In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-0161 Worksheet S Peri od. From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: То 7/9/2021 10:08 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/9/2021 Time: 10:08 am Manually prepared cost report use only 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 0 Ē 4 [6. Date Received: 7. Contractor No. Contractor 10. NPR Date: 5.]Cost Report Status [

 (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 Contractor's Vendor Code:
 4

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

 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH NORTH HOSPITAL (15-0161) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) CARA BREIDSTER Officer or Administrator of Provider(s) CF0 Title (Dated when report is electronically signed.) Date

			Title XVIII				
	Cost Center Description		Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III – SETTLEMENT SUMMARY						
1.00	Hospi tal	0	29, 018	-48, 692	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	29, 018	-48, 692	0	0	200.00

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

PLL	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION D	AIA	Provi d	er ccn:	15-0161	Period: From 01/0	1/2020	Workshee Part I	et S-2	
							To 12/3	1/2020	Date/Tin		
	1.00	2	. 00		3.00			4.00	7/9/2021	1 10:0	8 am
	Hospital and Hospital Health Care Cor										
	Street: 11700 NORTH MERIDIAN ST	P0 Box:									1.
)	City: CARMEL	State: Component N		CCN	e: 46032 CBSA		nty: HAMILT(er Date		ent Syste	m (P	2.
		component m		Number	Numbe		Certifie		, 0, or 1		
	_							V	XVIII		1
	Uponital and Uponital Decod Component	1.00		2.00	3.00	4.00	5.00	6.00	0 7.00	8.00	
	Hospital and Hospital-Based Componen Hospital	U HEALTH NORTH		150161	26900) 1	12/20/200	05 N	Р	P	3.
	•	HOSPI TAL			20700		12, 20, 20,			•	
	Subprovider - IPF										4.
	Subprovider - IRF Subprovider - (Other)										5.
	Swing Beds - SNF										7.
	Swing Beds - NF										8.
	Hospital-Based SNF Hospital-Based NF										9. 10.
	Hospital-Based OLTC										10.
	Hospital-Based HHA										12.
	Separately Certified ASC										13. 14.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.
00	Hospital-Based Health Clinic - FQHC										16.
	Hospital-Based (CMHC) I										17
	Renal Dialysis Other										18 19
							Fro	m:	To:		
20							1. (2.00		00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/		12/31/2	2020	20.
						1.00	2. (00	3.00)	
	Inpatient PPS Information Does this facility qualify and is it	currently recei	ving navme	ents for	-	Y	N				22.
	di sproporti onate share hospi tal adjus										
	§412.106? In column 1, enter "Y" for										
	facility subject to 42 CFR Section §4 hospital?) In column 2, enter "Y" for			ament							
01	Did this hospital receive interim und	compensated care	payments			Y	Y				22.
	cost reporting period? Enter in colum										
	the portion of the cost reporting per Enter in column 2, "Y" for yes or "N"										
	reporting period occurring on or after										
	Is this a newly merged hospital that					Ν	N				22.
	payments to be determined at cost rep Enter in column 1, "Y" for yes or "N'				ns)						
	cost reporting period prior to Octobe				yes						
	or "N" for no, for the portion of the	e cost reporting	period or	n or aft	ter						
	October 1. Did this hospital receive a geographi	c reclassificat	ion from 1	irban to		Ν	N		N		22.
	rural as a result of the OMB standard										22.
	adopted by CMS in FY2015? Enter in co	olumn 1, "Y" for	yes or "N	N" for r	סר						
	for the portion of the cost reporting in column 2, "Y" for yes or "N" for r				er						
	reporting period occurring on or after										
	Does this hospital contain at least										
	counted in accordance with 42 CFR 412 yes or "N" for no.	2.105)? Enter In	COLUMN 3,	Y TO	or						
	Which method is used to determine Med	dicaid days on l	ines 24 ar	nd/or 25	5		3 N				23.
	below? In column 1, enter 1 if date of										
	if date of discharge. Is the method or reporting period different from the m				cost						
	reporting period? In column 2, enter										
			In-State			Out-of	Out-of	Medi ca		her	
			Medicaid paid days			State Medicaid	State Medicaid	HMO da	5	caid iys	
						aid days	eligible			.93	
				day	/s		unpai d				
20	If this provider is an LDDC baseling	optor the	1.00	2.0		3.00	4.00	5.00		00	24
JU	If this provider is an IPPS hospital, in-state Medicaid paid days in columr		1, 32	.0	1, 403	125	21	4,	227	22	24.
	Medicaid eligible unpaid days in colu	umn 2,									
	out-of-state Medicaid paid days in co										
	aut of ototo Madiation dell's della						I		1		
	out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but	t unpaid davs in									

DSPI T	Financial Systems IU HEAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D/	<u>TH NORTH H</u>	Provider CC	CN: 15-0161	Perio	od:		Worksh	rm CMS-2 eet S-2	
					To		1/2020		ime Pre 21 10:0	
		In-State Medicaid	In-State Medicaid	Out-of State	Out- Sta	-	Medicai HMO dav)ther di cai d	
		pai d days	eligible	Medi cai d	Medi c	ai d	nino daj	/ I	days	
			unpai d days	paid days	el i gi unpa					
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.0	0	5.00	0	6.00	25.
. 00	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.									
					Ur	<u>001/ גו</u> 1. 0	ural S O		00	
. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		s at the be	ginning of	the		1			26.
. 00	Enter your standard geographic classification (not w	age) status			st		1			27.
. 00	reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th	ication in	column 2.		n		0			35.
	effect in the cost reporting period.				E	Begi nn	i ng:	Endi	ng:	
. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	script line	e 36 for num	ber	1.0	0	2.	00	36.
	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente	es.	•				0			37
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t						Ĭ			37
	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions)	or yes or '	N" for no.	(see						
00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.									38
						Y/I 1. 0			/N 00	-
. 00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio), (ii), or the mileage ii)? Enter	r (iii)? En e requireme in column	ter in colu ents in 2 "Y" for y	ımn ves	N			N	39. 40.
	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1			yes or "N"	for			XVIII	XIX	
							1.00		3.00	
. 00	Prospective Payment System (PPS)–Capital Does this facility qualify and receive Capital payme	nt for dism	proportiona	ite share in	accor	dance	N	Y	N	45
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks	eption for	extraordi n	ary circums	tances		N	N	N	46
. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	capital? F	nter "Y fo	r ves or "N	l" for	no	N	N	N	47
00	Is the facility electing full federal capital paymen Teaching Hospitals			2			N	N	N	48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you GME payment reduction? Enter "Y" for yes or "N" for	impacted by	/ CR 11642	ns? Enter "Y (or subsequ	" for went CR	yes o), MA	r N			56
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. I If line 56 is yes, did this facility elect cost reim	ryes or "N th of this Y", complet I, if appli	W for no i cost repor e Workshee cable.	n column 1. ting period t E-4. lf c	If co I? Ent column	lumn er "Y				57
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	Vkst. D-5.		45					
. 00	Are costs claimed on line 100 of Worksheet A? If ye	<u>s, complete</u>	e Wkst. D-2	2, Pt. I. NAHE 413. Y/N	85 W	orkshe Li ne	eet A	Qualifi Crite	hrough cation erion	59
				1.00		2.0	00		de 00	-
). 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413 instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	.85? (see Lumn 1. If CR) NAHE MA	°column 1	N						60.

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ΛTΑ	Provider C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/9/2021 10:0	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)				0.00	0.00	61.00
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61. 0 [.]
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
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 61.04 minus line 61.03). (see instructions)						61.0
1.06 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)			Descurre Carlo			61.00
	PI	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
1.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.1
 special ty, 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. o) Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. 				0.00		61. 2
					1.00	-
ACA Provisions Affecting the Health Resources and Sel 2.00 Enter the number of FTE residents that your hospital				cied for which	0.00	62.0
2.00 Enter the humber of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teach gram. (ing Health Cer see instructio	nter (THC) into			62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c	67. (see instr	ructions)	N	63.0
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Soction EEOA of the ACA Deep Year FTF Decidents in N	opprovi	don Sotting-	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	•	0	-mis base yea	i is your cost	reporting	
4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor 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	ty trai n-prima all no d non-p n colum	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.0

AND HOUT THE HEALTH CARE COMPL	EX IDENTIFICATION D	ATA Provider C		eriod: com 01/01/2020	Worksheet S-2 Part I	
			To			epare
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
	-		FTES	FTEs in	3/ (col. 3 +	
			Nonprovider Site	Hospi tal	col. 4))	
-	1.00	2.00	3.00	4.00	5.00	-
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.
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)						
			Unwei ghted	Unweighted	Ratio (col.	
			FTES	FTEs in	1/ (col . 1 +	
			Nonprovider Site	Hospi tal	col. 2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Current		n Nonprovider Settin	igsEffective f	or cost report	ing periods	
beginning on or after July 1, 20	10					
			0.00		0.00000	
00 Enter in column 1 the number of u	unweighted non-prima		0.00	0.00	0. 000000	66.
	unweighted non-prima ccurring in all nonp	provider settings.	0.00	0.00	0. 000000	66.
00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00	0.00	0. 000000	66.
00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)				66.
00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. ary care resident 3 the ratio of	0.00 Unwei ghted FTEs	0.00 Unweighted FTEs in	0.000000 Ratio (col. 3/ (col. 3 +	
20 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unwei ghted	Ratio (col.	
20 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
20 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
20 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
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00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (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.	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 20 Enter in column 1 the number of the FTEs attributable to rotations of the Enter in column 2 the number of the FTEs that trained in your hospita (column 1 divided by (column 1 + 20 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 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 20 Enter in column 1 the number of the FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospitat (column 1 divided by (column 1 + 20 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 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 20 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 20 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 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
 20 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 20 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 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
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DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	ovider CCN: 15-0161	Period: From 01/01/202 To 12/31/202	0 Part I 0 Date/Ti	et S-2 me Prepar <u>1 10:08</u> a	
5.00 If line 75 is yes: Column 1: Did the facility have an approved GM recent cost reporting period ending on or before November 15, 200 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Colu indicate which program year began during this cost reporting period.)4? Enter "Y" for yes y program in accordan umn 3: If column 2 is	n the most or "N" for ce with 42 Y,	00 2.00		76. 0
Long Term Care Hospital PPS			1.0	0	
 D. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and I. 00 Is this a LTCH co-located within another hospital for part or all "Y" for yes and "N" for no. 		ng period? Ente	er N		80. 0 81. 0
 TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFR 6.00 Did this facility establish a new Other subprovider (excluded uni §413.40(f)(1)(i)? Enter "Y" for yes and "N" for no. 	5		D. N		85.0 86.0
7.00 Is this hospital an extended neoplastic disease care hospital cla 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under sectio		N	8	87.0
		V 1.00	2. 0		
Title V and XIX Services		1.00	2.0	0	
D. 00 Does this facility have title V and/or XIX inpatient hospital ser yes or "N" for no in the applicable column.			Y		90.0
1.00 Is this hospital reimbursed for title V and/or XIX through the confull or in part? Enter "Y" for yes or "N" for no in the applicable 2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certain the second secon	e column.	N	N		91. (92. (
instructions) Enter "Y" for yes or "N" for no in the applicable of 0.00 Does this facility operate an ICF/IID facility for purposes of ti	column.	N	N		92. 93.
"Y" for yes or "N" for no in the applicable column. .00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "	N" for no in the	N	N	9	94.
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the applicable. 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or " applicable column.		0. 00 N	0. 0 N		95. 96.
.00 If line 96 is "Y", enter the reduction percentage in the applicate .00 Does title V or XIX follow Medicare (title XVIII) for the interns stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for ye	and residents post	0. 00 N	0. 0 Y		97.(98.(
 column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the reporti C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V title XIX. 			Y	9	98.
 title XIX. Does title V or XIX follow Medicare (title XVIII) for the calcula bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for title VIX. 		Ν	Y	9	98.
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title VVIX	access hospital (CAH "N" for no in column) N	N	9	98.
For title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimboutpatient services cost? Enter "Y" for yes or "N" for no in column 2 for title XIX.		d N	N	9	98.
 O5 Does title V or XIX follow Medicare (title XVIII) and add back th Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column column 2 for title XIX. 			Y	9	98.
. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimb Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for column 2 for title XIX. Rural Providers		N	Y	9	98.
15.00 Does this hospital qualify as a CAH? 16.00 If this facility qualifies as a CAH, has it elected the all-inclu	isive method of payme	nt N			05. 06.
for outpatient services? (see instructions) 7.00 Column 1: If line 105 is Y, is this facility eligible for cost retraining programs? Enter "Y" for yes or "N" for no in column 1. Column 2: If column 1 is Y and line 70 or line 75 is Y, do you tapproved medical education program in the CAH's excluded IPF and Enter "Y" for yes or "N" for no in column 2. (see instructions)	(see instructions) rain I&Rs in an	N		10	07.
08.00 ls this a rural hospital qualifying for an exception to the CRNA	fee schedul e? See 4	2 N		10	08.

	Provi der (eriod: rom 01/01/2020	Worksheet S- D Part I	-2
			o 12/31/2020		repared
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3.00	4.00	100.0
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. C
				1.00	_
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	or "N" for no. I	f yes,	N	110. C
			1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ac for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N		111. C
		1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceal participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112. C
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.0
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes				
6.001s this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
7.00 Is this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.	rance? Enter	N			117.(
8.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		-			118. (
In the portey is crann-made. Enter 2 in the portey is decar	ence.	Premi ums	Losses	Insurance	
					_
		1.00	2.00	3.00	
8.01 List amounts of malpractice premiums and paid losses:		1. 00 370, 65		3.00 0	0118.
8.01 List amounts of malpractice premiums and paid losses:				0	0118.
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schec and amounts contained therein.		370, 65 ⁻			118.
 8. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schec and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Holc §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment 	dule listing d Harmless pr n column 1, " ualifies for	370,65 than the cost centers rovision in ACA Y" for yes or the Outpatient	1.00	0	
 3. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schee and amounts contained therein. 3. 00D0 NOT USE THIS LINE 3. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment for no. 1. 00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic	370,65 than the cost centers rovision in ACA Y" for yes or the Outpatient tructions) res charged to	1.00 N N	0 2.00 N	118. 119. 120. 121.
 3. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. 3. 00 D0 NOT USE THIS LINE 3. 00 D0 NOT USE THIS LINE 3. 00 D1 USE THIS LINE 3. 00 D1 USE THIS LINE 4. 00 D1 USE THIS LINE 5. 00 Lis this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the outpatient of the Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost implatients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190	370,65 than the cost centers vovision in ACA Y" for yes or the Outpatient tructions) tes charged to (3(w) (3) of the	1.00 N	0 2.00	118. 119. 120. 121.
 3. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheer and amounts contained therein. 7. 00 D0 NOT USE THIS LINE 9. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00 Does this facility operate a transplant center? Enter "Y" for 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent	370,65 than the cost centers vision in ACA Y" for yes or the Outpatient tructions) es charged to (3(w)(3) of the er in column 2	1.00 N N	0 2.00 N	118. 119. 120.
 8. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schece and amounts contained therein. 9. 00D NOT USE THIS LINE 9. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert	370,65 than the cost centers rovision in ACA Y" for yes or the Outpatient the Outpatient tructions) res charged to 3(w)(3) of the er in column 2 " for no. If	1.00 N N Y Y	0 2.00 N	118. 119. 120. 121. 122. 125.
 3. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schee and amounts contained therein. 7. 00 D0 NOT USE THIS LINE 9. 00 D1 sthis a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? 1. 00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent 	370,65 than the cost centers rovision in ACA Y" for yes or the Outpatient tructions) res charged to 13(w) (3) of the er in column 2 " for no. If ification date	1.00 N N Y Y	0 2.00 N	118. 119. 120. 121. 122. 125. 126.
 3. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheer and amounts contained therein. 2. 00D0 NOT USE THIS LINE 3. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 1. 00Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2. 00Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 5. 00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2. 6. 00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2. 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2. ter the certi	370,65 than the cost centers vision in ACA Y" for yes or the Outpatient tructions) res charged to (w) (3) of the er in column 2 "for no. If ification date fication date	1.00 N N Y Y	0 2.00 N	118. 119. 120. 121. 122.
 3. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the certi 2.	370,65 than the cost centers vision in ACA Y" for yes or the Outpatient tructions) the cost centers ovision in ACA Y" for yes or the Outpatient tructions) the cost centers tructions) the cost centers tructions the cost centers tructions the cost centers the cost centers the cost centers the outpatient tructions) the cost centers the cost centers th	1.00 N N Y Y	0 2.00 N	118. 119. 120. 121. 122. 125. 125. 126. 127. 128.
 8. 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schece and amounts contained therein. 9. 00 D0 NOT USE THIS LINE 0. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 1. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6. 00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 8. 00 If this is a Medicare certified liver transplant center, ent 	dule listing d Harmless pr n column 1, " ualifies for nts? (see ins antable devic fined in §190 1 is "Y", ent or yes and "N nter the cert 2. ter the cert 2. ter the cert 2. er the cert 5.	370,65 than the cost centers the outpatient tructions) the Outpatient tructions) the column 2 (w) (3) of the er in column 2 (i for no. If i fication date fication date i cation date ir	1.00 N N Y Y	0 2.00 N	118. 119. 120. 121. 122. 125. 126. 127.

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLI		A Provider	CCN: 15-0161	Peri od:	u of Form CMS Worksheet S-	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pr 7/9/2021 10:	
				1.00		_
32.00 If this is a Medicare certified i in column 1 and termination date,			ification date	1.00	2.00	132.00
33.00 Removed and reserved 34.00 If this is an organ procurement o and termination date, if applicab	rganization (OPO), er		er in column 1			133.00 134.00
All Providers 40.00 Are there any related organizatio chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column	1. If yes, and ho	ome office cost	rs Y	15H059	140.00
1.00		2.00		3.00		
If this facility is part of a cha				name and address	of the home	
office and enter the home office 41.00 Name: IU HEALTH, INC	Contractor name and Contractor's Na			tor's Number: 0810	1	141.00
41. OONAME: TO HEALTH, TNC 42. OOStreet: 340 W. 10TH STREET	PO Box:	lille: WPS	Contrac		1	141.0
43. 00 City: INDIANAPOLIS	State:	IN	Zip Code	e: 4620	2	143.0
	1					
					1.00	
44.00 Are provider based physicians' co	sts included in Works	sheet A?			Y	144.00
				1.00	2.00	_
45.00 f costs for renal services are c	laimed on Wkst A li	ne 74 are the co	sts for	1.00	2.00	145.00
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for clude Medicare utiliz for no in column 2.	no in column 1. I zation for this co	f column 1 is ost reporting			
46.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS	Pub. 15-2, chapte		f N		146.0
					1.00	_
47.00 Was there a change in the statist	ical basis? Enter "Y	' for yes or "N" f	°or no.		N	147.00
48.00 Was there a change in the order o					N	148.00
49.00 Was there a change to the simplif	ied cost finding meth				N	149.00
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies t					
or charges? Enter "Y" for yes or						
55. 00 Hospi tal		N	N	N	N	155.0
56.00 Subprovi der – IPF		N	N	N	N	156.0
57.00 Subprovider - IRF		N	N	N	N	157.0
58. 00 SUBPROVI DER 59. 00 SNF		N	N	N	N	158.0 159.0
60.00HOME HEALTH AGENCY		N	N N	N	N	160.0
61. OOCMHC		IN IN	N N	N	N	161.0
						_
Multicampus					1.00	
65.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that h	nas one or more ca	ampuses in diff	erent CBSAs?	N	165.0
	Name	County		p Code CBSA	FTE/Campus	
	0	1.00	2.00	3.00 4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.0	00 166. 0
		I			1.00	_
Health Information Technology (HI	T) incentive in the	American Recovery	and Reinvestm	ent Act	1.00	
67.001s this provider a meaningful use 68.001f this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Er 05 is "Y") and is a m	nter "Y" for yes o meaningful user (I	or "N" for no.		Y	167.00 168.00
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user ? Enter "Y" for yes o	r, does this provi or "N" for no. (se	e instructions	5)		168.0
69.00 If this provider is a meaningful transition factor. (see instructi		janu is not a CA	ui (iine ius is	s wy, enter the	9.0	99169.0

Health Financial Systems	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0161					
			From 01/01/2020 To 12/31/2020		narod	
			10 12/31/2020	Date/Time Pre 7/9/2021 10:0		
			Begi nni ng	Endi ng		
			1.00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)			170.00			
			1.00	2.00]	
171.00 If line 167 is "Y", does this provider	have any days for indi	viduals enrolled in	Y	897	171.00	
section 1876 Medicare cost plans report						
"Y" for yes and "N" for no in column 1.	n					
1876 Medicare days in column 2. (see ir	nstructions)					

	Financial Systems IU HEALTH NOR TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		F	Period: From 01/01/202	eu of Form CMS- Worksheet S-: 0 Part II 0 Date/Time Pro	2
					7/9/2021 10:0	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter M	for all NO r	esnonses Ente	1.00	2.00	-
	mm/dd/yyyy format.		coponoco. Ente			
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation				1	
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in o	column 2. (see	Y/N	Date	V/I	-
			1.00	2.00	3.00	+
2.00	Has the provider terminated participation in the Medicare I	Program? If	N N	2.00	0.00	2.0
	yes, enter in column 2 the date of termination and in colu					
	voluntary or "I" for involuntary.					
8.00	Is the provider involved in business transactions, includin		Y			3.0
	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	_
I. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Dublic	Y	Α		
i. UU	Accountant? Column 2: If yes, enter "A" for Audited, "C" a		ř	A		4.0
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
5.00	Are the cost report total expenses and total revenues diffe		N			5.0
	those on the filed financial statements? If yes, submit rea	conciliation.		N/ (N)		
				Y/N 1.00	Legal Oper.	_
	Approved Educational Activities			1.00	2.00	
o. 00	Column 1: Are costs claimed for nursing school? Column 2:	lf ves, is t	he provider is	N		6.
	the legal operator of the program?	J				
. 00	Are costs claimed for Allied Health Programs? If "Y" see in			Ν		7.0
8.00	Were nursing school and/or allied health programs approved	and/or renewe	d during the	N		8.0
00	cost reporting period? If yes, see instructions.	araduata madi	ool oduootion	N		
9.00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. (
0.00	Was an approved Intern and Resident GME program initiated of		the current	Ν		10.0
	cost reporting period? If yes, see instructions.					
1.00	Are GME cost directly assigned to cost centers other than	l & R in an Ap	proved	Ν		11.0
	Teaching Program on Worksheet A? If yes, see instructions.		-		>/ (b)	_
					Y/N 1.00	
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes	s, see instruc	tions.		Y	12.
	If line 12 is yes, did the provider's bad debt collection			st reporting	N	13.
	period? If yes, submit copy.		-			
4.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I	fyes, see ins	tructions.	N	14.
E 00	Bed Complement	ng pariod2 lf	Noc coo inct	ructions	N	15
5.00	Did total beds available change from the prior cost report		<u>yes, see mst</u> rt A		N Nart B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data				1	
6.00	Was the cost report prepared using the PS&R Report only?	N		N		16.
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see instructions)					
7.00	Was the cost report prepared using the PS&R Report for	Y	04/02/2021	Y	04/02/2021	17.
	totals and the provider's records for allocation? If		0 17 027 2021		017 027 2021	
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
8.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
						1
9 00	cost report? If yes, see instructions.	N		Ν		10
9. 00		Ν		Ν		19.

Heal th	Financial Systems IU HEALTH NOF	RTH_HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2020 Fo 12/31/2020	Date/Time Pr	epared:
	· · · · · · · · · · · · · · · · · · ·	Doscr	iption	Y/N	7/9/2021 10: Y/N	<u>08 am</u>
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		0	N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHI LDRENS	HOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			ng the cost	N N	22.00 23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	orting period?	Y	24.00
25.00	Have there been new capitalized leases entered into during instructions.	lfyes, see	Ν	25.00		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during th copy.	yes, submit	Ν	27.00		
28.00	Interest Expense Were new Loans, mortgage agreements or letters of credit e	entered into du	ring the cost	reporti ng	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service Re	serve Fund)	Ν	29.00
30.00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	see	Ν	30.00		
31.00	instructions. Has debt been recalled before scheduled maturity without i instructions.	see	Ν	31.00		
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	ive bidding? If	N	33.00
	Provi der-Based Physi ci ans				•.	
	Are services furnished at the provider facility under an a If yes, see instructions.	0	•		Ν	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the p		N	35.00
				Y/N 1.00	Date 2.00	
24 00	Home Office Costs			V		24 00
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?	Y Y		36.00 37.00
38.00	If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			Ν		38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lfyes, see	Ν		40.00
		2.	00			
	Cost Report Preparer Contact Information		_			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA		UTTER		41.00
42.00	respectively. Enter the employer/company name of the cost report preparer.	I NDI ANA UNI VEF	RSITY HEALTH			42.00
	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	H. ORG	43.00			

Health Financial Systems IU HE	ALTH NOR	TH HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN.	NAI RE	Provi der		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
					7/9/2021 10:0	8 am
			3.00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the title/posit	tion	DI RECTOR OF	GOVERNMENT			41.00
held by the cost report preparer in columns 1, 2, a	and 3,	PROGRAMS				
respecti vel y.						
42.00 Enter the employer/company name of the cost report						42.00
preparer.						
43.00 Enter the telephone number and email address of the	e cost					43.00
report preparer in columns 1 and 2, respectively.						

