2, 26	4		7.00
3.00							8.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.0
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 466	7	2, 26	4 0.00	138.89	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
18.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00 22.00	OTHER LONG TERM CARE	0	0		0 0 00	0.00	21.0
2.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	U	0		0 0.00	0.00	22.0
24.00	HOSPICE						24.0
24. 10	HOSPICE (non-distinct part)				0		24.1
25.00	CMHC - CMHC				-		25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	26.2
27.00	Total (sum of lines 14-26)				0.00	138.89	27.0
28.00	Observation Bed Days		3	44	6		28.0
29.00	Ambulance Trips	0					29.0
30.00	Employee discount days (see instruction)				0		30.0
1. 00	Employee discount days - IRF				0		31.0
32.00	Labor & delivery days (see instructions)	0	0		0		32.0
32.01	Total ancillary labor & delivery room				0		32.0
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days LTCH site neutral days and discharges	0					33.0 33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Prep 5/28/2019 6:19	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00	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		0		46 2 61 41 0	550	1.00 2.00 3.00
4.00 5.00 6.00 7.00 8.00	HMO IRF 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				0		4.00 5.00 6.00 7.00 8.00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0. 00	0	3	46 2	550	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00
 22.00 23.00 24.00 24.10 25.00 26.00 	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00					22.00 23.00 24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room	0.00 0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

Heal th	Financial Systems IU HEALTH WHITE	HOSPI TAL		In Li€	eu of Form CMS-	2552-10			
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-1312	Peri od:	Worksheet S-1	0			
				From 01/01/2018 To 12/31/2018					
					1.00				
	Uncompensated and indigent care cost computation			->					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lir	ne 202 columr	1 8)	0. 323295	1.00			
2.00	Medicaid (see instructions for each line)				2 472 042	1 2 00			
2.00 3.00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				2, 472, 043 Y	2.00			
3.00 4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal navmonts	s from Medica	ai d2	Y Y	4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	in d :	0						
6.00	Medi cai d charges		4		12, 564, 281				
7.00	Medicaid cost (line 1 times line 6)				4, 061, 969	•			
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	us sum of lir	nes 2 and 5; if	1, 589, 926	•			
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions f								
9.00	Net revenue from stand-alone CHIP				0				
10.00	Stand-al one CHIP charges		0						
11.00	Stand-alone CHIP cost (line 1 times line 10)	(1) 44 1		с н	0	1			
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mir	nus line 9; i	f < zero then	0	12.00			
	enter zero) Other state or local government indigent care program (see ins	tructions fo	or each line						
13.00	Net revenue from state or local indigent care program (Not inc				0	13.00			
14.00	Charges for patients covered under state or local indigent car				0				
15.00	State or local indigent care program cost (line 1 times line 1	4)			0	15.00			
16.00	Difference between net revenue and costs for state or local in	digent care	program (lin	ne 15 minus line	0	16.00			
	13; if < zero then enter zero)								
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state	e/local indig	jent care program	ns (see				
17.00	instructions for each line) Private grants, donations, or endowment income restricted to f	unding chari	ty care		0	17.00			
18.00	Government grants, appropriations or transfers for support of				0				
19.00	Total unreimbursed cost for Medicaid, CHIP and state and Ioca 8, 12 and 16)			s (sum of lines	1, 589, 926				
			Uni nsured	Insured	Total (col. 1				
			patients	pati ents	+ col. 2)				
			1.00	2.00	3.00				
~~ ~~	Uncompensated Care (see instructions for each line)		0.445.0	75 105					
20.00	Charity care charges and uninsured discounts for the entire fa (see instructions)	сптту	2, 415, 39	75, 435	2, 490, 829	20.00			
21.00	Cost of patients approved for charity care and uninsured disco	unte (coo	780, 8	35 75, 435	856, 320	21.00			
21.00	instructions)		700, 00	75, 455	050, 520	21.00			
22.00	Payments received from patients for amounts previously written	off as	8, 4	95 1, 980	10, 475	22.00			
	charity care								
23.00	Cost of charity care (line 21 minus line 22)		772, 39	73, 455	845, 845	23.00			
				<u> </u>	1.00	0.4.00			
24.00	Does the amount on line 20 column 2, include charges for patie		ond 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 t		care program	's length of	0	25.00			
20.00	Istav limit	ine margent	cure progra	i s i cligti i cl	, o	20.00			
26.00	Total bad debt expense for the entire hospital complex (see in		2, 947, 746	26.00					
27.00	Medicare reimbursable bad debts for the entire hospital comple		ructions)		460, 886	•			
27.01	Medicare allowable bad debts for the entire hospital complex (see instruct	tions)		709, 054				
28.00	Non-Medicare bad debt expense (see instructions)				2, 238, 692				
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see i	nstructions)	1	971, 926				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	1 20			1, 817, 771				
	Cost of uncompensated care (line 23 column 3 plus line 29) 1,817,771 30.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30) 3,407,697 31.00								

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ON	IU HEALTH WHITE	Provider CC	N. 15 1212	Period:	u of Form CMS-2 Worksheet A	2552-10
RECLAS	STFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC	N: 15-1312	From 01/01/2018	worksneet A	
					To 12/31/2018	Date/Time Prep 5/28/2019 6:19	pared: 9 pm
	Cost Center Description	Sal ari es	Other		I Reclassificati		
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col. 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 902, 203	1, 902, 20	3 -1, 890, 627	11, 576	1.00
1.00	00100 CAF REL COSTS-BEDG & FIXT - HOSPITAL		1, 902, 203		0 2, 717, 096		1.00
1.01	00102 CAP REL COSTS-BLDG & FIXT - TLMOB		0		0 2,717,090	2, 717, 040	1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	46, 160	46, 16		1, 506, 903	4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL	480, 760	6, 356, 621	6, 837, 38		6, 733, 859	5.00
7.00	00700 OPERATION OF PLANT	215, 017	1, 833, 539	2, 048, 55		230, 995	7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL	215,017	1,033,039		0 1, 728, 594	1, 728, 594	7.00
7.01	00702 OPERATION OF PLANT - TLMOB	0	0				7.02
7.02 8.00		0	0		-	294, 897	8.00
	00800 LAUNDRY & LINEN SERVICE	224 041				68, 966	
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	324, 941	260, 368	585, 30		387, 741	9.00
10.00		523, 795	402, 903	926, 69		616, 519	
	01100 CAFETERIA	701 011	0		0 112, 365	112, 365	11.00
	01300 NURSI NG ADMI NI STRATI ON	721, 311	234, 458	955, 76		838, 886	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	116, 970	116, 97		661, 905	14.00
	01500 PHARMACY	404, 373	2, 330, 280	2, 734, 65		701, 402	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
~ ~ ~	INPATIENT ROUTINE SERVICE COST CENTERS	1 004 004	000.040	0.454.04	7 444 400	4 740 407	00.00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 224, 924	929, 343	2, 154, 26	7 -411, 130	1, 743, 137	30.00
	05000 OPERATING ROOM	462,002	720.024	1 102 00	8 -275, 785	016 222	F0 00
		463, 082	728, 926	1, 192, 00			
54.00	05400 RADI OLOGY-DI AGNOSTI C	310, 688	404, 081	714, 76		452, 969	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	79, 747	81, 485	161, 23		107, 707	
56.00	03630 ULTRA SOUND	138, 387	101, 352	239, 73		155, 907	56.00
57.00	05700 CT SCAN	384, 538	247, 326	631,86			
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	114, 396	172, 727	287, 12		121, 727	58.00
60.00		0	1, 372, 231	1, 372, 23		1, 372, 231	
66.00	06600 PHYSI CAL THERAPY	289, 577	88, 539	378, 11		313, 236	
67.00	06700 OCCUPATI ONAL THERAPY	113, 246	25, 217	138, 46		121, 738	
68.00		69,067	19, 776	88, 84		74, 292	
69.00	06900 ELECTROCARDI OLOGY	95, 070	38, 578	133, 64		107, 755	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 20, 626	20, 626	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 6, 676	6, 676	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 324, 414	324, 414	
73.01	07301 ONCOLOGY DRUGS	401 075	100 (50		0 1, 668, 014		
76.00		421, 375	198, 650	620, 02	5 -116, 311	503, 714	76.00
~ ~ ~	OUTPATIENT SERVICE COST CENTERS	115 0//	(2.001	170.0/	7 2/ 201	140.00/	
90.00		115, 366	63, 901	179, 26		142, 886	90.00
	09100 EMERGENCY	1, 180, 933	1, 801, 709	2, 982, 64	2 -420, 978	2, 561, 664	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
	OTHER REIMBURSABLE COST CENTERS						101 00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
440 00	SPECIAL PURPOSE COST CENTERS	7 (70 500	40 757 040	07 407 00	504,000	00 000 454	110 00
		7, 670, 593	19, 757, 343	27, 427, 93	6 594, 220	28, 022, 156	118.00
118.00	NONREIMBURSABLE COST CENTERS	-1					100.00
					0 0	0	190.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			_	
190. 00 191. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH	0	0		0 0		191.00
190. 00 191. 00 192. 00	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES	0 0 87, 427	0 23, 550	110, 97	0 0 7 -18, 206	92, 771	191. 00 192. 00
190. 00 191. 00 192. 00 192. 02	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19202 MOB	0	0	110, 97 576, 01	0 0 7 -18, 206 4 -576, 014	92, 771 0	191. 00 192. 00 192. 02
190. 00 191. 00 192. 00 192. 02 192. 03	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19202 MOB 19203 ARNETT SURGERY OFFI CE	0	0 23, 550	110, 97 576, 01	0 0 7 -18, 206 4 -576, 014 0 0	92, 771 0 0	191. 00 192. 00 192. 02 192. 03
190. 00 191. 00 192. 00 192. 02 192. 03 192. 04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSI CI ANS' PRI VATE OFFI CES 19202 MOB 19203 ARNETT SURGERY OFFI CE 19201 OCCUPATI ONAL MEDI CI NE	0	0 23, 550	110, 97 576, 01	0 0 7 -18, 206 4 -576, 014 0 0 0 0	92, 771 0 0 0	191. 00 192. 00 192. 02 192. 03 192. 04
190. 00 191. 00 192. 00 192. 02 192. 03 192. 04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19202 MOB 19203 ARNETT SURGERY OFFICE 19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0	0 23, 550	110, 97 576, 01	0 0 7 -18, 206 4 -576, 014 0 0 0 0 0 0	92, 771 0 0 0	191. 00 192. 00 192. 02 192. 03 192. 04 193. 00

		IU HEALIH WHII	Provider CC	N. 1E 1010		orm CMS-2552
LULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1312	Period: Works From 01/01/2018	sheet A
					To 12/31/2018 Date.	Time Prepare
			N 1 5		5/28,	/2019 6:19 pm
	Cost Center Description		Net Expenses			
			or Allocation			
		6.00	7.00			
~~	GENERAL SERVICE COST CENTERS	44.000				1
00	00100 CAP REL COSTS-BLDG & FIXT	44,008	55, 584			1
01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	-259, 165	2, 457, 931			1.
02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB	338, 217	619, 334			1
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-20, 792	1, 486, 111			4.
00	00500 ADMINI STRATI VE & GENERAL	-459, 832	6, 274, 027			5
00	00700 OPERATION OF PLANT	0	230, 995			7.
01	00701 OPERATION OF PLANT - HOSPITAL	-8, 380	1, 720, 214			7.
02	00702 OPERATION OF PLANT - TLMOB	0	294, 897			7.
00	00800 LAUNDRY & LINEN SERVICE	0	68, 966			8
00	00900 HOUSEKEEPI NG	0	387, 741			9
0. 00	01000 DI ETARY	-139, 847	476, 672			10
. 00	01100 CAFETERI A	-111, 273	1, 092			11.
. 00	01300 NURSI NG ADMI NI STRATI ON	-12, 703	826, 183			13
	01400 CENTRAL SERVICES & SUPPLY	-12, 411	649, 494			14
	01500 PHARMACY	295, 144	996, 546			15
. 00	01600 MEDICAL RECORDS & LIBRARY	0	0			16
. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0			
. 00	03000 ADULTS & PEDI ATRI CS	-245, 262	1, 497, 875			30
. 00	ANCI LLARY SERVICE COST CENTERS	243, 202	1,477,075			
. 00	05000 OPERATING ROOM	-125, 349	790, 874			50
	05400 RADI OLOGY-DI AGNOSTI C	-1, 762	451, 207			54
	05500 RADI OLOGY-THERAPEUTI C	-1,702	107, 707			55
. 00	03630 ULTRA SOUND	0	155, 907			56
. 00	05700 CT SCAN	0	414, 419			57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				58
. 00		0	121, 727			
		0	1, 372, 231			60
	06600 PHYSI CAL THERAPY	0	313, 236			66
. 00	06700 OCCUPATIONAL THERAPY	0	121, 738			67
	06800 SPEECH PATHOLOGY	0	74, 292			68
	06900 ELECTROCARDI OLOGY	0	107, 755			69
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	20, 626			71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	6, 676			72
	07300 DRUGS CHARGED TO PATIENTS	0	324, 414			73
	07301 ONCOLOGY DRUGS	0	1, 668, 014			73
. 00	03160 CARDI OPULMONARY	-24, 306	479, 408			76
	OUTPATIENT SERVICE COST CENTERS	[]				
	09000 CLI NI C	-1, 511	141, 375			90
	09100 EMERGENCY	58, 502	2, 620, 166			91
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92
. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0			92
	OTHER REIMBURSABLE COST CENTERS					
1.00	10100 HOME HEALTH AGENCY	0	0			101
	SPECIAL PURPOSE COST CENTERS					
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-686, 722	27, 335, 434			118
	NONREI MBURSABLE COST CENTERS					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			190
	19100 RESEARCH	0	o			191
2.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	92, 771			192
	19202 MOB	o	o			192
	19203 ARNETT SURGERY OFFICE	o	0			192
	19201 OCCUPATI ONAL MEDI CI NE	0	0			192
2.04		· · · · · ·	•			1.75
	19300 NONPALD WORKERS	0	0			193

IU HEALTH WHITE HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

	Financial Systems		IU HEALTH WHI	TE HOSPITAL Provider CCN:	15-1312 Pei	In Lie	eu of Form CMS- Worksheet A-0	
					Fro To	om 01/01/2018 12/31/2018		
		Increases					5/28/2019 6:	<u>19 pm</u>
	Cost Center	Line #	Sal ary	Other				
	2.00 A - CAFETERIA	3.00	4.00	5.00				
1.00			78, 446	33, 919				1.00
	O B - DRUGS EXPENSE		78, 446	33, 919				-
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	324, 414				1.00
2.00	ONCOLOGY DRUGS	73.01	0	1, 668, 014				2.00
3.00 4.00		0.00 0.00	0	0				3.00
5.00		0.00	0	0				5.00
6.00 7.00		0.00 0.00	0	0				6.00 7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10. 00 11. 00		0.00 0.00	0	0				10.00
12.00		0.00	0	O				12.00
13.00 14.00		0.00 0.00	0 0	0				13.00 14.00
15.00	L	0.00	0	0				15.00
	O C – MEDICAL SUPPLIES AND REBA		0	1, 992, 428				-
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	550, 916				1.00
2.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	20, 626				2.00
3.00	PATIENTS IMPL. DEV. CHARGED TO	72.00	О	6, 676				3.00
4.00	PATI ENTS	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	Ő				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	Ő				18.00
19. 00 20. 00		0.00 0.00	0 0	0				19.00 20.00
20.00		0.00	0	0				20.00
			0	578, 218				-
1.00	D - LAUNDRY LAUNDRY & LINEN SERVICE	8.00	0	68, 966				1.00
2.00	L	0.00	0	0				2.00
	O E - DEPRECIATION		0	68, 966				-
1.00	CAP REL COSTS-BLDG & FIXT -	1.01	0	1, 631, 497				1.00
2.00	HOSPITAL CAP REL COSTS-BLDG & FIXT -	1.02	0	250, 741				2.00
2.00	TLMOB	0.00						2.00
3.00 4.00		0.00 0.00	0 0	0				3.00 4.00
5.00		0.00	0	Ō				5.00
6.00 7.00		0.00 0.00	0	0				6.00 7.00
8.00		0.00	0	Ő				8.00
9.00		0.00	0	0				9.00
10. 00 11. 00		0.00 0.00	0 0	0				10.00 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
17.00 18.00		0.00	0	0				17.00
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
			-1	- 1				

Heal th	Financial Systems		IU HEALTH WHIT	E HOSPITAL	In Lieu of Fo	rm CMS-2552-10
	SI FI CATI ONS			Provider CCN: 15-1312	Period: Worksh	eet A-6
					From 01/01/2018 To 12/31/2018 Date/T	ime Prepared:
						2019 6: <u>1</u> 9 pm
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	F - OTHER CAPITAL EXPENSES		0	1, 882, 238		
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1, 060, 020		1.00
2.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	25, 579		2.00
3.00	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	30, 376		3.00
	TOTALS	+		1, 115, 975		
	G - OPERATION OF PLANT					
1.00	OPERATION OF PLANT -	7.01	0	1, 728, 594		1.00
	HOSPI TAL					
2.00	OPERATION_OF_PLANTTLMOB		0	294, 897		2.00
	H - EMPLOYEE BENEFITS		0	2, 023, 491		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 463, 150		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	ō		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 10. 00		0.00 0.00	0	0		9.00 10.00
10.00		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	ō		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20. 00 21. 00		0.00 0.00	0	0 0		20.00
21.00	<u> </u>	0.00		1,463,150		21.00
	I - HOUSEKEEPING SUPPLIES	I	0	1, 100, 100		
1.00	HOUSEKEEPI NG	9.00	0	7, 186		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	U U		6.00
7.00 8.00		0. 00 0. 00	0	0		7.00 8.00
8.00 9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	Ō		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	<u>0</u>		13.00
	0		0	7, 186		
	J - NON-CAPITAL EXPENSES					
1.00	ADMI NI STRATI VE & GENERAL	5.00	•_	236		1.00
500 00	TOTALS Grand Total: Increases		0 78, 446	<u>236</u> 9, 165, 807		500.00
500.00		I	/0, 440	7, 105, 007		1 500. 00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

IU HEALTH WHITE HOSPITAL Provider CCN: 15-1312

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

 Period:
 Worksheet A-6

 From 01/01/2018
 Date/Time Prepared:

 To
 12/31/2018
 Date/Time Prepared:

						5/28/2019 6	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00 A - CAFETERIA	7.00	8.00	9.00	10.00		
1.00	DI ETARY	10.00	78, 446	33, 919	0		1.00
1.00			78, 446	33, 919			1.00
	B - DRUGS EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	534			1.00
2.00	NURSING ADMINISTRATION	13.00	0	2			2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	636			3.00
4.00	PHARMACY	15.00	0	1, 932, 308			4.00
5.00	ADULTS & PEDIATRICS	30.00 50.00	0	5, 626			5.00
6.00 7.00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	54.00	0	5, 145 436			6.00 7.00
8.00	RADI OLOGY-THERAPEUTI C	55.00	0	23, 168			8.00
9.00	CT SCAN	57.00	0	7,403	-		9.00
10.00	PHYSICAL THERAPY	66.00	0	7			10.00
11.00	ELECTROCARDI OLOGY	69.00	0	43	0		11.00
12.00	CARDI OPULMONARY	76.00	0	3, 980	0		12.00
13.00	CLINIC	90.00	0	2, 247			13.00
14.00	EMERGENCY	91.00	0	10, 884			14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192.00	<u>0</u>	9	~ ~		15.00
			0	1, 992, 428			_
1.00	C - MEDICAL SUPPLIES AND REBA	4.00	0	459	0		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	757			2.00
3.00	OPERATION OF PLANT	7.00	0	23, 379			3.00
4.00	HOUSEKEEPING	9,00	0	24, 943			4.00
5.00	DI ETARY	10.00	0	3, 014			5.00
6.00	NURSING ADMINISTRATION	13.00	0	200	0		6.00
7.00	PHARMACY	15.00	0	17, 538	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	82, 283			8.00
9.00	OPERATING ROOM	50.00	0	134, 717			9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 587			10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	533			11.00
12.00	ULTRA SOUND	56.00	0	4, 549			12.00
13.00 14.00	CT SCAN MAGNETIC RESONANCE IMAGING	57.00 58.00	0	48, 595 14, 287			13.00 14.00
14.00	(MRI)	58.00	0	14, 207	0		14.00
15.00	PHYSICAL THERAPY	66.00	0	3, 706	0		15.00
16.00	OCCUPATI ONAL THERAPY	67.00	0	181			16.00
17.00	ELECTROCARDI OLOGY	69.00	0	6, 343	0		17.00
18.00	CARDI OPULMONARY	76.00	0	20, 978	0		18.00
19.00	CLINIC	90.00	0	5, 938			19.00
20.00	EMERGENCY	91.00	0	180, 038			20.00
21.00	PHYSICIANS' PRIVATE OFFICES	<u> </u>	0	<u>2, 193</u>			21.00
	D - LAUNDRY		0	578, 218	i l		-
1.00	HOUSEKEEPI NG	9.00	0	63, 682	0		1.00
2.00	DI ETARY	10.00	0	5, 284			2.00
	0			68, 966			
	E - DEPRECIATION	L		· · · · ·			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	830, 371			1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 414			2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 762			3.00
4.00	OPERATION OF PLANT	7.00	0	10, 396			4.00
5.00		10.00	0	50, 324			5.00
6.00 7.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00	0	5, 345 44, 633			6.00 7.00
8.00	ADULTS & PEDIATRICS	30.00	0	70, 915			8.00
9.00	OPERATING ROOM	50.00	0	60, 159			9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	Ő	187, 154			10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	14, 803	0		11.00
12.00	ULTRA SOUND	56.00	0	62, 261	0		12.00
13.00	CT SCAN	57.00	0	87, 717	0		13.00
14.00	MAGNETIC RESONANCE IMAGING	58.00	0	125, 915	0		14.00
15 00					_		45 00
15.00	PHYSICAL THERAPY	66.00	0	524			15.00
16. 00 17. 00	OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY	67.00 69.00	0	120 3, 890			16.00 17.00
17.00	CARDI OPULMONARY	76.00	0	3, 890			17.00
19.00	CLINIC	90.00	0	3, 098			19.00
20.00	EMERGENCY	91.00	0	53, 227			20.00
21.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 440			21.00
22.00	МОВ	192.02	0	250, 741			22.00
	0			1, 882, 238			
					'		

ECLASSI FI CATI ONS			Provi der	CCN: 15-1312	Peri od:	Worksheet A-6
					From 01/01/2018 To 12/31/2018	Date/Time Prepare
	Decreases					5/28/2019 6:19 pm
Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	-	
6.00	7.00	8.00	9.00	10.00	<u>·</u>	
F - OTHER CAPITAL EXPENSES						
. 00 CAP REL COSTS-BLDG & FIXT	1.00	0	1,060,020) î	11	1.
. 00 ADMI NI STRATI VE & GENERAL	5.00	0	25, 579		12	2.
. OO MOB	192.02	0	30, 376		13	3.
TOTALS		— — — o	1, 115, 975		-	
G - OPERATION OF PLANT	· · · · · ·	· ·	· · ·	-		
. 00 OPERATION OF PLANT	7.00	0	1, 728, 594	4	0	1.
. ОО МОВ	192.02	o	294, 897		0	2.
0		0	2,023,49		1	
H - EMPLOYEE BENEFITS	· · · · · ·	· ·	· · ·		- 4	
. 00 ADMI NI STRATI VE & GENERAL	5.00	0	60, 659	9	0	1.
. OO OPERATION OF PLANT	7.00	0	55, 192		0	2.
. 00 HOUSEKEEPI NG	9.00	0	116, 129		0	3.
. OO DI ETARY	10.00	o	133, 65		0	4.
. OO NURSING ADMINISTRATION	13.00	o	116, 46		0	5.
. 00 PHARMACY	15.00	0	38, 123		0	6.
. 00 ADULTS & PEDIATRICS	30.00	0	252, 13		0	7.
. OO OPERATING ROOM	50.00	0	75, 748		0	8.
. 00 RADI OLOGY-DI AGNOSTI C	54.00	0	70, 543		0	9.
0. 00 RADI OLOGY-THERAPEUTI C	55.00	0	15, 02		0	10.
1. 00 ULTRA SOUND	56.00	0	16, 804		0	11.
2. 00 CT SCAN	57.00	0	73, 730		0	12.
3. 00 MAGNETIC RESONANCE I MAGING	58.00	0	25, 194		0	13.
(MRI)	56.00	0	20, 192	+	0	13.
4.00 PHYSICAL THERAPY	66.00	0	60, 643	2	0	14.
5. 00 OCCUPATI ONAL THERAPY	67.00	0	16, 424		0	14.
6.00 SPEECH PATHOLOGY	68.00	0			0	15.
	69.00	0	14, 549		0	17.
7. 00 ELECTROCARDI OLOGY		0	15, 55		s	
8. 00 CARDI OPULMONARY	76.00	0	88, 220		0	18.
	90.00	0	28, 145		0	19.
0.00 EMERGENCY	91.00	0	176, 662		0	20.
1.00 PHYSICIANS' PRIVATE OFFICES	192.00				0	21.
I - HOUSEKEEPING SUPPLIES		U	1, 463, 150	J		
. 00 ADMI NI STRATI VE & GENERAL	5.00	0		1	0	1.
. 00 DI ETARY	10.00	0	5, 541		0	2.
		0			0	
. 00 NURSI NG ADMI NI STRATI ON	13.00	0	220			3.
. 00 PHARMACY	15.00	0	649		0	4.
. 00 ADULTS & PEDIATRICS	30.00	0	169		0	5.
. 00 OPERATING ROOM	50.00	0	16			6.
. 00 RADI OLOGY-DI AGNOSTI C	54.00	0	80		0	7.
. 00 ULTRA SOUND	56.00	0	218		U	8.
. 00 SPEECH PATHOLOGY	68.00	0		2	0	9.
0. 00 ELECTROCARDI OLOGY	69.00	0	60		0	10.
1. 00 CARDI OPULMONARY	76.00	0	35		0	11.
2.00 CLINIC	90.00	0	22		0	12.
3.00 <u>EMERGENCY</u>	91.00	0			Q	13.
0		0	7, 186	6		
J - NON-CAPITAL EXPENSES		_1				
. 00 CAP REL COSTS-BLDG & FIXT	<u> </u>		230		12	1.
TOTALS		0	230		_	
00.00 Grand Total: Decreases		78, 446	9, 165, 807	/		500.

Hoal th	Financial Systems	IU HEALTH WHI			lo li	eu of Form CMS-	2552 10
	CILIATION OF CAPITAL COSTS CENTERS	TO HEALTH WHI	Provi der C	CN: 15-1312	Peri od: From 01/01/2013 To 12/31/2013	Worksheet A-7 8 Part I	pared:
				Acqui si ti ons	S		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4,00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE			i			
1.00	Land	954, 570	0		0	0 0	1 1.00
2.00	Land Improvements	1, 046, 080	0		0	0 154, 793	2.00
3.00	Buildings and Fixtures	0	0		0	0 0	3.00
4.00	Building Improvements	40, 396, 582	0		0	0 1, 800, 079	4.00
5.00	Fixed Equipment	0	0		0	o o	5.00
6.00	Movable Equipment	5, 069, 275	1, 350, 788		0 1, 350, 78	8 230, 036	6.00
7.00	HIT designated Assets	15, 000	0		0	o o	7.00
8.00	Subtotal (sum of lines 1-7)	47, 481, 507	1, 350, 788		0 1, 350, 78	8 2, 184, 908	8.00
9.00	Reconciling Items	0	0		0	o o	9.00
10.00	Total (line 8 minus line 9)	47, 481, 507	1, 350, 788		0 1, 350, 78	8 2, 184, 908	10.00
		Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	954, 570	0				1.00
2.00	Land Improvements	891, 287	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	38, 596, 503	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	6, 190, 027	1, 501, 937				6.00
7.00	HIT designated Assets	15, 000	15, 000				7.00
8.00	Subtotal (sum of lines 1-7)	46, 647, 387	1, 516, 937				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	46, 647, 387	1, 516, 937				10.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Peri od:	Worksheet A-7	
					From 01/01/2018 To 12/31/2018		narod
					10 12/31/2010	5/28/2019 6: 1	
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	40.00	11.00	instructions)		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT	841, 947		1, 060, 02	71	0	1.00
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	041, 947	0	1,000,02		0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0		0 0	0	1.01
3.00	Total (sum of lines 1-2)	841, 947	0	1, 060, 02	0 71	0	3.00
		SUMMARY O	F CAPITAL	.,	·	-	
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15.00	-			
		14.00					
1.00	PART II - RECONCILIATION OF AMOUNTS FROM WORK CAP REL COSTS-BLDG & FIXT	SHEET A, COLUM	1, 902, 203	1			1.00
1.00	CAP REL COSTS-BLDG & FIXT - HOSPITAL	105	1, 902, 203				1.00
1.01	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0				1.01
3.00	Total (sum of lines 1-2)	165	1, 902, 203				3.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 6:19	pared:
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	1, 845, 857		1, 845, 857			1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	29, 866, 326	0	29, 866, 326			1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	14, 935, 204	0	14, 935, 204			1.02
3.00	Total (sum of lines 1-2)	46, 647, 387		46, 647, 387			3.00
			FION OF OTHER (F CAPI TAL	
	Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	55, 584	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0 0	1, 782, 533	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	0	588, 958	0	1.02
3.00	Total (sum of lines 1-2)	0	0	(2, 427, 075	0	3.00
			SL	JMMARY OF CAPI	TAL .		
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS		-			
1.00	CAP REL COSTS-BLDG & FIXT	0	- 165		100		1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	649, 819			0 0	2/ 10/ / /01	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0			619, 334	1.02
3.00	Total (sum of lines 1-2)	649, 819	25, 414	30, 376	165	3, 132, 849	3.00

	Financial Systems MENTS TO EXPENSES		IU HEALTH WHI	Provider CCN: 15-1312 F	Period:	u of Form CMS-2 Worksheet A-8	552-10
					From 01/01/2018 To 12/31/2018		
				Expense Classification on		572672019 0. 1	7 piii
				To/From Which the Amount is	to be Aujusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
1.01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL	В		CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	11	1. 01
1. 02	(chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB		0	CAP REL COSTS-BLDG & FIXT - TLMOB	1.02	0	1. 02
2.00	(chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00		3.00
	(chapter 2)						
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Tel evi si on and radi o servi ce		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-370, 923			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization	A-8-1	2, 607, 776			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	о	13.00
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee	В	-53, 576 0	CAFETERI A	11.00 0.00		14. 00 15. 00
16.00	and others Sale of medical and surgical		0		0.00		
18.00	supplies to other than patients		0		0.00	0	10.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and		0		0.00	0	18.00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19.00
20.00	books, etc.) Vending machines		0		0.00	О	20. 00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL	А	44, 008	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL	A	87, 945	CAP REL COSTS-BLDG & FIXT -	1.01	9	26. 01
26. 02	COSTS-BLDG & FIXT - HOSPITAL Depreciation - CAP REL	А	338, 217	HOSPITAL CAP REL COSTS-BLDG & FIXT -	1.02	9	26. 02
27.00	COSTS-BLDG & FIXT - TLMOB Depreciation - CAP REL		0	TLMOB *** Cost Center Deleted ***	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
	Physi ci ans' assi stant		0		0.00		29.00

Health Financial Systems	IU HEALTH WHITE HOSPITAL		In Lieu	u of Form CMS-2552-10
ADJUSTMENTS TO EXPENSES	Provider CCN: 15-1312	Peri od:		Worksheet A-8

ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
				Expense Classification on	Worksheet A	0,20,201, 0.1	
				To/From Which the Amount is			
					,		
			· ·				
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
20,00		1.00 A-8-3	2.00		4.00	5.00	20.00
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	limitation (chapter 14)						
30, 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30, 99
30. 77	i nstructi ons)		0	ADDETS & FEDIATRICS	30.00		30. 77
31 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
51.00	pathology costs in excess of	R 0 3	0		00.00		51.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	А	-34,437	CAP REL COSTS-BLDG & FIXT -	1.01	9	32.00
	Depreciation and Interest			HOSPI TAL			
33.00	CRNA COSTS	A	-47,625	OPERATING ROOM	50.00	0	33.00
33.01	EMPLOYEE BENEFITS	A	-1, 463, 150	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	LOSS ON ABANDONMENT	A	97, 528	CAP REL COSTS-BLDG & FIXT -	1.01	9	33.02
				HOSPI TAL			
33.03	MARKETING	A	-1, 511	CLINIC	90.00	0	33.03
33.04	MEDICAID HAF FEES	A	-1, 121, 062	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	MI SCELLANEOUS I NCOME	В	-4, 379	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	MI SCELLANEOUS I NCOME	В	-57, 697	CAFETERIA	11.00	0	33.06
33.07	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13.00		33.07
33.08	MI SCELLANEOUS I NCOME	В	-12, 411	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	MI SCELLANEOUS I NCOME	В		PHARMACY	15.00		33.09
33.10	MI SCELLANEOUS I NCOME	В	-1, 316	RADI OLOGY-DI AGNOSTI C	54.00		001.0
33.11	WIC PROGRAM COSTS	A	-217, 929		10.00		
33. 12		A		EMPLOYEE BENEFITS DEPARTMENT			33. 12
33. 13	ACCRUED PTO - GENERAL	A		ADMI NI STRATI VE & GENERAL	5.00		33.13
33.14	CONTRI BUTI ON EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00		33.14
33. 15	TELEPHONE EXPENSE	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 15
50.00			-686, 722				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) De	scription - all chapter referen	ices in this col	umn pertain to	CMS Pub 15-1			

(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.

Heal th	Financial Systems	IU HEALTH WH	ITE HOSPITAL	In Lie	eu of Form CMS-	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1312	Period: From 01/01/2018		
					Date/Time Pre 5/28/2019 6:1	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	3. 00	4,00	<u>5</u> 5. 00	
		I Z.00 MENTS REQUIRED AS A RESULT OF				
	HOME OFFICE COSTS:		TRANSACTIONS WITH RELATED U	RGANIZATIONS OR	CLAIMED	
1.00			HOME OFFICE ALLOCATION	1, 094, 457		1.00
2.00			HOME OFFICE ALLOCATION	1, 469, 635	0	2.00
3.00			HOME OFFICE ALLOCATION	4, 157, 591	4, 111, 036	3.00
3.01		ADMINISTRATIVE & GENERAL	POOLED CAPITAL - H.O.	561, 797	0	3.01
3.02		NURSING ADMINISTRATION	HOME OFFICE ALLOCATION	0	30, 029	3.02
4.00		ADMINISTRATIVE & GENERAL	RELATED PARTY	825, 490		4.00
4.01				44, 612	52, 992	4.01
4.02			RELATED PARTY	78, 082		4.02
4.03			RELATED PARTY	22, 175		4.03
4.04		-	RELATED PARTY	515, 465		4.04
4.05			RELATED PARTY	145, 229		4.05
4.06			RELATED PARTY	239, 767		4.06
4.07			RELATED PARTY	12, 255		4.07
4.08			RELATED PARTY	178, 211	119, 709	4.08
4.09			SHARED EMPLOYEES	95, 121	95, 121	4.09
4.10			SHARED EMPLOYEES	306, 480		4.10
4.11			SHARED EMPLOYEES	112, 068	112, 068	4.11
4.12			SHARED EMPLOYEES	1, 336, 661	1, 336, 661	4.12
4.13			SHARED EMPLOYEES	20, 800	20, 800	4.13
4.14	192.00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	28, 625	28, 625	4.14
4.15	0.00			0	0	4.15
5.00	TOTALS (sum of lines 1-4).			11, 244, 521	8, 636, 745	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	'or Home Office	
				1	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

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

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

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

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

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

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

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

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1312	Period: From 01/01/2018	Worksheet A-8-1
OTTEE COSTS				Date/Time Prepared:

			5/28/2019 6:	19 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	34, 437			1.00
2.00	1, 469, 635			2.00
3.00	46, 555			3.00
3.01	561, 797			3. 01
3.02	-30, 029			3. 02
4.00	52, 192			4.00
4.01	-8, 380	0		4.01
4.02	78, 082	0		4. 02
4.03	22, 175	0		4.03
4.04	299, 179	0		4.04
4.05	61, 218	0		4.05
4.06	-13, 281	0		4.06
4.07	-24, 306	0		4.07
4.08	58, 502	0		4.08
4.09	0	0		4.09
4.10	0	0		4.10
4.11	0	0		4.11
4.12	0	0		4. 12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
5.00	2, 607, 776			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

nas not	been posted to worksneet A,	columns i 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		
	Type of business		
	(00		
	6. 00		
E	B. INTERRELATIONSHIP TO RELATIONSHIP TO RELATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATIONSHIPATICATICATIONSHIPATICATICATICATICATICATICATICATICATICATIC	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 7.00	6.00
7.00	7.00
8.00 9.00	8.00
9.00	9.00
10. 00 100. 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.