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	CAL DATA	Provider C	CN: 15-0161	Period: From 01/01/2020 To 12/31/2020		pared:
	Component	Worksheet A	No. of Dodo	Red Dava	CAH Hours	I/P Days / O/P Visits / Trips Title V	
	Component	Line Number	No. of Beds	Bed Days Available	CAH HOUTS	n tie v	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00	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)	30.00	120	43, 92	20 0. 00	0	2.0
3.00 4.00 5.00 5.00 7.00	HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		120	43, 92	20 0.00	0	3.0 4.0 5.0 6.0 7.0
. 00 8. 00 9. 00 0. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT		120	43, 92	0.00		8. C 9. C 10. C
1.00 1.01 1.02	SURGICAL INTENSIVE CARE UNIT PEDIATRIC INTENSIVE CARE UNIT PREMATURE INTENSIVE CARE UNIT	34.00 34.01 34.02	0 6 23	2, 19		0	11. (
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00 3.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	43.00	149	54, 53	34 0.00	0 0 0	14.0
4.00 4.10 5.00 6.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	30. 00					24. (24. 25. (26. (
6. 25 7. 00 8. 00 9. 00 0. 00 1. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	89.00	149			0	27. (28. (29. (30. (31. (
2.00 2.01 3.00 3.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges		12	4, 39			32. (32. (33. (33. (

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2020 To 12/31/2020	Worksheet S-3 Part I Date/Time Pre 7/9/2021 10:0	epare
	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
-	6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10. 00	-
Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	7, 399	1, 177	22, 98		10.00	1.
00 HMO and other (see instructions) 00 HMO IPF Subprovider	3, 682 0	5, 163 0				2. 3.
00 HMO IRF Subprovider 00 Hospital Adults & Peds. Swing Bed SNF 00 Hospital Adults & Peds. Swing Bed NF	0 0	0 0 0		0		4. 5. 6.
 Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT 	7, 399	1, 177	22, 98			7. 8.
CORONARY CARE UNI T OO BURN INTENSI VE CARE UNI T OO SURGI CAL INTENSI VE CARE UNI T	0	0		0		9. 10. 11.
.01 PEDI ATRI C I NTENSI VE CARE UNI T .02 PREMATURE I NTENSI VE CARE UNI T .00 OTHER SPECI AL CARE (SPECI FY)	69 0	26 0	55 4, 52	1		11 11 12
.00 NURSERY .00 Total (see instructions) .00 CAH visits	7, 468 0	735 1, 938 0	3, 78 31, 84		924.14	13 14 15
00SUBPROVIDER - IPF00SUBPROVIDER - IRF00SUBPROVIDER						16 17 18
.00 SKILLED NURSING FACILITY .00 NURSING FACILITY .00 OTHER LONG TERM CARE .01 UPUEL LONG TERM CARE						19 20 21
.00 HOME HEALTH AGENCY .00 AMBULATORY SURGICAL CENTER (D. P.) .00 HOSPICE .00 HOSPICE						22 23 24
.10 HOSPICE (non-distinct part) .00 CMHC - CMHC .00 RURAL HEALTH CLINIC			12			24 25 26
 25 FEDERALLY QUALIFIED HEALTH CENTER 00 Total (sum of lines 14-26) 00 Observation Bed Days 	0	0 28	1, 76	0 0.00 0.00 5		27 28
 .00 Ambulance Trips .00 Employee discount days (see instruction) .00 Employee discount days - IRF 	0			0		29 30 31
 .00 Labor & delivery days (see instructions) .01 Total ancillary labor & delivery room outpatient days (see instructions) 	O	22	1, 58	9 0		32 32
.00 LTCH non-covered days .01 LTCH site neutral days and discharges	0					33

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IU HEALTH NORTI	Provi der C	CN: 15-0161	Peri od:	u of Form CMS-2 Worksheet S-3	
1100111					From 01/01/2020	Part I	
					To 12/31/2020	Date/Time Pre 7/9/2021 10:0	
		Full Time		Di s	charges		
	Company	Equi val ents	T: +1 - \/		T: +1 - VI V		
	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	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	0			8, 841	1.00
	8 exclude Swing Bed, Observation Bed and					-,	
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			7	56 770		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
8.00	beds) (see instructions) INTENSIVE CARE UNIT						8.00
8.00 9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
11.00	PEDIATRIC INTENSIVE CARE UNIT						11.00
11.02	PREMATURE INTENSIVE CARE UNIT						11.02
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	1, 6	46 89	8, 841	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER – I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.00 24.00
24.00	HOSPICE HOSPICE (non-distinct part)						24.00
24.10	CMHC - CMHC						24.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0,00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.00
33.01	LTCH site neutral days and discharges				0		33.01

	Financial Systems AL WAGE INDEX INFORMATION		IU HEALTH NOR	Provider C		eriod:	u of Form CMS-2 Worksheet S-3	
					F	rom 01/01/2020 o 12/31/2020	Part II Date/Time Pre	epar
		What A Line	Amount	Deal agai fi aat			7/9/2021 10:0	8 8
		Wkst. A Line Number	Amount Reported	Reclassificat ion of	Sal ari es	Paid Hours Related to	Average Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II – WAGE DATA SALARIES							+
00	Total salaries (see	200.00	62, 866, 334	-253, 501	62, 612, 833	1, 922, 214. 27	32. 57	1
00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0.00	
	A			-				
00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	
0	Physician-Part A -		0	0	0	0.00	0.00	
)1	Administrative Physicians - Part A - Teaching		0	0	0	0.00	0.00	
00	Physician and Non		60, 237					
00	Physician-Part B Non-physician-Part B for		0	0	0	0.00	0.00	
0	hospital -based RHC and FQHC		0			0.00	0.00	1
00	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	
	approved program)	21.00		-	-	0.00		
01	Contracted interns and residents (in an approved		0	0	0	0.00	0.00	
	programs)							
00	Home office and/or related organization personnel		0	0	0	0.00	0.00	
00	SNF	44.00	0	0	0	0.00	0.00	, ,
00	Excluded area salaries (see		785, 664	221, 178	1, 006, 842	30, 135. 85	33. 41	1
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		189, 837	0	189, 837	1, 875. 50	101.22	1
00	Care Contract Labor: Top Level		0	0	0	0.00	0.00	1:
	management and other							
	management and administrative services							
00	Contract Labor: Physician-Part		1, 308, 145	0	1, 308, 145	3, 722. 68	351.40	1
00	A - Administrative Home office and/or related		0	0	0	0.00	0.00	1
	organization salaries and							
01	wage-related costs Home office salaries		18, 794, 637	0	18, 794, 637	484, 618. 72	38.78	1
02	Related organization salaries		0	0	0	0.00	0.00	14
00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	1!
00	Home office and Contract		0	0	0	0.00	0.00	10
01	Physicians Part A - Teaching Home office Physicians Part A		0	0	0	0.00	0.00	1.
01	- Teaching		0			0.00	0.00	1
02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	10
	WAGE-RELATED COSTS			1	1			
00	Wage-related costs (core) (see instructions)		17, 849, 122	0	17, 849, 122			1
00	Wage-related costs (other)							1
00	(see instructions) Excluded areas		262, 528	0	262 520			1
	Non-physician anesthetist Part		202, 328	0	262, 528 0			20
00	A Non-physician anesthetist Part		<u>_</u>	_	_			2
00	B		0	0	0			1
00	Physician Part A - Administrative		0	0	0			2
01	Physician Part A - Teaching		0	о	о			2
	Physician Part B		14, 118	0	14, 118			2
	Wage-related costs (RHC/FQHC) Interns & residents (in an		0 0	0 0	0 0			2
	approved program)		~					
50	Home office wage-related (core)		5, 771, 635	0	5, 771, 635			2
51	Related organization		0	0	0			2
52	wage-related (core) Home office: Physician Part A		0	_	_			2!
J2	- Administrative -		0					1 25

	Financial Systems		IU HEALTH NOR				u of Form CMS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.		(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00	1, 013, 940					
27.00	Administrative & General	5.00	4, 018, 986					
28.00	Administrative & General under		300, 034	0	300, 03	4 1, 898. 21	158.06	28.00
~~ ~~	contract (see inst.)	(0 404 005	7				
29.00	Maintenance & Repairs	6.00	2, 136, 225					29.00
30.00	Operation of Plant	7.00	1,043,073					
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		
32.00	Housekeeping	9.00	1, 423, 253	-7,495	1, 415, 75		16. 18	
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00		
34.00	Dietary	10.00	840, 595	0	840, 59			
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	1, 163, 236	-4, 887	1, 158, 34	9 62, 317. 35	18. 59	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 973, 750	-17, 314	2, 956, 43	6 71, 618. 90	41.28	38.00
39.00	Central Services and Supply	14.00	922, 925	0	922, 92	45, 822. 37	20. 14	39.00
40.00	Pharmacy	15.00	3, 125, 593	-9, 157	3, 116, 43	6 57, 636. 87	54.07	40.00
41.00	Medi cal Records & Medi cal Records Library	16.00	0	0		0 0.00	0.00	41.00
42.00	Social Service	17.00	391, 926	0	391, 92	6 10, 970. 07	35. 73	42.00
43.00	Other General Service	18.00	219, 755					

Heal th	Financial Systems		IU HEALTH NOR	TH HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI 1	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2020	Worksheet S-3 Part III		
						To 12/31/2020		pared: 8 am	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average		
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage		
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷		
				(from	3)	col. 4	col. 5)		
				Worksheet					
				A-6)					
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY							
1.00	Net salaries (see		63, 106, 131	-253, 501	62, 852, 63	0 1, 922, 832. 48	32.69	1.00	
	instructions)								
2.00	Excluded area salaries (see		785, 664	221, 178	1, 006, 84	2 30, 135. 85	33. 41	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		62, 320, 467	-474, 679	61, 845, 78	8 1, 892, 696. 63	32.68	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		20, 292, 619	0	20, 292, 61	9 490, 216. 90	41.40	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		23, 620, 757	0	23, 620, 75	7 0.00	38. 19	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		106, 233, 843						
7.00	Total overhead cost (see		19, 573, 291	-184, 681	19, 388, 61	0 604, 347. 73	32.08	7.00	
	instructions)								

Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provider CCN: 15-016	From 01/01/2020	Worksheet S-3 Part IV Date/Time Pre 7/9/2021 10:0	pared:
					Amount	
					Reported 1.00	
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				2, 335, 454	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib		0	2.00		
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)			0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	structions)			0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla				0	6.00
7.00	Employee Managed Care Program Administration	Fees			0	7.00
	HEALTH AND INSURANCE COST			T		
8.00	Health Insurance (Purchased or Self Funded)				0	8.00
8.01	Health Insurance (Self Funded without a Thir				0	8.01
8.02	Health Insurance (Self Funded with a Third P	°arty Administrato	ır)		10, 197, 548	
8.03	Health Insurance (Purchased)				0	8.03
9.00	Prescription Drug Plan				0	9.00
10.00	Dental, Hearing and Vision Plan				283, 381	
11.00	Life Insurance (If employee is owner or bene				26, 574	
12.00	Accident Insurance (If employee is owner or				0	
13.00	Disability Insurance (If employee is owner o				327, 546	
14.00	Long-Term Care Insurance (If employee is own	ier or beneticiary	·)		0	
15.00	'Workers' Compensation Insurance			in the FACD 10/	316, 366	
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	londinary accruai req	urred by FASB 106.	0	16.00
	Non cumulative portion) TAXES					
17 00	FICA-Employers Portion Only				4, 579, 542	17.00
18.00	Medicare Taxes - Employers Portion Only				4, 37 9, 342	18.00
19.00	Unemployment Insurance					19.00
	State or Federal Unemployment Taxes				58, 163	
20.00	OTHER				00,100	20.00
21.00		Retirement Cost R	eported on lines 1 t	hrough 4 above. (see	. 0	21.00
22.00	Day Care Cost and Allowances				0	22.00
	Tuition Reimbursement				1, 194	23.00
	Total Wage Related cost (Sum of lines 1 -23)				18, 125, 768	
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					25.00

Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPIT	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0161	Period: From 01/01/2020		
				To 12/31/2020	7/9/2021 10:0	
	Cost Center Description			Contract Labor	Benefit Cost	
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi	fication:				
1.00	Total facility's contract labor and benefit	cost		189, 837	18, 125, 768	1.00
2.00	Hospi tal			189, 837	18, 125, 768	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CO	CN: 15-0161	Peri od:	Worksheet S-1	0
				From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	7/9/2021 10: 0	8 am
					1.00	
1 00	Uncompensated and indigent care cost computation	vided by Li		m ()	0.226600	1 1 00
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d Medicaid (see instructions for each line)		ine 202 colum	in 8)	0. 226680	1.00
2.00	Net revenue from Medicaid				9, 143, 921	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppleme	ntal payment	ts from Medic	ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments	From Medicai	id		0	5.00
6.00	Medicaid charges				96, 154, 967	6.00
7.00	Medicaid cost (line 1 times line 6)	.			21, 796, 408	
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(line 7 mir	nus sum of li	nes 2 and 5; if	12, 652, 487	8.00
	Children's Health Insurance Program (CHIP) (see instructions i	°or each lir	ne)			
9.00	Net revenue from stand-alone CHIP				0	
	Stand-al one CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)	(ling 11 mi		if , toro then	0	
12.00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(ITTHE IT MI	inus inne 9;	ii < zero then	0	12.00
	Other state or local government indigent care program (see ins	structions f	for each line)	I	
	Net revenue from state or local indigent care program (Not in				0	
14.00	Charges for patients covered under state or local indigent ca	re program ((Not included	in lines 6 or	149	14.00
15 00						15 00
	State or local indigent care program cost (line 1 times line Difference between net revenue and costs for state or local i		o program (Li	no 15 minus ling	34	
10.00	13; if < zero then enter zero)	lui gent care	e program (ri		. 34	10.00
	Grants, donations and total unreimbursed cost for Medicaid, Cl	HP and stat	te/local indi	gent care progra	ams (see	
	instructions for each line)			5		
	Private grants, donations, or endowment income restricted to				0	
	Government grants, appropriations or transfers for support of			<i>(</i>)))	0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loc. 8, 12 and 16)	al indigent	care program	is (sum of lines	12, 652, 521	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)		(240 2	200 770	(() 0 0 1 0	
20.00	Charity care charges and uninsured discounts for the entire factors (see instructions)	actificy	6, 248, 2	33 380, 779	6, 629, 012	20.00
21.00	Cost of patients approved for charity care and uninsured disc	ounts (see	1, 416, 3	19 380, 779	1, 797, 128	21.00
	instructions)	,				
22.00	Payments received from patients for amounts previously writte	n off as		0 0	0	22.00
	charity care		1 11 (0		1 707 100	
23.00	Cost of charity care (line 21 minus line 22)		1, 416, 3	19 380, 779	1, 797, 128	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pation	ent days bey	yond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indigent car	e program?				
25.00	If line 24 is yes, enter the charges for patient days beyond	the indigent	t care progra	m's length of	0	25.00
24 00	stay limit		`		0 504 1/0	
26.00 27.00	Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complex				8, 524, 160 142, 983	
27.00	Medicare allowable bad debts for the entire hospital complex				219, 974	
28.00	Non-Medicare bad debt expense (see instructions)				8, 304, 186	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see	instructions)	1, 959, 384	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				3, 756, 512	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	ine 30)			16, 409, 033	31.00

Bit Schull Flahtfull Rate Frank Bull Flaht Frank Bull Flaht Frank Bull Flaht Frank Bull Flaht Cost Lenter Description Salaries Uther Iotal Iotal Iotal Reclassified Reclassified <th></th> <th>n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O</th> <th>IU HEALTH NORT</th> <th>H HOSPITAL Provider CO</th> <th>CN: 15_0161 D</th> <th>In Lie eriod:</th> <th>u of Form CMS-2 Worksheet A</th> <th>2552-10</th>		n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IU HEALTH NORT	H HOSPITAL Provider CO	CN: 15_0161 D	In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
Cost Curtur Description Selaries Other Total (col, 1) Rectassi Total Fact asiance (col, 3, 1) International Control (col, 2) 1.00 2.00 3.00 4.00 5.00 1.00 00100 (bit (CP) RELCOST CANTERS 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.01	RECEA	STITICATION AND ADJUSTIMENTS OF TREAD BALANCE O			F	rom 01/01/2020	Date/Time Pre	
Image: Construction of the start set of the start s		Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		8 am
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Internal						A-6)	•	
1.00 00100 INW CAP REL COSTS-HUEG & FIXT 16.250 16.250 11.207.248 11.307.468 1.00 1.00 00100 INW CAP REL COSTS-HUEGES 0 0 0 0.745.723 T.45.723 1.00 1.02 00020 INW LEASU SPACE 0 0 8.775.147 2.00 0.00 0.004 INW LEASU SPACE 0 0.745.723 1.03.749 0 8.775.147 2.00 0.00050 INW LAT ENDERSING 0 0.771 6.71 6.71 6.71 8.775.147 0 8.775.172.161 9.94.873 1.757.849 9.84.85 5.00 0.3247 7.07.743 1.71.75.401 9.94.893 5.01 9.95.84 5.02 9.95.84 5.02 9.95.84 5.02 9.95.94 5.02 9.95.94 5.02 9.95.94 5.02 9.95.94 5.128.94 5.128.94 5.128.94 5.128.94 5.128.97 9.00 9.9000 HUE ALW PARAMOV 3.125.90 3.82.90 4.97.95.94 1.90.97.95 9.92.44 1.90.92.97 9.97.97 9.97.97.90 9.97.97 9.9			1.00	2.00	3.00	4.00		
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10.00 01000 DICTOR Feb 0.956 6-15, 848 1.66, 243 2-25, 765 1.202, 678 10.00 13.00 01300 MURSING ADMI NISTRATION 2, 973, 750 977, 466 3, 961, 732 2, 792, 662 -6110, 141 3, 441, 095 13.00 15.00 01500 PHARMACY 3, 125, 593 38, 382, 380 41, 787, 794 -37, 379, 602 4, 128, 341 15.00 01500 PHARMACY 3, 125, 593 38, 382, 380 41, 807, 993 -82, 379 587, 664 17.00 01700 SOCIAL SERVICE CAST CENTERS 219, 755 89, 248 309, 003 -67, 110 241, 893 18.00 00 03600 SURGICAL INTENSIVE CARE UNIT 0 0 0 30, 00 34.00 34.00 34.00 34.00 34.01 <			-			-		1
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70.00 07000 ELECTROENCEPHALOGRAPHY 140, 682 445, 848 586, 530 -72, 893 513, 637 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 5, 781, 429 5, 781, 429 5, 781, 429 5, 781, 429 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 10, 223, 206 10, 223, 206 72.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 37, 576, 673 37, 576 57.00 75.00 75.00 75.00 75.00 75.00 75.00 75.01 75.01 75.01								
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75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY 1,093,771 2,937,608 4,031,379 -2,409,227 1,622,152 75. 01 0UTPATI ENT SERVICE COST CENTERS 2,482,498 2,578,236 5,060,734 -892,119 4,168,615 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 2,482,498 2,578,236 5,060,734 -892,119 4,168,615 91. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART) SUBTOTALS (SUM OF LINES 1 through 117) 62,080,670 179,581,676 241,662,346 406,232 242,068,578 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 62,080,670 179,581,676 241,662,346 406,232 242,068,578 118. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.02 19202 CHI LDBI RTH EDUCATI ON 83,247 49,330 132,577 6,939 139,516 192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 0			0	0	0			
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92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 62,080,670 179,581,676 241,662,346 406,232 242,068,578 118.00 NONRET MBURSABLE COST CENTERS 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.01 192.02 192.02 CHI LDBI RTH EDUCATI ON 83,247 49,330 132,577 6,939 139,516 192.02 192.03 192.03 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.06 19206 HYSI CI ANS' PRI VATE OFFICES 0 49,702 49,702 -48,	91.00		2, 482, 498	2, 578, 236	5, 060, 734	-892, 119	4, 168, 615	91.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 62,080,670 179,581,676 241,662,346 406,232 242,068,578 118.00 NONREL MBURSABLE COST CENTERS 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19201 OTHER NON-REI MBURSABLE 120,355 908,845 1,029,200 -351,643 677,557 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 83,247 49,330 132,577 6,939 139,516 192.02 192.03 19203 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.03 192.04 19204 PHYSI CLANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.05 19205 PHYSI CLANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.05 19205 PHYSI CLANS' PRI VATE OFFICES 0 49,702 -374,099 1,077,943 192.05 192.06 192	92.00							92.00
NORREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19201 OTHER NON-REI MBURSABLE 120,355 908,845 1,029,200 -351,643 677,557 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 83,247 49,330 132,577 6,939 139,516 192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.05 PHYSI CI ANS' PRI VATE OFFICES 0 49,702 -374,099 1,077,943 192.05 192.06 19206 TI PTON HOSPI TAL 0 0 53,683 53,683 192.06 192.07 192.08 SAXONY HOSPI TAL 0								
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19201 OTHER NON-REI MBURSABLE 120, 355 908, 845 1, 029, 200 -351, 643 677, 557 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 83, 247 49, 330 132, 577 6, 939 139, 516 192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.03 192.04 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49, 702 49, 702 -48, 347 1, 355 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49, 702 49, 702 -48, 347 1, 355 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49, 702 -48, 347 1, 355 192.04 192.05 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 53, 683 53, 683 192.05 192.06 19206 TI PTON HOSPI TAL 0 0 0 245, 521 245, 521 <t< td=""><td>118.0</td><td></td><td>62,080,670</td><td>179, 581, 676</td><td>241, 662, 346</td><td>406, 232</td><td>242, 068, 578</td><td>118.00</td></t<>	118.0		62,080,670	179, 581, 676	241, 662, 346	406, 232	242, 068, 578	118.00
192.01 19201 OTHER NON-REI MBURSABLE 120, 355 908, 845 1, 029, 200 -351, 643 677, 557 192. 01 192.02 19202 CHI LDBI RTH EDUCATI ON 83, 247 49, 330 132, 577 6, 939 139, 516 192. 02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192. 03 192.04 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49, 702 49, 702 -48, 347 1, 355 192. 04 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 0 49, 702 49, 702 -48, 347 1, 355 192. 04 192.06 19206 TIPTON HOSPITAL 0 0 0 53, 683 53, 683 192. 05 192.07 IP207 WEST HOSPITAL 0 0 0 245, 521 245, 521 192. 07 192.08 19208 SAXONY HOSPITAL 0 0 0 61, 714 61, 714 192. 08	192.0		n	0	0	0	0	192,00
192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 0 49,702 49,702 -48,347 1,355 192.04 192.05 19205 PHYSI CI AN PRACTI CE 582,062 869,980 1,452,042 -374,099 1,077,943 192.05 192.06 19206 TI PTON HOSPI TAL 0 0 53,683 53,683 192.06 192.08 I208 SAXONY HOSPI TAL 0 0 0 61,714 61,714 192.08								
192.0419204PHYSI CI ANS' PRI VATE OFFICES049,70249,702-48,3471,355192.04192.0519205PHYSI CI AN PRACTI CE582,062869,9801,452,042-374,0991,077,943192.05192.0619206TI PTON HOSPI TAL00053,68353,683192.06192.0719207WEST HOSPI TAL000245,521245,521192.07192.0819208SAXONY HOSPI TAL00061,714192.08	192.0	2 19202 CHI LDBI RTH EDUCATI ON	83, 247	49, 330	132, 577	6, 939	139, 516	192.02
192.0519205PHYSI CI AN PRACTI CE582,062869,9801,452,042-374,0991,077,943192.05192.0619206TI PTON HOSPI TAL00053,68353,683192.06192.0719207WEST HOSPI TAL000245,521245,521192.07192.0819208SAXONY HOSPI TAL00061,71461,714192.08			0	-	-	-		
192.0619206TI PTON HOSPI TAL0053, 68353, 683192.06192.0719207WEST HOSPI TAL000245, 521245, 521192.07192.0819208SAXONY HOSPI TAL00061, 714192.08			582 042					
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200.00 101AL (SUM OF LINES 118 through 199) 62,866,334 181,459,533 244,325,867 0 244,325,867 200.00			0	0	0			
	200. 0	U IOTAL (SUM OF LINES 118 through 199)	62, 866, 334	181, 459, 533	244, 325, 867	0	244, 325, 867	200.00