PROVIDER BASED PHYSICIAN ADJUSTMENT Provider C0:: 15-1312 Period: From 0/07.07.078 To 12/31/2018 Worksheet A-B-2 (a) 000000000000000000000000000000000000	Heal th	Financial Syste	ems	IU HEALTH WH	ITE HOSPITAL		In Li	eu of Form CMS-	2552-10
To 100 22/2/2/19 Date/Time Program 1 0.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 1 0.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 1 0.00 3.00 4.00 5.00 6.00 7.00 0 2.00 3.00 4.00 5.00 6.00 7.00 0 2.00 3.00 4.01						CCN: 15-1312	Peri od:	Worksheet A-8	
West: A Line # Cost Center/Physician Total Remuneration Professional Component Provider Component REC Anount Rec Anount Hyper Component Physician Component 1.00 30.00 ADULTS & PEDIATRICS 306, 480 306, 480 0									
Wist: A Line Cost: Cost: Cost: Cost: Provider Component RCE Amount Physician/Provider (der Component 1.00 3.00 4.00 5.00 6.00 7.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 3.00 91.00 LIKRENCY 1.144, 711 0							10 12/31/2018		
Identifier Remuneration Component Component Identifier Identifier 1.00 30.00 AUULTS & PEDIATRICS 300.400 6.00 7.00 1.00 2.00 50.00 000 FRATINE CS 300.400 0.00 0 0 0 0 0 0.00 0.00 0.00 0		Wkst Aline #	Cost Center/Physician	Total	Professional	Provider	RCE Amount		
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1.00 2.00 3.00 4.00 5.00 6.00 7.00 1.00 30.00ADULTS & PEDIATRCS 30.64.40 30.64.40 64.43 64.443 64.43 <td></td> <td></td> <td>i denti i i ei</td> <td>Remarker attron</td> <td>oomponent</td> <td>oomponent</td> <td></td> <td></td> <td></td>			i denti i i ei	Remarker attron	oomponent	oomponent			
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200.00 1.515, 634 370, 923 1, 144, 711 0 0 200.00 Wkst. A Line # Cost Center/Physic an Identifier Unadjusted RCE Limit 5 Percent of Unadjusted RCE Limit Provider Cost of Limit Provider Continuing Education Provider Component Provider Share of col. Provider Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 2.00 50.00 OPERATING ROOM 0 0 0 0 0 0 0 2.00 3.00 91.00 DEMERGENCY 0	10,00	0, 00		0	0		o l	0	10.00
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Spectent of Unadjusted RCE Limit Cost of Unadjusted RCE Limit Provider Memberships & Continuing Education Provider Share of col. Provider Mapproxide 1.00 30.00 ADULTS & PEDIATRICS 0 0 0 12.00 13.00 14.00 2.00 50.00/PERATING ROM 0 0 0 0 0 0 0 1.00 3.00 91.00/EMERGENCY 0				1, 515, 634	370, 923	1, 144, 71	1	0	
Identifier Limit Unadjusted RCE Limit Remberships & Component Education Component Share of col. of Mal practice Insurance 1.00 2.00 8.00 9.00 12.00 13.00 14.00 1.00 30.00/ADULTS & PEDIATRICS 0		Wkst. A Line #	Cost Center/Physician					Physician Cost	
Image: Note of the image in the im									
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2.00 50.00 OPERATING ROOM 0		1.00	2.00	8.00	9.00	12.00	13.00	14.00	
3.00 91.00 EMERGENCY 0	1.00			0	-			0	1.00
4.00 0.00 0.00 0	2.00							0	2.00
5.00 0.00 0.00 0	3.00	91.00	EMERGENCY	0	0		0 0	0	3.00
6.00 0.00 0 </td <td>4.00</td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>4.00</td>	4.00			0	0		0 0	0	4.00
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8.00 0.00 <th< td=""><td>6.00</td><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>6.00</td></th<>	6.00			0	0		0 0	0	6.00
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Image: 100 minipage Share of col. 14 Image: 14 Image: 1		Wkst. A Line #					Adjustment		
Image: Note of the image in the image. Image in the image in th			Identi fi er		Limit	Di sal I owance			
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3.00 91.00 EMERGENCY 0 0 0 3.00 4.00 0.00 0 0 0 0 4.00 5.00 0.00 0 0 0 0 4.00 5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 7.00 8.00 9.00 0.00 0 0 0 9.00 9.00 0 9.00 0 9.00 10.00 10.00				-	-				
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Error 01/21/2018 Port 1 Port 1/2		Financial Systems	IU HEALTH WHI				u of Form CMS-	2552-10
Cost Center Description Not Expenses (X) Cost (X) Cos	COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	1	From 01/01/2018	Date/Time Pre	
Image: Process of the set of the				CAP	ITAL RELATED C	OSTS	0,20,201, 0.1	
DRIVERAL SERVICE COST_CENTERS		Cost Center Description	for Cost Allocation (from Wkst A	BLDG & FIXT			BENEFI TS	
1.00 001001 CAP FEL COSTS-BLOG & FLXT - HOSPITAL 55,584 55,584 1.00 1.00 00102 CAP FEL COSTS-BLOG & FLXT - HOSPITAL 2,457,931 0 2,457,931 0 2,457,931 0 1,02 0.00 00000 PRELICOSTS-BLOG & FLXT - TLM08 619,334 0 0 0 0 0 1,02 0 <td></td> <td></td> <td></td> <td>1.00</td> <td>1.01</td> <td>1. 02</td> <td>4.00</td> <td></td>				1.00	1.01	1. 02	4.00	
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7.01 00701 DEFRATION OF PLANT - HOSPITAL 1,720,214 7,682 560,186 0 7,01 7.02 00702 DEFRATION OF PLANT - TUNDB 294,997 4,30 0 139,603 0 7,02 8.00 00800 LAUNDRY & LINEN SERVICE 68,966 247 18,039 0 0 8,03 0 0 8,03 0 0 8,03 0 17,363 15,002 14,002 14,00 14,00 0	5.00			5, 211	100, 58	1 108, 495		5.00
7.02 OOYCOJ DEFEATION OF PLANT - TLMOB 294, 897 4, 930 0 139, 603 0 7.00 7.00 OOYCOJ DEFEATION OF PLANT - TLMOB 387, 741 825 55, 270 1, 992 62, 245 9, 00 7.00 OOYCOJ DEFEATION 68, 966 24, 716 0 61, 601 85, 301 10, 00 1000 DEFEATION 68, 966 24, 716 0 61, 601 85, 301 10, 00 11, 00 DEFEATION 82, 51, 813 699 29, 53, 73 8, 316 138, 173 13, 30 0 11, 00 114, 00 114, 00 14, 00 14, 00 0 0 0 0 14, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15, 00 15,	7.00	00700 OPERATION OF PLANT	230, 995	C		0 C	41, 188	7.00
3.00 000000 LANINGY & LINEN SERVICE 68, 966 247 18, 039 0<	7.01							
9.00 00000 HOUSEKEEPING 387,741 825 57.270 1.892 62,245 9.00 11.00 011000 CAFETERIA 1,092 613 0 17.363 15.027 11.00 13.00 01300 MURSING AGMINISTRATION 826,183 6699 29.537 8.316 138.7,131 13.00 14.00 01400 CENTERIAL SERVICES & SUPPLY 0449,494 2,187 159,442 0 0 14.00 15.00 1500 PERVICE COST CENTERS 14.907,875 6,033 440,154 0 234,647 0 6 0 16.00 01500 0F500 PERVICE COST CENTERS 14.97,707 308 22,442 0 15.5,266 55.00 6500 88,707 55.00 6500 6500 17.804 14,1419 290 21,116 0 75,276 55.00 65.00 6500 15.50 0 65.00 6500 15.50 0 0 0 0 0 0 0	7.02							7.02
10 00 01000 DIETARY 476, 672 2, 776 0 61, 601 85, 310 0.0 11 00 01100 CAFFERIA ADMINISTRATION 826, 183 699 29, 537 8, 316 138, 073 13.00 01300 NURSING ADMINISTRATION 826, 183 699 29, 537 8, 316 138, 073 13.00 0							-	•
11 00 01100 CAFETERIA 1, 092 613 0 17, 363 15, 027 11, 00 13 00 01400 OLHSING ADMINISTRATION 526, 183 609 29, 537 8, 316 138, 173 13, 00 14 00 01400 CENTRAL SERVICES & SUPPLY 649, 494 2, 187 159, 442 0 0 14, 00 15 00 01500 PHARMACY 96, 546 934 68, 094 0 7, 461 15, 00 10 00 1600 MEDICAL, RECORDS & LIBRARY 96, 546 934 66, 007 40, 00 0								
13 00 01300 NURSI NG ADMINISTRATION 826.183 649 29,537 8.316 138.07 13								•
14 00 01400 CENTRAL SERVICES & SUPPLY 649, 494 2, 187 159, 442 0 0 14.00 15 00 01500 MEDICAL RECORDS & LIBRARY 996, 546 934 68, 094 0								•
15.00 01500 PHARMACY 996, 546 994 66, 094 0 77, 461 15.00 0								•
6.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 16.00 0								
INPART ENT ROUTINE SERVICE COST CENTERS Impact of the service cost centers	16.00							•
AKCILLARY SERVICE COST CENTERS 0 <th< td=""><td></td><td></td><td></td><td></td><td>•</td><td></td><td></td><td>1</td></th<>					•			1
50:00 05000 0FEARTING ROM 790, 874 3, 956 288, 406 0 88, 707 50:00 60:00 06400 00 6400 55:00 50:00 55:00 55:00	30.00		1, 497, 875	6, 037	440, 15	4 0	234, 647	30.00
64:00 05400 RAD IOLOGY-DIAGNOSTIC 451,207 1.498 109,216 0 59,515 54.00 55:00 05500 05500 155,207 212 15,474 0 22,642 0 15,276 55.00 56:00 05000 CT SCAN 414,419 290 21,116 0 73,661 57.00 05:00 05000 MAGNETI C RESONANCE I MAGI NG (MRI) 121,727 409 29,794 0 21,913 58.00 06:00 06000 LABORATORY 1.372,231 1.360 99,128 0 60.00 60.00 60.00 60.00 60.00 65.00 0 55.471 66.70 0 21,693 67.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 7.652 0 21,693 67.00 7.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00	50.00		700.074	0.05/	000.40	(00.707	1 50 00
55.00 05500 RADI OLGOY-THERAPEUTI C 107, 707 308 22, 442 0 15, 276 55.00 60.00 G3600 ULTRA SOUND 155, 907 212 15, 474 0 26, 56.00 67.00 OSTOD CT SCAN 414, 419 290 21, 116 0 73, 661 57.00 68.00 OSBOD MAGENETIC RESONANCE I MAGI NG (MRI) 121, 727 409 29, 794 0 21, 913 58.00 66.00 OCOLABORATORY 1, 317 96, 050 0 55.471 66.00 0.00 OCOUD OCCUPATIONAL THERAPY 121, 738 105 7, 652 0 21, 693 67.00 0.00 OCOUD OCCUPATIONAL THERAPY 107, 755 313 22, 826 0 18, 211 69.00 71.00 OTION MEDI CAL SUPPLIES CHARGED TO PATIENTS 224, 414 0 0 0 73.00 73.00 OT300 DRUGS CHARGED TO PATIENTS 324, 414 0 0 0 73.00 73.00 73.00								•
56.00 03630 ULTRA SOUND 155.907 212 15.474 0 26.509 56.00 57.00 05700 CT SCAN 414,419 290 21,116 0 73.61 57.00 60.00 05000 LASORATORY 1,372,231 1,360 99.794 0 21,913 58.00 60.00 06000 PHYSI CAL THERAPY 313,236 1,317 96,050 0 65.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.00 103.230 68.00 7.55 313 22.2 62 0 10 7.10 7.20 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.200 7.20								•
57:00 057:00 CT SCAN 414,419 290 21,116 0 73,661 57.00 58:00 05800 MAGNETI C RESONANCE I MAGING (MRI) 121,727 409 29,794 0 21,913 58.00 50:00 06000 LABORATORY 1,372,231 1,360 99,128 0 60.00 50:00 06000 CCUPATIONAL THERAPY 313,236 1,317 96,050 0 21,693 67.00 50:00 06000 CCUPATIONAL THERAPY 121,738 105 7,652 0 18,211 69.00 69:00 06000 LECTROCARDIOLOGY 74,292 49 3,591 0 13,230 68.00 71:00 07100 MOID MEDICAL SUPPLIES CHARGED TO PATIENTS 20,626 0 0 0 72.00 73:01 07301 ONCOLOGY DRUGS 1,668,014 0 0 0 73.01 73:01 07301 ONCOLOGY DRUGS 1,668,014 0 0 0 0 0 0 73.01 74:00 09000 CHINI C 2,2099								
83.00 058.00 MAGNETIC RESONANCE I MAGING (MRI) 121,727 409 29,794 0 21,913 58.00 66.00 66.00 06000 LABORATORY 1,372,231 1,360 99,128 0 0 60.00 66.00 06000 LABORATORY 121,733 105 7,652 0 21,693 67.00 62.00 66.00 99,128 0 0 68.00 68.00 68.00 68.00 57.00 021,693 67.00 21,693 67.00 67.00 0 13.236 13.17 69.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 18.211 69.00 0 0 0 71.00 72.00 72.00 72.00 72.00 73.00 0 0 0 0 0 73.01 73.01 0.301 0.00 0 0 0 73.01 73.01 0.301 0.00 0 0 0 73.01 73.01 73.01 73.01 73.01 73.01 <td>57.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>	57.00							•
66.00 06600 PHYSI CAL THERAPY 313, 236 1, 317 96, 050 0 55, 471 66, 00 67.00 06700 0CCUPATI ONAL THERAPY 121, 738 105 7, 652 0 21, 693 67. 00 68.00 06800 SPECET APTHOLOGY 74, 292 49 3, 551 0 13, 236 68. 00 69.00 OMEDICAL SUPPLIES CHARGED TO PATIENTS 20, 626 0 0 0 0 71. 00 71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 6, 676 0 0 0 0 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 324, 414 0 0 0 0 73. 00 73.01 07310 NOCLOGY DRUGS 1, 668, 014 0 0 0 0 0 73. 01 00 OPOOD CLINIC 141, 375 716 52, 235 0 22, 62, 17 91. 00 01000 DESERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0	58.00							
67.00 06700 0CCUPATIONAL THERAPY 121,738 105 7,652 0 21,693 67.00 68.00 06800 SPECH PATHOLOGY 74,292 49 3,591 0 13,230 68.00 90.0 06900 CLECTROCARDI OLOGY 107,755 313 22,826 0 18,211 69.00 67.00 0 0 0 0 71.00 071.00 MEDI CAL SUPPLIES CHARGED TO PATIENTS 20,626 0 0 0 0 71.00 0 0 0 72.00 0 0 0 0 0 0 0 0 0 0 73.01 73.01 073.01 073.01 073.01 73.01	60.00	06000 LABORATORY	1, 372, 231	1, 360	99, 12	в О	0	60.00
58.00 06800 SPEECH PATHOLOGY 74, 292 49 3, 591 0 13, 230 68.00 59.00 06900 ELECTROCARDIOLOGY 107, 755 313 22, 826 0 18, 211 69.00 71.00 07100 MPL DEV. CHARGED TO PATIENTS 20, 626 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 324, 414 0 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 1, 668, 014 0 0 0 73.00 73.01 OR301 ONCOLOGY DRUGS 1, 479, 408 619 45, 140 0 80, 718 76.00 76.00 03160 CARDI OPULMONARY 479, 408 619 45, 140 0 0 0 0 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 <t< td=""><td>66.00</td><td>06600 PHYSI CAL THERAPY</td><td>313, 236</td><td>1, 317</td><td>96, 05</td><td>0 0</td><td>55, 471</td><td>66.00</td></t<>	66.00	06600 PHYSI CAL THERAPY	313, 236	1, 317	96, 05	0 0	55, 471	66.00
69.00 06900 ELECTROCARDI OLOGY 107,755 313 22,826 0 18,211 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 20,626 0 0 0 72.00 72.00 07200 INPL. DEV. CHARGED TO PATIENTS 324,414 0 0 0 73.00 73.01 07000 COLOGY DRUGS 1,668,014 0 0 0 73.01 73.01 0.000 COLUMENDARY 479,408 619 45,140 0 80,718 76.00 0.00 09000 CLINIC 141,375 716 52,235 0 22,099 90.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 0 92.00 92.01 92.02 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.00 92.01 92.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92	67.00							1
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 20,626 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6,676 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 72.00 0 0 0 0 73.00 73.00 07300 NCGS CHARGED TO PATIENTS 324,414 0 0 0 0 0 73.00 73.01 73.01 07301 NCGS CHARGED TO PATIENTS 324,414 0 0 0 0 0 73.01 73.01 07301 NCGS CHARGED TO PATIENTS 324,414 0 0 0 0 0 0 73.01 <	68.00							•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6, 676 0 0 0 72.00 73.01 <								•
73.00 07300 DRUGS CHARGED TO PATIENTS 324,414 0 0 0 73.00 73.01 07301 DICOLOGY DRUGS 1,668,014 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 479,408 619 45,140 0 80,718 76.00 0UTPATIENT SERVICE COST CENTERS 141,375 716 52,235 0 226,099 90.00 92.00 09200 DERGENCY 2,620,166 2,929 213,558 0 226,217 91.00 92.01 92.01 DSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 92.01 92.01 DSECIAL PURPOSE COST CENTERS 110.00 0						-		
73.01 07301 0NCOLOGY DRUGS 1,668,014 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 479,408 619 45,140 0 80,718 76.00 001704T ENT SERVICE COST CENTERS 0 22,099 90.00 80,718 76.00 90.00 09000 CLINIC 141,375 716 52,235 0 22,099 90.00 91.00 09100 EMERGENCY 2,620,166 2,929 213,558 0 226,217 91.00 92.00 09200 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 92.01 92.01 09207 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 0 0 92.01 91000 THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 101.00 SUBTOTALE SUBMESABLE COST CENTERS 91 117.02 73.35,434 45,622 2,457,931 337,270 1,469,364 118.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></t<>						-		
76.00 03160 CARDI OPULMONARY 479,408 619 45,140 0 80,718 76.00 OUTPATI ENT SERVICE COST CENTERS								•
OUTPATIENT SERVICE COST CENTERS 90.00 OUTPATIENT SERVICE COST CENTERS 90.00 OPODO CLINIC 91.00 OPODO CLINIC 91.00 OPODO CLINIC 91.00 OPODO CLINIC 92.00 OPSERVATION BEDS (NON-DISTINCT PART) 92.01 OPODI OBSERVATION BEDS (DISTINCT PART) 92.01 OPODI OBSERVATION BEDS (DISTINCT PART) 92.01 OPODI OBSERVATION BEDS (DISTINCT PART) 92.01 OTHER REIMBURSABLE COST CENTERS 101.00 10100 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 92.01 O NOREI MBURSABLE COST CENTERS 118.00 ISUBTOTALS (SUM OF LINES 1 through 117) 92.01 O NOREI MBURSABLE COST CENTERS 1190.00 IFSEARCH 00 O 0192.00 PHYSI CI ANS' PRI VATE OFFICES 92.771 1,748 0 0 192.02 19203 192.03 19203 19204 0 <td>76.00</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>	76.00							•
91.00 09100 EMERGENCY 2, 620, 166 2, 929 213, 558 0 226, 217 91.00 92.01 92.01 09201 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 0 92.01 07HER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 100.00 101.00 100.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00				1 -	, ···			
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92.00 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 92.01 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 0 0 0 0 0 92.01 92.01 071102 OTHER REIMBURSABLE COST CENTERS 0<								•
92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 92.01 0THER REI MBURSABLE COST CENTERS 0			2, 620, 166	2, 929	213, 55	в О	226, 217	•
OTHER REI MBURSABLE COST CENTERS 101:00 HOME HEALTH AGENCY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
101.00 HOME HEALTH AGENCY 0	92.01		0	0		0 0	0	92.01
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 27, 335, 434 45, 622 2, 457, 931 337, 270 1, 469, 364 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 190.00 190.00 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 191.00 19200 PHYSI CLANS' PRI VATE OFFICES 92, 771 1, 748 0 49, 500 16, 747 192.02 192.02 19200 MOB 0 6, 487 0 183, 678 0 192.02 192.03 19203 ARNETT SURGERY OFFICE 0 1, 727 0 48, 886 0 192.02 193.00 193000 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00	101 00		0	0		0	0	101 00
SUBTOTALS SUBTOTALS <t< td=""><td>101.00</td><td></td><td>0</td><td></td><td></td><td><u> </u></td><td>0</td><td></td></t<>	101.00		0			<u> </u>	0	
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 92,771 1,748 0 49,500 16,747 192.02 192.02 MOB 0 6,487 0 183,678 0 192.02 192.03 ARNETT SURGERY OFFICE 0 1,727 0 48,886 0 192.02 193.00 19300 NONPAID WORKERS 0 0 0 0 192.04 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	118.00		27, 335, 434	45, 622	2, 457, 93	1 337, 270	1, 469, 364	118.00
191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 92,771 1,748 0 49,500 16,747 192.02 192.02 MOB 0 6,487 0 183,678 0 192.02 192.03 19203 ARNETT SURGERY OFFICE 0 1,727 0 48,886 0 192.04 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			1		1			
192.00 PHYSICIANS' PRIVATE OFFICES 92,771 1,748 0 49,500 16,747 192.00 192.02 MOB 0 6,487 0 183,678 0 192.02 192.03 19203 ARNETT SURGERY OFFICE 0 1,727 0 48,886 0 192.02 192.04 19201 OCCUPATI ONAL MEDI CINE 0 0 0 0 192.04 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0			0					
192.02 192.02 MOB 0 6,487 0 183,678 0 192.02 192.03 19203 ARNETT SURGERY OFFICE 0 1,727 0 48,886 0 192.03 192.04 19201 OCCUPATI ONAL MEDI CI NE 0 0 0 0 192.04 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	-		· · ·		
192.03 192.03 ARNETT SURGERY OFFICE 0 1, 727 0 48, 886 0 192.03 192.04 192.01 OCCUPATIONAL MEDICINE 0 0 0 0 192.04 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			92, /71					
192.04 192.04 192.04 0 0 0 192.04 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0					
193.00 193.00 NONPAID WORKERS 0 0 0 0 193.00 193.00 200.00 0 0 0 0 193.00 200.00 0 0 0 0 0 0 0 0 0 193.00 200.00				1,727		40,080 C 1		
200.00 Cross Foot Adjustments 200.00			0 0					
201.00 Negative Cost Centers 0 0 0 0 0 201.00								200.00
				c		o o	0	
			27, 428, 205	55, 584	2, 457, 93	1 619, 334	1, 486, 111	202.00

COST 4	Financial Systems LLOCATION - GENERAL SERVICE COSTS	TO HEALTH WIT	TE HOSPITAL Provider CO	CN: 15-1312	Peri od:	u of Form CMS-: Worksheet B	2002-10
5051 P	LEGGATION GENERAL SERVICE COSTS			1	From 01/01/2018 To 12/31/2018	Part I	pared: 9 pm
	Cost Center Description	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATI ON OF PLANT - HOSPI TAL	OPERATION OF PLANT - TLMOB	
		4A	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02 4.00	00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT						1.02
4.00 5.00	00500 ADMINI STRATI VE & GENERAL	6, 580, 407	6, 580, 407				4.00
7.00	00700 OPERATION OF PLANT	272, 183		358, 09	5		7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL	2, 288, 082					7.01
7.02	00702 OPERATION OF PLANT - TLMOB	439, 430		35, 050		613, 182	
8.00	00800 LAUNDRY & LINEN SERVICE	87, 252		1, 759		0	8.00
9.00	00900 HOUSEKEEPI NG	507, 973	160, 337	5, 864	4 94, 259	3, 126	9.00
10.00	01000 DI ETARY	625, 759				101, 749	•
11.00	01100 CAFETERI A	34, 095				28, 680	
13.00	01300 NURSING ADMINISTRATION	1,002,908				13, 737	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	811, 123				0	
15.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 143, 035				0	
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	16.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 178, 713	687, 689	42, 91	5 750, 644	0	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	2/1/0//10	001,007	12/ / /	,00,011		
50.00	05000 OPERATI NG ROOM	1, 171, 943	369, 912	28, 11	9 491, 852	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	621, 436	196, 150	10, 648	3 186, 258	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	145, 733	45, 999	2, 188	3 38, 272	0	55.00
56.00	03630 ULTRA SOUND	198, 102				0	56.00
57.00	05700 CT SCAN	509, 486				0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	173, 843				0	58.00
60.00		1, 472, 719				0	60.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	466, 074 151, 188		9, 36		0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	91, 162				0	68.00
69.00	06900 ELECTROCARDI OLOGY	149, 105		2, 220		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 626		2,22		0	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 676			-	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	324, 414			0 0	0	73.00
73.01	07301 ONCOLOGY DRUGS	1, 668, 014			o o	0	73.01
76.00	03160 CARDI OPULMONARY	605, 885	191, 242	4, 40	1 76, 982	0	76.00
	OUTPATIENT SERVICE COST CENTERS		1				
90.00	09000 CLINIC	216, 425				0	
91.00	09100 EMERGENCY	3, 062, 870		20, 822	2 364, 205	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0				0	92.00
92.01	OTHER REIMBURSABLE COST CENTERS	U	0		0 0	0	92.01
101 00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS						
118.00		27, 026, 661	6, 453, 664	287, 278	3, 064, 909	147, 292	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0 0	(0 0		190.00
	19100 RESEARCH	0	-	(0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	160, 766				81, 761	
		190, 165				303, 382	
	19203 ARNETT SURGERY OFFICE	50, 613	15, 975	12, 27	+ 0		192.03
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0	0				192.04
		0	0		ן וי	0	193.00 200.00
200 00		U	1	1	1		
200.00 201.00		0		(0	201.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod:	Worksheet B	
					rom 01/01/2018 o 12/31/2018	Part I Date/Time Pre	pared:
						5/28/2019 6:1	9 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE 8.00	9.00	10.00	11.00	ADMI NI STRATI ON 13.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00 7.01	00701 OPERATION OF PLANT - HOSPITAL						7.00 7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.01
8.00	00800 LAUNDRY & LINEN SERVICE	147, 315					8.00
9.00	00900 HOUSEKEEPI NG	0					9.00
10.00	01000 DI ETARY	0	32, 107	972, 596			10.00
11.00	01100 CAFETERI A	0	9, 174	C	87, 070		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	C	8, 260	1, 396, 804	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 932	C	0	0	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0		C	3, 659 0	0	
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	<u> </u>		0	0	10.00
30, 00	03000 ADULTS & PEDIATRICS	147, 315	197, 886	972, 596	18, 444	755, 750	30.00
	ANCI LLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	86, 493	C	5, 865	145, 683	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		C		0	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	3, 604	C	776	0	
56.00	03630 ULTRA SOUND	0	2,621	C		0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	3, 604 4, 914	C	4,816	0	57.00 58.00
60.00	06000 LABORATORY		36, 694	0	1, 454 8, 095	0	60.00
66.00	06600 PHYSI CAL THERAPY	0	30, 797	0	3, 535	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	2, 293	C	876	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	1, 311	C	578	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	1, 322	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY DRUGS	0	0	C	0	0	73.00 73.01
73. 01 76. 00	03160 CARDI OPULMONARY	0	Ŭ	0	5, 460	0	
70.00	OUTPATIENT SERVICE COST CENTERS		51,452		3,400	0	/0.00
90.00	09000 CLINIC	0	22, 606	C	1, 702	0	90.00
91.00	09100 EMERGENCY	0	108, 444	C	15, 025	495, 371	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
101 00	OTHER REIMBURSABLE COST CENTERS	-					101 00
101.00	SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	101.00
118.00		147, 315	619, 868	972, 596	85, 550	1, 396, 804	118 00
110.00	NONREI MBURSABLE COST CENTERS	147, 515	017,000	772, 370	03, 330	1, 370, 004	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190.00
191.00	19100 RESEARCH	0	0	C	0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	32, 435	C	1, 520		192.00
	19202 MOB	0	119, 256	C	0		192.02
	19203 ARNETT SURGERY OFFICE 19201 OCCUPATIONAL MEDICINE	0	0	C	0		192. 03 192. 04
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS		0		0		192.04 193.00
200.00				C C		0	200.00
201.00		0	0	C	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	147, 315	771, 559	972, 596	87, 070	1, 396, 804	202.00