Health Financial Systems	IU HEALTH NO	RTH HOSPI TAL	In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provider CCN: 15-0161	Period: From 01/01/2020	Worksheet A
				Date/Time Prepared: 7/9/2021 10:08 am
Cost Center Description	Adjustments	Not Exponsos		

				7/9/2021 10:0	<u> 18 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	-1, 233, 047	10, 074, 451		1.00
1.01	00101 NEW CAP REL COSTS-INTEREST	12, 436, 818	12, 436, 818		1.01
1.02	00102 MOB LEASED SPACE	-987, 356			1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 262, 547	9, 738, 696		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	702, 181	13, 960, 094		4.00
5.01	00540 NONPATI ENT TELEPHONES	-745			5.01
5.02	00550 DATA PROCESSI NG	8, 366, 467	8, 366, 782		5.02
5.02	00560 PURCHASING RECEIVING AND STORES	1, 071, 921	1, 029, 139		5.02
5.03	00570 ADMI TTI NG	1, 942, 444	2, 842, 274		5.03
5.04	00590 OTHER ADMINI STRATI VE & GENERAL	-17, 816, 458			5.05
6.00	00600 MAINTENANCE & REPAIRS	-1, 888, 152			6.00
7.00	00700 OPERATION OF PLANT				7.00
		-165, 417	4, 725, 046		
8.00	00800 LAUNDRY & LINEN SERVICE	0			8.00
9.00	00900 HOUSEKEEPI NG	0	4, 874, 539		9.00
10.00	01000 DI ETARY	-9, 650			10.00
11.00	01100 CAFETERI A	-966, 018			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-326, 363			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-91, 389			14.00
15.00	01500 PHARMACY	-109, 861	4, 018, 480		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	66, 835		16.00
17.00	01700 SOCIAL SERVICE	0	587, 664		17.00
18.00	01850 PATIENT TRANSPORTATION	-57, 397	184, 496		18.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•	1
30.00	03000 ADULTS & PEDI ATRI CS	-4, 936, 376	15, 157, 492		30.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34.00
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	-764, 793	1, 022, 411		34.01
34.02	03402 PREMATURE INTENSIVE CARE UNIT	-641, 554	2, 977, 410		34.02
43.00	04300 NURSERY	0			43.00
101.00	ANCI LLARY SERVICE COST CENTERS	0	1,000,100		- 10100
50.00	05000 OPERATI NG ROOM	-749, 598	4, 978, 734		50.00
51.00	05100 RECOVERY ROOM	0	2, 213, 848		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-1, 370, 645	3, 129, 474		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-161, 636			54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	-493, 088	2, 860, 306		55.00
56.00	05600 RADI OLOGT - MERALEUTIC	-475,000	2, 860, 360		56.00
		-	8, 495, 308		
60.00		-892			60.00
65.00		-375	2, 164, 134		65.00
66.00	06600 PHYSI CAL THERAPY	-16, 107	2,069,172		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	284, 941		67.00
68.00	06800 SPEECH PATHOLOGY	0	144, 333		68.00
69.00	06900 ELECTROCARDI OLOGY	0	595, 488		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	513, 637		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	10, 223, 206		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	37, 576, 673		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501 CARDIAC CATHERIZATION LABORATORY	0	1, 622, 152		75.01
	OUTPATIENT SERVICE COST CENTERS			·	1
91.00	09100 EMERGENCY	-1, 172, 543	2, 996, 072		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	SPECIAL PURPOSE COST CENTERS			I	
118.00		-8, 177, 082	233, 891, 496		118.00
110.00	NONREI MBURSABLE COST CENTERS	0,117,002	200,071,170		
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
	19201 OTHER NON-REI MBURSABLE	0	677, 557		192.00
	19201 OTHER NON-RETMOORSABLE	-			
		-18, 879			192.02
	19203 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.03
	19204 PHYSI CLANS' PRI VATE OFFI CES	-445, 276	-443, 921		192.04
	19205 PHYSI CI AN PRACTI CE	0	1,077,943		192.05
	19206 TI PTON HOSPI TAL	0	53, 683		192.06
	19207 WEST HOSPI TAL	0	245, 521		192.07
192.08	19208 SAXONY HOSPI TAL	0	61, 714		192.08
200.00	TOTAL (SUM OF LINES 118 through 199)	-8, 641, 237	235, 684, 630		200.00

	Financial Systems		IU HEALTH NORTH	HOSPITAL Provider CCN: 15-0161		u of Form CMS-2552-10 Worksheet A-6
					From 01/01/2020 To 12/31/2020	Date/Time Prepared:
		Increases				7/9/2021 10:08 am
	Cost Center	Line #	Salary	Other		
	2.00 A - LEASES	3.00	4.00	5.00		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	1, 842, 449		1.00
2.00	FIXT MOB LEASED SPACE	1. 02	О	745, 723		2.00
3.00	NEW CAP REL COSTS-MVBLE	2.00	0	176, 622		3.00
4.00	EQUI P	0.00	О	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			8.00
	O B - DEPRECIATION		0	2,764,794		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	9, 465, 049		1.00
2.00	FIXT NEW CAP REL COSTS-MVBLE	2.00	О	8, 299, 527		2.00
3.00	EQUI P	0.00	0	0		3.00
3.00 4.00		0.00	0	0		4.00
5.00		0.00	0	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 10. 00		0. 00 0. 00	0	0 0		9.00 10.00
11.00		0.00	0	0		11.00
12.00 13.00		0. 00 0. 00	0	0 0		12.00 13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0 0		15.00 16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0 0		18.00 19.00
20.00		0.00	0	0		20.00
21.00 22.00		0. 00 0. 00	0	0 0		21.00 22.00
22.00		0.00	0	0		22.00
24.00		0.00	0	0		24.00
25.00 26.00		0. 00 0. 00	0	0 0		25.00 26.00
27.00		0.00	О	0		27.00
28.00 29.00		0. 00 0. 00	0	0 0		28.00 29.00
30.00		0.00	О	0		30.00
31.00 32.00		0. 00 0. 00	0	0 0		31.00 32.00
32.00 33.00		0.00	0	0		33.00
34.00		0.00	0	0 17, 764, 576		34.00
	C - EMPLOYEE BENEFITS		0	17, 704, 570		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	11, 660, 728		1.00
2.00 3.00		0.00	0	0 0		2.00 3.00
4.00		0.00	0	0		4.00
5.00 6.00		0. 00 0. 00	0	0 0		5.00 6.00
7.00		0.00	0	0		7.00
8.00 9.00		0. 00 0. 00	0	0 0		8.00 9.00
10.00		0.00	0	0		10.00
11. 00 12. 00		0.00 0.00	0	0 0		11.00 12.00
13.00		0.00	0	0		13.00
14.00 15.00		0.00 0.00	0	0		14.00 15.00
15.00 16.00		0.00	0	0 0		16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0 0		18.00 19.00
20.00		0.00	0	0		20.00
21.00 22.00		0. 00 0. 00	0	0 0		21.00 22.00
23.00		0.00	0	0		23.00

IU HEALTH NORTH HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0161 Period: From 01/01/2020 Worksheet A-6

KLULAS.	STFLCATIONS			Provider CCN: 15-0161	Period: Worksheet From 01/01/2020 Date/Time To 12/31/2020 Date/Time 7/9/2021	Prepared:
	Cost Center	I ncreases Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00		0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0		0 0 0 0 0 0 0 0 0 0 0 11, 660, 728		24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00
	E - LABOR AND DELIVERY		L.			
1.00 2.00	ADULTS & PEDIATRICS NURSERY	30.00 43.00	290, 714 2 <u>2, 3</u> 79 313, 093	39, 991 3, <u>078</u> 43, 069		1.00 2.00
1.00 2.00 3.00	P - WARKETING PHARMACY CHILDBIRTH EDUCATION	15.00 192.02 0.00		131 10, 739 0 10, 870		1.00 2.00 3.00
1 00	G - NURSERY	42.00				1.00
1.00	<u>NURSERY</u>	<u> </u>	<u>960, 0</u> 16 	<u>102, 682</u> 102, 682		1.00
1.00	H - FMLA EMPLOYEE BENEFITS DEPARTMENT	4.00	0	194		1.00
2.00	OTHER ADMI NI STRATI VE & GENERAL	5.05	0	3, 142		2.00
3.00 4.00	MAI NTENANCE & REPAI RS HOUSEKEEPI NG	6.00 9.00	0	7, 933 7, 495		3.00
5.00	CAFETERI A	11.00	0	4, 887		5.00
6.00 7.00	NURSING ADMINISTRATION PHARMACY	13.00 15.00	0	6, 206 9, 157		6.00 7.00
8.00 9.00	ADULTS & PEDIATRICS PREMATURE INTENSIVE CARE UNIT	30. 00 34. 02	0 0	52, 242 15, 674		8.00 9.00
10.00	OPERATING ROOM	50.00	О	22, 378		10.00
11. 00 12. 00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00	0	18, 292 27, 997		11.00 12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 191		13.00
14.00 15.00	RADI OLOGY – THERAPEUTI C LABORATORY	55.00 60.00	0	19, 697 822		14.00 15.00
16.00	RESPI RATORY THERAPY	65.00	0	15, 589		16.00
17.00 18.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	4, 926 1, 226		17.00 18.00
19.00	CARDI AC CATHERI ZATI ON	75. 01	Ö	7, 113		19.00
20.00	LABORATORY <u>EMERGENCY</u>	91.00	0	2 <u>1, 340</u> 253, 501		20.00
1.00	J - BILLABLE SUPPLIES PREMATURE INTENSIVE CARE	34.02	0	2, 207		1.00
2. 00	UNIT MEDICAL SUPPLIES CHARGED TO	71.00	0	5, 781, 429		2.00
3.00	PATI ENTS	0.00	О	0		3.00
4.00 5.00		0. 00 0. 00	0	0		4.00
5.00 6.00		0.00	0	0		5.00 6.00
7.00 8.00		0.00 0.00	0	0		7.00 8.00
9.00		0.00	0	0		9.00
10. 00 11. 00		0.00 0.00	0	0		10.00 11.00
12.00		0.00	0	0		12.00
13.00 14.00		0. 00 0. 00	0	0		13.00 14.00
15.00		0.00	0	0		15.00
16.00 17.00		0. 00 0. 00	0	0		16.00 17.00
18.00	L	0.00	0	0		18.00
	0 K – NON-BILLABLE SUPPLIES	<u> </u>	U	5, 783, 636		
1.00 2.00	DATA PROCESSING OPERATION OF PLANT	5. 02 7. 00	0	432 692		1.00 2.00
2.00 3.00	NURSI NG ADMI NI STRATI ON	13.00	0	692 156		3.00

ASS	SEFECATEONS			Provider CCN: 15-01		u of Form CMS-2552- Worksheet A-6
					To 12/31/2020	
	Cost Center	I ncreases Li ne #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
)	CENTRAL SERVICES & SUPPLY RADIOISOTOPE	14.00 56.00	0	7, 013, 512 6, 116		4. 5.
)	CARDI AC CATHERI ZATI ON	75.01	0	28, 074		6.
		102 01		20		-
)	OTHER NON-REIMBURSABLE CHILDBIRTH EDUCATION	192. 01 192. 02	0	39 3		7.
		0.00	0	0		9.
0		0.00 0.00	0	0 0		10.
0		0.00	0	Ö		12.
0		0.00	0	0		13.
0 0		0.00 0.00	0 0	0 0		14.
0		0.00	О	0		16.
0		0.00	0 0	0 0		17.
0		0.00 0.00	0	0		18. 19.
0		0.00	О	0		20.
0 0		0.00 0.00	0 0	0 0		21.
))		0.00	0	0		22.
0		0.00	0	0		24.
))		0.00 0.00	0 0	0 0		25. 26.
)		0.00	0	Ö		27.
C		0.00	0	0		28.
C	<u> </u>		0	<u> </u>		29.
	L - BILLABLE DRUGS					-
	DRUGS CHARGED TO PATIENTS	73.00 0.00	0 0	37, 576, 673 0		1.
		0.00	0	Ö		3.
		0.00 0.00	0	0 0		4.
		0.00	0	0		5.
		0.00	0	0		7.
		0.00 0.00	0 0	0 0		8.
C		0.00	0	0		10.
2		0.00	0	0		11.
C	<u> </u>		0	0 37, 576, 673		12.
	M - NON-BILLABLE DRUGS PURCHASING RECEIVING AND	5.03	0	580		1.
	STORES	5.03	0	560		1.
	CENTRAL SERVICES & SUPPLY	14.00	0	18		2.
	PHARMACY	15.00 0.00	0	601, 392 0		3.
		0.00	0	0		5.
		0.00 0.00	0	0		6.
		0.00	0	0		8.
		0.00	0	0		9.
))		0.00 0.00	0	0 0		10.
)		0.00	0	0		12
))		0.00 0.00	0	0 0		13
5		0.00	0	0		15
)		0.00	0	0		16.
)		0. 00 0. 00	0 0	0 0		17. 18.
0				601, 990		
	N – IMPLANTS PREMATURE INTENSIVE CARE	34.02	0	323		1.
	UNIT IMPL. DEV. CHARGED TO	72.00	0	10, 223, 206		2.
	PATIENT					
		0.00 0.00	0	0 0		3.
		0.00	0	0		4.
		0.00 0.00	0	0 0		6. 7.

Heal th	Financial Systems		IU HEALTH NORTH	HOSPI TAL		In Lieu	of Form CMS-	-2552-10
RECLASS	SEFECATEONS			Provider (CCN: 15-0161	Period:	Worksheet A-	6
						From 01/01/2020 To 12/31/2020	Data /Tima Dr	onorod.
						10 12/31/2020	Date/Time Pr 7/9/2021 10:	os am
		Increases		1		1		
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
	0		0	10, 223, 529				
	0 - NORTH TO TIPTON ISR ALLO				I			
	TI PTON HOSPI TAL	192.06	35, 595	18, 088				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00			0	0				4.00
	TOTALS		35, 595	18, 088				_
	P - NORTH TO WEST ISR ALLOCA							
	WEST HOSPI TAL	192.07	148, 119	97, 402				1.00
2.00		0.00	0	0				2.00
3.00				0				3.00
	TOTALS		148, 119	97, 402	<u> </u>			-
	Q - NORTH TO SAXONY ISR ALLO		27.4/4	24.250				1 00
	SAXONY HOSPI TAL	192.08	37, 464	24, 250				1.00
2.00		0.00	0	0				2.00
3.00				0				3.00
	TOTALS		37, 464	24, 250				E00.00
ວບບ. ບບ	Grand Total: Increases		1, 494, 287	93, 974, 812	l			500.00

Heal th	Fi nanci al	Systems
RECLAS	SI FI CATI ON	S

	Financial Systems		IU HEALTH NOF			In Lieu of Form C	MS-2552-10
RECLAS	SI FI CATI ONS			Provi der (Period: Worksheet From 01/01/2020	A-6
						To 12/31/2020 Date/Time 7/9/2021 1	
		Decreases				7/9/2021 1	0:08 am
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.	4	
	6.00 A - LEASES	7.00	8.00	9.00	10.00		
1.00	OTHER ADMI NI STRATI VE &	5.05	0	2, 300, 649	10)	1.00
2 00	GENERAL	7 00	0	7 725	10		2 00
2.00 3.00	OPERATION OF PLANT CAFETERIA	7.00 11.00	0	7, 735 85			2.00 3.00
4.00	ADULTS & PEDIATRICS	30.00	0	67, 863			4.00
5.00	OPERATING ROOM	50.00	0	108, 674			5.00
6.00 7.00	RADI OLOGY-DI AGNOSTI C OTHER NON-REI MBURSABLE	54.00 192.01	0	47, 652 22, 150			6.00 7.00
8.00	PHYSICIAN_PRACTICE	192.05	0	209, 986			8.00
			0	2, 764, 794			
1.00	B - DEPRECIATION NEW CAP REL COSTS-BLDG &	1.00	0	16, 250			1.00
	FIXT						
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,300			2.00
3.00 4.00	NONPATI ENT TELEPHONES DATA PROCESSI NG	5. 01 5. 02	0	2, 433 788			3.00
5.00	PURCHASI NG RECEI VI NG AND	5. 03	0	5, 102			5.00
(00	STORES	5.04	0	1 00/ 000			(00
6.00 7.00	ADMI TTI NG OTHER ADMI NI STRATI VE &	5.04 5.05	0	1, 026, 382 9, 057, 405			6.00 7.00
	GENERAL		0				
8.00	MAINTENANCE & REPAIRS	6.00	0	206, 874			8.00
9. 00 10. 00	OPERATI ON OF PLANT HOUSEKEEPI NG	7.00 9.00	0	13, 961 2, 191			9.00 10.00
11.00	DI ETARY	10.00	0	6, 203			11.00
12.00	CAFETERI A	11.00	0	27, 913			12.00
13.00 14.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	0	14, 340 200, 155			13.00 14.00
14.00	PHARMACY	14.00	0	104, 868			14.00
16.00	ADULTS & PEDIATRICS	30. 00	0	277, 769	0 0		16.00
17.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	24, 298	C	0	17.00
18.00	PREMATURE INTENSIVE CARE	34.02	0	97, 120			18.00
19.00 20.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	2, 239, 671 42, 810			19.00 20.00
20.00	DELIVERY ROOM & LABOR ROOM	52.00	0	218, 952			20.00
22.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 324, 478	s C		22.00
23.00 24.00	RADI OLOGY – THERAPEUTI C LABORATORY	55.00 60.00	0	425, 396 7, 637		-	23.00 24.00
24.00	RESPIRATORY THERAPY	65.00	0	44, 487			24.00
26.00	PHYSI CAL THERAPY	66.00	0	15, 599) (26.00
27.00	SPEECH PATHOLOGY	68.00	0	1, 337			27.00
28.00 29.00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00	0	184, 694 30, 710			28.00 29.00
30.00	CARDI AC CATHERI ZATI ON	75.01	0	729, 188			30.00
21 00	LABORATORY	01.00	0	24 702			21.00
31.00 32.00	EMERGENCY OTHER NON-REI MBURSABLE	91.00 192.01	0	36, 703 292, 361			31.00 32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.04	0	48, 347			33.00
34.00	PHYSICIAN_PRACTICE	1 <u>92.</u> 05	<u>0</u>	36,854		2	34.00
	O C - EMPLOYEE BENEFITS		0	17, 764, 576			
1.00	ADMI TTI NG	5.04	0	126, 971			1.00
2.00	OTHER ADMINISTRATIVE &	5.05	0	443, 746	, C	D	2.00
3.00	GENERAL MAINTENANCE & REPAIRS	6.00	0	371, 133	c c		3.00
4.00	OPERATION OF PLANT	7.00	0	214, 824			4.00
5.00	HOUSEKEEPI NG	9.00	0	465, 862			5.00
6.00 7.00	DI ETARY CAFETERI A	10. 00 11. 00	0	239, 694 383, 528			6.00 7.00
8.00	NURSI NG ADMI NI STRATI ON	13.00	0	484, 757			8.00
9.00	CENTRAL SERVICES & SUPPLY	14.00	0	221, 765			9.00
10. 00 11. 00	PHARMACY SOCI AL SERVI CE	15.00 17.00	0	488, 453 75, 106			10.00 11.00
12.00	PATIENT TRANSPORTATION	18.00	0	67, 110			12.00
13.00	ADULTS & PEDIATRICS	30.00	0	2, 638, 645	i C		13.00
14.00	PEDIATRIC INTENSIVE CARE	34.01	0	212, 442	2 C		14.00
15.00	UNIT PREMATURE INTENSIVE CARE	34.02	О	429, 508	s (15.00
	UNI T						
16. 00 17. 00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0 0	843, 455 376, 210			16.00 17.00
.7.00		51.00	Ŋ	570,210	·	-1	1 17.00

	Financial Systems		IU HEALTH NOR		In Lieu of Form CMS-2552-10	0
RECLAS	SI FI CATI ONS			Provider CCN: 15-0161	Period: Worksheet A-6 From 01/01/2020	
					To 12/31/2020 Date/Time Prepared	
		Decreases			7/9/2021 10: 08 am	-
	Cost Center	Line #	Sal ary	Other Wkst. A-7 Re	ef.	
10.00		7.00	8.00	9.00 10.00	0 10.00	_
18.00 19.00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00	0	626, 437 612, 712	0 18.00 0 19.00	
20.00	RADI OLOGY - THERAPEUTI C	55.00	0	445, 033	0 20.00	
21.00	RADI OI SOTOPE	56.00	0	55, 908	0 21.00	
22.00		60.00	0	128, 731	0 22.00 23.00	
23.00 24.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	464, 676 354, 917	0 23.00 0 24.00	
25.00	OCCUPATI ONAL THERAPY	67.00	Ō	23, 436	0 25.00	
26.00	SPEECH PATHOLOGY	68.00	0	25, 412	0 26.00	
27.00 28.00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69.00 70.00	0	65, 634 29, 393	0 27.00 0 28.00	
29.00	CARDI AC CATHERI ZATI ON	75. 01	0	189, 111	0 29.00	
	LABORATORY		-			
30.00		91.00	0	389, 676	0 30.00	
31.00 32.00	OTHER NON-REIMBURSABLE CHILDBIRTH EDUCATION	192. 01 192. 02	0	37, 171 3, 803	0 31.00 0 32.00	
33.00	PHYSI CI AN PRACTI CE	192.05	0	125, 469	0 33.00	
	0		0	11, 660, 728		
1.00	E - LABOR AND DELIVERY DELIVERY ROOM & LABOR ROOM	52.00	313, 093	43,069	0 1.00	h
2.00		0.00	015,075	43,007	0 2.00	
	0		313, 093	43,069		
1.00	F - MARKETING OTHER ADMINISTRATIVE &	5.05	0	8, 919	0 1.00	0
1.00	GENERAL	5.05	0	0, 919	1.00	J
2.00	ADULTS & PEDIATRICS	30.00	О	200	0 2.00	C
3.00	LABORATORY		º		_ 0 3.00)
	U G - NURSERY		0	10, 870		
1.00	ADULTS & PEDI ATRI CS	30.00	960, 016	102, 682	0 1.00	С
	0		960, 016	102, 682		
1.00	H - FMLA EMPLOYEE BENEFITS DEPARTMENT	4.00	194	0	0 1.00	b
2.00	OTHER ADMINISTRATIVE &	5. 05	3, 142	ŏ	0 2.00	
	GENERAL					_
3.00 4.00	MAI NTENANCE & REPAI RS HOUSEKEEPI NG	6.00 9.00	7, 933 7, 495	0	0 3.00 0 4.00	
5.00	CAFETERIA	11.00	4, 887	ő	0 5.00	
6.00	NURSING ADMINISTRATION	13.00	6, 206	0	0 6.00	C
7.00		15.00	9, 157	0		
8.00 9.00	ADULTS & PEDIATRICS PREMATURE INTENSIVE CARE	30.00 34.02	52, 242 15, 674	0	0 8.00 0 9.00	
1100	UNI T	01102	,			-
10.00	OPERATING ROOM	50.00	22, 378	0	0 10.00	
11.00 12.00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00	18, 292 27, 997	0	0 11.00 0 12.00	
13.00	RADI OLOGY-DI AGNOSTI C	54.00	7, 191	ő	0 13.00	
14.00	RADI OLOGY - THERAPEUTI C	55.00	19, 697	0	0 14.00	
15.00	LABORATORY	60.00	822 15, 589	0	0 15.00 0 16.00	
16.00 17.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	4, 926	0	0 17.00	
18.00	ELECTROCARDI OLOGY	69.00	1, 226	Ō	0 18.00	
19.00	CARDI AC CATHERI ZATI ON	75.01	7, 113	0	0 19.00	C
20.00	LABORATORY EMERGENCY	91.00	21, 340	0	0 20.00	5
	0		253, 501			-
4 9 9	J - BILLABLE SUPPLIES	5 00		o.(_
1.00	PURCHASING RECEIVING AND STORES	5.03	0	36, 799	0 1.00	J
2.00	ADMI TTI NG	5.04	о	2	0 2.00	С
3.00	OTHER ADMINISTRATIVE &	5.05	0	7,874	0 3.00	C
4.00	GENERAL NURSI NG ADMI NI STRATI ON	13.00	0	50	0 4.00	5
4.00 5.00	CENTRAL SERVICES & SUPPLY	14.00	0	822	0 5.00	
6.00	PHARMACY	15.00	О	920	0 6.00	0
7.00	ADULTS & PEDIATRICS	30.00	0	84, 055	0 7.00 0 8.00	
8.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	5	0 8.00	J
9.00	OPERATING ROOM	50.00	о	4, 242, 279	0 9.00	
10.00	RECOVERY ROOM	51.00	0	9, 651	0 10.00	
11. 00 12. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52.00 54.00	0	297, 798 151, 776	0 11.00 0 12.00	
13.00	RADI OLOGY - THERAPEUTI C	55.00	0	18, 088	0 13.00	
14.00	RADI OI SOTOPE	56.00	0	42	0 14.00	
						-