Heal th	Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 5/28/2019 6:1	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	L	14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	ГГ					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT						5.00
7.00 7.01	00701 OPERATION OF PLANT - HOSPITAL						7.00 7.01
7.01	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 358, 538					14.00
15.00	01500 PHARMACY	43, 287	1, 697, 454				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	183, 810	4, 734		0 5, 940, 496	0	30.00
	ANCI LLARY SERVICE COST CENTERS	000 770					
50.00	05000 OPERATING ROOM	282, 773	4, 330		0 2, 586, 970	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	8, 211 1, 288	268 28		0 1, 045, 203 0 237, 888	0	54.00 55.00
56.00	03630 ULTRA SOUND	9, 874	20		0 237, 888	0	56.00
57.00	05700 CT SCAN	111, 375	489		0 828, 655	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	32, 125	0		0 320, 924	0	58.00
60.00	06000 LABORATORY	0	0		0 2, 161, 076	0	60.00
66.00	06600 PHYSI CAL THERAPY	8, 058	3		0 828, 749	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	389	0		0 216, 262	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 128, 299	0	68.00
69.00	06900 ELECTROCARDI OLOGY	8, 116	36		0 246, 797	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	198, 993	0		0 226, 129	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	15,009	0		0 23, 792	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	272, 996		0 699, 808	0	73.00
73.01 76.00	07301 ONCOLOGY DRUGS 03160 CARDI OPULMONARY	0	1, 403, 645		0 3, 598, 151 0 962, 606	0	73.01 76.00
70.00	OUTPATIENT SERVICE COST CENTERS	47, 112	72		0 962, 606	0	70.00
90.00	09000 CLINIC	11, 599	1, 891		0 416, 711	0	90.00
91.00	09100 EMERGENCY	391, 510	8, 954		0 5, 433, 972	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
	OTHER REIMBURSABLE COST CENTERS	· · · · ·					
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
110 00	SPECIAL PURPOSE COST CENTERS	1 252 520	1 (07 44/		0 04 000	0	110.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 353, 529	1, 697, 446		0 26, 204, 983	0	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19100 RESEARCH		0		0 0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	5,009	8		0 344, 671		192.00
	19202 MOB	0	0		0 718, 942		192.02
192.03	19203 ARNETT SURGERY OFFICE	0	0		0 159, 609		192.03
	19201 OCCUPATIONAL MEDICINE	o	О		0 0	0	192. 04
	19300 NONPAID WORKERS	0	0		0 0		193.00
200.00					0		200. 00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	1, 358, 538	1, 697, 454		0 27, 428, 205	0	202.00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-	1312 Period: From 01/01/2018	Worksheet B Part I
			To 12/31/2018	
Cost Center Description	Total			572872014 0. 14 pili
	26.00			
GENERAL SERVICE COST CENTERS				1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.00
1. 02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB				1.01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL				5.00
7. 00 00700 OPERATI ON OF PLANT				7.00
7.01 00701 OPERATION OF PLANT - HOSPITAL				7.00
7.02 00702 OPERATION OF PLANT - TLMOB				7. 02
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
INPATIENT ROUTINE SERVICE COST CENTERS				10100
30. 00 03000 ADULTS & PEDI ATRI CS	5, 940, 496			30.00
ANCI LLARY SERVICE COST CENTERS	677167176			
50. 00 05000 OPERATING ROOM	2, 586, 970			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1,045,203			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	237, 888			55.00
56. 00 03630 ULTRA SOUND	302, 495			56.00
57. 00 05700 CT SCAN	828, 655			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	320, 924			58.00
60. 00 06000 LABORATORY	2, 161, 076			60.00
66. 00 06600 PHYSI CAL THERAPY	828, 749			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	216, 262			67.00
68. 00 06800 SPEECH PATHOLOGY	128, 299			68.00
69. 00 06900 ELECTROCARDI OLOGY	246, 797			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	226, 129			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	23, 792			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	699, 808			73.00
73. 01 07301 ONCOLOGY DRUGS	3, 598, 151			73.01
76.00 03160 CARDI OPULMONARY	962, 606			76.00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	416, 711			90.00
91. 00 09100 EMERGENCY	5, 433, 972			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	o			92.01
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	26, 204, 983			118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
191. 00 19100 RESEARCH	0			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	344, 671			192.00
192. 02 19202 MOB	718, 942			192.00
192. 03 19203 ARNETT SURGERY OFFICE	159,609			192.02
192. 04 19201 OCCUPATI ONAL MEDI CI NE	137,009			192.03
193. 00 19300 NONPALD WORKERS	0			193.00
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				200.00
202.00 TOTAL (sum Lines 118 through 201)	27, 428, 205			201.00
	2.7, 20, 200			1202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/28/2019 6:1	pared:
		CAP	ITAL RELATED (COSTS		
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - TLMOB	Subtotal	
	0	1.00	1.01	1.02	2A	
GENERAL SERVICE COST CENTERS						1.00
1.0100101CAPRELCOSTS-BLDG& FIXT- HOSPITAL1.0200102CAPRELCOSTS-BLDG& FIXT- TLMOB4.0000400EMPLOYEEBENEFITSDEPARTMENT	0	0		0 0	0	1. 01 1. 02 4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	561, 797 0	5, 211 0	100, 58	1 108, 495 0 0	776, 084 0	5.00 7.00
7. 01 00701 OPERATI ON OF PLANT - HOSPI TAL	0	7, 682			567, 868	7.01
7. 02 00702 OPERATION OF PLANT - TLMOB 8. 00 00800 LAUNDRY & LINEN SERVICE	0	4, 930 247		0 139, 603	144, 533 18, 286	7.02 8.00
9. 00 00900 HOUSEKEEPING	0	825			57, 987	9.00
10. 00 01000 DI ETARY	0	2, 176		0 61, 601	63, 777	1
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	613 699		0 17, 363 7 8, 316	17, 976 38, 552	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	2, 187	159, 44		161, 629	
15. 00 01500 PHARMACY	0	934			69, 028	
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0		0 0	0	16.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 037	440, 15	4 0	446, 191	30.00
ANCI LLARY SERVI CE COST CENTERS		0.05/				
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0	3, 956 1, 498			292, 362 110, 714	50.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	308			22, 750	
56.00 03630 ULTRA SOUND	0	212			15, 686	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	290 409			21, 406 30, 203	
60. 00 06000 LABORATORY	0	1, 360			100, 488	
66. 00 06600 PHYSI CAL THERAPY	0	1, 317	96, 05	0 0	97, 367	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	105			7,757	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	49 313			3, 640 23, 139	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 73. 01 07301 ONCOLOGY DRUGS	0	0		0 0 0 0	0	73.00 73.01
76. 00 03160 CARDI OPULMONARY	0	619	45, 14		45, 759	1
		71/	F 2 22		F2 0F1	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0				52, 951 216, 487	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,727	210,00	0	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	E(1 707	45 (22	2 457 02	1 227 270	2 402 (20	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	561, 797	45, 622	2, 457, 93	1 337, 270	3, 402, 620	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0 0 49,500		191. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	1, 748 6, 487		0 49,500 0 183,678	51, 248 190, 165	1
192.03 19203 ARNETT SURGERY OFFICE	0	1, 727		0 48, 886	50, 613	192. 03
192. 04 19201 OCCUPATI ONAL MEDI CI NE	0	0		0 0		192.04
193.00 19300 NONPALD WORKERS 200.00 Cross Foot Adjustments	0	0		0 0		193. 00 200. 00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	561, 797	55, 584	2, 457, 93	1 619, 334	3, 694, 646	202.00

Cost Center Description EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE BENEFITS DEPARTMENT OPERATION OF PLANT OPERATION OF PLANT OPERATION OF PLANT OPERATION OF PLANT OPERATION PLANT OPERATION PLANT	/Time Prep /2019 6: 19 ATI ON OF - TLMOB 7. 02 161, 883 0 825 26, 862	1.00 1.01 1.02 4.00 5.00 7.00 7.01 7.02
Cost Center Description EMPLOYEE BENEFITS DEPARTMENT ADMI NI STRATI VE & GENERAL OPERATI ON OF PLANT OPERATI ON OF PLANT OPERATI ON OF PLANT OPERATI HOSPI TAL 1.00 00100 CAP REL COSTS CENTERS 5.00 7.00 7.01 7 1.01 00101 CAP REL COSTS-BLDG & FIXT HOSPI TAL	ATI ON OF - TLMOB 7. 02 161, 883 0 825 26, 862	1.00 1.01 1.02 4.00 5.00 7.00 7.01 7.02
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 5.00 00500 ADMINISTRATIVE & GENERAL 0 776, 084 7.01 00701 OPERATION OF PLANT 0 10, 132 10, 132 7.01 00701 OPERATION OF PLANT 0 85, 176 1, 544 654, 588 7.02 00702 OPERATION OF PLANT 0 16, 358 992 0 8.00 00800 LAUNDRY & LI NEN SERVICE 0 3, 248 50 6, 570 9.00 09000 HOUSEKEEPING 0 18, 910 166 20, 131 10.00 01000 DI ETARY 0 23, 295 438 0 11.00 01100 CAFETERIA 0 1, 269 123 0 13.00 01300 NURSI NG ADMINISTRATION	161, 883 0 825 26, 862	1.01 1.02 4.00 5.00 7.00 7.01 7.01
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT HOSPITAL 1.02 00102 CAP REL COSTS-BLDG & FIXT TLMOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 5.00 00500 ADMINISTRATIVE & GENERAL 0 776,084 7.01 00701 OPERATION OF PLANT 0 10,132 10,132 7.01 00701 OPERATION OF PLANT HOSPITAL 0 85,176 1,544 654,588 7.02 00702 OPERATION OF PLANT TLMOB 0 16,358 992 0 8.00 00800 LAUNDRY & LI NEN SERVICE 0 3,248 50 6,570 9.00 00900 HOUSEKEEPING 0 18,910 166 20,131 10.00 DITARY 0 37,334 141 10,759 13.00 01300 NURSI NG ADMINI STRATI ON 0 37,334 141 10,759 14.00 CAFTERI A 0	0 825 26, 862	1.01 1.02 4.00 5.00 7.00 7.01 7.02
1. 01 00101 CAP_REL_COSTS-BLDG & FIXT - HOSPITAL 1. 02 00102 CAP_REL_COSTS-BLDG & FIXT - TLMOB 4. 00 00400 EMPLOYEE_BENEFITS_DEPARTMENT 0 5. 00 00500 ADMI NI STRATI VE & GENERAL 0 776,084 7. 00 00700 OPERATI ON OF PLANT 0 10,132 10,132 7. 01 00710 OPERATI ON OF PLANT 0 85,176 1,544 654,588 7. 02 00702 OPERATI ON OF PLANT 0 85,176 1,544 654,588 7. 02 00702 OPERATI ON OF PLANT TLMOB 0 16,358 992 0 8. 00 0800 LAUNDRY & LI NEN SERVICE 0 3,248 50 6,570 9. 00 0900 HOUSEKEEPI NG 0 18,910 166 20,131 10. 00 DI TARY 0 23,295 438 0 11. 00 O1000 DI ETARY 0 37,334 141 10,759 14. 00 CAFTERI A 0 30,195 440 58,074 58,074	0 825 26, 862	1.01 1.02 4.00 5.00 7.00 7.01 7.02
7.01 00701 OPERATI ON OF PLANT - HOSPI TAL 0 85, 176 1, 544 654, 588 7.02 00702 OPERATI ON OF PLANT - TLMOB 0 16, 358 992 0 8.00 00800 LAUNDRY & LI NEN SERVICE 0 3, 248 50 6, 570 9.00 00900 HOUSEKEEPI NG 0 18, 910 166 20, 131 10.00 DI DI ETARY 0 23, 295 438 0 11.00 O1100 CAFETERI A 0 1, 269 123 0 13.00 D1300 NURSI NG ADMI NI STRATI ON 0 37, 334 141 10, 759 14.00 O1400 CENTRAL SERVI CES & SUPPLY 0 30, 195 4440 58, 074 15.00 01500 PHARMACY 0 42, 551 188 24, 802 16.00 D1600 MEDI CAL RECORDS & LI BRARY 0 0 0 0	0 825 26, 862	7. 01 7. 02
8.00 00800 LAUNDRY & LI NEN SERVICE 0 3, 248 50 6, 570 9.00 00900 HOUSEKEEPING 0 18, 910 166 20, 131 10.00 01000 DI ETARY 0 23, 295 438 0 11.00 01100 CAFETERIA 0 1, 269 123 0 13.00 01300 NURSI NG ADMI NI STRATI ON 0 37, 334 141 10, 759 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 30, 195 440 58, 074 15.00 01500 PHARMACY 0 42, 551 188 24, 802 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0	0 825 26, 862	
10.00 01000 DI ETARY 0 23,295 438 0 11.00 01100 CAFETERIA 0 1,269 123 0 13.00 01300 NURSI NG ADMI NI STRATI ON 0 37,334 141 10,759 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 30,195 440 58,074 15.00 01500 PHARMACY 0 42,551 188 24,802 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0	26, 862	8.00
11.00 01100 CAFETERIA 0 1,269 123 0 13.00 01300 NURSI NG ADMI NI STRATI ON 0 37,334 141 10,759 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 30,195 440 58,074 15.00 01500 PHARMACY 0 42,551 188 24,802 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0		9.00
13.00 01300 NURSI NG ADMI NI STRATI ON 0 37, 334 141 10, 759 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 30, 195 440 58, 074 15.00 01500 PHARMACY 0 42, 551 188 24, 802 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0		10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 30, 195 440 58, 074 15.00 01500 PHARMACY 0 42, 551 188 24, 802 16.00 01600 MEDICAL RECORDS & LI BRARY 0 0 0 0 11.00 11.00 NPATIENT ROUTINE SERVICE COST CENTERS 100 100 100	7,572	11.00
15. 00 01500 PHARMACY 0 42, 551 188 24, 802 16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 1NPATI ENT ROUTI NE SERVICE COST CENTERS 0 0 0 0 0 0 0	3, 627 0	13.00 14.00
16.00 OI O <td>0</td> <td>14.00</td>	0	14.00
	0	16.00
30. 00 03000 ADULTS & PEDI ATRI CS 0 81, 105 1, 214 160, 320	0	30.00
ANCI LLARY SERVICE COST CENTERS		
50. 00 05000 OPERATI NG ROOM 0 43, 627 796 105, 047	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 23, 134 301 39, 780 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 5, 425 62 8, 174	0	54.00 55.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 0 5, 425 62 8, 174 56. 00 03630 ULTRA SOUND 0 7, 375 43 5, 636	0	55.00 56.00
57. 00 (05700) CT SCAN 0 18, 966 58 7, 691	ő	57.00
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 6, 471 82 10, 852	0	58.00
60. 00 06000 LABORATORY 0 54, 823 273 36, 106	0	60.00
66.00 06600 PHYSI CAL THERAPY 0 17, 350 265 34, 985	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 5, 628 21 2, 787	0	67.00
68. 00 06800 SPEECH PATHOLOGY 0 3, 394 10 1, 308	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 0 5, 551 63 8, 314 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 768 0 0	0	69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 249 0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 12.077 0 0	ő	73.00
73. 01 07301 ONCOLOGY DRUGS 0 62, 093 0 0	0	73.01
76. 00 03160 CARDI OPULMONARY 0 22, 555 125 16, 441	0	76.00
OUTPATIENT SERVICE COST CENTERS		
90. 00 09000 CLINIC 0 8, 057 144 19, 026	0	90.00
91. 00 09100 EMERGENCY 0 114, 020 589 77, 785 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	0	91.00 92.00
92. 01 09201 OBSERVATION BEDS (INNEDISTINCT PART) 0 0 0 0	0	92.00 92.01
OTHER REI MEURSABLE COST CENTERS		,2.01
101.00 10100 HOME HEALTH AGENCY 0 0 0 0	0	101.00
SPECIAL PURPOSE COST CENTERS		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 761, 136 8, 128 654, 588 NONREI MBURSABLE COST CENTERS 0 761, 136 8, 128 654, 588	38, 886	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	0	190. 00
191. 00 19100 RESEARCH 0 0 0 0		191.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 5, 985 352 0	21, 585	
192. 02 19202 MOB 0 7, 079 1, 305 0	80, 094	
192.03 19203 ARNETT SURGERY OFFICE 0 1,884 347 0 192.04 19201 OCCUPATI ONAL MEDI CI NE 0 0 0 0	21, 318	192.03 192.04
193. 00 19300 NONPAI D WORKERS 0 0 0 0		192.04
		200.00
200.00 Cross Foot Adjustments		201.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 0 0	0].	2011.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	F	Period: From 01/01/2018 Fo 12/31/2018	Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	5/28/2019 6: 1 NURSI NG ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB	20.154					7.02
8.00	00800 LAUNDRY & LINEN SERVICE	28, 154					8.00
9.00	00900 HOUSEKEEPING	0	98, 019	110 45	1		9.00
10. 00 11. 00	01000 DI ETARY	0	4,079	118, 45			10.00
13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0	1, 165 0	(93, 079	
13.00	01400 CENTRAL SERVICES & SUPPLY	0	499	(2,000	93,079	1
15.00	01500 PHARMACY	0	3, 038	(-	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0,000	(.,	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			`		<u> </u>	
30, 00	03000 ADULTS & PEDIATRICS	28, 154	25, 141	118, 45	1 5, 953	50, 361	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	10, 988	(1, 893	9, 708	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 289	(1, 360	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	458	(251	0	55.00
56.00	03630 ULTRA SOUND	0	333	(D 475	0	56.00
57.00	05700 CT SCAN	0	458	(0 1, 554	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	624	(10,	0	58.00
60.00	06000 LABORATORY	0	4, 662	(2/010	0	60.00
66.00	06600 PHYSI CAL THERAPY	0	3, 912	(,	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	291	(0	67.00
68.00	06800 SPEECH PATHOLOGY	0	166	(101	0	68.00
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	(0	
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(5	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(-	0	73.00
73.00	07301 ONCOLOGY DRUGS	0	0	(5	0	73.01
76.00	03160 CARDI OPULMONARY	0	Ŭ Ŭ	(-	0	76.00
	OUTPATIENT SERVICE COST CENTERS	-			.,	-	
90.00	09000 CLI NI C	0	2, 872	(549	0	90.00
91.00	09100 EMERGENCY	0		(4, 850	33, 010	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(0 0	0	92.01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	i	1		1		
118.00		28, 154	78, 748	118, 451	1 27, 614	93, 079	118.00
100.00	NONREI MBURSABLE COST CENTERS	0				0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0	4, 121	(191. 00 192. 00
	19202 MOB	0	15, 150	(192.00
	19203 ARNETT SURGERY OFFICE		15, 150	(192.02
	19201 OCCUPATI ONAL MEDI CI NE		0	(192.03
	19300 NONPALD WORKERS	0	0	(0 0		193.00
200.00			Ĭ				200.00
201.00		0	0	(0 0	0	201.00
202.00		28, 154	98, 019	118, 451	1 28, 105	93, 079	202.00
			•				