	Financial Systems SIFICATIONS			Provider C		Period:	Worksheet A-6
						From 01/01/2020 To 12/31/2020	Date/Time Prepare 7/9/2021 10:08 an
		Decreases	· · · ·				1/ 1/ 2021 10:08 all
	Cost Center 6.00	Line # 7.00	Sal ary 8.00	0ther 9.00	<u>Wkst. A-7 Ref.</u> 10.00	-	
. 00	LABORATORY	60.00	0	9.00	C)	15.
. 00	RESPI RATORY THERAPY	65.00	0	15, 249	C		16.
. 00	CARDI AC CATHERI ZATI ON	75.01	0	880, 059	C		17.
. 00	LABORATORY EMERGENCY	91.00	0	38, 093	C		18.
. 00			— — — o	<u>5, 783, 636</u>			10.
	K - NON-BILLABLE SUPPLIES						
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 543	C		1.
00	PURCHASING RECEIVING AND STORES	5.03	0	4, 310	C		2.
00	ADMI TTI NG	5.04	о	22, 448	C		3.
00	OTHER ADMINISTRATIVE &	5.05	О	2, 247	C		4.
~~	GENERAL	(01 001			_
00 00	MAI NTENANCE & REPAI RS HOUSEKEEPI NG	6.00 9.00	0	91, 291 39, 505	C		5.
00	DI ETARY	10.00	0	7,868	C		7.
00	CAFETERI A	11.00	О	2, 945	C		8.
00	CENTRAL SERVICES & SUPPLY	14.00	0	396, 870	C		9.
. 00 . 00	PHARMACY MEDICAL RECORDS & LIBRARY	15. 00 16. 00	0	281, 141 11	C		10.
. 00	SOCIAL SERVICE	17.00	0	65	0		12.
. 00	ADULTS & PEDIATRICS	30.00	0	1, 260, 658	C		13.
. 00	PEDIATRIC INTENSIVE CARE	34.01	0	31, 553	C		14.
00	UNI T PREMATURE INTENSI VE CARE	34. 02	0	142 445	C		15.
. 00	UNIT	34.02	0	163, 465	L.		15.
. 00	OPERATI NG ROOM	50.00	o	3, 248, 604	C		16.
. 00	RECOVERY ROOM	51.00	О	197, 870	C		17.
. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	278, 579	C		18.
00 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY - THERAPEUTI C	54.00 55.00	0	275, 291 131, 342	C		19. 20.
. 00	LABORATORY	60.00	0	9, 309	C		20.
. 00	RESPI RATORY THERAPY	65.00	0	214, 165	C		22.
. 00	PHYSI CAL THERAPY	66.00	0	18, 176	C		23.
. 00 . 00	OCCUPATIONAL THERAPY	67.00	0	3, 993	C		24.
. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68. 00 69. 00	0	2, 864 2, 296			25.
. 00	ELECTROENCEPHALOGRAPHY	70.00	Ő	6, 699	C		27.
. 00	EMERGENCY	91.00	О	352, 129	C		28.
. 00	PHYSICIAN_PRACTICE	192.05	•	<u>1, 787</u>	C)	29.
	L – BILLABLE DRUGS		0	7,049,024			
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33, 755	C		1.
00	PHARMACY	15.00	О	37, 071, 017	C		2.
00	SOCIAL SERVICE	17.00	0	7, 158	C		3.
00 00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50. 00 54. 00	0	128, 006 163, 600	C		4.
00	RADI OLOGY - THERAPEUTI C	55.00	0	1, 054	C		6.
00	RADI OI SOTOPE	56.00	0	117, 035	C		7.
00	RESPI RATORY THERAPY	65.00	0	7, 737	C		8.
00	PHYSI CAL THERAPY	66.00	0	28	C		9.
00	ELECTROCARDI OLOGY CARDI AC CATHERI ZATI ON	69.00 75.01	0	36, 288 10, 992	C		10.
00	LABORATORY	, 0. 01	Ű	10, 772	C C		
00	EMERGENCY	<u>91.00</u>	0	3	<u>C</u>)	12.
			0	37, 576, 673			
00	M - NON-BILLABLE DRUGS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	9	C		1.
00	OTHER ADMINI STRATIVE &	5.05	0	455	C		2.
	GENERAL		-		c c		
00	NURSING ADMINISTRATION	13.00	0	42	C		3.
0	ADULTS & PEDIATRICS	30.00 34.01	0	169, 409	C		4.
00	PEDIATRIC INTENSIVE CARE	34.01	U	43	U		5.
00	PREMATURE INTENSIVE CARE	34. 02	0	11, 431	C		6.
	UNI T				-		
00	OPERATING ROOM	50.00	0	148,060	C		7.
~	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00	0	37, 370	C		8.
	THAT FY INT NUMBER OF A SUR KUUM	52.00	U	33, 705			9.
00		54 00	O	40 357	C		10
00 00	RADI OLOGY - THERAPEUTI C	54.00 55.00	0 0	40, 357 60, 895	C		10.
00 00 00 00 00 00	RADI OLOGY-DI AGNOSTI C		-		-		

CLAS	SI FI CATI ONS			Provi der	CCN: 15-0161		orksheet A-6
						From 01/01/2020 To 12/31/2020 Da	ate/Time Prepared
							<u>/9/2021 10:08 am</u>
		Decreases			_	1	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ret	<u>f.</u>	
	6.00	7.00	8.00	9.00	10.00	-	
. 00	ELECTROCARDI OLOGY	69.00	0	8		0	15.0
. 00	CARDI AC CATHERI ZATI ON	75.01	0	18, 306		0	16.0
00	LABORATORY EMERGENCY	91, 00	0	74 101		0	17 (
. 00 . 00	PHYSICIAN PRACTICE	192.05	0	74, 131		0	17.0
. 00	PHYSICIAN PRACTICE	192.05	— — — 0	<u>3</u> 3 601, 990	<u> </u>	9	18.0
	N - IMPLANTS		U	001, 990			
00	PURCHASING RECEIVING AND	5.03	0	398		0	1.0
00	STORES	5.05	0	390		0	1.0
00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 786		0	2.0
00	PHARMACY	15.00	0	34, 726		0	3.0
00	ADULTS & PEDIATRICS	30.00	0	855		0	4.0
00	OPERATING ROOM	50.00	0	9, 518, 707			5.0
00	RECOVERY ROOM	51.00	0	9, 518, 707		0	6.0
00	RADI OLOGY-DI AGNOSTI C	54.00	0	2		0	7.0
00	RADI OLOGY - THERAPEUTI C	55.00	0	583		0	8.0
00	RESPIRATORY THERAPY	65.00	0	131		0	9.0
. 00	PHYSICAL THERAPY	66.00	0	49, 090		0	10.0
. 00	ELECTROENCEPHALOGRAPHY	70.00	0	49,090		0	10.0
		70.00	0			0	
. 00	CARDI AC CATHERI ZATI ON LABORATORY	/5.01	0	609, 645		0	12.0
. 00	EMERGENCY	91.00	o	1, 384		0	13.0
. 00			— — — 0	<u>1, 384</u> 10, 223, 529		9	13.0
	0 - NORTH TO TIPTON ISR ALLOO		U	10, 223, 329	'		
00	OTHER ADMINISTRATIVE &	5. 05	14, 951	14, 201		0	1.0
00	GENERAL	5.05	14, 901	14, 201		0	1.1
00	OPERATION OF PLANT	7.00	3, 710	2, 268	,	0	2.0
00	NURSI NG ADMI NI STRATI ON	13.00	11, 108	2,200		0	3.0
00	RADI OLOGY-DI AGNOSTI C	54.00	5, 826	1, 619	·	0	4.0
00	TOTALS		35, 595	<u>1,012</u> 18,088			4.0
	P - NORTH TO WEST ISR ALLOCAT		35, 575	10,000			
00	OTHER ADMINISTRATIVE &	5.05	74, 517	70, 777	1	0	1.0
00	GENERAL	5.05	74, 517	10, 111		0	1. (
00	OPERATION OF PLANT	7.00	18, 493	11, 306		0	2.0
00	RADI OLOGY-DI AGNOSTI C	54.00	55, 109	15, 319		0	3.0
00	TOTALS		148, 119	97,402			5.0
	Q - NORTH TO SAXONY ISR ALLOO		140, 117	77,402	-		
00	OTHER ADMINI STRATI VE &	5. 05	18, 337	17, 416		0	1.0
00	GENERAL	5.05	10, 337	17,410			1.0
00	OPERATION OF PLANT	7.00	4, 551	2, 782	,	0	2.0
00	RADI OLOGY-DI AGNOSTI C	54.00	14, 576	4, 052		0	3.0
00	TOTALS					4	3.1
	Grand Total: Decreases		1, 747, 788	93, 721, 311			500.0

Heal th	Financial Systems	IU HEALTH NOR	TH HOSPI TAL		_	In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		То	iod: m 01/01/2020 12/31/2020		pared:	
				Acquisition	IS				
		Begi nni ng	Purchases	Donati on		Total	Disposals and		
		Bal ances					Retirements		
		1.00	2.00	3.00		4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES							
1.00	Land	0	0		0	0	0	1.00	
2.00	Land Improvements	11, 942, 223	99, 079		0	99, 079	0	2.00	
3.00	Buildings and Fixtures	155, 595, 370	40, 688, 512		0	40, 688, 512	0	3.00	
4.00	Building Improvements	12, 302, 961	857, 659		0	857, 659	532, 215	4.00	
5.00	Fixed Equipment	0	0		0	0	0	5.00	
6.00	Movable Equipment	83, 730, 530	17, 971, 742		0	17, 971, 742	414, 278	6.00	
7.00	HIT designated Assets	0	0		0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	263, 571, 084	59, 616, 992		0	59, 616, 992	946, 493	8.00	
9.00	Reconciling Items	0	0		0	0	0	9.00	
10.00	Total (line 8 minus line 9)	263, 571, 084	59, 616, 992		0	59, 616, 992	946, 493	10.00	
		Endi ng	Fully				· ·		
		Bal ance	Depreciated						
			Assets						
		6.00	7.00						
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES							
1.00	Land	0	0					1.00	
2.00	Land Improvements	12,041,302	11, 917, 611					2.00	
3.00	Buildings and Fixtures	196, 283, 882	0					3.00	
4.00	Building Improvements	12, 628, 405	619, 446					4.00	
5.00	Fixed Equipment	0	0					5.00	
6.00	Movable Equipment	101, 287, 994	54, 104, 854					6.00	
7.00	HIT designated Assets	0	0					7.00	
8.00	Subtotal (sum of lines 1-7)	322, 241, 583	66, 641, 911					8.00	
9.00	Reconciling Items	0000	0					9.00	
10.00	Total (line 8 minus line 9)	322, 241, 583	66, 641, 911					10.00	
				1					

Health Financial Systems	IU HEALTH NOR	TH_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2020 To 12/31/2020		pared:
		Sl	JMMARY OF CAP	ITAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1	and 2			
1.00NEW CAP REL COSTS-BLDG & FIXT1.01NEW CAP REL COSTS-INTEREST1.02MOB LEASED SPACE	16, 250 0 0	0 0 0		0 0 0 0 0 0	0 0 0	1.00 1.01 1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	16, 250	0)	0 0	0	3.00
	SUMMARY OF					
Cost Center Description	Other	Total (1)				
	Capital-Relat					
	ed Costs (see	9 through 14)				
	instructions) 14.00	15.00	-			
PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1. 00 NEW CAP REL COSTS-BLDG & FIXT 1. 01 NEW CAP REL COSTS-INTEREST	0	16, 250				1.00 1.01
1. 02 MOB LEASED SPACE	0	Ő				1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	0	16, 250				3.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Prep 7/9/2021 10:08	
	COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 -			
	1.00	2.00	col. 2) 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		•			
1.00 NEW CAP REL COSTS-BLDG & FIXT	220, 953, 589	0	220, 953, 58	9 0. 685677	0	1.00
1.01 NEW CAP REL COSTS-INTEREST	0	0		0. 000000	0	1.01
1.02 MOB LEASED SPACE	0	0		0. 000000	0	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	101, 287, 995	l o	101, 287, 99	5 0. 314323	0	2.00
3.00 Total (sum of lines 1-2)	322, 241, 584				0	3.00
	ALLOCA	TION OF OTHER (F CAPI TAL	
Cost Conton Description	Taxes	Other	Total (sum of	Depreciation	Lease	
Cost Center Description	Taxes	Capital-Relat		Depreciation	Lease	
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		7.00	0.00	7.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	0		0 8, 295, 091	1, 779, 360	1.00
1. 01 NEW CAP REL COSTS-INTEREST	0			14, 652, 440		1.00
1. 02 MOB LEASED SPACE	0			0 14,002,440		1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0			9, 562, 074		2.00
3.00 Total (sum of lines 1-2)	0			32, 509, 605		3.00
	0		JMMARY OF CAPI		1, 714, 347	3.00
		50		IAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	interest	(see		Capi tal -Rel at		
		instructions)		ed Costs (see		
				i nstructi ons)	, through (1)	
	11.00	12.00	13.00	14,00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	10, 074, 451	1.00
1.01 NEW CAP REL COSTS-INTEREST	-2, 215, 622			0 0	12, 436, 818	1.01
1.02 MOB LEASED SPACE	0	0		0 0	-241, 633	1.02
2. 00 NEW CAP REL COSTS-MVBLE EQUIP	0	l o		0 0	9, 738, 696	2.00
3.00 Total (sum of lines 1-2)	-2, 215, 622	-		0 0	32,008,332	3.00
	, , , ,	-		-		

Heal th	Fi nan	ici al	Systems
AD IIIST	MENTS	TO F	TYPENSES

	FINANCIAL SYSTEMS		TU HEALTH NOR			J OT FORM UMS-2	
ADJUST	MENTS TO EXPENSES			F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet A-8 Date/Time Prep 7/9/2021 10:08	pared:
				Expense Classification on To/From Which the Amount is		17 97 2021 10. 00	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		<u>(2)</u> 1.00	2.00	3.00	4.00	Ref. 5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
1. 01	2) Investment income - NEW CAP REL COSTS-INTEREST (chapter 2)	В	-2, 215, 622	NEW CAP REL COSTS-INTEREST	1. 01	11	1.01
1. 02	Investment income - MOB LEASED SPACE (chapter 2)		0	MOB LEASED SPACE	1. 02	0	1. 02
2.00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	2) Investment income - other (chapter 2)		0		0.00	0	3.00
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 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -10, 644, 363		0.00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	33, 724, 205			0	12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests	В	0 -900, 912	CAFETERIA	0.00 11.00	0 0	13.00 14.00
15.00	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)		-				
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	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL			NEW CAP REL COSTS-BLDG &	1.00	0	26.00
26.01	COSTS-BLDG & FIXT Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-INTEREST	1. 01	0	26. 01
	COSTS-INTEREST				1 1		1

ealth Financial Systems DJUSTMENTS TO EXPENSES		IU HEALTH NOF		ri od:	u of Form CMS- Worksheet A-8	
				om 01/01/2020 12/31/2020	Date/Time Pre 7/9/2021 10:0	pared:
			Expense Classification on V To/From Which the Amount is t		11 11 2021 10.0	
				o be Aujusteu		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
7.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		0	NEW CAP REL COSTS-MVBLE	2.00	C	27.00
8.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
9.00 Physicians' assistant		0		0.00	C	
0.00 Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.0
therapy costs in excess of limitation (chapter 14)						
0.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30.9
instructions)						
1.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
limitation (chapter 14)						
2.00 CAH HIT Adjustment for		0		0.00	C	32.0
Depreciation and Interest		510				
3.00 MISCELLANEOUS INCOME 3.01 MISCELLANEOUS INCOME	B		EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 01	C	
3. 02 MI SCELLANEOUS I NCOME	B		OTHER ADMINISTRATIVE &	5.05	C	
			GENERAL			
3. 03 MI SCELLANEOUS I NCOME	В		MAINTENANCE & REPAIRS	6.00	C	
3. 04 MISCELLANEOUS INCOME 3. 05 MISCELLANEOUS INCOME	BB		OPERATION OF PLANT	7.00 10.00	C	
3. 06 MI SCELLANEOUS I NCOME	B		NURSING ADMINISTRATION	13.00	C	
3.07 MISCELLANEOUS INCOME	В		PHARMACY	15.00	C	
3. 08 MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00	C	
3. 09 MISCELLANEOUS INCOME 3. 10 MISCELLANEOUS INCOME	BB		RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	C	
3. 11 IC LEASE INCOME	B		NEW CAP REL COSTS-BLDG &	1.00	10	•
	_		FLXT			
3.12 IC LEASE INCOME 3.13 INTERCOMPANY	B		MOB LEASED SPACE ADMI TTI NG	1. 02 5. 04	1C C	
3. 14 INTERCOMPANY	B		OTHER ADMINISTRATIVE &	5.05	C	
			GENERAL			
3. 15 INTERCOMPANY	В		MAINTENANCE & REPAIRS	6.00	C	
3. 16 I NTERCOMPANY 3. 17 I NTERCOMPANY	BB		OPERATION OF PLANT	7.00 11.00	C	
3. 18 I NTERCOMPANY	B		NURSING ADMINISTRATION	13.00	C	
3. 19 I NTERCOMPANY	В	-91, 389	CENTRAL SERVICES & SUPPLY	14.00	C	
3. 20 INTERCOMPANY	В		PHARMACY PATI ENT TRANSPORTATI ON	15.00	C	
3. 21 I NTERCOMPANY 3. 22 I NTERCOMPANY	BB		OPERATING ROOM	18. 00 50. 00	C	
3. 23 I NTERCOMPANY	B		RADI OLOGY-DI AGNOSTI C	54.00	C	
3. 24 I NTERCOMPANY	В		CHILDBIRTH EDUCATION	192.02	C	
3. 25 I NTERCOMPANY	B	-445, 276	PHYSICIANS' PRIVATE OFFICES	192.04	C	
3. 26 I NTERCOMPANY 3. 27 I NTERCOMPANY	BB			0. 00 0. 00	C	
3. 28 I NTERCOMPANY	B	0		0.00	C	
3. 29 RADI OLOGY START-UP	A	0		0.00	C	
3.30 EMPLOYEE BENEFITS	A	-11, 703, 313	EMPLOYEE BENEFITS DEPARTMENT	4.00	C	
3. 31 ACCRUED PTO 3. 32 MEDI CAI D HOSPI TAL ASSESSMENT	A A	-12 520 382	OTHER ADMINISTRATIVE &	0. 00 5. 05	C	
FEE		-12, 320, 302	GENERAL	5.05	C	35.5
3.33 TELEPHONE EQUI PMENT	A		NURSING ADMINISTRATION	13.00	C	
3. 34 TELEPHONE EQUI PMENT	A	-1, 045	ADULTS & PEDIATRICS	30.00	C	
3.35 TELEPHONE EQUI PMENT 3.36 TELEPHONE EQUI PMENT	A A			0. 00 0. 00	C	
3. 37 TELEPHONE EQUI PMENT	A	-	PREMATURE INTENSIVE CARE	34. 02	C	
3. 38 TELEPHONE EQUI PMENT	A	0		0.00	C	33.3
3.39 TELEPHONE EQUI PMENT	A	0		0.00	C	33.3
3. 40 TELEPHONE EQUI PMENT	A		RADI OLOGY-DI AGNOSTI C	54.00	C	
3. 41 TELEPHONE EQUI PMENT 3. 42 TELEPHONE EQUI PMENT	A A	-892	LABORATORY	60. 00 0. 00	C	
3. 43 TELEPHONE EQUIPMENT	A	0		0.00	C	
3. 44 UNWONTED SI TUATI ONS	A	0		0.00	C	33.4
3. 45 UNWONTED SI TUATI ONS	A		ADULTS & PEDIATRICS	30.00	C	
3.46 UNWONTED SITUATIONS	A	-100	OPERATING ROOM	50.00	C	33.4

Health Financial Systems			IU HEALTH NOR	TH HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-0161	Peri od:	Worksheet A-8	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	narod
					10 12/31/2020	7/9/2021 10:0	is am
				Expense Classification	on Worksheet A		
				To/From Which the Amount i	is to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	cost center bescription	(2)	Allourt	cost center	ETTIC //	Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.47	UNWONTED SI TUATI ONS	A	0		0.00	0	33.47
33.48	UNWONTED SI TUATI ONS	А	-1, 668	NURSING ADMINISTRATION	13.00	0	33.48
33.49	UNWONTED SI TUATI ONS	A	-200	EMERGENCY	91.00	0	33.49
33.50	PHYSICIAN MALPRACTICE INS	A	0		0.00	0	33.50
33. 51	CANCER CENTER PLANNING -	A	0	OTHER ADMINISTRATIVE &	5.05	0	33.51
	SALARY			GENERAL			
33. 52	CANCER CENTER PLANNING - OTHER	A	-	OTHER ADMINISTRATIVE &	5.05	0	33.52
			_	GENERAL		_	
	CARMEL REHAB START-UP	A	0		0.00		00.00
	CARMEL REHAB START-UP	A		PHYSI CAL THERAPY	66.00		00.01
	CANCER CENTER PLANNING	A		OTHER ADMINISTRATIVE &	5.05	0	33.55
	START-UP			GENERAL			
	TOTAL (sum of lines 1 thru 49)		-8, 641, 237				50.00
	(Transfer to Worksheet A,						
(1) 5	column 6, line 200.)						

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

(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

STATELENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS Provider CCN: 15-0161 Period From 0/01/2020 To 12/31/2020 Worksheet A-8-1- Date/frime Properties Li ne No. Cost Center Expense I tens Amount of Li low be Cost Amount of Li low be Cost State Amount of Li low be Cost Amount of Li low be Cost State Incl uded in Wiss. A cost State Monunt of Li low be Cost State Monunt of Li low be State Monunt low be State Monunt of Li low be State Monunt State Monunt State Monunt low be State Monunt low be State Monunt low be State Monut low be State Monunt low be State	Heal th	Financial Systems	IU HEALTH NO	RTH HOSPI TAL	In Lie	u of Form CMS-2	2552-10
Intervent To 12/31/2020 Date/Time Prepared: To Date/Time Prepared: To Line No. Cost Center Expense I tems Amount of Allowable Cost Amount of Newsberg Amount of Amount of the I lowable Cost Amount of Amount of the I lowable Cost 1.00 2.00 3.00 4.00 5 0.01 1.00NEW CAP REL COSTS-BLDG & FLX OFFICE ALLOCATION 4.00 5.00 1.00 1.00NEW CAP REL COSTS-INTEREST NOME OFFICE ALLOCATION 4.64, 756 1.834, 714 1.00 2.00 1.00NEW CAP REL COSTS-INTEREST NOME OFFICE ALLOCATION 14.652, 440 0 2.00 3.01 2.00NEW CAP REL COSTS-INTEREST NOME OFFICE ALLOCATION 1, 262, 547 0 3.01 4.00 5.02DATA PROCESSING HOME OFFICE ALLOCATION 1, 262, 547 0 3.00 4.00 5.02DATA PROCESSING HOME OFFICE ALLOCATION 1, 262, 547 0 3.00 4.00 5.03DATA PROCESSING HOME OFFICE ALLOCATION 2, 649, 474 4.03 4.01 5.03DATA PROCESSING HOME OFFICE ALLOCATION 2, 649, 474 4.03 5.03OAD	STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0161			-1
Line No. Cost Center Expense I tems Amount of All lowable Cost Amount of Anount of All lowable Cost Amount of Incl uded in Wks. A. col um 1.00 2.00 3.00 4.00 5.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME 0 5.00 0.00 1.00/WW CAP REL COSTS-BLDG & FIX HOME OFFICE ALLOCATION 664,756 1.834,714 1.00 2.00 1.00/WW CAP REL COSTS-INTEREST HOME OFFICE ALLOCATION 664,756 1.834,714 1.00 3.00 0.00 0.01 0.0551-WITEREST HOME OFFICE ALLOCATION 1.4652,440 0 2.00 3.01 0.00 0.00 0.01 0.00 0.01 0.01 0.00 0.01 0.01 0.00 0.01 0.01 0.02 0.00 0.01 0.01 0.00 0.00 0.00 0.01 0.01 0.02 0.00 0.01 0.01 0.02 0.01 0.01 0.02 0.01 0.01 0.00 0.01 0.01 0.00 0.00 0.01	OFFICE	COSTS					
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4.09 34.02 PREMATURE INTENSIVE CARE UNI INTERCOMPANY 666,100 666,100 4.09 4.10 50.00 OPERATI NG ROOM INTERCOMPANY 574,241 574,241 4.10 4.11 52.00 DELI VERY ROOM & LABOR ROOM INTERCOMPANY 1,353,656 1,353,656 4.11 4.12 54.00 RADI OLOGY - DI AGNOSTI C INTERCOMPANY 128,653 128,653 4.12 4.13 55.00 RADI OLOGY - THERAPEUTI C INTERCOMPANY 7,266,847 7,266,847 4.14 4.15 66.00 RESPI RATORY THERAPY INTERCOMPANY 12,371 12,371 4.15 4.16 66.00 PHYSI CAL THERAPY INTERCOMPANY 7,266,847 7,266,847 4.14 4.15 66.00 PHYSI CAL THERAPY INTERCOMPANY 12,371 4.23 168,391 4.17 4.18 70.00 ELECTROCACADI OLOGY INTERCOMPANY 108,391 168,391 4.19 4.20 91.00 OMERENCY INTERCOMPANY 190,343 190,343 190,343 190,343 4.19 4.21 192.01 OTHER NON-RE	4.07	30.00	ADULTS & PEDIATRICS	I NTERCOMPANY	4, 979, 436	4, 979, 436	4.07
4. 10 50. 00 OPERATI NG ROOM INTERCOMPANY 574, 241 574, 241 4. 10 4. 11 52. 00 DELI VERY ROOM & LABOR ROOM INTERCOMPANY 1, 353, 656 1, 353, 656 4. 11 4. 12 54. 00 RADI OLOGY-DI AGNOSTI C INTERCOMPANY 128, 653 128, 653 4. 12 4. 13 55. 00 RADI OLOGY- THERAPEUTI C INTERCOMPANY 559, 029 459, 029 4. 34 4. 14 60. 00 LABORATORY INTERCOMPANY 559, 029 4. 14 4. 15 65. 00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66. 00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4. 14 4. 17 69. 00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 168, 391 4. 17 4. 18 70. 00 ELECTROCARPHY INTERCOMPANY 190, 343 190, 343 4. 19 4. 20 91. 00 EMERGENCY INTERCOMPANY 190, 343 190, 343 4. 20 4. 21 192. 01 OTHER NON-REI MBURSABLE INTERCOMPANY 1,	4.08	34.01	PEDIATRIC INTENSIVE CARE UNI	I NTERCOMPANY	785, 253	785, 253	4.08
4. 11 52.00 DELIVERY ROOM & LABOR ROOM INTERCOMPANY 1, 353, 656 1, 353, 656 4. 11 4. 12 54.00 RADI OLOGY-DI AGNOSTI C INTERCOMPANY 128, 653 128, 653 4. 12 4. 13 55.00 RADI OLOGY - THERAPEUTI C INTERCOMPANY 559, 029 559, 029 4. 13 4. 14 60.00 LABORATORY INTERCOMPANY 7, 266, 847 7, 266, 847 4. 14 4. 15 65.00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66.00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4. 936 4. 17 69.00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 4. 17 4. 18 70.00 ELECTROENCEPHALOGRAPHY INTERCOMPANY 259, 351 259, 351 4. 19 75.01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 4. 936 4. 20 91.00 EMERGENCY INTERCOMPANY 190, 343 190, 343 4. 20 4. 21 192.01 OTHER NON-REI MBURSABLE INTERCOMPANY 9	4.09	34.02	PREMATURE INTENSIVE CARE UNI	I NTERCOMPANY	666, 100	666, 100	4.09
4. 12 54. 00 RADI OLOGY-DI AGNOSTI C INTERCOMPANY 128, 653 129, 653 4. 12 4. 13 55. 00 RADI OLOGY - THERAPEUTI C INTERCOMPANY 559, 029 559, 029 4. 13 4. 14 60. 00 LABORATORY INTERCOMPANY 7, 266, 847 7, 266, 847 4. 14 4. 15 65. 00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66. 00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4, 936 4. 17 69. 00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 168, 391 4. 17 4. 18 70. 00 ELECTROCARDI OLOGY INTERCOMPANY 259, 351 259, 351 259, 351 259, 351 4. 18 4. 19 75. 01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 4. 19 4. 20 91. 00 EMERGENCY INTERCOMPANY 1, 307, 918 1, 307, 918 4. 20 4. 21 192. 01 OTHER NON-REI IMBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 <	4.10	50.00	OPERATING ROOM	I NTERCOMPANY	574, 241	574, 241	4.10
4. 12 54. 00 RADI OLOGY-DI AGNOSTI C INTERCOMPANY 128, 653 128, 653 4. 12 4. 13 55. 00 RADI OLOGY - THERAPEUTI C INTERCOMPANY 559, 029 559, 029 4. 13 4. 14 60. 00 LABORATORY INTERCOMPANY 7, 266, 847 7, 266, 847 4. 14 4. 15 65. 00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66. 00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4, 936 4. 17 69. 00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 168, 391 4. 17 4. 18 70. 00 ELECTROENCEPHALOGRAPHY INTERCOMPANY 259, 351 259, 351 4. 18 4. 20 91. 00 EMERGENCY INTERCOMPANY 190, 343 190, 343 4. 90 4. 21 192. 01 OTHER NON-REI MBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 192. 02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 9, 597 9, 597 4. 22 4. 23 192. 02 PHYSI CI AN PRACTI CE <td< td=""><td>4.11</td><td>52.00</td><td>DELIVERY ROOM & LABOR ROOM</td><td>I NTERCOMPANY</td><td>1, 353, 656</td><td>1, 353, 656</td><td>4.11</td></td<>	4.11	52.00	DELIVERY ROOM & LABOR ROOM	I NTERCOMPANY	1, 353, 656	1, 353, 656	4.11
4. 13 55.00 RADIOLOGY - THERAPEUTIC INTERCOMPANY 559,029 559,029 4. 13 4. 14 60.00 LABORATORY INTERCOMPANY 7, 266, 847 7, 266, 847 4. 14 4. 15 65.00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66.00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4, 936 4. 17 69.00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 168, 391 4. 17 4. 18 70.00 ELECTROCARDI OLOGY INTERCOMPANY 259, 351 259, 351 4. 18 4. 19 75.01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 190, 343 190, 343 190, 343 190, 343 4. 19 4. 20 91.00 EMERGENCY INTERCOMPANY 9, 597 9, 597 4. 20 4. 21 192.01 OTHER NON-RELIMBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 192.02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 9, 597 9, 597 4. 22 <t< td=""><td>4.12</td><td>54.00</td><td>RADI OLOGY-DI AGNOSTI C</td><td>INTERCOMPANY</td><td></td><td>128, 653</td><td>4.12</td></t<>	4.12	54.00	RADI OLOGY-DI AGNOSTI C	INTERCOMPANY		128, 653	4.12
4. 14 60.00 LABORATORY INTERCOMPANY 7, 266, 847 7, 266, 847 4. 14 4. 15 65.00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66.00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4, 936 4. 16 4. 17 69.00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 168, 391 4. 17 4. 18 70.00 ELECTROCARDI OLOGY INTERCOMPANY 259, 351 259, 351 4. 18 4. 19 75.01 CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 4. 19 4. 20 91.00 EMERGENCY INTERCOMPANY 190, 343 190, 343 4. 20 4. 21 192.01 OTHER NON-REI MBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 192.02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 27, 400 27, 400 4. 22 4. 23 192.05 PHYSI CI AN PRACTI CE INTERCOMPANY 27, 400 27, 400 4. 23 5.00 TOTALS (sum of Lines 1-4). Transfer column	4.13	55.00	RADIOLOGY - THERAPEUTIC	INTERCOMPANY	559,029	559, 029	4.13
4. 15 65.00 RESPI RATORY THERAPY INTERCOMPANY 12, 371 12, 371 4. 15 4. 16 66.00 PHYSI CAL THERAPY INTERCOMPANY 4, 936 4, 936 4, 936 4. 17 69.00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 168, 391 4. 17 4. 18 70.00 ELECTROENCEPHALOGRAPHY INTERCOMPANY 259, 351 259, 351 4. 18 4. 19 75.01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 4. 09 4. 20 91.00 EMERGENCY INTERCOMPANY 1, 307, 918 1, 307, 918 4. 20 4. 21 192.01 OTHER NON-REI MBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 23 192.02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 27, 400 27, 400 4. 22 4. 23 192.05 PHYSI CI AN PRACTI CE INTERCOMPANY 153, 030 153, 030 4. 23 5.00 TOTALS (sum of Lines 1-4). Transfer col umn 6, Line 5 to INTERCOMPANY 84, 246, 663 50, 522, 458 5. 00 Worksheet A-8, col umn 2,							
4. 16 66.00 PHYSI CAL THERAPY INTERCOMPANY 4,936 4,936 4,936 4.16 4. 17 69.00 ELECTROCARDI OLOGY INTERCOMPANY 168,391 168,391 4.17 4. 18 70.00 ELECTROENCEPHALOGRAPHY INTERCOMPANY 259,351 259,351 4.18 4. 19 75.01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190,343 190,343 4.19 4. 20 91.00 EMERGENCY INTERCOMPANY 1,307,918 1,307,918 4.20 4. 21 192.01 OTHER NON-REI MBURSABLE INTERCOMPANY 9,597 9,597 4.21 4. 22 192.02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 9,597 9,597 4.22 4. 23 192.02 PHYSI CI AN PRACTI CE INTERCOMPANY 27,400 27,400 4.22 4. 23 192.05 PHYSI CI AN PRACTI CE INTERCOMPANY 153,030 153,030 4.23 5.00 TOTALS (sum of Lines 1-4). Transfer column 6, Line 5 to NTERCOMPANY 84,246,663 50,522,458 5.00 Worksheet A-8, column 2, INTERCOLOMPA							
4. 17 69.00 ELECTROCARDI OLOGY INTERCOMPANY 168, 391 4. 17 4. 18 70.00 ELECTROENCEPHALOGRAPHY INTERCOMPANY 259, 351 259, 351 259, 351 4. 19 75.01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 190, 343 4. 19 4. 20 91.00 EMERGENCY INTERCOMPANY 1, 307, 918 1, 307, 918 4. 20 4. 21 192.01 OTHER NON-REI MBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 192.02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 27, 400 27, 400 27, 400 4. 22 4. 23 192.05 PHYSI CI AN PRACTI CE INTERCOMPANY 153, 030 153, 030 4. 23 5.00 TOTALS (sum of Lines 1-4). Transfer column 6, Line 5 to 84, 246, 663 50, 522, 458 5.00 Worksheet A-8, column 2, 6 Lines 5, 000 Sono 84, 246, 663 50, 522, 458 5.00							
4. 18 70.00 ELECTROENCEPHALOGRAPHY INTERCOMPANY 259, 351 259, 351 4. 18 4. 19 75.01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 4. 19 4. 20 91.00 EMERGENCY INTERCOMPANY 1, 307, 918 1, 307, 918 4. 20 4. 21 192.01 OTHER NON-REI MBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 192.02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 27, 400 27, 400 27, 400 4. 22 4. 23 192.05 PHYSI CI AN PRACTI CE INTERCOMPANY 153, 030 153, 030 4. 23 5.00 TOTALS (sum of Lines 1-4). Transfer column 6, Line 5 to Worksheet A-8, column 2, A <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
4. 19 75. 01 CARDI AC CATHERI ZATI ON LABORA INTERCOMPANY 190, 343 190, 343 4. 19 4. 20 91. 00 EMERGENCY INTERCOMPANY 1, 307, 918 1, 307, 918 4. 20 4. 21 192. 01 OTHER NON-RELIMBURSABLE INTERCOMPANY 9, 597 9, 597 4. 21 4. 22 192. 02 CHI LDBI RTH EDUCATI ON INTERCOMPANY 27, 400 27, 400 4. 22 4. 23 192. 05 PHYSI CI AN PRACTI CE INTERCOMPANY 153, 030 153, 030 4. 23 5. 00 TOTALS (sum of Lines 1-4). Transfer column 6, Line 5 to Worksheet A-8, column 2, A A A A A							
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4. 22 192.02 CHILDBIRTH EDUCATION INTERCOMPANY 27,400 27,400 4.22 4. 23 192.05 PHYSICIAN PRACTICE INTERCOMPANY 153,030 153,030 4.23 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, A A A A							
4. 23 192.05 PHYSICIAN PRACTICE INTERCOMPANY 153,030 4.23 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to 84,246,663 50,522,458 5.00 Worksheet A-8, column 2, Version 2, Version 2, Version 2, Version 2, Version 2,							
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, 5.00							
Transfer column 6, line 5 to Worksheet A-8, column 2,			PHISICIAN PRACIICE	INTERCOMPANY			
Worksheet A-8, column 2,	5.00				84, 246, 663	50, 522, 458	5.00
line i2.							
* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A column 6 lines as							

* 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.

1103 110	t been posted to worksheet A,	corumna r anazor z, tric amou	int arrowable 3		+ or this part.				
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownership		Ownership				
	1.00	2.00	3.00	4.00	5.00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	В	0.00 IU HEALTH 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	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 NORTH HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FRO OFFICE COSTS	DM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-0161	Period: Worksheet A-8-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

Net Adjustments (col. 4 minus col. 5)* Wkst. A-7 Ref. 6.00 7.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1.00 -1,169,958 9 2.00 14,652,440 9 3.01 1,262,547 9 3.02 12,406,006 0 4.00 8,366,467 0 4.01 1,071,921 0 4.02 2,049,048 0 4.03 -172,143 0 4.04 -172,143 0 4.05 0 0 4.06 0 0
(col. 4 minus col. 5)* 7.00 A. COSTS I NCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1.00 -1,169,958 9 2.00 14,652,440 9 3.00 0 0 3.01 1,262,547 9 3.02 12,406,006 0 4.00 8,366,467 0 4.01 1,071,921 0 4.02 2,049,048 0 4.03 -4,742,123 0 4.04 -172,143 0 4.05 0 0 4.06 0 0
col. 5)*
col. 5)*
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1.00 -1, 169, 958 9 1.00 2.00 14, 652, 440 9 2.00 3.00 0 0 3.00 3.01 1, 262, 547 9 3.00 3.02 12, 406, 006 0 3.00 4.00 8, 366, 467 0 4.00 4.02 2, 049, 048 0 4.00 4.03 -4, 742, 123 0 4.00 4.05 0 0 4.00 4.06 0 0 4.00
OFFICE COSTS: 1.00 1.00 -1,169,958 9 2.00 14,652,440 9 3.00 0 0 3.01 1,262,547 9 3.02 12,406,006 0 4.00 8,366,467 0 4.01 1,071,921 0 4.02 2,049,048 0 4.03 -4,742,123 0 4.04 -172,143 0 4.05 0 0 4.06 0 0
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$ \begin{array}{cccccccccccccccccccccccccccccccccccc$
3.00 0 0 3.01 3.01 1,262,547 9 3.00 3.02 12,406,006 0 3.00 4.00 8,366,467 0 3.00 4.01 1,071,921 0 4.00 4.02 2,049,048 0 4.00 4.03 -4,742,123 0 4.00 4.04 -172,143 0 4.00 4.05 0 0 4.00
3.01 1,262,547 9 3.0 3.02 12,406,006 0 3.0 4.00 8,366,467 0 4.0 4.01 1,071,921 0 4.0 4.02 2,049,048 0 4.0 4.03 -4,742,123 0 4.0 4.04 -172,143 0 4.0 4.05 0 0 4.00
3. 02 12, 406, 006 0 3. 02 4. 00 8, 366, 467 0 4. 00 4. 01 1, 071, 921 0 4. 0 4. 02 2, 049, 048 0 4. 0 4. 03 -4, 742, 123 0 4. 0 4. 04 -172, 143 0 4. 0 4. 05 0 0 4. 0
4.00 8,366,467 0 4.00 4.01 1,071,921 0 4.0 4.02 2,049,048 0 4.0 4.03 -4,742,123 0 4.0 4.04 -172,143 0 4.0 4.05 0 0 4.0 4.06 0 0 4.0
4.01 1,071,921 0 4.0 4.02 2,049,048 0 4.0 4.03 -4,742,123 0 4.0 4.04 -172,143 0 4.0 4.05 0 0 4.0 4.06 0 0 4.0
4. 02 2, 049, 048 0 4. 00 4. 03 -4, 742, 123 0 4. 00 4. 04 -172, 143 0 4. 00 4. 05 0 0 4. 00 4. 06 0 0 4. 00
4. 03 -4, 742, 123 0 4. 00 4. 04 -172, 143 0 4. 00 4. 05 0 0 4. 00 4. 06 0 0 4. 00
4.04 -172,143 0 4.00 4.05 0 0 4.00 4.06 0 0 4.00
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4.06 0 0 4.0
4. U/ J U/ J 4. U
4.08 0 0 4.00
4.09 0 0 4.0
4.10 0 0 4.10
4.11 0 0 4.1
4.12 0 0 4.13
4.13 0 0 4.1
4.14 0 0 4.1-
4.15 0 0 4.1
4.16 0 0 4.10
4.17 0 0 4.1
4.18 0 0 4.17
4.19 0 0 4.1
4.20 0 0 4.20
4.21 0 0 4.2
4.22 0 0 4.2
4.23 0 0 4.2
5.00 33,724,205 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	Deen posted to worksheet A,	COLUMNIS I ANU/O	Ζ,	the amount	arrowabre	siloui u be	Thui cateu	TH COLUMN 4 OF	this part.	
	Related Organization(s)									
	and/or Home Office									
	Type of Business	1								
	5.									
	6.00	1								
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION	(S) /	AND/OR HOME	OFFICE:					

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

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

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

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

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

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

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

	Financial Syste R BASED PHYSIC		TU HEALTH NU	RTH HOSPITAL	CCN: 15-0161	Period:	eu of Form CMS- Worksheet A-8	
PROVIDE	R DASED PHISIC	I AN ADJUSTMENT		Provider (. 13-0101	From 01/01/2020	0	
						To 12/31/2020	Date/Time Pro 7/9/2021 10:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	<i>,</i>
		Identifier	Remuneration	Component	Component		ider Component	
	1.00	2.00	2.00	1.00	F 00	(00	Hours	
1.00	1.00	2.00 OTHER ADMINISTRATIVE &	3. 00 492, 273	4.00	5.00	6.00 0 211,500	7.00	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	4, 936, 008			0 179,000		
3.00		PEDIATRIC INTENSIVE CARE UNIT	764, 793	764, 793		0 169, 700	0	3.00
4.00	34.02	PREMATURE INTENSIVE CARE	641, 100	641, 100		0 169, 700	0	4.00
5.00		OPERATING ROOM	742,030	742, 030		0 246, 400	0	5.00
6.00		DELIVERY ROOM & LABOR ROOM	1, 370, 645			0 237, 100		1
7.00		RADI OLOGY-DI AGNOSTI C	32, 083			0 271,900		
8.00		EMERGENCY	1, 172, 343			0 211, 500		1
9.00	55.00	RADI OLOGY - THERAPEUTI C	493, 088			0 211, 500		9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			10, 644, 363			0	0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		& Component Share of col.	of Malpractice Insurance	•
				Limit	Conti nui ng Educati on	12	Thsurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.05	OTHER ADMINISTRATIVE &	0	0		0 0	0	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	0			0 0	0	
3.00		PEDIATRIC INTENSIVE CARE UNIT	0	0		0 0	0	3.00
4.00	34.02	PREMATURE INTENSIVE CARE	0	0		0 0	0	4.00
5.00		UNIT OPERATING ROOM	0	0			0	5.00
6.00		DELIVERY ROOM & LABOR ROOM					0	
7.00		RADI OLOGY-DI AGNOSTI C		0			0	
8.00		EMERGENCY	0	0			0	
9.00		RADI OLOGY - THERAPEUTI C	0	Ö				4
10.00	0. 00		0	0		0 0	0 0	10.00
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OTHER ADMINISTRATIVE &	0			0 492, 273	6	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	0	0		0 4, 936, 008		2.00
3.00		PEDIATRIC INTENSIVE CARE	0	0		0 764, 793		3.00
4.00		UNIT PREMATURE INTENSIVE CARE	0	0		0 641,100		4.00
4.00		UNIT	0			0 641, 100		4.00
5.00		OPERATING ROOM	0	0		0 742,030		5.00
6.00		DELIVERY ROOM & LABOR ROOM	0	0		0 1, 370, 645	•	6.00
7.00		RADI OLOGY-DI AGNOSTI C	0			0 32,083	1	7.00
8.00	91.00	EMERGENCY	0	0		0 1, 172, 343		8.00
9.00		RADI OLOGY – THERAPEUTI C	0			0 493, 088		9.00
10 00	0.00		0	0		0 0		10.00
10.00 200.00	0.00		0			0 10, 644, 363		200.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH NOR	TH HOSPITAL Provider C	CN: 15-0161 P	In Lieu eriod:	u of Form CMS-: Worksheet B	2552-10
				rom 01/01/2020	Part I Date/Time Pre 7/9/2021 10:0	epared:
			CAPI TAL REL	ATED COSTS	// // 2021 10.0	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW INTEREST	MOB LEASED SPACE	NEW MVBLE EQUI P	
	0	1.00	1.01	1.02	2.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	10, 074, 451	10, 074, 451				1.00
1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	12, 436, 818 -241, 633 9, 738, 696	0 0 0	12, 436, 818		9, 738, 696	1.01 1.02
4.0000400EMPLOYEE BENEFITS DEPARTMENT5.0100540NONPATIENT TELEPHONES5.0200550DATA PROCESSING	13, 960, 094 -745 8, 366, 782	28, 153 0 124, 090	0	0	1, 681 0 0	5.01
5. 03 00560 PURCHASING RECEIVING AND STORES	1,029,139	234,055		0	6, 599	
5. 04 00570 ADMI TTI NG 5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL	2, 842, 274 31, 444, 814	77, 299 268, 545		0	463, 919 1, 127, 730	
6. 00 00600 MAI NTENANCE & REPAI RS	4, 431, 503	96, 467	119, 087	0	126, 693	6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	4, 725, 046 128, 965	1, 476, 957 0		0	53, 476 0	1
9. 00 00900 HOUSEKEEPI NG	4, 874, 539	124, 404	-	0	2, 834	
10.00 01000 DI ETARY	1, 193, 028	53, 324		0	8, 023	
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	1, 588, 115 3, 114, 732	320, 535 208, 923		0	47, 001 8, 036	
14. 00 01400 CENTRAL SERVICES & SUPPLY	8, 892, 805	355, 614		0	284, 342	
15.00 01500 PHARMACY	4,018,480	157, 933		0	125, 945	1
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	66, 835 587, 664	18, 638 12, 949			0	1
18.00 01850 PATIENT TRANSPORTATION	184, 496	0			0	18.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	15, 157, 492	1, 731, 474	2, 137, 487	0	337, 170	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 34. 02 03402 PREMATURE INTENSIVE CARE UNIT	1, 022, 411 2, 977, 410	163, 681 435, 365		0	27, 924 80, 238	
43. 00 04300 NURSERY	1, 088, 155	435, 305 202, 095		0	15, 542	
ANCI LLARY SERVICE COST CENTERS	4 070 724	923, 898	1 140 542	0	1, 553, 303	50.00
51.00 05100 RECOVERY ROOM	4, 978, 734 2, 213, 848	182, 025		-	53, 536	
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 129, 474	560, 299		0	251, 993	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	4, 269, 756 2, 860, 306	295, 030 782, 405		0	3, 710, 908 571, 056	
56. 00 05600 RADI OL SOTOPE	270, 467	21, 247		0	5, 096	
60. 00 06000 LABORATORY	8, 495, 308	217, 947		0	978	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 164, 134 2, 069, 172	37, 060 6, 847		0	79, 355 14, 881	
67.00 06700 OCCUPATI ONAL THERAPY	284, 941	0	0		0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	144, 333 595, 488	0 42, 809	-	0	1, 729 238, 889	
70. 00 07000 ELECTROENCEPHALOGRAPHY	513, 637	14, 400		0	43, 087	1
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	5, 781, 429	0	0	0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS	10, 223, 206 37, 576, 673	0	0	0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY OUTPATIENT SERVICE COST CENTERS	1, 622, 152	264, 562	326, 600	0	414, 084	75.01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	2, 996, 072	232, 034	286, 444	0	69, 037	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	233, 891, 496	9, 671, 064	· · · · · · · · · · · · · · · · · · ·	0	9, 725, 085	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 OTHER NON-RELIMBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATION	0 677, 557 120, 637	0 45, 281 0	-	-	0 0	192.00 192.01 192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES 192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	0 -443, 921	0 331, 522	0 409, 261	0		192.03 192.04
192. 05 19205 PHYSI CI AN PRACTI CE	1, 077, 943	0	0	0	12, 528	192.05
192. 06 19206 TI PTON HOSPI TAL	53, 683	2, 590		0		192.06
192. 07 19207 WEST HOSPI TAL 192. 08 19208 SAXONY HOSPI TAL	245, 521 61, 714	19, 070 4, 924		0		192.07 192.08
200.00 Cross Foot Adjustments		.,	0,077	J		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	235, 684, 630	0 10, 074, 451	0 12, 436, 818	-241, 633 -241, 633	0 9, 738, 696	201. 00 202. 00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre 7/9/2021 10:0	pared:
Cost Center Description	EMPLOYEE BENEFI TS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	
	4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS	[[1		1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	14, 024, 683 0 0 99, 809 789, 961 484, 563 231, 392 0 322, 336	-745 0 0 0 0 0 0 0 0 0 0 0	8, 644, 060 0 73, 080 335, 340 294, 103 163, 725 0 395, 175	1, 558, 731 1, 559 2, 736 6, 811 0 0	3, 653, 365 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ \end{array}$
10. 00 01000 DI ETARY	191, 384	0	218, 300		0	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON	263, 729	0	281, 422		0	11.00 13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	673, 112 210, 129	0	322, 283 206, 934		0	14.00
15. 00 01500 PHARMACY	709, 541	0	260, 287		0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	-	0	16.00
17.00 01700 SOCIAL SERVICE	89, 233	0	49, 503		0	17.00
18.00 01850 PATIENT TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	50, 033	0	64, 062	0	0	18.00
30. 00 03000 ADULTS & PEDI ATRI CS	3, 071, 462	0	1, 945, 532	89, 775	306, 892	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	-	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	193, 853	0	109, 807		11, 789	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	607, 081 223, 669	0 0	348, 866 141, 181		76, 361 23, 387	34.02 43.00
ANCI LLARY SERVICE COST CENTERS	220,007		111,101	0	20,007	10.00
50. 00 05000 OPERATI NG ROOM	973, 538	0			691, 669	50.00
51.00 05100 RECOVERY ROOM	456, 711	0	253, 524		92, 084	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	623, 481 849, 784	0	347, 081 458, 673		123, 561 212, 583	52.00 54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	569, 954	0	332, 991		203, 522	55.00
56. 00 05600 RADI OI SOTOPE	56, 546	0	27, 334		28, 956	56.00
	152, 643	0	289, 500		162, 046	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	451, 224 433, 262	0 0	157, 807 218, 112		44, 690 29, 630	
67. 00 06700 OCCUPATI ONAL THERAPY	60, 212	0	30, 340		6, 567	67.00
68.00 06800 SPEECH PATHOLOGY	30, 349	0	14, 278		2, 682	68.00
69. 00 06900 ELECTROCARDI OLOGY	86, 672	0			46, 142	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	32, 030 0	0	18, 599 0		10, 936 125, 165	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	670, 273	312, 911	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	754, 530	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY OUTPATI ENT SERVI CE COST CENTERS	247, 407	0	139, 866	1, 335	116, 907	75.01
91. 00 09100 EMERGENCY	560, 349	0	340, 224	24, 183	270, 355	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	13, 795, 449	0	8, 482, 965	1, 558, 601	3, 653, 365	118.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
192. 01 19201 OTHER NON-REI MBURSABLE	27, 402	0	30, 904			192.01
192. 02 19202 CHI LDBI RTH EDUCATI ON	18, 953	0	12, 775			192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.03
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES 192. 05 19205 PHYSI CLAN PRACTI CE	0 132, 522	0	0 92, 430	-		192. 04 192. 05
192. 06 19206 TI PTON HOSPI TAL	8, 104	0	4, 133			192.05
192. 07 19207 WEST HOSPI TAL	33, 723	0	16, 720	0	0	192.07
192. 08 19208 SAXONY HOSPI TAL	8, 530	0	4, 133	0		192.08
200.00Cross Foot Adjustments201.00Negative Cost Centers	_	-745	_			200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum Lines 118 through 201)	14, 024, 683	-745 -745		1, 558, 731		
	, 52 ., 500	. 10	2, 31., 300	.,,	2, 333, 300	