	Financial Systems	IU HEALTH WHIT	E_HOSPI TAL		In Lie	u of Form CMS-2	552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018		pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	[]		[4 00
	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
	00102 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01 1. 02
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
							11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	250 027					13.00
	01400 CENTRAL SERVICES & SUPPLY	250, 837 7, 992	148, 780				14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	0	148, 780		0		16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		0		10.00
30.00	03000 ADULTS & PEDIATRICS	33, 938	415		0 951, 243	0	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	52, 210	379		0 517, 010	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 516	24		0 179, 118	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	238	2		0 37, 360	0	55.00
	03630 ULTRA SOUND	1, 823	0		0 31, 371	0	56.00
	05700 CT SCAN	20, 564	43		0 70, 740	0	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	5, 931 0	0		0 54,632 0 198,965	0	58.00 60.00
	06600 PHYSI CAL THERAPY	1, 488	0		0 198, 965 0 156, 508		66. 00
	06700 OCCUPATI ONAL THERAPY	72	0		0 16, 839	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0 8, 705	-	68.00
	06900 ELECTROCARDI OLOGY	1, 499	3		0 38, 996	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	36, 742	0		0 37, 510	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 771	0		0 3, 020	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	23, 928		0 36, 005		73.00
	07301 ONCOLOGY DRUGS	0	123, 028		0 185, 121		73.01
	03160 CARDI OPULMONARY	8, 699	6		0 99, 343	0	76.00
	OUTPATIENT SERVICE COST CENTERS	2, 142	166		0 85, 907	0	90.00
	09100 EMERGENCY	72, 287	785		0 533, 590		90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	12,201	/05		0 333, 370		92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0		92.01
	OTHER REIMBURSABLE COST CENTERS				-		
	10100 HOME HEALTH AGENCY	0	0		0 0	0 1	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	249, 912	148, 779		0 3, 241, 983	0 1	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 04 700		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19202 MOB	925			0 84, 708 0 293, 793		192.00 192.02
	19202 ARNETT SURGERY OFFICE		0		0 293, 793		192.02
	19201 OCCUPATI ONAL MEDI CI NE	0	0		0 0		192.03
	19300 NONPAI D WORKERS	0	0		0 0		193.00
200.00	Cross Foot Adjustments		Ű		0	0 2	200. 00
201.00	Negative Cost Centers	0	0		0 0	0 2	201.00
202.00	TOTAL (sum lines 118 through 201)	250, 837	148, 780		0 3, 694, 646	02	202.00

	nancial Systems N OF CAPITAL RELATED COSTS	IU HEALTH WHITE	Provi der CCN: 15-1312		of Form CMS-2552 Worksheet B
				From 01/01/2018 To 12/31/2018	Part II Date/Time Prepare 5/28/2019 6:19 pm
	Cost Center Description	Total			
GEN	ERAL SERVICE COST CENTERS	26.00		<u> </u>	
	00 CAP REL COSTS-BLDG & FIXT				1
	01 CAP REL COSTS-BLDG & FIXT - HOSPITAL				1
	02 CAP REL COSTS-BLDG & FIXT - TLMOB				1
	OO EMPLOYEE BENEFITS DEPARTMENT				4
	00 ADMI NI STRATI VE & GENERAL				5
	OO OPERATION OF PLANT				7
	OT OPERATION OF PLANT - HOSPITAL				7
	02 OPERATION OF PLANT - TLMOB				7
1	00 LAUNDRY & LINEN SERVICE				8
	00 HOUSEKEEPING				9
	00 DI ETARY				10
	00 CAFETERI A				11
1	00 NURSI NG ADMI NI STRATI ON				13
	00 CENTRAL SERVICES & SUPPLY				14
1	OO PHARMACY				15
1	00 MEDICAL RECORDS & LIBRARY				16
	ATLENT ROUTINE SERVICE COST CENTERS				10.
	00 ADULTS & PEDIATRICS	951, 243			30
	I LLARY SERVICE COST CENTERS	731, 243			
	OO OPERATI NG ROOM	517,010			50
	00 RADI OLOGY-DI AGNOSTI C	179, 118			54
	00 RADI OLOGY-THERAPEUTI C	37, 360			55
	30 ULTRA SOUND	31, 371			56
	OO CT SCAN	70, 740			57
	00 MAGNETIC RESONANCE I MAGING (MRI)	54,632			58
	000 LABORATORY	198, 965			60
	00 PHYSI CAL THERAPY	156, 508			66
1	OO OCCUPATI ONAL THERAPY	16, 839			67.
	BOO SPEECH PATHOLOGY	8, 705			68
	00 ELECTROCARDI OLOGY	38, 996			69.
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 510			71
1	00 I MPL. DEV. CHARGED TO PATIENTS	3, 020			72
	OO DRUGS CHARGED TO PATIENTS	36,005			73
	OI ONCOLOGY DRUGS	185, 121			73
	60 CARDI OPULMONARY	99, 343			76
	PATIENT SERVICE COST CENTERS				
	DOO CLINIC	85, 907			90
1.00 091	00 EMERGENCY	533, 590			91
	00 OBSERVATION BEDS (NON-DISTINCT PART)				92
1	01 OBSERVATION BEDS (DISTINCT PART)	0			92
OTH	ER REIMBURSABLE COST CENTERS				
01.00101	OO HOME HEALTH AGENCY	0			101
SPE	CIAL PURPOSE COST CENTERS				
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 241, 983			118
NON	REIMBURSABLE COST CENTERS				
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190
	00 RESEARCH	0			191
	200 PHYSICIANS' PRIVATE OFFICES	84, 708			192
2. 02 192		293, 793			192
2. 03 192	03 ARNETT SURGERY OFFICE	74, 162			192
	01 OCCUPATIONAL MEDICINE	0			192
	OO NONPALD WORKERS	0			193
00.00	Cross Foot Adjustments	0			200
01.00	Negative Cost Centers	0			201
02.00	TOTAL (sum lines 118 through 201)	3, 694, 646			202

	Financial Systems LOCATION – STATISTICAL BASIS	IU HEALTH WHI	TE HOSPITAL Provider C		eri od:	u of Form CMS- Worksheet B-1	
				Fr To	rom 01/01/2018 0 12/31/2018		
		CAP	I TAL RELATED CO	DSTS		5/28/2019 6:1	9 pm
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	BLDG & FIXT - TLMOB (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	
		1.00	1.01	1.02	4.00	5A	
	GENERAL SERVICE COST CENTERS	94, 811					1 1 00
1.01 1.02 4.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	94, 811 0 0 0 8, 889	57, 501 0 0 2, 353	37, 310 0	7, 758, 020 480, 760	-6, 580, 407	1.00 1.01 1.02 4.00 5.00
7.00	00700 OPERATION OF PLANT	0, 887	2, 353	0, 550	215, 017	-0, 580, 407	7.00
	00701 OPERATION OF PLANT - HOSPITAL	13, 105	13, 105		0	0	
	00702 OPERATION OF PLANT - TLMOB 00800 LAUNDRY & LINEN SERVICE	8, 410 422	422	8, 410	0	0	
	00900 HOUSEKEEPI NG	1, 407	1, 293		324, 941	0	
	01000 DI ETARY	3, 711	0		445, 349	0	10.00
		1,046	0	1, 046	78, 446	0	11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 192 3, 730	691 3, 730		721, 311	0	13.00
	01500 PHARMACY	1, 593			404, 373	0	
	01600 MEDICAL RECORDS & LIBRARY	0			0	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	10, 297	10, 297	0	1, 224, 924	0	30.00
	ANCILLARY SERVICE COST CENTERS	10,277	10,277		1, 224, 724	0	30.00
	05000 OPERATING ROOM	6, 747	6, 747		463, 082	0	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 555 525	2, 555 525		310, 688 79, 747	0	54.00 55.00
	03630 ULTRA SOUND	362	362		138, 387	0	56.00
	05700 CT SCAN	494	494		384, 538	0	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	697	697		114, 396	0	58.00
60.00	06000 LABORATORY	2, 319	2, 319	0	0	0	60.00
	06600 PHYSI CAL THERAPY	2, 247	2, 247		289, 577	0	66.00
	06700 OCCUPATI ONAL THERAPY	179	179		113, 246	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	84 534	84 534		69, 067 95, 070	0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	034	034	0	95,070	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07301 ONCOLOGY DRUGS	0	0	0	0	0	
		1,056	1, 056	0	421, 375	0	76.00
	DUTPATI ENT SERVICE COST CENTERS	1, 222	1, 222	0	115, 366	0	90.00
	09100 EMERGENCY	4, 996			1, 180, 933	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	-			0	0	
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	77, 819	57, 501	20, 318	7, 670, 593	-6, 580, 407	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100 RESEARCH	0	0	0	0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 982	0	2, 982	87, 427		192.00
		11,065		11,065	0		192.02
	19203 ARNETT SURGERY OFFICE	2,945	0	2, 945	0		192.03
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS			0	0		192. 04 193. 00
200.00	Cross Foot Adjustments			Ŭ	Ŭ	0	200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	55, 584	2, 457, 931	619, 334	1, 486, 111		202. 00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 586261	42. 745883	16. 599678	0. 191558 0		203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part				0.00000		205. 00
206.00	II) NAHE adjustment amount to be allocated						206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						

Health Fi	inancial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO	CN: 15-1312 P	eriod: rom 01/01/2018	Worksheet B-1	
					o 12/31/2018	Date/Time Pre	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	5/28/2019 6:1 LAUNDRY &	9 pili
		& GENERAL	PLANT (SQUARE FEET)	PLANT - HOSPI TAL	PLANT - TLMOB		
		(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(PATTENT DAYS)	
		5.00	7.00	7.01	7. 02	8.00	
	ENERAL SERVICE COST CENTERS	1		[1.00
	D101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
	D102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
	D400 EMPLOYEE BENEFITS DEPARTMENT D500 ADMINISTRATIVE & GENERAL	20, 847, 798					4.00 5.00
7.00 00	0700 OPERATION OF PLANT	272, 183					7.00
	0701 OPERATION OF PLANT - HOSPITAL	2, 288, 082					7.01
	D702 OPERATION OF PLANT - TLMOB D800 LAUNDRY & LINEN SERVICE	439, 430 87, 252			22, 364 0	2, 264	7.02 8.00
	D900 HOUSEKEEPI NG	507, 973				0	9.00
	1000 DI ETARY	625, 759			3, 711	0	10.00
	1100 CAFETERIA 1300 NURSING ADMINISTRATION	34, 095 1, 002, 908	1, 046 1, 192		1, 046 501	0	11.00 13.00
	1400 CENTRAL SERVICES & SUPPLY	811, 123				0	14.00
	1500 PHARMACY	1, 143, 035				0	15.00
	1600 MEDICAL RECORDS & LIBRARY NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	16.00
	3000 ADULTS & PEDI ATRI CS	2, 178, 713	10, 297	10, 297	0	2, 264	30.00
	NCI LLARY SERVI CE COST CENTERS	4 474 040	(747	(747			50.00
	5000 OPERATI NG ROOM 5400 RADI OLOGY-DI AGNOSTI C	1, 171, 943 621, 436			0	0	50.00 54.00
	5500 RADI OLOGY-THERAPEUTI C	145, 733	525		0	0	55.00
	3630 ULTRA SOUND	198, 102	362		0	0	56.00
	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	509, 486 173, 843			0	0	57.00 58.00
	5000 LABORATORY	1, 472, 719	-		0	0	60.00
	5600 PHYSI CAL THERAPY	466, 074	2, 247		0	0	66.00
	5700 OCCUPATI ONAL THERAPY 5800 SPEECH PATHOLOGY	151, 188 91, 162	179		0	0	67.00 68.00
	5900 ELECTROCARDI OLOGY	149, 105	534		0	0	69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 626	0	0	0	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS	6, 676 324, 414	0	0	0	0	72.00
	7301 ONCOLOGY DRUGS	1, 668, 014	-	-	0	0	73.00
	3160 CARDI OPULMONARY	605, 885	1, 056	1, 056	0	0	76.00
	JTPATIENT SERVICE COST CENTERS	216, 425	1, 222	1, 222	0	0	90.00
	2100 EMERGENCY	3, 062, 870				0	90.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	9201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.01
	THER REIMBURSABLE COST CENTERS	0	0	0	0	0	101.00
SF	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) DNREIMBURSABLE COST CENTERS	20, 446, 254	68, 930	42, 043	5, 372	2, 264	118.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	9100 RESEARCH	0	0	0	0		191.00
192.0019 192.0219	9200 PHYSICIANS' PRIVATE OFFICES	160, 766			2, 982 11, 065		192.00 192.02
	2203 ARNETT SURGERY OFFICE	190, 165 50, 613			2, 945		192.02
192.04 19	9201 OCCUPATIONAL MEDICINE	0	0	0	0	0	192.04
	P300 NONPAID WORKERS	0	0	0	0	0	193.00
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	6, 580, 407	358, 095	3, 064, 909	613, 182	147, 315	
202 00	Part I)	0.215440	1 1/7/75	72 000200	27 4102/1	4E 0/04/2	202 00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0. 315640 776, 084				65.068463 28.154	203.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 037226	0. 117921	15. 569488	7. 238553	12. 435512	205.00
206.00	II) NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
I		1	I	I	I I		I

Health Financial Systems	IU HEALTH WHI	TE_HOSPITAL		In Lieu	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2018	Worksheet B-1	
				o 12/31/2018	Date/Time Pre 5/28/2019 6:1	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	(TIME SPENT)	(PATIENT DAYS)	(FTE'S)	ADMI NI STRATI ON	SERVI CES & SUPPLY	
				(DI RECT	(COSTED	
				NURSING HOURS)	REQUIS.)	
GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	13.00	14.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT						7.00
7.01 00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02 00702 OPERATION OF PLANT - TLMOB						7.02
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	2, 355					8.00 9.00
10. 00 01000 DI ETARY	98					10.00
11. 00 01100 CAFETERI A	28	0	10, 541			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0		1,000		(04.074	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	12 73		0 443	-	604, 271 19, 254	
16. 00 01600 MEDICAL RECORDS & LIBRARY	0		443		19, 234	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	-	· · · · ·	-			
30. 00 03000 ADULTS & PEDIATRICS	604	2, 264	2, 233	40, 365	81, 758	30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	264	0	710	7, 781	125, 776	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	55		510		3, 652	•
55. 00 05500 RADI OLOGY - THERAPEUTI C	11		94		573	
56. 00 03630 ULTRA SOUND	8		178		4, 392	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	11	0	583 176		49, 539 14, 289	•
60. 00 06000 LABORATORY	112		980		14, 207	60.00
66. 00 06600 PHYSI CAL THERAPY	94		428		3, 584	
67. 00 06700 OCCUPATI ONAL THERAPY	7	0	106		173	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	4	0	70 160		0 3, 610	68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		88, 511	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	6, 676	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73. 01 07301 0NCOLOGY DRUGS 76. 00 03160 CARDI OPULMONARY	0 96		0 661	0	0 20, 955	73.01 76.00
OUTPATIENT SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			<u> </u>	20,700	/0.00
90. 00 09000 CLI NI C	69		206		5, 159	
91.00 09100 EMERGENCY	331	0	1, 819	26, 458	174, 142	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.00 92.01
OTHER REIMBURSABLE COST CENTERS	0					/2.01
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS	1 902	2 264	10 257	74 604	602 042	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	1, 892	2, 264	10, 357	74, 604	602, 043	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0		0	-		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 02 19202 MOB	99 364		184 0			192.00 192.02
192.03 19203 ARNETT SURGERY OFFICE	0		0	-		192.02
192.04 19201 OCCUPATI ONAL MEDI CI NE	0	0	0	0		192.04
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
200.00Cross Foot Adjustments201.00Negative Cost Centers						200. 00 201. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	771, 559	972, 596	87, 070	1, 396, 804	1, 358, 538	
Part I)	,,,		5., 670	.,	.,,	
203.00 Unit cost multiplier (Wkst. B, Part I)	327. 625902				2.248226	•
204.00 Cost to be allocated (per Wkst. B, Part II)	98, 019	118, 451	28, 105	93, 079	250, 837	204.00
205.00 Unit cost multiplier (Wkst. B, Part	41. 621656	52. 319346	2.666256	1.247641	0. 415107	205.00
11)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

Hoal th	Financial Systems				l n	Liou of Form (MS 2552 10
	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH WHIT	Provider CCI	N: 15-1312	Peri od:	Lieu of Form C Worksheet	
					From 01/01/2 To 12/31/2		Prepared [.]
		DUADMAOV				5/28/2019	
	Cost Center Description	PHARMACY (COSTED	MEDI CAL RECORDS &				
		REQUIS.)	LI BRARY				
			(GROSS CHARGES)				
		15.00	16.00				
1 00	GENERAL SERVICE COST CENTERS	[]					1.00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7. 02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY	2 017 1/1					14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 017, 161 0	o				15.00 16.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS						10.00
30.00	03000 ADULTS & PEDIATRICS	5, 626	0				30.00
50, 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	5, 145	0				50.00
	05400 RADI OLOGY-DI AGNOSTI C	319	Ő				54.00
	05500 RADI OLOGY-THERAPEUTI C	33	0				55.00
	03630 ULTRA SOUND 05700 CT SCAN	0 581	0				56.00 57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o				58.00
	06000 LABORATORY	0	o				60.00
	06600 PHYSI CAL THERAPY	4	0				66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0				67.00 68.00
	06900 ELECTROCARDI OLOGY	43	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	О				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATTENTS	324, 414 1, 668, 014	0				73.00 73.01
	03160 CARDI OPULMONARY	85	0				76.00
00.00	OUTPATIENT SERVICE COST CENTERS	2 247	0				
	09000 CLINIC 09100 EMERGENCY	2, 247 10, 641	0				90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	10,011	0				92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0				92. 01
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0				101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0				101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	2,017,152	0				118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19100 RESEARCH	0	0				191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	9	О				192.00
	19202 MOB	0	0				192.02
	19203 ARNETT SURGERY OFFICE 19201 OCCUPATI ONAL MEDI CI NE	0	0				192. 03 192. 04
	19300 NONPALD WORKERS	0	0				193.00
200.00	Cross Foot Adjustments						200.00
201.00		1 / 07 / 5					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 697, 454	0				202.00
203.00		0. 841506	0. 000000				203.00
204.00	Cost to be allocated (per Wkst. B,	148, 780	о				204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 073757	0. 000000				205.00
200.00		0.073737	0.000000				200.00
206.00							206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	5, 940, 496		5, 940, 4	96 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS	1			-		
50. 00 05000 OPERATI NG ROOM	2, 586, 970		2, 586, 9			
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 045, 203		1, 045, 2		-	
55. 00 05500 RADI OLOGY-THERAPEUTI C	237, 888		237, 8		0	55.00
56. 00 03630 ULTRA SOUND	302, 495		302, 4		0	56.00
57.00 05700 CT SCAN	828, 655		828, 6		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	320, 924		320, 9		0	58.00
60. 00 06000 LABORATORY	2, 161, 076		2, 161, 0		0	60.00
66.00 06600 PHYSI CAL THERAPY	828, 749				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	216, 262		216, 2		0	67.00
68.00 06800 SPEECH PATHOLOGY	128, 299		128, 2		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	246, 797		246, 7		0	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	226, 129		226, 1		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	23, 792		23, 7		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	699, 808		699, 8		0	73.00
73. 01 07301 ONCOLOGY DRUGS	3, 598, 151		3, 598, 1			73.01
76.00 03160 CARDI OPULMONARY	962, 606		962, 6	0 00	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	416, 711		416, 7			
91.00 09100 EMERGENCY	5, 433, 972		5, 433, 9		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 056, 146		1, 056, 1		0	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0			0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						1.0.0.00
101.00 10100 HOME HEALTH AGENCY	0		07.0/1.1	0		101.00
200.00 Subtotal (see instructions)	27, 261, 129					200.00
201.00 Less Observation Beds	1, 056, 146		1, 056, 1			201.00
202.00 Total (see instructions)	26, 204, 983	0	26, 204, 9	83 0	0	202.00