Health Financial Systems	IU HEALTH NOR			Inlie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0161 P	eriod:	Worksheet B	
				rom 01/01/2020 p 12/31/2020		pared:
Cost Center Description	Subtotal	OTHER	MAINTENANCE &	OPERATION OF	7/9/2021 10:0 LAUNDRY &	8 am
	Subtotui	ADMI NI STRATI V	REPAI RS	PLANT	LINEN SERVICE	
	5A. 04	E & GENERAL 5.05	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS	57.04	3.03	0.00	7.00	0.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST						1.00
1. 01 00101 NEW CAP REL COSTS-INTEREST 1. 02 00102 MOB LEASED SPACE						1.01 1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATIENT TELEPHONES						4.00 5.01
5. 02 00550 DATA PROCESSI NG						5.02
5. 03 00560 PURCHASING RECEIVING AND STORES						5.03
5. 04 00570 ADMI TTI NG 5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL	34, 300, 642	34, 300, 642	,			5.04 5.05
6. 00 00600 MAI NTENANCE & REPAI RS	5, 559, 227	945, 736	6, 504, 963			6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE	8, 473, 886			10, 954, 584 0	150, 905	7.00 8.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	128, 965 5, 875, 611			175, 417	150, 903	9.00
10. 00 01000 DI ETARY	1, 730, 434	294, 381	37, 517	75, 191	0	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	2, 896, 721 4, 585, 017			451, 973 294, 593	0	11. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	10, 416, 635			501, 436	0	14.00
15.00 01500 PHARMACY	5, 486, 927			222, 695	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	108, 482 755, 340			26, 281 18, 258	0	16. 00 17. 00
18.00 01850 PATIENT TRANSPORTATION	298, 591			0	0	18.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 O3000 ADULTS & PEDI ATRI CS	24, 777, 284	4, 215, 112	1, 218, 188	2, 441, 481	108, 919	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	24, 777, 284			2, 441, 481	00, 919	34.00
34. 01 03401 PEDIATRI CINTENSI VE CARE UNI T	1, 733, 627			230, 800	2, 644	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	5, 073, 960 1, 943, 514			613, 890 284, 966	21, 424 17, 918	34.02 43.00
ANCI LLARY SERVI CE COST CENTERS	Γ	1				
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	11, 098, 785 3, 490, 041			1, 302, 750 256, 666	0	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	5, 748, 224			790, 054	0	52.00
54.00 05400 RADI OLOGY - DI AGNOSTI C	10, 180, 075			416,010	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	6, 295, 175 435, 976			1, 103, 237 29, 960	0	55.00 56.00
60. 00 06000 LABORATORY	9, 588, 142	1, 631, 135	153, 338	307, 319	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 994, 642 2, 781, 638			52, 257 9, 655	0	65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	382, 324			y, 033 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	193, 562			0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 109, 209 650, 938			60, 363 20, 305	0	69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 285, 642	1, 069, 313	0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS	11, 206, 390 38, 331, 203			0	0	72.00 73.00
75.00 07500 ASC (NON-DISTINCT PART)	38, 331, 203		0	0	0	73.00 75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	3, 132, 913	532, 971	186, 134	373, 048	0	75.01
OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY	4, 778, 698	812, 952	163, 249	327, 181	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		100,21,	0277.01		92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	232, 828, 440	33, 773, 514	6, 221, 158	10, 385, 786	150, 905	118 00
NONREI MBURSABLE COST CENTERS	232, 020, 440		0,221,130	10, 303, 700	130, 703	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 OTHER NON-REI MBURSABLE	0 837, 043			0 63, 848		192. 00 192. 01
192. 02 19201 CHI LOBI RTH EDUCATI ON	152, 365			63, 848 0		192.01 192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192.03
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES 192. 05 19205 PHYSI CLAN PRACTI CE	297, 945 1, 315, 553			467, 465 0		192. 04 192. 05
192. 06 19206 TI PTON HOSPI TAL	71, 707	12, 199	1, 822	3, 652	0	192.06
192. 07 19207 WEST HOSPI TAL	338, 575			26, 889		192.07
192.08 19208 SAXONY HOSPITAL 200.00 Cross Foot Adjustments	85, 380 0		3, 465	6, 944		192.08 200.00
201.00 Negative Cost Centers	-242, 378		-	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	235, 684, 630	34, 300, 642	6, 504, 963	10, 954, 584	150, 905	202.00

Health Financial Systems	IU HEALTH NORTH			In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet B Part I Date/Time Pre 7/9/2021 10:0	pared: 8 am
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS		1				1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-INTEREST 1.01 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-INTEREST 5.01 00540 EMPLOYEE BENEFITS DEPARTMENT 5.01 00550 DATA PROCESSING 5.02 00550 DATA PROCESSING 5.03 00560 PURCHASING RECEIVING AND STORES 5.04 00570 ADMINTTING 5.05 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 PHARMACY 16.00 01500 <td>7, 138, 112 49, 792 299, 303 195, 084 332, 058 147, 471 17, 403 12, 091 0</td> <td>2, 187, 315 0 0 0 0 0 0 0 0 0 0 0</td> <td>4, 366, 301 204, 446 131, 272 165, 118 0 31, 403 40, 639</td> <td>0 0 0</td> <td>13, 403, 673 174, 799 6 53 0</td> <td>15.00 16.00 17.00</td>	7, 138, 112 49, 792 299, 303 195, 084 332, 058 147, 471 17, 403 12, 091 0	2, 187, 315 0 0 0 0 0 0 0 0 0 0 0	4, 366, 301 204, 446 131, 272 165, 118 0 31, 403 40, 639	0 0 0	13, 403, 673 174, 799 6 53 0	15.00 16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	1, 616, 782 0	1, 960, 786 0	1, 234, 184 0		793, 598 0	1
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	152, 839 406, 527 188, 708	42, 218 0 0	69, 658 221, 309 89, 561	192, 818 577, 547	18, 552 98, 874 0	34.01 34.02
ANCI LLARY SERVICE COST CENTERS	862, 699	0	379, 932	666, 512	2, 105, 525	50.00
51. 00 05100 RECOVERY ROOM	169, 968	9, 122	160, 828		120, 268	•
52.00 05200 DELIVERY ROOM & LABOR ROOM	523, 185	114, 574	220, 177		182, 553	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	275, 488 730, 579	0	290, 968 211, 239		169, 095 80, 165	•
56. 00 05600 RADI 0L0GT - THERAPEUTIC	19,840	0	17, 340		80, 105	•
60. 00 06000 LABORATORY	203, 511	0	183, 650		5, 887	•
65. 00 06500 RESPIRATORY THERAPY	34, 605	0	100, 108		129, 249	•
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	6, 393 0	0	138, 363 19, 247		11, 324 2, 336	•
68. 00 06800 SPEECH PATHOLOGY	0	0	9, 057		1, 687	1
69. 00 06900 ELECTROCARDI OLOGY	39, 973	0	29, 258	0	2, 132	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 446	0	11, 798	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	3, 350, 737 5, 925, 058	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
75. 00 07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY OUTPATI ENT SERVI CE COST CENTERS	247, 038	43, 574	88, 726	158, 685	11, 798	75.01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	216, 664	17, 041	215, 827	455, 538	213, 777	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS		2, 187, 315			13, 402, 525	1
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON 192. 03 19203 PHYSI CI ANS' PRI VATE OFFI CES	0 42, 281 0 0	0 0 0 0	0 19, 604 8, 104 0	0	2 0	192.00 192.01 192.02 192.03
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	309, 562	Ő	0	0	0	192.04
192. 05 19205 PHYSI CI AN PRACTI CE	0	0	58, 634			192.05
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL	2, 418 17, 806	0	2, 622 10, 607			192.06 192.07
192. 08 19207 WEST HOSPITAL 192. 08 19208 SAXONY HOSPITAL	4, 598	0	2, 622			192.07
200.00 Cross Foot Adjustments		-				200.00
201.00 Negative Cost Centers	0	0	0	-		201.00
202.00 TOTAL (sum lines 118 through 201)	7, 138, 112	2, 187, 315	4, 366, 301	6, 206, 132	13, 403, 673	1202. UU

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		eriod: rom 01/01/2020	Worksheet B Part I	
			T		Date/Time Pre	
				OTHER GENERAL	7/9/2021 10:0	
Cost Costos Deseriation	DUADMACY		50CL AL	SERVI CE	Cultertal	
Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	PATI ENT TRANSPORTATI O	Subtotal	
		LI BRARY		Ν		
GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	18.00	24.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-INTEREST						1.01
1. 02 00102 MOB LEASED SPACE 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.02 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES						5.01
5. 02 00550 DATA PROCESSI NG 5. 03 00560 PURCHASI NG RECEI VI NG AND STORES						5.02 5.03
5. 04 00570 ADMI TTI NG						5.04
5. 05 00590 OTHER ADMINI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS						5.05 6.00
7. 00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	7, 241, 561					14.00 15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	183, 740				16.00
17.00 01700 SOCI AL SERVI CE 18.00 01850 PATI ENT TRANSPORTATI ON	0	0	954, 753 0	390, 026		17.00 18.00
INPATIENT ROUTINE SERVICE COST CENTERS	0		0	370, 020		10.00
30. 00 03000 ADULTS & PEDI ATRI CS	32, 132	15, 405	689, 111	32, 777	41, 595, 915	30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	0 8	0 592	0 16, 730	0 1, 259	0 2, 871, 829	34.00 34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	2, 168	3, 833	135, 549	8, 156	8, 332, 722	34.02
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	1, 174	113, 363	2, 498	3, 316, 959	43.00
50.00 05000 OPERATI NG ROOM	28, 083	34, 718	0	73, 873	19, 091, 015	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 088 6, 393	4, 622	0	9, 835 13, 197	5, 370, 181 9, 495, 914	51.00 52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	6, 393 7, 972	6, 202 10, 671	0	22, 705	9, 495, 914	
55. 00 05500 RADI OLOGY – THERAPEUTI C	11, 550	10, 216	0	21, 737	10, 404, 484	55.00
56. 00 05600 RADI 0I SOTOPE 60. 00 06000 LABORATORY	45 9	1, 453 8, 134	0	3, 093 17, 307	597, 705 12, 220, 441	56.00 60.00
65. 00 06500 RESPI RATORY THERAPY	1, 419	2, 243	0	4, 773	3, 855, 907	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 487	0	3, 165	3, 430, 054	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	330 135	0	701 286	469, 979 237, 656	
69. 00 06900 ELECTROCARDI OLOGY	2	2, 316	0	4, 928	1, 466, 998	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	549	0	1, 168	823, 244	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	6, 283 15, 707	0	13, 368 33, 420	10, 725, 343 19, 087, 006	
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 127, 159	38, 231	0	80, 419	52, 097, 882	73.00
75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0 3, 472	0 5, 868	0	0	0	75.00 75.01
OUTPATIENT SERVICE COST CENTERS	3,472	5, 000	0	12, 486	4, 796, 713	75.01
91.00 09100 EMERGENCY	14, 060	13, 571	0	28, 875	7, 257, 433	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	7, 241, 560	183, 740	954, 753	390, 026	230, 959, 624	118.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
192. 01 19201 OTHER NON-REI MBURSABLE	0	0	0	0	1, 137, 033	
192. 02 19202 CHI LOBI RTH EDUCATI ON	0	0	0	0	188, 205	192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES 192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0 1, 358, 902	192.03 192.04
192. 05 19205 PHYSI CLAN PRACTI CE	1	0	0	0	1, 600, 770	
192. 06 19206 TI PTON HOSPI TAL	0	0	0	0	100, 048	1
192. 07 19207 WEST HOSPI TAL 192. 08 19208 SAXONY HOSPI TAL	0	0 0	0 0	0	464, 892 117, 534	
200.00 Cross Foot Adjustments		-	_		0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 7, 241, 561	0 183, 740	0 954, 753	0 390, 026	-242, 378 235, 684, 630	
	7, 241, 001	103, 740	754,755	570, 020	200, 004, 030	1202.00

Health Financial Systems	IU HEALTH NORTH	H HOSPI TAL	In Lieu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0161	Period: Worksheet B	
			From 01/01/2020 Part I To 12/31/2020 Date/Time Pre	epared:
Cost Center Description	Intern &	Total	7/9/2021 10: (08 am
	Residents			
	Cost & Post			
	Stepdown			
	Adjustments 25.00	26.00		
GENERAL SERVICE COST CENTERS	23.00	20.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1.01 00101 NEW CAP REL COSTS-INTEREST				1.01
1.02 00102 MOB LEASED SPACE				1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATI ENT TELEPHONES				4.00 5.01
5. 02 00550 DATA PROCESSI NG				5.02
5. 03 00560 PURCHASING RECEIVING AND STORES				5.03
5. 04 00570 ADMI TTI NG				5.04
5. 05 00590 OTHER ADMINI STRATI VE & GENERAL				5.05
6.00 00600 MAINTENANCE & REPAIRS				6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE				7.00 8.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE				16.00 17.00
18. 00 01850 PATI ENT TRANSPORTATI ON				18.00
INPATIENT ROUTINE SERVICE COST CENTERS	н н 			
30. 00 03000 ADULTS & PEDI ATRI CS	0	41, 595, 915		30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34.00
34. 01 03401 PEDIATRI CINTENSI VE CARE UNI T 34. 02 03402 PREMATURE INTENSI VE CARE UNI T	0	2, 871, 829 8, 332, 722		34.01 34.02
43. 00 04300 NURSERY	0	3, 316, 959		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0	19, 091, 015		50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	5, 370, 181		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	9, 495, 914 13, 414, 244		52.00 54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	Ő	10, 404, 484		55.00
56. 00 05600 RADI OI SOTOPE	0	597, 705		56.00
60. 00 06000 LABORATORY	0	12, 220, 441		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	3, 855, 907		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 430, 054 469, 979		66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	237, 656		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 466, 998		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	823, 244		70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	10, 725, 343		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	19, 087, 006 52, 097, 882		72.00 73.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	52, 047, 882		75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	Ő	4, 796, 713		75.01
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0	7, 257, 433		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0			92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	230, 959, 624		118.00
NONREI MBURSABLE COST CENTERS				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
192. 01 19201 OTHER NON-REI MBURSABLE	0	1, 137, 033		192.01
192. 02 19202 CHI LDBI RTH EDUCATI ON 192. 03 19203 PHYSI CI ANS' PRI VATE OFFI CES	0	188, 205 0		192.02 192.03
192. 04 19203 PHYSICIANS PRIVATE OFFICES	0	1, 358, 902		192.03
192. 05 19205 PHYSI CI AN PRACTI CE	0	1, 600, 770		192.05
192. 06 19206 TI PTON HOSPI TAL	0	100, 048		192.06
192. 07 19207 WEST HOSPI TAL	0	464, 892		192.07
192.08 19208 SAXONY HOSPITAL 200.00 Cross Foot Adjustments	0	117, 534		192.08 200.00
200.00Cross Foot Adjustments201.00Negative Cost Centers		-242, 378		200.00
202.00 TOTAL (sum Lines 118 through 201)	0	235, 684, 630		202.00

	Financial Systems ION OF CAPITAL RELATED COSTS	IU HEALTH NOR	Provi der C		Period:	u of Form CMS- Worksheet B	2552-1
				F	From 01/01/2020 To 12/31/2020	Part II Date/Time Pre	epared
				CAPI TAL RE	LATED COSTS	7/9/2021 10:0	08 am
	Cost Center Description	Di rectly Assigned New Capital	NEW BLDG & FIXT	NEW INTEREST	MOB LEASED SPACE	NEW MVBLE EQUI P	
		Related Costs					
	SENERAL SERVICE COST CENTERS	0	1.00	1.01	1.02	2.00	
1.00 0 1.01 0	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE						1.0 1.0 1.0
2.00 0 4.00 0	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES	0	28, 153 0			1, 681 0	2.0 4.0 5.0
	00550 DATA PROCESSI NG	0	124, 090		-	0	
	00560 PURCHASING RECEIVING AND STORES	0	234, 055			6, 599	
	00570 ADMETTENG 00590 OTHER ADMENESTRATIVE & GENERAL	0	77, 299 268, 545			463, 919 1, 127, 730	
1	00600 MAINTENANCE & REPAIRS	0	208, 545 96, 467			1, 127, 730	
	00700 OPERATION OF PLANT	0	1, 476, 957			53, 476	
	00800 LAUNDRY & LINEN SERVICE	0	0		-	0	
	00900 HOUSEKEEPI NG	0	124, 404			2,834	
	01000 DI ETARY 01100 CAFETERI A	0	53, 324 320, 535	65, 829 395, 698		8, 023 47, 001	
	01300 NURSI NG ADMI NI STRATI ON	0	208, 923			8, 036	
	01400 CENTRAL SERVICES & SUPPLY	0	355, 614			284, 342	
	01500 PHARMACY	0	157, 933			125, 945	
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	18, 638 12, 949			0	
	01850 PATIENT TRANSPORTATION	0	0			0	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	1, 731, 474			337, 170	
	03400 SURGI CAL I NTENSI VE CARE UNI T 03401 PEDI ATRI CI NTENSI VE CARE UNI T	0	0 163, 681			0 27, 924	
	03402 PREMATURE I NTENSI VE CARE UNI T	0	435, 365			80, 238	
	04300 NURSERY	0	202, 095			15, 542	
	NCI LLARY SERVICE COST CENTERS			1 1 1 2 5 1		1 550 000	1
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	923, 898 182, 025			1, 553, 303 53, 536	
	D5200 DELIVERY ROOM & LABOR ROOM	0	560, 299			251, 993	
	05400 RADI OLOGY-DI AGNOSTI C	0	295, 030			3, 710, 908	
	05500 RADI OLOGY - THERAPEUTI C	0	782, 405			571, 056	
	05600 RADI OI SOTOPE 06000 LABORATORY	0	21, 247 217, 947			5, 096 978	
	06500 RESPIRATORY THERAPY	0	37,060			79, 355	
	06600 PHYSI CAL THERAPY	0	6, 847	8, 453		14, 881	
	06700 OCCUPATI ONAL THERAPY	0	0	(0 0		67.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	E2 04		1, 729	
	07000 ELECTROCARDI OLOGY	0	42, 809 14, 400			238, 889 43, 087	
1	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	(0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	
	07500 ASC (NON-DISTINCT PART) 07501 CARDIAC CATHERIZATION LABORATORY	0	0 264, 562	326, 600		0 414, 084	
	DUTPATIENT SERVICE COST CENTERS		201,002	020,000	<u>, </u>	111,001	1 / 0. (
91.00 0	09100 EMERGENCY	0	232, 034	286, 444	4 0	69, 037	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) IONREIMBURSABLE COST CENTERS	0	9, 671, 064	11, 938, 841	0	9, 725, 085	118.0
192.001	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192. C
	19201 OTHER NON-REI MBURSABLE	0	45, 281	55, 899			192.0
	19202 CHI LDBI RTH EDUCATI ON 19203 PHYSI CI ANS' PRI VATE OFFI CES	0	0	(192. (192. (
	19203 PHYSICIANS' PRIVATE OFFICES		0 331, 522	409, 26		0 1, 083	
	19205 PHYSI CLAN PRACTICE	0	001, 022	+07,20		12, 528	
	19206 TI PTON HOSPI TAL	0	2, 590	3, 19	0		192.
	19207 WEST HOSPI TAL	0	19, 070				192.
	19208 SAXONY HOSPITAL	0	4, 924	6, 079	0	0	192.0
200.00	Cross Foot Adjustments				241 (22)	0	200.0
201.00	Negative Cost Centers		0	(-241,633		17(1) 1