Health Financial Systems	IU HEALTH WHIT	E HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 6:1	pared: 9 pm
		Title	XVIII	Hospi tal	Cost	<u> </u>
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 396, 365		4, 396, 3	55		30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	6, 165, 676			0.000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	67, 212	4, 988, 178	5, 055, 3	0. 206750	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	974, 048	974, 04	18 0. 244226	0.000000	55.00
56.00 03630 ULTRA SOUND	140, 872	2, 247, 880	2, 388, 7	52 0. 126633	0.000000	56.00
57.00 05700 CT SCAN	195, 291	4, 601, 700	4, 796, 9	0. 172745	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	66, 687	1, 465, 054	1, 531, 7	41 0. 209516	0.000000	58.00
60. 00 06000 LABORATORY	809, 566	5, 367, 134	6, 176, 70	0. 349875	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY	392, 797	1, 246, 936	1, 639, 7	0. 505417	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	176, 253	212, 878	389, 13	0. 555756	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	28, 368	178, 833	207, 20	0. 619201	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 337, 267	1, 337, 20	0. 184553	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 024	549, 187	558, 2	0. 405096	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	110, 178	110, 1	0. 215941	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 660, 351	3, 831, 814	5, 492, 10	0. 127419	0. 000000	73.00
73.01 07301 ONCOLOGY DRUGS	0	7, 211, 870	7, 211, 8	0. 498921	0.000000	73.01
76.00 03160 CARDI OPULMONARY	803, 498	2, 784, 746	3, 588, 24	0. 268267	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	1, 242, 630	1, 242, 6	0. 335346	0.00000	90.00
91.00 09100 EMERGENCY	496, 959	23, 913, 495	24, 410, 4	0. 222608	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 561	3, 368, 690	3, 383, 2	0. 312169	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0.000000	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	9, 257, 804	71, 798, 194	81, 055, 9	98		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9, 257, 804	71, 798, 194	81, 055, 9	98		202.00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-25	552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1312	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepa 5/28/2019 6:19	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0.000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000				55.00
56.00 03630 ULTRA SOUND	0.000000				56.00
57.00 05700 CT SCAN	0.000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
60. 00 06000 LABORATORY	0.000000				60.00
66. 00 06600 PHYSI CAL THERAPY	0.000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
73.01 07301 ONCOLOGY DRUGS	0.000000				73.01
76.00 03160 CARDI OPULMONARY	0. 000000				76.00
OUTPATIENT SERVICE COST CENTERS	•				
90. 00 09000 CLINIC	0. 000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000				92.01
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY				1	101.00
200.00 Subtotal (see instructions)				2	200.00
201.00 Less Observation Beds				2	201.00
202.00 Total (see instructions)				2	202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	5, 940, 496		5, 940, 4	96 0	5, 940, 496	30.00
ANCI LLARY SERVI CE COST CENTERS	T	1				
50.00 05000 OPERATING ROOM	2, 586, 970		2, 586, 9		2, 586, 970	
54.00 05400 RADI OLOGY-DI AGNOSTI C	1,045,203		1, 045, 20		1, 045, 203	
55. 00 05500 RADI OLOGY-THERAPEUTI C	237, 888		237, 8		237, 888	
56.00 03630 ULTRA SOUND	302, 495		302, 4		302, 495	•
57.00 05700 CT SCAN	828, 655		828, 6		828, 655	
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)	320, 924		320, 92		320, 924	
	2, 161, 076		2, 161, 0		2, 161, 076	
66.00 06600 PHYSI CAL THERAPY	828, 749		828, 7		828, 749	•
67.00 06700 OCCUPATI ONAL THERAPY	216, 262		216, 20		216, 262	•
68. 00 06800 SPEECH PATHOLOGY	128, 299		128, 2		128, 299	
69. 00 06900 ELECTROCARDI OLOGY	246, 797		246, 7		246, 797	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	226, 129		226, 1		226, 129	
	23, 792		23, 7		23, 792	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 07301 ONCOLOGY DRUGS	699,808		699,80		699, 808	
73. 01 07301 ONCOLOGY DRUGS 76. 00 03160 CARDI OPULMONARY	3, 598, 151 962, 606		3, 598, 1 962, 60		3, 598, 151 962, 606	
OUTPATIENT SERVICE COST CENTERS	902,000		902, 0	0	902, 000	78.00
90. 00 09000 CLINIC	416, 711		416, 7	1	416, 711	90.00
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY	5, 433, 972		5, 433, 9		5, 433, 972	1
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 056, 146				1, 056, 146	
	1, 056, 146		1, 056, 1	0 0		1
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0			0 0	0	92.01
101.00 10100 HOME HEALTH AGENCY	0	1	1	0	0	101.00
200.00 Subtotal (see instructions)	27, 261, 129	_	27, 261, 1	0		
201.00 Less Observation Beds	1, 056, 146		1, 056, 1		1, 056, 146	
201.00 Total (see instructions)	26, 204, 983					
	20, 204, 903	1 0	20, 204, 90	0	20, 204, 903	202.00

Health Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018		pared: 9 pm
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 396, 365		4, 396, 3	55		30.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	6, 165, 676	6, 165, 6	76 0. 419576	0. 000000	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	67, 212	4, 988, 178	5, 055, 39	0. 206750	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	974, 048	974, 04	48 0. 244226	0. 000000	55.00
56.00 03630 ULTRA SOUND	140, 872	2, 247, 880	2, 388, 7	52 0. 126633	0. 000000	56.00
57.00 05700 CT SCAN	195, 291	4, 601, 700	4, 796, 9	91 0. 172745	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	66, 687	1, 465, 054	1, 531, 7	0. 209516	0. 000000	58.00
60. 00 06000 LABORATORY	809, 566	5, 367, 134	6, 176, 70	0. 349875	0. 000000	60.00
66. 00 06600 PHYSI CAL THERAPY	392, 797	1, 246, 936	1, 639, 7	0. 505417	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	176, 253	212, 878	389, 13	0. 555756	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	28, 368	178, 833	207, 20	0. 619201	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 337, 267	1, 337, 20	67 0. 184553	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 024	549, 187	558, 2	0. 405096	0. 000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	110, 178	110, 1	0. 215941	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 660, 351	3, 831, 814	5, 492, 10	0. 127419	0. 000000	73.00
73.01 07301 ONCOLOGY DRUGS	0	7, 211, 870	7, 211, 8	0. 498921	0. 000000	73.01
76.00 03160 CARDI OPULMONARY	803, 498	2, 784, 746	3, 588, 24	0. 268267	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	1, 242, 630	1, 242, 6	0. 335346	0.00000	90.00
91.00 09100 EMERGENCY	496, 959	23, 913, 495	24, 410, 4	0. 222608	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 561	3, 368, 690	3, 383, 2	0. 312169	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0.000000	0. 000000	92.01
OTHER REIMBURSABLE COST CENTERS	· · · · ·				-	1
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	9, 257, 804	71, 798, 194	81, 055, 9	98		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9, 257, 804	71, 798, 194	81, 055, 9	98		202.00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 6:1	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVICE COST CENTERS	1 1				00100
50. 00 05000 OPERATING ROOM	0.000000				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 03630 ULTRA SOUND	0. 000000				56.00
57. 00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00
60, 00 06000 LABORATORY	0.000000				60.00
66. 00 06600 PHYSI CAL THERAPY	0,000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0,000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
73.01 07301 ONCOLOGY DRUGS	0.000000				73.01
76.00 03160 CARDI OPULMONARY	0.000000				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0.000000				92.01
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/28/2019 6:1	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. 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						
50. 00 05000 OPERATI NG ROOM	517, 010				0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	179, 118					
55. 00 05500 RADI OLOGY-THERAPEUTI C	37, 360				0	55.00
56.00 03630 ULTRA SOUND	31, 371				876	
57.00 05700 CT SCAN	70, 740				525	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	54, 632					
60. 00 06000 LABORATORY	198, 965				13, 993	
66. 00 06600 PHYSI CAL THERAPY	156, 508	1, 639, 733	0. 09544	132, 859	12, 681	66.00
67.00 06700 OCCUPATI ONAL THERAPY	16, 839	389, 131			2, 173	67.00
68.00 06800 SPEECH PATHOLOGY	8, 705				603	
69. 00 06900 ELECTROCARDI OLOGY	38, 996				0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 510	558, 211	0.06719	4, 893	329	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 020	110, 178	0. 02741	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	36, 005	5, 492, 165	0. 00655	6 867, 362	5, 686	73.00
73.01 07301 ONCOLOGY DRUGS	185, 121	7, 211, 870	0. 02566	09 0	0	73.01
76.00 03160 CARDI OPULMONARY	99, 343	3, 588, 244	0. 02768	455, 404	12, 608	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	85, 907	1, 242, 630	0.06913	33 0	0	90.00
91.00 09100 EMERGENCY	533, 590	24, 410, 454	0. 02185	69 8, 835	193	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	169, 120	3, 383, 251	0. 04998	37 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0. 00000	0 0	0	92.01
200.00 Total (lines 50 through 199)	2, 459, 860	76, 659, 633		2, 123, 092	51, 533	200. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2018		
				To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
			e XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health		
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0 0	0	50.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0			0 0		54.00
56. 00 03630 ULTRA SOUND	0			0 0		55.00
57. 00 05700 CT SCAN	0			0 0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0		58.00
60. 00 06000 LABORATORY	0				0	60.00
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	C		0 0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	0	C)	0 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0	0)	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	- I					
90. 00 09000 CLINIC	0	0		0 0	0	
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0		0 0	0	
200.00 Total (lines 50 through 199)	0	0	9	0 0	0	200. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS		F	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1	-		1	-	
50.00 05000 OPERATI NG ROOM	0	0	(6, 165, 676		•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(5, 055, 390		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	(974, 048		•
56.00 03630 ULTRA SOUND	0	0	(2, 388, 752		
57.00 05700 CT SCAN	0	0	(4, 796, 991	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(1, 531, 741	0.00000	58.00
60. 00 06000 LABORATORY	0	0	(6, 176, 700	0.00000	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0	(1, 639, 733	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	(389, 131	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	(207, 201	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(1, 337, 267	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(558, 211	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(110, 178	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(5, 492, 165	0. 000000	73.00
73.01 07301 ONCOLOGY DRUGS	0	0		7, 211, 870	0. 000000	73.01
76.00 03160 CARDI OPULMONARY	0	0		3, 588, 244	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS			•			1
90. 00 09000 CLINIC	0	0	(1, 242, 630	0.00000	90.00
91.00 09100 EMERGENCY	0	0	(24, 410, 454	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(3, 383, 251	0. 000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	(0	0. 000000	92.01
200.00 Total (lines 50 through 199)	0	0		76, 659, 633		200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CN: 15-1312 Period: From 01/01/2018 To 12/31/2018 Worksheet D Pate 1 V Date/Time Prepared: 50 12/31/2018 VIET Cost Center Description Outpatient Ratio of Cost (col. 6 + col. 7) Inpatient Program Program Program Pass-Through Costs (col. 8 x col. 10) Outpatient Program Pass-Through Costs (col. 9 x col. 12) Worksheet D Date/Time Prepared: Cost MARILLARY SERVICE COST CENTERS 0.00 0.00000 0	Health Financial Systems	IU HEALTH WHITE	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Outpatient Ratio of Cost to Charges (col. 6 + col. Inpatient Program Charges Unpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges Outpatient Program Charges ANCI LLARY SERVICE COST CENTERS 0		RVICE OTHER PASS			From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	pared: 9 pm
Rati o of Cost to Charges (col. 6 + col. 7) Program Charges (col. 6 + col. 7) Program Charges (col. 6 + col. 7) Program Pass-Through Costs (col. 8 x col. 10) Program Pass-Through Costs (col. 9 x col. 12) ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05400 (PRADI LOGY-DI AGNOSTI C 0.000000 0 0 0 50.00 55.00 05500 (RADI OLOGY-DI AGNOSTI C 0.000000 0 0 0 55.00 56.00 05600 (LTRA SOUND 0.000000 0 0 0 55.00 56.00 05700 (CT SCAN 0.000000 35,567 0 0 0 56.00 57.00 05700 (CT SCAN 0.000000 23,263 0 0 0 66.00 66.00 06600 PHYSI CAL THERAPY 0.000000 132,859 0 0 66.00 66.00 67.00 06700 (OCUPATI ONAL THERAPY 0.000000 14,357 0 0 0 66.00 68.00 6600 SPEECH PATHOLOGY 0.000000 14,357 0 </td <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Hospi tal</td> <td>Cost</td> <td></td>			Title	XVIII	Hospi tal	Cost	
Image: tool charges Charges Pass-Through Costs (col. 8 x col. 10) Charges Pass-Through Costs (col. 8 x col. 10) Pass-Through Costs (col. 9 x col. 10) ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 50.00 05000 0PERATI NG ROM 0.000000 0 0 0 50.00 54.00 05400 RADI 0LOGY-DI AGNOSTI C 0.000000 29,252 0 0 0 55.00 55.00 05500 RADI 0LOGY-THERAPEUTI C 0.000000 66.687 0 0 55.00 56.00 03630 ULTRA SOUND 0.000000 65.60 0 57.00 57.00 57.00 57.00 57.00 58.00 66.00 58.00 66.00	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$		Ratio of Cost	Program	Program	Program	Program	
T) x col. 10) x col. 12) 9.00 10.00 11.00 12.00 13.00 50.00 05000 (DPERATI ING ROM 0.000000 0 0 0 50.00 54.00 05000 (DEGY-DI AGNOSTI C 0.000000 29,252 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 0 55.00 0 55.00 0 0 0 0 55.00 0 55.00 0 0 0 0 0 55.00 0 55.00 0 0 0 0 55.00 0 55.00 0 55.00 0 0 0 55.00 0 0 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 55.00 0 56.00 57.00 55.00 0 56.0		to Charges	Charges	Pass-Through	n Charges	Pass-Through	
ANCI LLARY SERVICE COST CENTERS 9.00 10.00 11.00 12.00 13.00 ANCI LLARY SERVICE COST CENTERS 0.00000 0		(col. 6 ÷ col.	-	Costs (col.	8	Costs (col. 9	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROM 0.000000 0 0 0 50. 00 54. 00 05400 RADIOLOGY-DIAGNOSTIC 0.000000 29, 252 0 0 0 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTIC 0.000000 0 0 0 0 55. 00 56. 00 03630 ULTRA SOUND 0.000000 66, 687 0 0 0 56. 00 58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 23, 263 0 0 0 57. 00 50. 00 06600 LABORATORY 0.000000 23, 263 0 0 0 60. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 0 67. 00 0 68. 00 6600 9219 0 0 68. 00 69. 00 0 67. 00 0 68. 00 69. 00 <td></td> <td>7)</td> <td></td> <td>x col. 10)</td> <td></td> <td>x col. 12)</td> <td></td>		7)		x col. 10)		x col. 12)	
50.00 05000 OPERATING ROOM 0.000000 0 0 0 0 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 29,252 0 0 0 54.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 0.000000 29,252 0 0 0 55.00 03630 ULTRA SOUND 0.000000 29,252 0 0 0 55.00 03630 ULTRA SOUND 0.000000 66.687 0 0 55.00 0500 OS800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 23,263 0 0 0 66.00 06000 LABORATORY 0.000000 132,859 0 0 0 66.00 66.00 64.00 06600 PEECH PATHOLOGY 0.000000 14,357 0 0 68.00 69.00 68.00 69.00 69.00 69.00 69.00 69.00 0 0 67.00 71.00 71.00 <		9.00	10.00	11.00	12.00	13.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 29,252 0 0 0 55.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 56.00 03630 ULTRA SOUND 0.000000 66,687 0 0 55.00 57.00 D5700 CT SCAN 0.000000 23,263 0 0 58.00 60.00 06000 LABORATORY 0.000000 132,859 0 0 66.00 66.00 06000 PHYSI CAL THERAPY 0.000000 132,859 0 0 66.00 67.00 06700 CCUPATI ONAL THERAPY 0.000000 14,357 0 0 68.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 71.00 71.00 OTIO CARGED TO PATI ENTS 0.000000 0 0 0 72.00 72.00 OPALI ES CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 <	ANCI LLARY SERVI CE COST CENTERS						
55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55.00 56.00 03630 ULTRA SOUND 0.000000 66.687 0 0 0 56.00 57.00 05700 CT SCAN 0.000000 35,567 0 0 0 57.00 58.00 05800 MaGNETI C RESONANCE I MAGI NG (MRI) 0.000000 23,263 0 0 0 66.00 60.00 06000 LABORATORY 0.000000 132,859 0 0 0 66.00 67.00 05700 0CUPATI ONAL THERAPY 0.000000 14,357 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 73.01 73.01 073	50.00 05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
56.00 03630 ULTRA SOUND 0.00000 66,687 0 0 56.00 57.00 05700 CT SCAN 0.000000 35,567 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 23,263 0 0 0 58.00 60.00 06000 LABORATORY 0.000000 434,394 0 0 0 66.00 66.00 06000 CUPATI ONAL THERAPY 0.000000 50,219 0 0 66.00 67.00 06300 SPEECH PATHOLOGY 0.000000 14,357 0 0 68.00 68.00 06300 SPEECH PATHOLOGY 0.000000 0 0 68.00 69.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 73.00 73.01 07301 NCOLOGY DRUGS 0.0	54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	29, 252		0 0	0	54.00
57. 00 05700 CT SCAN 0.00000 35,567 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 23, 263 0 0 0 58. 00 60. 00 06000 LABORATORY 0.000000 434, 394 0 0 0 60. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 132, 859 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 50, 219 0 0 68. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 0 0 0 0 71. 00 73. 00 07300 DRGS CHARGED TO PATI ENTS 0.000000 0 0 0 72. 00 73. 01 07301 DNCS CHARGED TO PATI ENTS 0.0000000 0 0	55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	0		0 0	0	55.00
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 23, 263 0 0 0 58.00 60.00 06000 LABORATORY 0.000000 434, 394 0 0 0 60.00 66.00 06000 PHYSI CAL THERAPY 0.000000 132, 859 0 0 0 66.00 67.00 06700 OCUPATI ONAL THERAPY 0.000000 50, 219 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 867, 362 0 0 0 73.01 73.01 </td <td>56.00 03630 ULTRA SOUND</td> <td>0. 000000</td> <td>66, 687</td> <td></td> <td>0 0</td> <td>0</td> <td>56.00</td>	56.00 03630 ULTRA SOUND	0. 000000	66, 687		0 0	0	56.00
60.00 06000 LABORATORY 0.00000 434, 394 0 0 0 60.00 66.00 06600 PHYSI CAL THERAPY 0.000000 132, 859 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 50, 219 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 14, 357 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 4, 893 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 0 0 0 0 73.01 73.01 07301 DNCLOGY DRUGS 0.000000 0 0 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 0 0 <td>57.00 05700 CT SCAN</td> <td>0. 000000</td> <td>35, 567</td> <td></td> <td>0 0</td> <td>0</td> <td>57.00</td>	57.00 05700 CT SCAN	0. 000000	35, 567		0 0	0	57.00
66.00 06600 PHYSI CAL THERAPY 0.00000 132,859 0 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 50,219 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 14,357 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 4,893 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.01 07301 ONCLOGY DRUGS 0.000000 0 0 0 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01	58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	23, 263		0 0	0	58.00
67.00 06700 OCCUPATIONAL THERAPY 0.000000 50,219 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 14,357 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 4,893 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0.000000 867,362 0 0 73.00 73.01 07301 ONCLOGY DRUGS 0.000000 0 0 0 73.00 73.01 07301 ONCLOGY DRUGS 0.000000 0 0 0 73.01 74.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 90.00 09100 ELETROCATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 91.00 92.01 0920	60. 00 06000 LABORATORY	0. 000000	434, 394		0 0	0	60.00
68.00 06800 SPEECH PATHOLOGY 0.000000 14,357 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 4,893 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 867,362 0 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 04000 CLI NI C 0.000000 0 0 0 0 90.00 91.00 90.00 09100 EMERGENCY 0.000000 8.835 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 0	66. 00 06600 PHYSI CAL THERAPY	0. 000000	132, 859		0 0	0	66.00
69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 4,893 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 867,362 0 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 0 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 0017PATI ENT SERVICE COST CENTERS 0.000000 455,404 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 0 0 0 90.00 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 8,835 0 0 0 92.00	67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	50, 219		0 0	0	67.00
69.00 06900 ELECTROCARDIOLOGY 0.000000 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 4,893 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 867,362 0 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 0 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 04700 01700 CLINIC 0.000000 455,404 0	68.00 06800 SPEECH PATHOLOGY	0. 000000	14, 357		0 0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 867,362 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 0UTPATIENT SERVICE COST CENTERS 0.000000 455,404 0 0 0 76.00 90.00 09000 CLINIC 0.000000 8,835 0 0 90.00 91.00 91.00 91.00 91.00 92.00 92.00 92.01 052.01 92.01 0 0 0 92.00 92.01 92.01 0 0 0 92.01 92.01	69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.00000 867,362 0 0 73.00 73.01 07301 0NCOLOGY DRUGS 0.00000 0 0 0 73.01 73.01 07301 0NCOLOGY DRUGS 0.00000 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 0UTPATI ENT SERVICE COST CENTERS 0.000000 455,404 0 0 0 76.00 90.00 09100 CLINIC 0.000000 8,835 0 0 91.00 91.00 91.00 92.00 92.00 92.01 052RVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	4, 893		0 0	0	71.00
73.01 07301 0NCOLOGY DRUGS 0.00000 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 0 90.00 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 8,835 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01	72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.01 07301 0NCOLOGY DRUGS 0.000000 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 455,404 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0.000000 0 0 0 0 90.00 90.00 09100 CLINIC 0.000000 8,835 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01	73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	867, 362		0 0	0	73.00
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 8,835 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01	73. 01 07301 ONCOLOGY DRUGS	0, 000000	0		0 0	0	73.01
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0.000000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 8,835 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 0 0 0 92.01	76.00 03160 CARDI OPULMONARY	0, 000000	455, 404		0 0	0	76.00
90.00 09000 CLINIC 0.00000 0 0 0 90.00 91.00 09100 EMERGENCY 0.000000 8,835 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0.000000 0 0 0 92.00 92.01 09201 OBSERVATI ON BEDS (DISTINCT PART) 0.000000 0 0 0 92.01							
91.00 09100 EMERGENCY 0.000000 8,835 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 0 0 0 0 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 0 0 0 92.01		0, 000000	0		0 0	0	90.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0. 000000 0 0 0 0 92. 01	91. 00 09100 EMERGENCY		8, 835		0 0	0	91.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0. 000000 0 0 0 0 92. 01			0		0 0		
			0		0 0	0	
			2, 123, 092		0 0		

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1312	Period: From 01/01/2018	Worksheet D Part V	
				To 12/31/2018	Date/Time Pre	pared:
					5/28/2019 6:1	9 pm
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Services	Services Not		
	Part I, col. 9		Subject To Ded. & Coins	Subject To . Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 419576	0	2, 171, 67	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 206750				0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 244226		460, 80		0	55.00
56. 00 03630 ULTRA SOUND	0. 126633		884, 42		0	56.00
57. 00 05700 CT SCAN	0. 172745		1, 816, 7		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 209516		564, 6		0	58.00
60. 00 06000 LABORATORY	0. 349875		2, 086, 62		0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 505417		500, 93		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 555756		60, 26		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 619201		21, 22		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 184553		490, 7		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 405096		172, 75		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 215941		37, 08		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 127419		1, 500, 89			73.00
73. 01 07301 ONCOLOGY DRUGS	0. 498921				0	73.01
76. 00 03160 CARDI OPULMONARY	0. 268267				0	76.00
OUTPATIENT SERVICE COST CENTERS		-		· · ·		
90. 00 09000 CLI NI C	0. 335346	0	810, 74	3 0	0	90.00
91. 00 09100 EMERGENCY	0. 222608	0	6, 700, 09	2, 161	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 312169		1, 669, 83		0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
200.00 Subtotal (see instructions)		0	27, 709, 17	78 5, 699	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	27, 709, 17	78 5, 699	0	202.00