Cost Center Description Subtotal EMPLOYEE BENEFITS NONPATIENT TELEPHONES DATA PROCESSING PROCH RELEIV STO 1.00 CENERAL SERVICE COST CENTERS 2A 4.00 5.01 5.02 5.0 1.00 COTOO NEW CAP REL COSTS-BLOG & FIXT 1.01 COTOO NEW CAP REL COSTS-NUBLE EQUIP 4.00 00000 NEW CAP REL COSTS-INBLE EQUIP 4.00 00000 NEW CAP REL COSTS-INBLE EQUIP 5.01 00540 NONPATIENT TELEPHONES 0 0 5.01 05500 PATA PROCESSING 5.02 000000 NEW CAP RECEVING AND STORES 5.277.278 0 0 0 0 5.03 00560 PATA PROCESSING 5.04 0.0000 OTHER ADMINI STRATI VE & GENERAL 1.777.179 3.640 0 1.0757 6.00 000000 AMINTERNANCE & REPAIRS 3.3723 1.066 0 5.252 0 <td< th=""><th>me Prepared: 21 10:08 am SING NG AND ES</th></td<>	me Prepared: 21 10:08 am SING NG AND ES
Cost Center Description Subtotal EMPLOYEE BRINETIS DEPARTMENT DNNPATIENT TELPHONES DDATA PROCESSING TELPHONES PURCHV RECEIVI Store CenterAL SERVICE COST CENTERS 2A 4.00 5.01 5.02 5.0 Control New CAP REL COSTS-BLOG & FLXT 2A 4.00 5.01 5.02 5.0 1.01 00100 New CAP REL COSTS-INTEREST 0 0.0	SI NG VG AND ES 3 1.00 1.01 1.02 2.00 4.00 5.01 5.02 29,592 5.03 530 5.04 930 5.05 2,314 6.00 0 7.00 0 8.00 933 9.00 186 10.00 75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 16.00 2 17.00 0 18.00 1.00 1.01 1.01 1.02 2.00 4.00 5.01 5.02 1.00 4.00 5.01 5.02 5.03 5.04 9.00 1.00 5.01 5.02 2.314 6.00 0 7.00 0 8.00 9.33 9.00 1.00 0 1.00 1.00 1.01 5.02 2.314 6.00 0 1.00 1.00 1.00 5.01 5.02 5.03 5.04 9.30 0 1.00 0 1.01 5.02 2.314 6.00 0 1.00 0 1.00 0 1.01 5.02 0 2.01 5.02 0 1.00 0 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 0 1.01 1.00 1.00 1.00 1.00 1.00 0 1.01 1.00 0 1.00 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 1.00 0 0 1.00 0 1.000 0 1.00 0 0 0 0 0
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-INTEREST 1.01 00101 NEW CAP REL COSTS-INTEREST 1.00 00000 EMPLOYEE BEWEITS DEPARTENT 6.00 00400 EMPLOYEE BEWEITS DEPARTMENT 6.01 00540 ROMPATIENT TELEPHORES 0.01 00540 ROMPATIENT TELEPHORES 0.01 00540 ROMPATIENT TELEPHORES 0.01 0.0540 ROMPATIENT TELEPHORES 0.01 0.0570 ROM TINK ROECI VING AND STORES 0.0200 OPERATION RECEI VING AND STORES 529, 592 0.01 0.05757 0.00000 OPERATION RECEI VING AND STORES 529, 592 0.00000 OPERATION RECEI VING AND STORES 529, 592 0.00000 OPERATION OF PLANT 3,353, 723 0.00000 OPERATION OF PLANT 3,353, 723 0.00000 INUSKEKEPING 280, 814 0.00 0 0 0.00000 INUSKEKEPING 280, 814 0.1000 OPERATION OF PLANT 3,352,723 1.000 11000 CAFETERIA 763, 234 1.000 11000 CAFETERIA 763,234 1.000 01000 CARDERING ADMINISTRATION 474,872	1.00 1.01 1.02 2.00 4.00 5.01 5.02 29,592 5.03 530 5.04 930 5.05 2,314 6.00 0 7.00 0 8.00 933 9.00 186 10.00 75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
1.00 00100 NEW CAP REL COSTS-BLOG & FIXT 1.01 00101 NEW CAP REL COSTS-MUREEST 2.00 00200 NEW CAP REL COSTS-MURLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6.01 00540 NEW CAP REL COSTS-MURLE EQUIP 6.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6.02 00550 DATA PROCESSING 5.02 00550 DATA PROCESSING 5.03 00560 PURCHASING RECEIVING AND STORES 5.04 00570 ADMITTING 6.00 00600 MAINTENNATIVE & GENERAL 1.727, 791 3, 460 5.05 00590 OTHER ADMINISTRATIVE & GENERAL 1.727, 791 3, 460 5.05 00590 OTHER ADMINISTRATIVE & GENERAL 1.00 10000 ALMINEY & LINEN SERVICE 0.00 00000 0.00000 HULINERW & LINEN SERVICE 0.01000 DETARY 127, 176 1.00 10000 ALMINEY & SERVICE 0.01000 OULANDRY & LINEN SERVICE 200, 814 1.00 10000 ALMINEY ALINESTRATION 1.00 10000 ALMINEY ALINESTRATION 0.010000 OULENDRY & SERVICE & SUPPLY	$\begin{array}{cccccccccccccccccccccccccccccccccccc$
1. 01 00101 NEW CAP REL COSTS-INTEREST	$\begin{array}{cccccccccccccccccccccccccccccccccccc$
5.03 00560 PURCHASI NG RECEI VI NG AND STORES 529, 592 0 0 0 0 5 5.04 00570 ADMI TTI NG 636, 643 460 0 2, 344 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 1, 727, 791 3, 640 0 10, 757 6.00 00500 AUNINEY & LINEN SERVICE 0 0 0 0 7.00 00700 OPERATI NO FLANT 3, 353, 723 1, 066 0 5, 522 8.00 00800 LAUNDRY & LINEN SERVICE 0	$\begin{array}{cccc} 29, 592 & 5.03 \\ 530 & 5.04 \\ 930 & 5.05 \\ 2, 314 & 6.00 \\ 0 & 7.00 \\ 0 & 8.00 \\ 933 & 9.00 \\ 186 & 10.00 \\ 75 & 11.00 \\ 6 & 13.00 \\ 9, 448 & 14.00 \\ 6, 718 & 15.00 \\ 0 & 16.00 \\ 2 & 17.00 \\ 0 & 18.00 \end{array}$
5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 1,727,791 3,640 0 10,757 6.00 00600 MAI NTENANCE & REPAI RS 342,247 2,233 0 9,434 7.00 00700 OPERATI ON OF PLANT 3,353,723 1,066 0 5,252 8.00 00000 HUNDRY & LI NEN SERVICE 0	930 5.05 2,314 6.00 0 7.00 0 8.00 933 9.00 186 10.00 75 11.00 6,718 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
6.00 00600 MAI NTENANCE & REPAI RS 342,247 2,233 0 9,434 7.00 00700 OPERATI ON OF PLANT 3,353,723 1,066 0 5,252 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 0 0 9.00 00900 HOUSEKEEPI NG 280,814 1,485 0 12,676 10.00 01100 CAFETERI A 763,234 1,215 0 9,027 13.00 01300 NURSI NG ADMI NI STRATI ON 474,872 3,101 0 10,338 14.00 10400 CENTRAL SERVI CES & SUPPLY 1,078,958 968 0 6,638 15.00 01500 PHARMACY 41,646 0 0 0 0 17.00 1700 SIGLA LISERVI CE 28,934 411 0 1,588 18.00 01500 PHARMACY 42,06,131 14,124 0 62,409 34.01 03400 SURGI CAL INTENSI VE CARE UNI T 1,053,057 2,797 0 11,191 43.00 03400 SURGI CAL INTENSI VE CAR	2, 314 6. 00 0 7. 00 0 8. 00 933 9. 00 186 10. 00 75 11. 00 6 13. 00 9, 448 14. 00 6, 718 15. 00 0 16. 00 2 17. 00 0 18. 00
7.00 00700 OPERATION OF PLANT 3,353,723 1,066 0 5,252 8.00 00800 LAUNDRY & LI NEN SERVICE 0	0 7.00 933 9.00 186 10.00 75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
8.00 0800 LAUNDRY & LINEN SERVICE 0 0 0 0 9.00 00900 HUSEKEEPING 280, 814 1, 485 0 12, 676 10.00 01000 DI ETARY 127, 176 882 0 7, 002 11.00 01100 CAFETERIA 763, 234 1, 215 0 9, 027 13.00 01400 CENTRAL SERVICES & SUPPLY 1, 078, 958 9668 0 6, 633 15.00 01500 PHARMACY 478, 845 3, 269 0 8, 349 16.00 10160 ALEPECRES & LIBRARY 41, 646 0 0 0 0 0 0 17.00 01700 SOCIAL SERVICE 0 231 0 2,55 0 INPAPTIENT RONDINE SERVICE 28, 934 411 0 1,588 0 <td< td=""><td>0 8.00 933 9.00 186 10.00 75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00</td></td<>	0 8.00 933 9.00 186 10.00 75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
10.00 01000 DI ETARY 127, 176 882 0 7, 002 11.00 01100 CAFETERIA 763, 234 1, 215 0 9, 027 13.00 01300 NURSING ADMIN INSTRATION 474, 872 3, 101 0 10, 338 14.00 01400 CENTRAL SERVI CES & SUPPLY 1, 078, 958 968 0 6, 638 15.00 01500 PHARMACY 478, 845 3, 269 0 8, 349 16.00 01600 MEDI CAL RECORDS & LI BRARY 41, 646 0 0 0 2, 055 17.00 01700 SOCI AL SERVI CE 28, 934 411 0 1, 588 18.00 01850 PATI ENT TRANSPORTATI ON 0 2, 055 0 2, 055 30.00 03000 ADULTS & PEDI ATRIC C COST CENTERS	186 10.00 75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
11.00 OI100 CAFETERIA 763, 234 1, 215 0 9, 027 13.00 OI300 NURSI NG ADMINISTRATION 474, 872 3, 101 0 10, 338 14.00 OI400 CENTRAL SERVICES & SUPPLY 1,078, 958 968 0 6,638 15.00 O1500 PHARMACY 478, 845 3,269 0 8,349 16.00 OI700 SOCI AL SERVICE 28,934 411 0 1,588 18.00 O1850 PATIENT RANSPORTATION 0 231 0 2,055 INPATIENT ROUTINE SERVICE COST CENTERS	75 11.00 6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
13.00 01300 NURSI NG ADMI NI STRATI ON 474, 872 3, 101 0 10, 338 14.00 01400 CENTRAL SERVI CES & SUPPLY 1, 078, 958 968 0 6, 638 15.00 01500 PHARMACY 478, 845 3, 269 0 8, 349 16.00 01600 MEDI CAL RECORDS & LI BRARY 41, 646 0 0 0 17.00 01700 SOCI AL SERVI CE 28, 934 411 0 1, 588 18.00 01850 PATI ENT TRANSPORTATI ON 0 231 0 2, 055 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI C S 4, 206, 131 14, 124 0 62, 409 34.01 03401 PEDI ATRI C INTENSI VE CARE UNI T 393, 668 893 0 3, 522 34.02 03402 PREMATURE INTENSI VE CARE UNI T 1, 053, 057 2, 797 0 11, 191 43.00 04300 NURSERY 467, 122 1, 031 0 4, 529 ANCI LLARY SERVI CE COST CENTERS 50.00 05000	6 13.00 9,448 14.00 6,718 15.00 0 16.00 2 17.00 0 18.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 1,078,958 968 0 6,638 15.00 01500 PHARMACY 478,845 3,269 0 8,349 16.00 01700 SOCIAL SERVICE 28,934 411 0 1,588 18.00 01850 PATIENT TRANSPORTATION 0 2,055 0 INPATIENT TRANSPORTATION 0 0 0 0 0.00 03000 ADULTS & PEDIATRICS 4,206,131 14,124 0 62,409 34.00 03400 SURGICAL INTENSIVE CARE UNIT 393,668 893 0 3,522 34.02 03401 PEDIATRIC S 4,67,122 1,031 0 4,529 ANCILLARY SERVICE COST CENTERS SO 00 05000 OPERATING ROOM 3,617,744 4,485 0 19,212 ANCILLARY SERVICE COST CENTERS SO 00 05000 OPERATING ROOM 1,503,976 2,873 0 11,193 50.00 05100 REOVERY ROOM & LABOR ROOM 1,503,976 2,873 0 <td>9, 448 14.00 6, 718 15.00 0 16.00 2 17.00 0 18.00</td>	9, 448 14.00 6, 718 15.00 0 16.00 2 17.00 0 18.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 41,646 0 0 0 17.00 01700 SOCI AL SERVI CE 28,934 411 0 1,588 18.00 01850 PATI ENT TRANSPORTATI ON 0 231 0 2,055 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03400 SURGI CAL INTENSI VE CARE UNI T 0 0 0 0 34.01 03402 PREMATURE INTENSI VE CARE UNI T 393,668 893 0 3,522 34.02 03402 PREMATURE INTENSI VE CARE UNI T 1,053,057 2,797 0 11,191 43.00 04300 NURSERY 467,122 1,031 0 4,529 ANCI LLARY SERVICE COST CENTERS O 0 8,132 50.00 05000 PERATING ROOM 3,617,744 4,485 0 19,212 51.00 05100 RECOVERY ROOM 3,617,744 4,485 0 19,212 51.00 05000 DELTATING ROOM 1,503,976 2,873 0 11,133	0 16.00 2 17.00 0 18.00
17.00 01700 SOCI AL SERVI CE 28,934 411 0 1,588 18.00 01850 PATI ENT TRANSPORTATI ON 0 231 0 2,055 INPATI ENT ROUTINE SERVICE COST CENTERS	2 17.00 0 18.00
18.00 01850 PATI ENT TRANSPORTATION 0 231 0 2,055 INPATI ENT ROUTINE SERVICE COST CENTERS	0 18.00
INPATI ENT ROUTI NE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 4, 206, 131 14, 124 0 62, 409 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 0 0 0 34. 01 03401 PEDI ATRI C I INTENSI VE CARE UNI T 393, 668 893 0 3, 522 34. 02 03402 PREMATURE I NTENSI VE CARE UNI T 1,053, 057 2,797 0 11, 191 43. 00 04300 NURSERY 467, 122 1,031 0 4,529 ANCI LLARY SERVICE COST CENTERS 50. 00 05100 RECOVERY ROOM 3,617,744 4,485 0 19,212 51. 00 05100 RECOVERY ROOM 460,269 2,104 0 8,132 52. 00 05100 RECOVERY ROOM 1,503,976 2,873 0 11, 133 54. 00 05400 RADI OLOGY - THERAPEUTI C 2,319,333 2,626 0 10,681 55. 00 05600 RADI OLOGY - THERAPEUTI C 2,319,333 2,626 0 10,681 56. 00 06600 RADI OLOGY - THERAPEUTI C 2,573 26	
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 0 0 34.01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 393, 668 893 0 3, 522 34.02 03402 PREMATURE I NTENSI VE CARE UNI T 1, 053, 057 2, 797 0 11, 191 43.00 04300 NURSERY 0 4, 529 0 4, 529 50.00 05000 OPERATI NG ROOM 3, 617, 744 4, 485 0 19, 212 51.00 05100 RECOVERY ROOM 460, 269 2, 104 0 8, 132 52.00 05200 DELI VERY ROOM & LABOR ROOM 1, 503, 976 2, 873 0 11, 133 54.00 05400 RADI OLOGY - I HERAPEUTI C 2, 319, 333 2, 626 0 10, 681 55.00 05500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 10, 713 60.00 06000 LABORATORY 487, 979 703 0 9, 286 65.00 06500 RESPI RATORY THERAPY 162, 166 2, 079 0 5, 662 65.00 <t< td=""><td>30, 502 30. 00</td></t<>	30, 502 30. 00
34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 393, 668 893 0 3, 522 34. 02 03402 PREMATURE I NTENSI VE CARE UNI T 1, 053, 057 2, 797 0 11, 191 43. 00 04300 NURSERY 467, 122 1, 031 0 4, 529 ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 3, 617, 744 4, 485 0 19, 212 51. 00 05100 RECOVERY ROOM 460, 269 2, 104 0 8, 132 52. 00 05200 DELI VERY ROOM & LABOR ROOM 1, 503, 976 2, 873 0 11, 133 54. 00 05400 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 10, 681 55. 00 05500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 10, 681 56. 00 06500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 10, 681 56. 00 06500 RADI OLOGY - THERAPY 162, 166 2, 079 0 5, 062 66. 00 06600 PHYSI CA	
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 1,053,057 2,797 0 11,191 43. 00 04300 NURSERY 467,122 1,031 0 4,529 ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 3,617,744 4,485 0 19,212 51. 00 05100 RECOVERY ROOM 460,269 2,104 0 8,132 52. 00 05200 DELI VERY ROOM & LABOR ROOM 1,503,976 2,873 0 11,133 54. 00 05400 RADI OLOGY - DI AGNOSTI C 4,370,150 3,915 0 14,713 55. 00 05500 RADI OLOGY - THERAPEUTI C 2,319,333 2,626 0 10,681 56. 00 06000 LABORATORY 487,979 703 0 9,286 65.00 66.00 66.00 66.00 PHYSI CAL THERAPY 162,166 2,079 0 5,062 66.996 67.00 67.00 67.00 67.00 67.00 67.00 67.996 67.996 67.996 67.996 67.996 67.996 67.996	0 34.00 713 34.01
43.00 04300 NURSERY 467, 122 1,031 0 4,529 ANCI LLARY SERVICE COST CENTERS	3,800 34.02
50.00 05000 0PERATING ROOM 3, 617, 744 4, 485 0 19, 212 51.00 05100 RECOVERY ROOM 460, 269 2, 104 0 8, 132 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 503, 976 2, 873 0 11, 133 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 370, 150 3, 915 0 14, 713 55.00 05500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 0 877 60.00 05600 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 877 60.00 06500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 877 60.00 06600 LABORATORY 487, 979 703 0 9, 286 65.00 06500 RESPI RATORY THERAPY 162, 166 2, 079 0 5, 062 66.00 06600 PHYSI CAL THERAPY 0 277 0 973 68.00 06600 SPECH PATHOLOGY 1, 729 140 0 458 69.00	0 43.00
51.00 05100 RECOVERY ROOM 460, 269 2, 104 0 8, 132 52.00 05200 DELI VERY ROOM & LABOR ROOM 1, 503, 976 2, 873 0 11, 133 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 370, 150 3, 915 0 14, 713 55.00 05500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 10, 681 56.00 05600 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 877 60.00 06000 LABORATORY 487, 979 703 0 9, 286 65.00 06500 RESPI RATORY THERAPY 162, 166 2, 079 0 5, 062 66.00 06600 PHYSI CAL THERAPY 0 277 0 973 68.00 06800 SPEECH PATHOLOGY 1, 729 140 0 458 69.00 06900 ELECTROCARDI OLOGY 334, 545 399 0 1, 479 70.00 07000 ELECTROENCEPHALOGRAPHY 75, 264 148 0 597 <td>80, 927 50. 00</td>	80, 927 50. 00
52.00 05200 DELI VERY ROOM & LABOR ROOM 1,503,976 2,873 0 11,133 54.00 05400 RADI OLOGY-DI AGNOSTI C 4,370,150 3,915 0 14,713 55.00 05500 RADI OLOGY - THERAPEUTI C 2,319,333 2,626 0 10,681 56.00 05000 RADI OLOGY - THERAPEUTI C 2,319,333 2,626 0 877 60.00 06000 LABORATORY 487,979 703 0 9,286 65.00 06500 RESPI RATORY THERAPY 162,166 2,079 0 5,062 66.00 06600 PHYSI CAL THERAPY 0 277 0 973 68.00 06800 SPECH PATHOLOGY 1,729 140 458 69.00 06900 ELECTROCARDI OLOGY 334,545 399 0 1,479 70.00 07000 ELECTROENCEPHALOGRAPHY 75,264 148 0 597	4, 623 51.00
55.00 05500 RADI OLOGY - THERAPEUTI C 2, 319, 333 2, 626 0 10, 681 56.00 05600 RADI OL SOTOPE 52, 573 261 0 877 60.00 06000 LABORATORY 487, 979 703 0 9, 286 65.00 06500 RESPI RATORY THERAPY 162, 166 2, 079 0 5, 062 66.00 06600 PHYSI CAL THERAPY 30, 181 1, 996 6, 996 67.00 06700 OCCUPATI ONAL THERAPY 0 277 0 973 68.00 06800 SPEECH PATHOLOGY 1, 729 140 0 458 69.00 06900 ELECTROCARDI OLOGY 334, 545 399 0 1, 479 70.00 07000 ELECTROENCEPHALOGRAPHY 75, 264 148 0 597	7,016 52.00
56.00 05600 RADI OI SOTOPE 52, 573 261 0 877 60.00 06000 LABORATORY 487, 979 703 0 9, 286 65.00 06500 RESPI RATORY THERAPY 162, 166 2, 079 0 5, 062 66.00 06600 PHYSI CAL THERAPY 30, 181 1, 996 6, 996 67.00 06700 OCUPATI ONAL THERAPY 0 277 0 973 68.00 06800 SPEECH PATHOLOGY 1, 729 140 0 458 69.00 06900 ELECTROCARDI OLOGY 334, 545 399 0 1, 479 70.00 07000 ELECTROENCEPHALOGRAPHY 75, 264 148 0 597	6, 499 54.00
60.00 06000 LABORATORY 487,979 703 0 9,286 65.00 06500 RESPI RATORY THERAPY 162,166 2,079 0 5,062 66.00 06600 PHYSI CAL THERAPY 30,181 1,996 0 6,996 67.00 06700 OCCUPATI ONAL THERAPY 0 277 0 973 68.00 06800 SPECH PATHOLOGY 1,729 140 0 458 69.00 06900 ELECTROCARDI OLOGY 334,545 399 0 1,479 70.00 07000 ELECTROENCEPHALOGRAPHY 75,264 148 0 597	3, 081 55. 00 34 56. 00
66. 00 06600 PHYSI CAL THERAPY 30, 181 1, 996 0 6, 996 67. 00 06700 0CCUPATI ONAL THERAPY 0 277 0 973 68. 00 06800 SPEECH PATHOLOGY 1, 729 140 0 458 69. 00 06900 ELECTROCARDI OLOGY 334, 545 399 0 1, 479 70. 00 07000 ELECTROENCEPHALOGRAPHY 75, 264 148 0 597	226 60.00
67.00 06700 0CCUPATI ONAL THERAPY 0 277 0 973 68.00 06800 SPEECH PATHOLOGY 1,729 140 0 458 69.00 06900 ELECTROCARDI OLOGY 334,545 399 0 1,479 70.00 07000 ELECTROENCEPHALOGRAPHY 75,264 148 0 597	4, 968 65. 00
68.00 06800 SPEECH PATHOLOGY 1,729 140 0 458 69.00 06900 ELECTROCARDI OLOGY 334,545 399 0 1,479 70.00 07000 ELECTROENCEPHALOGRAPHY 75,264 148 0 597	435 66.00
69. 00 06900 ELECTROCARDI OLOGY 334, 545 399 0 1, 479 70. 00 07000 ELECTROENCEPHALOGRAPHY 75, 264 148 0 597	90 67.00 65 68.00
	82 69.00
	160 70.00
	28, 787 71. 00 27, 728 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	0 73.00
75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0	0 75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY 1, 005, 246 1, 140 0 4, 487	453 75.01
OUTPATI ENT_SERVICE_COST_CENTERS 91.00 O9100 EMERGENCY 587, 515 2, 582 0 10, 913	8,217 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0	92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 334, 990 63, 534 0 272, 110 5 NONREIMBURSABLE COST CENTERS	<u>29, 548</u> 118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0	0 192.00
192. 01 19201 OTHER NON-REI MBURSABLE 101, 180 126 0 991	0 192.01
192.02 CHI LDBI RTH EDUCATI ON 0 87 0 410 192.03 19203 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0	0 192.02
192. 04 19203 PHYSICIANS PRIVATE OFFICES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0100 00
192. 05 19205 PHYSI CI AN PRACTI CE 12, 528 611 0 2, 965	0 192.03
192.06 19206 TI PTON HOSPI TAL 5, 787 37 0 133	0 192.03 0 192.04 44 192.05
192.07 WEST HOSPI TAL 42, 611 155 0 536 192.08 SAXONY HOSPI TAL 11, 003 39 0 133	0 192.04 44 192.05 0 192.06
192.08 SAXONY HOSPITAL 11,003 39 0 133 200.00 Cross Foot Adjustments 0 133	0 192.04 44 192.05 0 192.06 0 192.07
201.00 Negative Cost Centers -241,633 0 0 0	0 192.04 44 192.05 0 192.06 0 192.07 0 192.08
202.00 TOTAL (sum lines 118 through 201) 32,008,332 64,589 0 277,278	0 192.04 44 192.05 0 192.06 0 192.07