Health Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-1312	Period:	Worksheet D
				From 01/01/2018 To 12/31/2018	Part V Date/Time Prepared:
					5/28/2019 6:19 pm
		Title	XVIII	Hospi tal	Cost
	Cost				
Cost Center Description	Cost	Cost			
	Reimbursed	Reimbursed			
		Services Not			
	Subject To Ded. & Coins. [Subject To Ded. & Coins.			
		(see inst.)			
	6.00	7.00			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00			
0. 00 05000 OPERATI NG ROOM	911, 181	0			50.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	263, 375	0			54.00
5. 00 05500 RADI OLOGY-THERAPEUTI C	112, 540	0			55.00
6.00 03630 ULTRA SOUND	111, 997	0			56.00
7.00 05700 CT SCAN	313, 829	0			57.00
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	118, 296	0			58.00
0. 00 06000 LABORATORY	730, 057	0			60.00
6. 00 06600 PHYSI CAL THERAPY	253, 179	0			66.00
7.00 06700 OCCUPATI ONAL THERAPY	33, 494	0			67.00
8.00 06800 SPEECH PATHOLOGY	13, 141	0			68.00
9. 00 06900 ELECTROCARDI OLOGY	90, 562	0			69.00
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	69, 983	0			71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 008	0			72.00
3.00 07300 DRUGS CHARGED TO PATIENTS	191, 243	451			73.00
3.01 07301 ONCOLOGY DRUGS	2, 644, 855	0			73.01
6. 00 03160 CARDI OPULMONARY	317, 829	0			76.00
OUTPATIENT SERVICE COST CENTERS	T				
D. 00 09000 CLINIC	271, 879	0			90.00
1. 00 09100 EMERGENCY	1, 491, 494	481			91.00
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	521, 271	0			92.00
2. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0			92.01
00.00 Subtotal (see instructions)	8, 468, 213	932			200.00
01.00 Less PBP Clinic Lab. Services-Program	0				201.00
000 Only Charges 202.00 Net Charges (line 200 - line 201)	8, 468, 213	932			202.00
202.00 Net Charges (line 200 - line 201)	0,408,213	932			J202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1312	Period: From 01/01/2018	Worksheet D Part V	
		Component (CCN: 15-Z312	To 12/31/2018	Date/Time Pre	
		Titlo	XVIII	Swing Beds - SNF	5/28/2019 6:1 Cost	9 pm
		II ti e	Charges	Swirtig beus - Sivi	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 419576	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 206750	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 244226	0		0 0	0	
56. 00 03630 ULTRA SOUND	0. 126633	0		0 0	0	
57. 00 05700 CT SCAN	0. 172745	0		0 0	0	01100
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 209516	0		0 0	0	
60. 00 06000 LABORATORY	0. 349875	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 505417	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 555756	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0. 619201	0		0 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 184553	0		0 0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 405096	0		0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 215941	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 127419	0		0 0	0	
73. 01 07301 ONCOLOGY DRUGS	0. 498921	0		0 0	0	
76. 00 03160 CARDI OPULMONARY	0. 268267	0		0 0	0	76.00
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C	0.225244	0		0 0	0	90.00
90. 00 109000 CETNIC 91. 00 109100 EMERGENCY	0. 335346 0. 222608	0		0 0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 222608	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 312189	0		0 0	0	•
200.00 Subtotal (see instructions)	0. 000000	0				200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	0	200.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00
	1	0	I		0	1202.00

Health Financial Systems	IU HEALTH WHITE	HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der CCN: 15-1312	Peri od:	Worksheet D
			From 01/01/2018	Part V
		Component CCN: 15-Z312	To 12/31/2018	Date/Time Prepared: 5/28/2019 6:19 pm
		Title XVIII	Swing Beds - SNF	
	Costs		Joining Deus Olli	0031
Cost Center Description	Cost	Cost		
	Reimbursed	Reimbursed		
	Servi ces S	Services Not		
		Subject To		
		ed. & Coins.		
		(see inst.)		
	6.00	7.00		
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0	0		50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55.00
56.00 03630 ULTRA SOUND	0	0		56.00 57.00
57.00 05700 CT SCAN	0	0		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 60.00 06000 LABORATORY	0	0		58.00 60.00
60. 00 06000 LABORATORY 66. 00 06600 PHYSI CAL THERAPY	0	0		66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		73.00
73. 01 07301 0NC0LOGY DRUGS	0	0		73.00
76.00 03160 CARDI OPULMONARY	0	0		76.00
OUTPATIENT SERVICE COST CENTERS				70.00
90. 00 09000 CLINIC	0	0		90.00
91. 00 09100 EMERGENCY	0	o		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
200.00 Subtotal (see instructions)	0	o		200.00
201.00 Less PBP Clinic Lab. Services-Program	0			201.00
Only Charges				
202.00 Net Charges (line 200 - line 201)	0	0		202.00

Health Financial Systems	IU HEALTH WHI	TE_HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1312	Period: From 01/01/2018	Worksheet D Part V	
				To 12/31/2018	Date/Time Pre	
					5/28/2019 6:1	9 pm
			e XIX	Hospi tal	Cost	
Cost Center Description	Cost to Charge	DDC Deimburged	Charges Cost	Cost	Costs PPS Services	
cost center bescription		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(366 1131.)	
	Part I, col. 9	,	Subject To			
			Ded. & Coins			
			(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. 419576	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 206750	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 244226	0		0 0	0	55.00
56.00 03630 ULTRA SOUND	0. 126633	0		0 0	0	56.00
57. 00 05700 CT SCAN	0. 172745	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 209516	0		0 0	0	58.00
60. 00 06000 LABORATORY	0. 349875	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 505417	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 555756	0		0 0	0	01100
68.00 06800 SPEECH PATHOLOGY	0. 619201	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 184553			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 405096			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 215941			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 127419			0 0	0	
73.01 07301 ONCOLOGY DRUGS	0. 498921			0 0	0	
76.00 03160 CARDI OPULMONARY	0. 268267	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	T	1				-
90. 00 09000 CLINIC	0. 335346			0 0		
91.00 09100 EMERGENCY	0. 222608			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 312169			0 0	0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	1 21 01
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges				0	_	202.00
202.00 Net Charges (line 200 - line 201)	I	0	l	0 0	0	202.00

Health Financial Systems		IU HEALTH WHI	TE_HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER H	HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-1312	Period: From 01/01/2018		an a made
					To 12/31/2018	Date/Time Pro 5/28/2019 6:	19 pm
			Ti tl	e XIX	Hospi tal	Cost	
		Cos					
Cost Center Descripti	on	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
ANCI LLARY SERVICE COST CEN	TEDC	6.00	7.00				-
50. 00 05000 OPERATING ROOM	IEKS	0	C				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0				54.00
55. 00 05500 RADI 0L0GY-THERAPEUTI 0	`	0	0				55.00
56. 00 03630 ULTRA SOUND	5	0	0				56.00
57. 00 05700 CT SCAN		0	0				57.00
58.00 05800 MAGNETIC RESONANCE II	MAGING (MRL)	0	0				58.00
60. 00 06000 LABORATORY		0	0				60.00
66. 00 06600 PHYSI CAL THERAPY		0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0	0				67.00
68. 00 06800 SPEECH PATHOLOGY		0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY		0	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHAI	RGED TO PATLENTS	0	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO		0	0				72.00
73.00 07300 DRUGS CHARGED TO PAT		0	0				73.00
73.01 07301 ONCOLOGY DRUGS		0	0)			73.01
76.00 03160 CARDI OPULMONARY		0	C)			76.00
OUTPATIENT SERVICE COST CE	NTERS		-				
90. 00 09000 CLINIC		0	C)			90.00
91.00 09100 EMERGENCY		0	C				91.00
92.00 09200 OBSERVATI ON BEDS (NOI	N-DISTINCT PART)	0	C				92.00
92.01 09201 OBSERVATION BEDS (DIS	STINCT PART)	0	0				92.01
200.00 Subtotal (see instrue	ctions)	0	0				200.00
201.00 Less PBP Clinic Lab.	Servi ces-Program	0					201.00
Only Charges	-						
202.00 Net Charges (line 200) – line 201)	0	0				202.00

	J	WHITE HOSPITAL		u of Form CMS-2	
COMPUT	TATION OF INPATIENT OPERATING COST	Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018		pared:
		Title XVIII	Hospi tal	5/28/2019 6:19 Cost	9 pm
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-be	ed days excluding newborn)		2, 710	1.00
2.00	Inpatient days (including private room days, excluding s	swing-bed and newborn days)		2, 178	
3.00	Private room days (excluding swing-bed and observation b do not complete this line.	oed days). If you have only pr	ivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observat	tion bed days)		1, 732	4.00
5.00	Total swing-bed SNF type inpatient days (including priva	ate room days) through Decembe	r 31 of the cost	319	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including priva	ate room days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line	e)			
7.00	Total swing-bed NF type inpatient days (including privative) reporting period	te room days) through December	31 of the cost	213	7.00
8.00	Total swing-bed NF type inpatient days (including privation)	te room days) after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line			4 4 4 7	0.00
9.00	Total inpatient days including private room days applica newborn days)	able to the Program (excluding	swing-bed and	1, 147	9.00
10.00			oom days)	319	10.00
11.00	through December 31 of the cost reporting period (see in Swing-bed SNF type inpatient days applicable to title XN		oom days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this line)	<u> </u>	0	
12.00	Swing-bed NF type inpatient days applicable to titles V through December 31 of the cost reporting period	or XIX only (including privat	e room days)	0	12.00
13.00	0	or XIX only (including privat	e room days)	0	13.00
14.00	after December 31 of the cost reporting period (if caler				14.00
	5 51 5 11	Program (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to s	convigos through December 21 a	f the cost		17.00
17.00	reporting period	services thiough becember 31 d	T the cost		17.00
18.00	5 11	services after December 31 of	the cost		18.00
19.00		ervices through December 31 of	the cost	129.14	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to se	ervices after December 31 of t	he cost	0.00	20.00
20.00	reporting period			0.00	20.00
21.00				5, 940, 496	
22.00	Swing-bed cost applicable to SNF type services through [5 x line 17)	December 31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after Dec	cember 31 of the cost reportin	g period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through De	ecember 31 of the cost reporti	ng period (line	27, 507	24.00
25.00	7 x line 19) Swing-bed cost applicable to NF type services after Dece	mbor 21 of the cost reporting	poriod (lipo 9	0	25.00
23.00	x line 20)	ember 31 01 the cost reporting	period (inne o	0	23.00
	5			782, 912	
27.00	General inpatient routine service cost net of swing-bed PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Cost (The 21 minus The 26)		5, 157, 584	27.00
28.00		ng-bed and observation bed ch	arges)	0	28.00
29.00				0	29.00
		22.27 · Lipp 28)		0	30.00
31.00 32.00				0. 000000 0. 00	
33.00		ne 4)		0.00	1
34.00	o		tions)	0.00	
35.00				0.00	
36.00				0	36.00
37.00	5	cost and private room cost di	fferential (line	5, 157, 584	37.00
	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COS	ST ADJUSTMENTS			1
38.00	5 1 1	, ,		2, 368. 04	
				2, 716, 142	
40.00 41.00	Medically necessary private room cost applicable to the Total Program general inpatient routine service cost (li	3 1		0 2, 716, 142	40.00
41.00	The service cost (II	110 J7 T 1110 40)	I	2, / 10, 142	I +1.00

OMPUTA	Financial Systems TION OF INPATIENT OPERATING COST	IU HEALTH WHIT	Provider C	CN: 15-1312	Peri od:	eu of Form CMS- Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
				XVIII	Hospi tal	Cost	, p
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)						42. (
	Intensive Care Type Inpatient Hospital Units						1 40
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 44.
	BURN INTENSIVE CARE UNIT						44.
	SURGI CAL I NTENSI VE CARE UNI T						46.
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	Line 200)			518, 081	48.
	Total Program inpatient costs (sum of lines			ns)		3, 234, 223	
	PASS THROUGH COST ADJUSTMENTS	¥ • •					
	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sun	n of Parts I and	0	50.
	III) Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst D s	um of Parts II	0	51.
	and IV)	attent and trais	Services (II	om wkst. D, s			51.
2.00	Total Program excludable cost (sum of lines					0	
	Total Program inpatient operating cost exclu		ated, non-phy	si ci an anesth	netist, and	0	53.
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program discharges					0	54.
	Target amount per discharge					0.00	55.
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	norting period e	nding 1996 u	ndated and co	mounded by the	0.00	
	market basket	por tring period e	and fig 1770, c		inpounded by the	0.00	57.
	Lesser of lines 53/54 or 55 from prior year					0.00	
	If line 53/54 is less than the lower of line					0	61.
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		5 (TINES 54 X	60), or 1% of	the target		
	Relief payment (see instructions)					0	62.
	Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	to through Dooon	han 21 of the	aget reporti	ng partiad (Caa	755 405	
	instructions)(title XVIII only)	is through becen		cost reporti	ng period (see	755, 405	04.
	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	o	65.
	instructions)(title XVIII only)						
	Total Medicare swing-bed SNF inpatient routi	ne costs (line é	64 plus line 6	5)(title XVII	l only). For	755, 405	66.
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 d	f the cost re	porting period	0	67.
	(line 12 x line 19)	U U					
	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68.
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino costs (1	ino 67 i lino	60)		0	69.
-	PART III - SKILLED NURSING FACILITY, OTHER N			,		0	07.
	Skilled nursing facility/other nursing facil						70.
	Adjusted general inpatient routine service c		ne 70 ÷ line	2)			71.
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v !:	no 35)			72.
	Total Program general inpatient routine serv			ne 30)			74.
	Capital -related cost allocated to inpatient	•	,	orksheet B, F	Part II, column		75.
1	26, line 45)	- >	-				
	Per diem capital-related costs (line 75 ÷ li Program capital related costs (line 0 × line						76.
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.
	Aggregate charges to beneficiaries for exces	,	ovider record	s)			79.
. 00	Total Program routine service costs for comp	arison to the co		•	nus line 79)		80.
	Inpatient routine service cost per diem limi						81.
	Inpatient routine service cost limitation (l Reasonable inpatient routine service costs (,					82.
	Program inpatient ancillary services (see in		·)				84.
	Utilization review - physician compensation		is)				85.
5. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86.
	PART IV - COMPUTATION OF OBSERVATION BED PAS					446	87.
						. 446	1 × /
7.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			2, 368. 04	

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	951, 243	5, 940, 496	0. 16012	9 1, 056, 146	169, 120	90.00
91.00 Nursing School cost	0	5, 940, 496	0.00000	0 1, 056, 146	0	91.00
92.00 Allied health cost	0	5, 940, 496	0.00000	0 1, 056, 146	0	92.00
93.00 All other Medical Education	0	5, 940, 496	0.00000	1, 056, 146	0	93.00

	Financial Systems IU HEALTH WHITE HO ATION OF INPATIENT OPERATING COST Pi	rovider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet D-1 Date/Time Prep 5/28/2019 6:19	pared:
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00 2.00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-bed			2, 710 2, 178	1.00 2.00
2.00	Private room days (excluding swing-bed and observation bed days)		ivate room days,	2, 178	2.00
4 00	do not complete this line.		<u> </u>	1 700	4 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		er 31 of the cost	1, 732 319	4.00 5.00
	reporting period	<i>, , , , , , , , , ,</i>			
6.00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room d	lays) through December	31 of the cost	213	7.00
8.00	reporting period Total swing-bed NF type inpatient days (including private room d	lavs) after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	ays) arter becember e	in on the cost	Ű	0.00
9.00	Total inpatient days including private room days applicable to t newborn days)	he Program (excluding	swing-bed and	7	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days)	0	10.00
11.00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII only		soom dave) ofter	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, ente		oom days) arter	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX o through December 31 of the cost reporting period	only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX o	only (including privat	e room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year	, enter O on this lir	ie)		44.00
14.00 15.00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00
16.00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 c	of the cost		17.00
	reporting period	0			
18.00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services t	hrough December 31 of	the cost	129.14	19.00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services a	after December 31 of t	the cost	0.00	20.00
20.00	reporting period			0.00	20.00
21.00 22.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	21 of the cost report	ing pariod (line)	5, 940, 496 0	21.00 22.00
22.00	5 x line 17)	ST OF THE COST TEPOLT		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 x line 18)	of the cost reportin	ng period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 3	31 of the cost reporti	ng period (line	27, 507	24.00
25 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	poriod (lipo 9	0	25. 00
25.00	x line 20)			0	25.00
26.00	Total swing-bed cost (see instructions)	no 21 minus Line 2()		782, 912	
27.00	General inpatient routine service cost net of swing-bed cost (li PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ne zi minus iine zo)		5, 157, 584	27.00
28.00	General inpatient routine service charges (excluding swing-bed a	and observation bed ch	narges)	0	28.00
29.00 30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ l	ine 28)		0. 000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00 34.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0.00 0.00	33.00 34.00
35.00	Average per diem private room cost differential (line 34 x line		-	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and	l private room cost di	fferential (line	0 5, 157, 584	36.00 37.00
	27 minus line 36)			5, 157, 504	57.00
37.00					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	MENTS			
	PART II - HOSPITÁL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST Adjusted general inpatient routine service cost per diem (see in			2, 368.04	38. 00
37.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	nstructions) 3)		2, 368. 04 16, 576 0	38. 00 39. 00 40. 00

OMPUTA	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1312	Period: From 01/01/2018	Worksheet D-1	l
					To 12/31/2018		
			Titl	e XIX	Hospi tal	Cost	i z pin
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)						42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43
	CORONARY CARE UNIT						44
	BURN INTENSIVE CARE UNIT						45
	SURGI CAL INTENSIVE CARE UNIT						46
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.
	Cost Center Description					1.00	-
1	Program inpatient ancillary service cost (Wk					6, 496	
	Total Program inpatient costs (sum of lines	41 through 48)((see instructio	ons)		23, 072	49.
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	n Wkst D su	m of Parts L and	0	50.
)					-	
	Pass through costs applicable to Program inp	atient ancillar	ry services (fi	rom Wkst. D,	sum of Parts II	0	51
	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.
	Total Program inpatient operating cost exclu		ated, non-phy	/sician anest	hetist, and	0	
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
1	Difference between adjusted inpatient operat	ing cost and ta	arget amount (I	ine 56 minus	line 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1006	undated and c	omnounded by the	0.00	
	market basket	por tring period	chung 1770, t		onpounded by the	0.00	<u> </u>
	Lesser of lines 53/54 or 55 from prior year					0.00	
	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61
	amount (line 56), otherwise enter zero (see		15 (TTHES 54 X	00), 01 1% 0	i the target		
2.00	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	ember 31 of the	e cost report	ing period (See	0	64.
	instructions)(title XVIII only)	0		·	0 1		
	Medicare swing-bed SNF inpatient routine cos	sts after Decemb	per 31 of the o	cost reportin	g period (See	0	65
	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVI	ll only). For	0	66
	CAH (see instructions)				J		
	Title V or XIX swing-bed NF inpatient routin	ne costs through	n December 31 d	of the cost r	eporting period	0	67.
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.
	(line 13 x line 20)					-	
	Total title V or XIX swing-bed NF inpatient			,		0	69.
-	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70
	Adjusted general inpatient routine service o)		71
	Program routine service cost (line 9 x line						72
	Medically necessary private room cost applic Total Program general inpatient routine serv						73
	Capital -related cost allocated to inpatient				Part II, column		75
	26, line 45)			/			
	Per diem capital-related costs (line 75 ÷ li						76
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77
	Aggregate charges to beneficiaries for exces	,	provider record	ls)			79
. 00	Total Program routine service costs for comp	parison to the c		· · · · · · · · · · · · · · · · · · ·	nus line 79)		80
	Inpatient routine service cost per diem limi						81
	Inpatient routine service cost limitation (l Reasonable inpatient routine service costs (82
1	Program inpatient ancillary services (see in		,				84
5.00	Utilization review - physician compensation	(see instruction					85
	Total Program inpatient operating costs (sum		nrough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					446	87
	Adjusted general inpatient routine cost per		line 2)			2, 368. 04	
5. 00 p						1, 056, 146	1

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	951, 243	5, 940, 496	0. 16012	9 1, 056, 146	169, 120	90.00
91.00 Nursing School cost	0	5, 940, 496	0.00000	0 1, 056, 146	0	91.00
92.00 Allied health cost	0	5, 940, 496	0.00000	0 1, 056, 146	0	92.00
93.00 All other Medical Education	0	5, 940, 496	0.00000	0 1, 056, 146	0	93.00

Health Financial Systems IU HEAL	TH WHITE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1312	Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	narod
			10 12/31/2010	5/28/2019 6:1	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			2, 386, 602		30.00
ANCI LLARY SERVICE COST CENTERS			2,000,002		00.00
50. 00 05000 0PERATING ROOM		0. 4195	76 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2067	50 29, 252	6, 048	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2442	26 0	0	55.00
56.00 03630 ULTRA SOUND		0. 1266	33 66, 687	8, 445	56.00
57. 00 05700 CT SCAN		0. 1727			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2095			1
60. 00 06000 LABORATORY		0. 3498			1
66. 00 06600 PHYSI CAL THERAPY		0. 5054			
67.00 06700 OCCUPATI ONAL THERAPY		0. 5557			
68.00 06800 SPEECH PATHOLOGY		0. 6192			
69. 00 06900 ELECTROCARDI OLOGY		0. 1845		Ű	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0.4050			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS		0.2159		-	72.00 73.00
73. 01 07301 ONCOLOGY DRUGS		0. 1274 0. 4989			
76. 00 03160 CARDI OPULMONARY		0. 2682			
OUTPATIENT SERVICE COST CENTERS		0.2002	455, 404	122, 170	70.00
90. 00 09000 CLINIC		0. 3353	46 0	0	90.00
91. 00 09100 EMERGENCY		0. 2226			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)		0. 3121			
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000		0	92.01
200.00 Total (sum of lines 50 through 94 and 96 throug	h 98)		2, 123, 092	518, 081	200.00
201.00 Less PBP Clinic Laboratory Services-Program on	y charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			2, 123, 092		202.00

Health Financial Systems IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	Composit		From 01/01/2018		
	component	CCN: 15-Z312	To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
	Title	XVIII 3	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
	-	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-1	1	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
ANCI LLARY SERVI CE COST CENTERS		0.44057	(50.00
50. 00 OS000 OPERATING ROOM		0. 41957		0	50.00
54.00 O5400 RADI OLOGY-DI AGNOSTI C		0. 20675			•
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 24422	-	0	55.00
56. 00 03630 ULTRA SOUND 57. 00 05700 CT SCAN		0. 12663 0. 17274			56.00 57.00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 17274			
60.00 06000 LABORATORY		0. 20951			60.00
66. 00 06600 PHYSI CAL THERAPY		0. 50541			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 55575			
68. 00 06800 SPEECH PATHOLOGY		0. 61920			•
69. 00 06900 ELECTROCARDI OLOGY		0. 18455		4, 377	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 40509		-	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21594		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 12741	-	-	
73. 01 07301 0NC0LOGY DRUGS		0. 49892		0	73.01
76. 00 03160 CARDI OPULMONARY		0. 26826		13, 150	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 33534	6 0	0	90.00
91. 00 09100 EMERGENCY		0. 22260	8 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 31216	9 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 00000	0 0	0	92.01
200.00 Total (sum of lines 50 through 94 and 96 through 98)			459, 086	159, 572	200.00
201.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			459, 086		202.00

Health Financial Systems IU HEALTH WHIT	E HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018		pared:
	Titl	e XIX	Hospi tal	Cost	· · · · ·
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			14, 608		30.00
ANCI LLARY SERVI CE COST CENTERS		1	-	1	
50. 00 05000 OPERATING ROOM		0. 4195		-	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2067			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 2442		0	55.00
56.00 03630 ULTRA SOUND		0. 1266		0	56.00
57.00 05700 CT SCAN		0. 1727			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 2095			1
60. 00 06000 LABORATORY		0. 3498			
66. 00 06600 PHYSI CAL THERAPY		0. 5054			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5557			
68.00 06800 SPEECH PATHOLOGY		0. 6192	532	329	
69. 00 06900 ELECTROCARDI OLOGY		0. 1845		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4050	96 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2159		-	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1274	19 2, 383	304	73.00
73.01 07301 ONCOLOGY DRUGS		0. 4989	21 0	0	73.01
76. 00 03160 CARDI OPULMONARY		0. 2682	67 213	57	76.00
OUTPATIENT SERVICE COST CENTERS				_	
90. 00 09000 CLINIC		0. 3353	46 0	0	90.00
91. 00 09100 EMERGENCY		0. 2226		1, 687	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3121	69 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000	0 00	0	92.01
200.00 Total (sum of lines 50 through 94 and 96 through 98)			23, 680	6, 496	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			23, 680		202.00

CALCUL	Financial Systems IU HEALTH WHITE HOSPI ATION OF REIMBURSEMENT SETTLEMENT Prov	ider CCN: 15-1312	Period: From 01/01/2018	u of Form CMS-2 Worksheet E Part B	
			To 12/31/2018	Date/Time Pre	
		Title XVIII	Hospi tal	5/28/2019 6:1 Cost	9 pili
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			8, 469, 145	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) OPPS payments			0	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)	`		0	4.0
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructions Line 2 times line 5	;)		0. 000 0	5.00 6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co Organ acquisitions	I. 13, line 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			8, 469, 145	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69))		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	,		0	14.00
15 00	Customary charges			0	15 00
15.00 16.00	Aggregate amount actually collected from patients liable for paymen Amounts that would have been realized from patients liable for paym			0	15.00 16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		a onargobaoro	Ū	101.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if	line 18 exceeds li	ne 11) (see	0	18.00 19.00
17.00	instructions)		110 11) (300	0	17.00
20. 00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			8, 553, 836	21 00
22.00	Interns and residents (see instructions)			0, 333, 030	22.00
23.00	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			59, 033	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instr	ructions)	5, 060, 241	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t	the sum of lines 22	2 and 23] (see	3, 434, 562	27.00
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29.00
30.00	Subtotal (sum of lines 27 through 29)			3, 434, 562	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			3, 434, 402	31.00 32.00
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0, 101, 102	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			677, 364 440, 287	34.00 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ons)		526, 516	
37.00	Subtotal (see instructions)	,		3, 874, 689	37.00
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	39.97
39. 98	Partial or full credits received from manufacturers for replaced de	vices (see instruc	ctions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 3, 874, 689	39.99 40.00
40. 00 40. 01	Sequestration adjustment (see instructions)			3, 874, 889 77, 494	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			3, 662, 330	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 134, 865	42.00 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	342, 726	
	§115. 2				
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. OC
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91. OC
	The rate used to calculate the Time Value of Money			0.00	92.00
92.00 93.00	Time Value of Money (see instructions)			0	93.00

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2018 To 12/31/2018		pareo 9 pm
		Title	XVIII	Hospi tal	Cost	<i>y</i> pm
		I npati en			't B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 511, 74	.9	3, 545, 130	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					0.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	08/08/2018	207,60		117, 200	3.
02				0	0	3.
03				0	0	3.
04				0	0	3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3
52				0	o	3
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		207,60	0	117, 200	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 719, 34	.9	3, 662, 330	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
~ -	Program to Provider					_
01 02	TENTATI VE TO PROVIDER			0	0	5 5
02 03				0	0	5
55	Provider to Program	I		0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5
~~	5. 50-5. 98)					,
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		165, 33	0	134, 865	6.
02	SETTLEMENT TO PROGRAM		100, 00	0	134,003	6
00	Total Medicare program liability (see instructions)		2, 884, 67	9	3, 797, 195	7
			,, .,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		C		1.00	2.00	

ANALYS	I Financial Systems I U HEALTH WHI SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-1312	Peri od:	eu of Form CMS- Worksheet E-1	
		Component (CCN: 15-Z312	From 01/01/2018 To 12/31/2018	3 Date/Time Pre	epared
		Title	XVIII	Swing Beds - SN	5/28/2019 6:1 F Cost	19 pm
		Inpatien			rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
I. 00	Total interim payments paid to provider		732, 5	28	C	1.0
2.00	Interim payments payable on individual bills, either			0	C	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
. 00	List separately each retroactive lump sum adjustment					3.0
	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)					-
. 01	Program to Provider ADJUSTMENTS TO PROVIDER	08/08/2018	73, 0	00	C	3.0
. 01	ADJUSTMENTS TO PROVIDER	08/08/2018	/3,0	0		
. 02				0		
. 04				0		
. 05				0	C	3. (
	Provider to Program				-	
50	ADJUSTMENTS TO PROGRAM			0	C	
51 52				0		
. 52				0		
. 54				0		
. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		73, 0	00	C	3.0
	3. 50-3. 98)					
. 00	Total interim payments (sum of lines 1, 2, and 3.99)		805, 5	28	C	4.0
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		I		1	
00	List separately each tentative settlement payment after					5.0
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	C	5.
. 02				0		
03				0	C	5.
	Provider to Program				1	
50	TENTATI VE TO PROGRAM			0	C	
51 52				0		
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0		
,,	5. 50-5. 98)			0		/ ^{3.}
00	Determined net settlement amount (balance due) based on					6.
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		97, 3		C	
02	SETTLEMENT TO PROGRAM		002.0	0	0	
00	Total Medicare program liability (see instructions)		902, 8	Contractor	NPR Date) 7.
				Number	(Mo/Day/Yr)	
)			

Heal th	Financial Systems IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018		
				5/28/2019 6:	
		Title XVIII	Hospi tal	Cost	
				1 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	1			-
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		. 14		1.00
2.00					2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			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				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of α line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(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 I	ine 31) (see instruction	IS)		32.00

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1312	Period:	Worksheet E-2	
		Component CCN: 15-Z312	From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Title XVIII	Swing Beds - SNF	5/28/2019 6:1 Cost	9 pn
			Part A	Part B	
			1.00	2.00	
(COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		762, 959	0	1 1
	Inpatient routine services - swing bed-NF (see instructions)				2
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	161, 168	0	3
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins	tructions)			
	Per diem cost for interns and residents not in approved teaching			0.00	4
	nstructions)				
	Program days		319	0	
	nterns and residents not in approved teaching program (see in			0	
	Jtilization review - physician compensation - SNF optional met	hod only	0	_	7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		924, 127	0	
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9)		924, 127	0	
	Deductibles billed to program patients (exclude amounts applic	able to physician	0	0	11
1.1	professional services) Subtotal (line 10 minus line 11)		924, 127	0	12
	Coinsurance billed to program patients (from provider records)	(aveluda coi nsuranca	2, 848	0	
	for physician professional services)	(exclude collisulance	2, 040	0	'`
	30% of Part B costs (line 12 x 80%)			0	14
	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	921, 279	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	- /	0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)			1
	Rural community hospital demonstration project (§410A Demonstr		0		16
	adjustment (see instructions)				
99	Demonstration payment adjustment amount before sequestration		0	0	10
00	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	1
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	0	0	
	Total (see instructions)		921, 279	0	
	Sequestration adjustment (see instructions)		18, 426	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Interim payments		805, 528	0	
	Tentative settlement (for contractor use only)	1 01)	0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, a		97, 325	0	
	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	37, 160	0	2:
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			1
	is this the first year of the current 5-year demonstration per				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				200
	Cost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201
	56 (title XVIII hospital)				
2. 00 1	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, line	e		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				20
	Medicare swing-bed SNF discharges (see instructions)				20
	computation of Demonstration Target Amount Limitation (N/A in	first year of the curren	nt 5-year demonst	ration	
	veri od)				1001
	Medicare swing-bed SNF target amount	mag Line 204)			205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 til adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				206
	Program reimbursement under the §410A Demonstration (see instr				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		207
	and 3)	, cor. r, sum or rrnes			200
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				1
- and	Total adjustment to Medicare swing-bed SNF PPS payment (line 2)	09 plus line 210) (see			21!

	Financial Systems IU HEALTH WHIT			u of Form CMS-2			
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2018 To 12/31/2018	Worksheet E-3 Part V Date/Time Pre 5/28/2019 6:1	pared:		
		Title XVIII	Hospi tal	Cost	, bii		
		·					
				1.00			
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	E PART A SERVICES - COST	REIMBURSEMENT				
1.00	Inpatient services	3, 234, 223					
2.00	Nursing and Allied Health Managed Care payment (see instruct		0				
3.00	Organ acquisition		0				
4.00	Subtotal (sum of lines 1 through 3)			3, 234, 223			
5.00	Primary payer payments		0				
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 266, 565	6.00		
	COMPUTATION OF LESSER OF COST OR CHARGES				-		
7 00	Reasonable charges			0	7		
7.00 8.00	Routine service charges Ancillary service charges			0	7.00		
9.00	Organ acquisition charges, net of revenue			0			
10.00	Total reasonable charges			0			
10.00	Customary charges			0	10.00		
11.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	1 11. 00		
12.00	Amounts that would have been realized from patients liable f			0			
	had such payment been made in accordance with 42 CFR 413.13(J	-			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13.00				
14.00	Total customary charges (see instructions)	0	14.00				
15.00	Excess of customary charges over reasonable cost (complete o	nly if line 14 exceeds li	ne 6) (see	0	15.00		
	instructions)						
16.00	Excess of reasonable cost over customary charges (complete o	nly if line 6 exceeds lir	e 14) (see	0	16.00		
47 00	instructions)				1		
17.00	Cost of physicians' services in a teaching hospital (see ins	structions)		0	17.00		
18.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E	(1 line 10)		0	18.00		
19.00	Cost of covered services (sum of lines 6, 17 and 18)	-4, 1111e 49)		3, 266, 565			
20.00	Deductibles (exclude professional component)			340, 264			
20.00	Excess reasonable cost (from line 16)			0,204			
22.00	Subtotal (line 19 minus line 20 and 21)			2, 926, 301			
23.00	Coi nsurance			3, 350			
24.00	Subtotal (line 22 minus line 23)			2, 922, 951	24.00		
25.00	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		31, 690	25.00		
26.00	Adjusted reimbursable bad debts (see instructions)			20, 599	26.00		
27.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		5, 397	27.00		
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 943, 550	28.00		
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0			
29.50	Pioneer ACO demonstration payment adjustment (see instructio	ins)		0	29.50		
29.99	Demonstration payment adjustment amount before sequestration			0			
30.00	Subtotal (see instructions)			2, 943, 550			
30.01	Sequestration adjustment (see instructions)			58, 871 0			
30.02							
31.00	Interim payments			2, 719, 349			
32.00	Tentative settlement (for contractor use only)	00 01 and 00)		0			
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.		abantan 1	165, 330			
34.00	Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	chapter I,	131, 354	34.00		

	ystems IU HEALTH WHI you are nonproprietary and do not maintain			Period:	u of Form CMS-2 Worksheet G	
nd-type account ly)	ng records, complete the General Fund column			From 01/01/2018 To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
		General Fund	Specific Purpose Fund	Endowment Fund		<u>9 p</u>
		1.00	2.00	3.00	4.00	
CURRENT ASS 00 Cash on har		25, 582, 113		0 0	0	, ,
00 Temporary i		20, 002, 113		0 0	0	
00 Notes recei				0 0	0	
00 Accounts re		2,065,307		0 0	0	
00 Other recei		0	1	0 0	0	
	for uncollectible notes and accounts receivable	0		0 0	0	
00 Inventory		256, 445		0 0	0	
00 Prepaid exp	benses	73, 630		0 0	0	
00 Other curre	ent assets	C		0 0	0	
00 Due from of		0		0 0	0	
	ent assets (sum of lines 1-10)	27, 977, 495		0 0	0	1
FI XED ASSET	\$	070.770	1			1
00 Land	(amonto	972, 779	1	0 0	0	
00 Land improv		122, 178		0 0 0 0	0	
00 Accumulated	l depreciation	-85, 007 30, 277, 094			0	
	l depreciation	-5, 809, 935		0 0	0	
	mprovements	0,007,730	1	0 0	0	
	depreciation			0 0	0	
00 Fixed equip	•			0 0	0	
	l depreciation	0		0 0	0	
	and trucks	C)	0 0	0	2
. 00 Accumul ated	I depreciation	0		0 0	0	22
.00 Major moval	ble equipment	10, 083, 124		0 0	0	2
	I depreciation	-5, 892, 655		0 0	0	
	ment depreciable	C		0 0	0	
	I depreciation	0		0 0	0	1 -
.00 HIT designa		0		0 0	0	
	l depreciation	0		0 0	0	1 -
	ment-nondepreciable			0 0 0 0	0	
00 Total fixed OTHER ASSET	lassets (sum of lines 12-29) s	29, 667, 578	1	0 0	0	30
00 Investments		169, 526		0 0	0	3.
00 Deposits or		0		0 0	0	
	iners/officers	0		0 0	0	
00 Other asset		c		0 0	0	
.00 Total other	assets (sum of lines 31-34)	169, 526		0 0	0	3!
.00 Total asset	s (sum of lines 11, 30, and 35)	57, 814, 599		0 0	0	30
CURRENT LIA	BILITIES					
00 Accounts pa		3, 135, 635		0 0	0	3
	ages, and fees payable	751, 130		0 0	0	1 -
00 Payroll tax		39, 235		0 0	0	
	oans payable (short term)	620, 000		0 0	0	
.00 Deferred in		0		0 0	0	
. 00 Accel erated						42
00 Due to othe		4, 816, 465		0 0 0 0	0	
	ent liabilities ent liabilities (sum of lines 37 thru 44)	9, 362, 465	1	0 0	0	
LONG TERM L	· · · · · · · · · · · · · · · · · · ·	7, 302, 403	1	- U	0	1 4
.00 Mortgage pa		0		0 0	0	40
00 Notes paya		20, 315, 000		0 0	0	
00 Unsecured I		0		0 0	0	
	term liabilities	30, 459		0 0	0	
0	term liabilities (sum of lines 46 thru 49)	20, 345, 459		0 0	0	
00 Total liabi	lities (sum of lines 45 and 50)	29, 707, 924		0 0	0	5
CAPI TAL ACC						
00 General fur		28, 106, 675				52
00 Specific pu	•			0		5
	ed - endowment fund balance - restricted			0		54
	ed - endowment fund balance - unrestricted			0		5!
U U	oody created - endowment fund balance			0		50
	balance - invested in plant				0	
	balance - reserve for plant improvement,				0	58
	;, and expansion balances (sum of lines 52 thru 58)	28, 106, 675			0	5
	lities and fund balances (sum of lines 51 and	57, 814, 599	1		0	
. Jo protur TIdU		37, 514, 377	I	- 0	0	1 0

Heal th	Financial Systems	IU HEALTH WHIT	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1312	Period: From 01/01/2018 To 12/31/2018	5/28/2019 6:1	9 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) NET INTERCOMPANY TRANSACTIONS Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ROUNDING Total deductions (sum of lines 12-17)	0 160, 236 0 0 0 0 0 0 3 0 0 0 0 0 0 0 0 0 0 0	338, 715 27, 946, 442 160, 236 28, 106, 678 3			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		28, 106, 675		0		19.00
		Endowment Fund	PI ant	Fund			
	1	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) NET INTERCOMPANY TRANSACTIONS	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) Deductions (debit adjustments) (specify) 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		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 WHIT IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1312	Peri		u of Form CMS- Worksheet G-2	
STATE			50. 10 1012		m 01/01/2018 12/31/2018	Parts I & II Date/Time Pre 5/28/2019 6:1	epared:
	Cost Center Description		I npati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						-
	General Inpatient Routine Services						-
1.00	Hospi tal		3, 972, 0	38		3, 972, 038	
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF		424, 3	27		424, 327	
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						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		4, 396, 3	65		4, 396, 365	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNI T						12.00
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	oflines		0		0	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and	16)	4, 396, 3	65		4, 396, 365	17.00
18.00	Ancillary services		4, 349, 9	19	43, 273, 379	47, 623, 298	18.00
19.00	Outpatient services		511, 5	20	28, 524, 815	29, 036, 335	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY				0	0	22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	PHYSI CI AN REVENUE			0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	9, 257, 8	04	71, 798, 194	81, 055, 998	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				28, 114, 927		29.00
30.00	ADD (SPECIFY)			0			30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECIFY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer			28, 114, 927		43.00
	to Wkst. G-3, line 4)			1			1

	Financial Systems	IU HEALTH WHITE H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provider CO	CN: 15-1312	Peri od:	Worksheet G-3	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
					10 12/01/2010	5/28/2019 6: 1	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Par					81, 055, 998	1.00
2.00	Less contractual allowances and discounts of	on patients' accounts	6			53, 888, 420	2.00
3.00	Net patient revenues (line 1 minus line 2)					27, 167, 578 28, 114, 927	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)						4.00
5.00	Net income from service to patients (line 3	3 minus line 4)				-947, 349	5.00
(00	OTHER I NCOME						1 00
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00
8.00	Revenues from telephone and other miscellar	0	8.00				
9.00	Revenue from tel evision and radio service	0	9.00				
10.00							10.00 11.00
11. 00 12. 00	Rebates and refunds of expenses Parking lot receipts					0	12.00
12.00	Revenue from Laundry and Linen service					0	12.00
13.00	Revenue from meals sold to employees and gu	lasts				0	
14.00	Revenue from rental of living quarters	JESTS				0	15.00
16.00	Revenue from sale of medical and surgical s	supplies to other the	an nationts			0	16.00
17.00	Revenue from sale of drugs to other than pa		an patrents			0	17.00
18.00	Revenue from sale of medical records and ab					0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms,					0	19.00
20.00	Revenue from gifts, flowers, coffee shops,					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					1, 286, 064	
25.00	Total other income (sum of lines 6-24)					1, 286, 064	
26.00	Total (line 5 plus line 25)					338, 715	
27.00	OTHER EXPENSES (SPECIFY)					000, 710	27.00
28.00	Total other expenses (sum of line 27 and su	ubscripts)				0	28.00
29.00	Net income (or loss) for the period (line 2					338, 715	