Health Financial Systems	IU HEALTH NOF	RTH HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B	
			Ť		Date/Time Pre 7/9/2021 10:0	pared: 8 am
Cost Center Description	ADMI TTI NG	OTHER ADMI NI STRATI V	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
		E & GENERAL				
GENERAL SERVICE COST CENTERS	5.04	5.05	6.00	7.00	8.00	
1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 NEW CAP REL COSTS-INTEREST 1. 02 00102 MOB LEASED SPACE						1.01 1.02
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATIENT TELEPHONES 5. 02 00550 DATA PROCESSING						5.01 5.02
5. 03 00560 PURCHASI NG RECEI VI NG AND STORES						5.03
5. 04 00570 ADMI TTI NG 5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL	639, 977 0					5.04 5.05
6.00 00600 MAINTENANCE & REPAIRS	0	48, 060	404, 288			6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE					1, 115	7.00 8.00
9. 00 00900 HOUSEKEEPI NG	0			-	0	9.00
10. 00 01000 DI ETARY	0				0	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON					0	11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	90, 052	15, 550	160, 112	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0				0	15.00 16.00
17. 00 01700 SOCI AL SERVI CE	0					17.00
18. 00 01850 PATIENT TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 581	0	0	0	18.00
30. 00 03000 ADULTS & PEDIATRICS	53, 745	214, 200	75, 711	779, 584	805	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			-		34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 34. 02 03402 PREMATURE INTENSIVE CARE UNIT	2, 065 13, 373			73, 696 196, 020		34.01 34.02
43. 00 04300 NURSERY	4, 096			90, 992	132	43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	121, 129	95, 949	40, 399	415, 978	0	50.00
51.00 05100 RECOVERY ROOM	16, 126	30, 171	7, 959	81, 955	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	21, 639 37, 229			252, 270 132, 835		52.00 54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	35, 642		34, 212	352, 272	0	55.00
56. 00 05600 RADI OI SOTOPE 60. 00 06000 LABORATORY	5, 071 28, 378				0	56.00 60.00
65. 00 06500 RESPIRATORY THERAPY	7, 826			16, 686	0	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 189			3, 083	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	1, 150 470			0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	8, 081	9, 589	1, 872	-	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 915 21, 920			6, 484 0	0	70.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	54, 799				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 75.00 07500 ASC (NON-DISTINCT PART)	132, 315			-	0	73.00 75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	20, 473			-	0	75.00
0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY	47, 346	41, 312	10, 146	104, 471	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47, 340	41, 312	10, 140	104, 471	0	91.00 92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	(20.077	1 714 001	204 450	2 214 250	1 115	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	639, 977	1, 716, 331	386, 650	3, 316, 259	1, 115	118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			-		192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON						192.01 192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0	C	0	0	0	192.03
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES 192. 05 19205 PHYSI CLAN PRACTI CE	0	2, 576 11, 373		149, 265 0		192.04 192.05
192. 06 19206 TI PTON HOSPI TAL	0	620	113	1, 166	0	192.06
192. 07 19207 WEST HOSPI TAL	0	2,927				192.07
192.08 19208 SAXONY HOSPITAL 200.00 Cross Foot Adjustments		738	215	2, 217		192.08 200.00
201.00 Negative Cost Centers	0	-	-	-	0	201.00
202.00 TOTAL (sum lines 118 through 201)	639, 977	1, 743, 118	404, 288	3, 497, 880	1, 115	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2020	Worksheet B Part II Date/Time Pre	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	7/9/2021 10:0 CENTRAL SERVI CES & SUPPLY	<u>8 am</u>
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS	T		1			1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSING 5.03 00560 PURCHASING RECEIVING AND STORES 5.04 00570 ADMITTING 5.05 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LI BRARY	408, 155 2, 847 17, 114 11, 155 18, 987 8, 432 995	179, 394 0 0 0 0 0 0 0 0	974, 041 45, 608 29, 284 36, 835 0	0 0 0	1, 409, 997 18, 388 1	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17.00 01700 SOCIAL SERVICE 18.00 01850 PATIENT TRANSPORTATION	691 0	0		0	6 0	17.00 18.00
INPATIENT ROUTINE SERVICE COST CENTERS		0	7,000		0	10.00
30. 00 03000 ADULTS & PEDIATRICS 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	92, 446	160, 814 0			83, 483 0	30.00 34.00
34. 01 03400 PEDIATRIC INTENSIVE CARE UNIT	8, 739	3, 463	-	-	1, 952	34.00
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	23, 245 10, 790	0 0			10, 401 0	34.02 43.00
ANCI LLARY SERVICE COST CENTERS	10,770	0		22, 110		10.00
50. 00 05000 OPERATING ROOM	49, 329	0			221, 492	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 719 29, 916	748 9, 397	35, 878 49, 117	46, 549 57, 558	12, 652 19, 204	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 752	0			17, 788	
55. 00 05500 RADI OLOGY - THERAPEUTI C	41, 774	0		35, 380	8, 433	
56. 00 05600 RADI 0I SOTOPE 60. 00 06000 LABORATORY	1, 134 11, 637	0 0			93 619	56.00 60.00
65. 00 06500 RESPI RATORY THERAPY	1, 979	0			13, 596	
66. 00 06600 PHYSI CAL THERAPY	366	0			1, 191	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0 0		0	246 177	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 286	0	6, 527	0	224	
70. 00 07000 ELECTROENCEPHALOGRAPHY	769	0	2, 632		439	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	352, 482 623, 280	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	023, 280	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	14, 126	3, 574	19, 793	17, 589	1, 241	75.01
0UTPATI ENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY	12, 389	1, 398	48, 147	50, 494	22, 488	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	12,007	.,	10,117	007171	22, 100	92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	386, 617	179, 394	951, 244	686, 912	1, 409, 876	118.00
NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
192. 01 19201 OTHER NON-REI MBURSABLE	2, 418	0				192.01
192. 02 19202 CHI LDBI RTH EDUCATI ON	0	0	1, 808	201		192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES 192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	0 17, 701	0	0	0		192.03 192.04
192. 05 19205 PHYSICIAN PRACTICE	0	0	13, 080	181		192.04
192. 06 19206 TI PTON HOSPI TAL	138	0	585	624	0	192.06
192. 07 19207 WEST HOSPI TAL	1,018	0	2, 366			192.07
192.08 19208 SAXONY HOSPITAL 200.00 Cross Foot Adjustments	263	0	585	0	0	192.08 200.00
201.00 Negative Cost Centers	0	0	о	о	0	200.00
202.00 TOTAL (sum lines 118 through 201)	408, 155	179, 394	974, 041	687, 918	1, 409, 997	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	IU HEALTH NOR	TH HOSPITAL Provider CC	CN: 15-0161 P€	In Lieu eriod:	ı of Form CMS- Worksheet B	2552-10
				om 01/01/2020	Part II Date/Time Pre 7/9/2021 10:0	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	OTHER GENERAL SERVICE PATIENT TRANSPORTATIO N	Subtotal	
GENERAL SERVICE COST CENTERS	15.00	16.00	17.00	18.00	24.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATIENT TELEPHONES 5.02 00550 DATA PROCESSING						1.00 1.01 1.02 2.00 4.00 5.01 5.02
5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG						5. 03 5. 04 5. 05 6. 00 7. 00 8. 00 9. 00
10.00 01000 DI ETARY 11.00 01100 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE 18.00 01850 PATI ENT TRANSPORTATI ON	686, 284 0 0 0	52, 787 0 0	51, 563 0	13, 933		10.00 11.00 13.00 14.00 15.00 16.00 17.00 18.00
INPATIENT ROUTINE SERVICE COST CENTERS				10, 700		10.00
30. 00 03000 ADULTS & PEDI ATRI CS	3, 045	4, 450	37, 216	1, 198	6, 367, 885	1
34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 34.02 03402 PREMATURE INTENSIVE CARE UNIT	0 1 205	0 171 1, 107	0 904 7, 321	0 46 298	0 548, 909 1, 499, 262	34.02
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	339	6, 122	91	653, 302	43.00
50. 00 05000 OPERATING ROOM	2, 661	10, 030	0	2, 700	4, 840, 670	50.00
51.00 05100 RECOVERY ROOM	672	1, 335	0	360	719, 252	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	606	1, 792	0	482	2,041,172	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	756	3, 083	0	830	4, 780, 657	1
55. 00 05500 RADI OLOGY - THERAPEUTI C	1, 095	2, 951	0	795	2, 949, 821	55.00
56. 00 05600 RADI OI SOTOPE 60. 00 06000 LABORATORY	4	420 2, 350	0 0	113 633	78, 712 786, 853	1
65.00 06500 RESPIRATORY THERAPY	135	648	0	174	265, 282	
66. 00 06600 PHYSI CAL THERAPY	0	430	0	116	105, 195	
67.00 06700 OCCUPATI ONAL THERAPY	0	95	0	26	10, 456	
68.00 06800 SPEECH PATHOLOGY	0	39	0	10	6, 782	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	669 159	0	180 43	385, 207 94, 867	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 815	0	489	559, 832	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	4, 537	0	1, 222	1,008,445	1
73.00 07300 DRUGS CHARGED TO PATIENTS	675, 441	10, 752	0	2, 616	1, 152, 557	1
75. 00 07500 ASC (NON-DI STINCT PART)	0 329	0	0	0	1 240 271	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY OUTPATI ENT SERVI CE COST CENTERS	529	1, 695	0	456	1, 248, 371	75.01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	1, 333	3, 920	0	1, 055	953, 726	91.00 92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	686, 284	52, 787	51, 563	13, 933	31, 057, 215	118,00
NONREI MBURSABLE COST CENTERS	000, 204	52,707	51, 505	13, 733	51, 557, 215	1.10.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	0	192.00
192.01 19201 OTHER NON-REI MBURSABLE	0	0	0	0	138, 691	1
192. 02 19202 CHI LDBI RTH EDUCATI ON	0	0	0	0		192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES 192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0 925, 904	192.03
192. 05 19205 PHYSICIANS PRIVATE OFFICES	0	0	0	0		192.04
192. 06 19206 TI PTON HOSPI TAL	0	ō	Ö	0		192.06
192. 07 19207 WEST HOSPI TAL	0	О	0	0		192.07
192.08 19208 SAXONY HOSPITAL	0	0	0	0		192.08
200.00Cross Foot Adjustments201.00Negative Cost Centers		0	0	0	0 -241, 633	200.00
202.00 TOTAL (sum lines 118 through 201)	686, 284	52, 787	51, 563	13, 933	32, 008, 332	
	, ., .,			.,		•

Health Financial Systems	IU HEALTH NORTH	I HOSPI TAL	In Lieu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-C		
			To 12/31/2020 Date/Time Pre 7/9/2021 10:00	epared:
Cost Center Description	Intern & Residents	Total	17772021 10.0	
	Cost & Post			
	Stepdown Adjustments			
	25.00	26.00		
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
1. 01 00101 NEW CAP REL COSTS-BEDG & TTXT				1.00
1.02 00102 MOB LEASED SPACE				1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				2.00
5. 01 00540 NONPATI ENT TELEPHONES				5.01
5. 02 00550 DATA PROCESSI NG				5.02
5. 03 00560 PURCHASING RECEIVING AND STORES				5.03
5. 04 00570 ADMI TTI NG 5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL				5.04 5.05
6.00 00600 MAI NTENANCE & REPAI RS				6.00
7.00 00700 OPERATION OF PLANT				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00 9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERIA				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY				14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00 01700 SOCI AL SERVI CE				17.00
18.00 01850 PATIENT TRANSPORTATION				18.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 367, 885		30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0, 307, 003		34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	548, 909		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0	1, 499, 262		34.02
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	653, 302		43.00
50.00 OFERATING ROOM	0	4, 840, 670		50.00
51.00 05100 RECOVERY ROOM	0	719, 252		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 54. 00 05400 RADIOLOGY-DIAGNOSTIC	0	2, 041, 172 4, 780, 657		52.00 54.00
55. 00 05500 RADIOLOGY - THERAPEUTIC	0	2, 949, 821		55.00
56. 00 05600 RADI OI SOTOPE	0	78, 712		56.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	786, 853 265, 282		60.00 65.00
66. 00 06600 PHYSICAL THERAPY	0	205, 282 105, 195		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	10, 456		67.00
68.00 06800 SPEECH PATHOLOGY	0	6, 782		68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	385, 207 94, 867		69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	559, 832		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	1,008,445		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 152, 557		73.00
75.00 07500 ASC (NON-DI STI NCT PART) 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0 1, 248, 371		75.00 75.01
OUTPATIENT SERVICE COST CENTERS	<u> </u>	1,210,071		/0.01
91.00 09100 EMERGENCY	0	953, 726		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS	0			92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	31, 057, 215		118.00
NONREI MBURSABLE COST CENTERS	·			
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	0	138, 691 3, 823		192.01 192.02
192. 03 19203 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192.02
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	Ō	925, 904		192.04
192. 05 19205 PHYSI CI AN PRACTI CE	0	40, 903		192.05
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL		9, 203 59, 033		192.06 192.07
192. 08 19208 SAXONY HOSPI TAL	o o	15, 193		192.08
200.00 Cross Foot Adjustments	0	0		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	-241, 633 32, 008, 332		201.00 202.00
202.00 TOTAL (SUM TIMES TTO LINUUGH 201)	ı V	JZ, UUU, JJZ		1202.00

	ncial Systems TION - STATISTICAL BASIS	IU HEALTH NOR	TH HOSPITAL		eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre 7/9/2021 10:0	
			CAPI TAL REI	LATED COSTS		17 77 2021 10:0	
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW INTEREST (SQUARE FEET)	MOB LEASED SPACE (MOB SQ FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
CENE		1.00	1.01	1.02	2.00	4.00	
1.00 00100 1.01 00100 1.02 00100 2.00 00200 4.00 00400	RAL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT NEW CAP REL COSTS-INTEREST 2 MOB LEASED SPACE 0 NEW CAP REL COSTS-MVBLE EQUIP 0 EMPLOYEE BENEFITS DEPARTMENT 0 NONPATIENT TELEPHONES	513, 505 0 0 1, 435 0	513, 505 0 1, 435 0	88, 507	7, 529, 341 1, 300 0	61, 599, 087 0	1.00 1.01 1.02 2.00 4.00 5.01
5.03 00560 5.04 00570 5.05 00590 6.00 00600 7.00 00700	DATA PROCESSING D PURCHASING RECEIVING AND STORES D ADMITTING O THER ADMINISTRATIVE & GENERAL D MAINTENANCE & REPAIRS D OPERATION OF PLANT D LAUNDRY & LINEN SERVICE	6, 325 11, 930 3, 940 13, 688 4, 917 75, 282 0	11, 930 3, 940	196 0	5, 102 358, 673 871, 889 97, 951	0 438, 381 3, 469, 658 2, 128, 292 1, 016, 319 0	5.02 5.03 5.04 5.05 6.00 7.00 8.00
9.00 00900 10.00 01000 11.00 01100 13.00 01300 14.00 01400 15.00 01500 16.00 01600 17.00 01700	HOUSEKEEPING DIETARY DIATARY D	6, 341 2, 718 16, 338 10, 649 18, 126 8, 050 950 660 0	10, 649 18, 126 8, 050 950 660	0 3, 869 0 237 0	36, 338 6, 213 219, 835 97, 373 0 0	1, 415, 758 840, 595 1, 158, 349 2, 956, 436 922, 925 3, 116, 436 0 391, 926 219, 755	13.00 14.00 15.00 16.00
I NPA	TIENT ROUTINE SERVICE COST CENTERS	00.055	00.055		040 470		
34.00 03400 34.01 03400 34.02 03400 43.00 04300	D ADULTS & PEDIATRICS D SURGICAL INTENSIVE CARE UNIT 1 PEDIATRIC INTENSIVE CARE UNIT 2 PREMATURE INTENSIVE CARE UNIT D NURSERY LLARY SERVICE COST CENTERS	88, 255 0 8, 343 22, 191 10, 301	88, 255 0 8, 343 22, 191 10, 301	0 0 0 491 0	0 21, 589 62, 035	13, 490, 482 0 851, 437 2, 666, 414 982, 395	30.00 34.00 34.01 34.02 43.00
50.00 0500 51.00 0510 52.00 0520 54.00 0540 55.00 0550 56.00 0560	D OPERATING ROOM D RECOVERY ROOM D DELIVERY ROOM & LABOR ROOM D RADI OLOGY-DI AGNOSTI C D RADI OLOGY - THERAPEUTI C D RADI OLOGY - THERAPEUTI C D RADI OI SOTOPE D LABORATORY	47, 092 9, 278 28, 559 15, 038 39, 880 1, 083 11, 109	9, 278 28, 559	0 0 14, 593 0	41, 391 194, 825 2, 869, 039 441, 504 3, 940	4, 275, 960 2, 005, 962 2, 738, 445 3, 732, 409 2, 503, 345 248, 361 670, 435	51.00 52.00 54.00 55.00 56.00
66.00 06600 67.00 06700 68.00 06800 69.00 06900 70.00 07000 71.00 07100	D RESPI RATORY THERAPY D PHYSI CAL THERAPY D OCCUPATI ONAL THERAPY D SPEECH PATHOLOGY D ELECTROCARDI OLOGY D ELECTROENCEPHALOGRAPHY D MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 889 349 0 2, 182 734 0		6, 431 0 0 0	11, 505	1, 981, 860 1, 902, 968 264, 463 133, 300 380, 681 140, 682 0	66.00 67.00 68.00 69.00 70.00 71.00
73.00 0730 75.00 0750 75.01 0750	DI IMPL. DEV. CHARGED TO PATI ENT DRUGS CHARGED TO PATI ENTS ASC (NON-DI STINCT PART) I CARDI AC CATHERI ZATI ON LABORATORY ATI ENT SERVI CE COST CENTERS	0 0 0 13, 485	0 0 0 13, 485	0		0 0 1, 086, 658	72.00 73.00 75.00 75.01
91.00 0910 92.00 0920	D EMERGENCY D OBSERVATION BEDS (NON-DISTINCT PART)	11, 827	11, 827	0	53, 375	2, 461, 158	91.00 92.00
118.00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) EIMBURSABLE COST CENTERS	492, 944	492, 944	40, 654	7, 518, 818	60, 592, 245	118.00
192. 00 1920 192. 01 1920 192. 02 1920 192. 03 1920	D PHYSI CI ANS' PRI VATE OFFI CES 1 OTHER NON-REI MBURSABLE 2 CHI LDBI RTH EDUCATI ON 3 PHYSI CI ANS' PRI VATE OFFI CES	0 2, 308 0 0	0 2, 308 0 0	0 0 0 0		120, 355 83, 247	
192.05 1920 192.06 1920 192.07 1920	4 PHYSI CI ANS' PRI VATE OFFI CES 5 PHYSI CI AN PRACTI CE 6 TI PTON HOSPI TAL 7 WEST HOSPI TAL 8 SAXONY HOSPI TAL	16, 898 0 132 972 251	16, 898 0 132 972 251	41, 706 852 4, 249	0	582, 062 35, 595 148, 119	192.06 192.07
200. 00 201. 00 202. 00	B SAXUMY HUSPITAL Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	251		1, 046 -241, 633		37, 464 14, 024, 683	200. 00 201. 00
202.00	Part I) Unit cost multiplier (Wkst. B, Part I)					0. 227677	

Health Fir	nancial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-0161	Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		epared: 08 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW INTEREST (SQUARE FEET)	MOB LEASED SPACE (MOB SQ FEET	EQUI P	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	
		1.00	1.01	1.02	2.00	4.00	
204.00	Cost to be allocated (per Wkst. B, Part II)					64, 589	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)					0. 001049	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	ncial Systems ATION - STATISTICAL BASIS	IU HEALTH NOR			eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2020	Date/Time Pre	
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	7/9/2021 10:0 Reconciliatio	
	cost center bescription	TELEPHONES	PROCESSI NG	RECEI VI NG AND	(GROSS	n	
		(FTEs)	(FTEs)	STORES	CHARGES)		
				(COSTED REQUI SI TI ONS)			
		5. 01	5.02	5. 03	5.04	5A. 05	
	RAL SERVICE COST CENTERS						1 1 0
	0 NEW CAP REL COSTS-BLDG & FIXT 1 NEW CAP REL COSTS-INTEREST						1.0
1.02 0010	2 MOB LEASED SPACE						1.0
	O NEW CAP REL COSTS-MVBLE EQUIP						2.0
	O EMPLOYEE BENEFITS DEPARTMENT O NONPATIENT TELEPHONES	92, 024					4.0
	O DATA PROCESSI NG	0	92, 024	Ļ			5.0
	O PURCHASING RECEIVING AND STORES	0	0				5.0
	0 ADMI TTI NG 0 OTHER ADMI NI STRATI VE & GENERAL	778 3, 570	778 3, 570		1, 018, 881, 519 0	-34, 300, 642	5.0 5.0
	O MAI NTENANCE & REPAI RS	3, 570	3, 131		0	-34, 300, 042	6.0
	O OPERATION OF PLANT	1, 743	1, 743	0	0	0	7.0
	O LAUNDRY & LINEN SERVICE	0	0		0	0	8.0
	O HOUSEKEEPI NG O DI ETARY	4, 207 2, 324	4, 207 2, 324		0	0	9.0 10.0
	O CAFETERI A	2, 996	2, 996		0	0	11.0
	O NURSI NG ADMI NI STRATI ON	3, 431	3, 431		0	0	13.0
	0 CENTRAL SERVICES & SUPPLY 0 PHARMACY	2, 203	2, 203		0	0	14.0
	O MEDICAL RECORDS & LIBRARY	2, 771 0	2, 771 0		0	0	15.0 16.0
	O SOCIAL SERVICE	527	527		0	0	17.0
	O PATI ENT TRANSPORTATI ON	682	682	0	0	0	18.0
	TI ENT ROUTI NE SERVI CE COST CENTERS	20, 712	20, 712	1, 369, 290	85, 580, 620	0	30.0
	O SURGI CAL I NTENSI VE CARE UNI T	20, 712	20, 712		03, 500, 020	0	34.0
34.01 0340	1 PEDIATRIC INTENSIVE CARE UNIT	1, 169	1, 169		3, 287, 630	0	34.0
	2 PREMATURE INTENSIVE CARE UNIT	3, 714	3, 714		21, 294, 202	0	34.0
	O NURSERY LLARY SERVICE COST CENTERS	1, 503	1, 503	0	6, 521, 780	0	43.0
50.00 0500	O OPERATING ROOM	6, 376	6, 376		192, 880, 427	0	50.0
	O RECOVERY ROOM	2,699	2,699		25, 678, 779	0	51.0
	O DELIVERY ROOM & LABOR ROOM O RADIOLOGY-DIAGNOSTIC	3, 695 4, 883	3, 695 4, 883		34, 456, 542 59, 281, 438	0	52.0 54.0
	0 RADI OLOGY - THERAPEUTI C	3, 545	3, 545		56, 754, 513	0	55.0
	0 RADI OI SOTOPE	291	291		8,074,851	0	56.0
	0 LABORATORY 0 RESPI RATORY THERAPY	3, 082 1, 680	3, 082 1, 680		45, 188, 525 12, 462, 262	0	60.0 65.0
	O PHYSI CAL THERAPY	2, 322	2, 322		8, 262, 730	0	66.0
	0 OCCUPATI ONAL THERAPY	323	323		1, 831, 385	0	67.0
	0 SPEECH PATHOLOGY	152	152		747, 781	0	
	0 ELECTROCARDI OLOGY 0 ELECTROENCEPHALOGRAPHY	491 198	491 198		12, 867, 323 3, 049, 651	0	69.0 70.0
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		34, 903, 782	0	71.0
	O I MPL. DEV. CHARGED TO PATI ENT	0	0		87, 259, 185	0	72.0
	0 DRUGS CHARGED TO PATIENTS 0 ASC (NON-DISTINCT PART)	0	0		210, 505, 337	0	73.0 75.0
	1 CARDI AC CATHERI ZATI ON LABORATORY	1, 489	1, 489		32, 601, 026	0	75.0
	ATIENT SERVICE COST CENTERS						
	O EMERGENCY O OBSERVATION BEDS (NON-DISTINCT PART)	3, 622	3, 622	368, 855	75, 391, 750	0	91.0 92.0
	I AL PURPOSE COST CENTERS	I					72.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	90, 309	90, 309	23, 772, 425	1, 018, 881, 519	-34, 300, 642	118.0
	EIMBURSABLE COST CENTERS OPHYSICIANS' PRIVATE OFFICES	~	^		~	^	192. 0
	1 OTHER NON-REIMBURSABLE	0 329	0 329		0		192.0
	2 CHI LDBI RTH EDUCATI ON	136	136		Ő		192.0
	3 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		192.0
	4 PHYSI CI ANS' PRI VATE OFFI CES 5 PHYSI CI AN PRACTI CE	0 984	0 984		0		192. 0 192. 0
	6 TI PTON HOSPI TAL	904 44	904 44		0		192.0
92.07 1920	7 WEST HOSPI TAL	178	178	0	Ō	0	192.0
	8 SAXONY HOSPITAL	44	44	0	0	0	192.0
200.00 201.00	Cross Foot Adjustments Negative Cost Centers						200. 0 201. 0
201.00	Cost to be allocated (per Wkst. B,	-745	8, 644, 060	1, 558, 731	3, 653, 365		201.0
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	93. 932670		0.003586		203.0
204.00	Cost to be allocated (per Wkst. B, Part II)	0	277, 278	529, 592	639, 977		204.0

Health Fina	ncial Systems	IU HEALTH NORTH HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provider C		Period: From 01/01/2020	Worksheet B-1		
					Γο 12/31/2020			
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	Reconciliatio		
		TELEPHONES	PROCESSI NG	RECEIVING AND	(GROSS	n		
		(FTEs)	(FTEs)	STORES	CHARGES)			
				(COSTED				
				REQUISITIONS)				
		5. 01	5.02	5.03	5.04	5A. 05		
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000000	3. 013105	0. 02227	0. 000628		205.00	
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00	
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00	

ealth Financial Systems OST ALLOCATION - STATISTICAL BASIS	IU HEALTH NOR	Provider C		eriod: rom 01/01/2020	u of Form CMS-2 Worksheet B-1	
			T		Date/Time Pre	
Cost Center Description	OTHER ADMI NI STRATI V E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATI ON OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	7/9/2021 10:0 HOUSEKEEPI NG (SQUARE FEET)	
	5. 05	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS .00 00100 NEW CAP REL COSTS-BLDG & FIXT .01 00101 NEW CAP REL COSTS-INTEREST .02 00102 MOB LEASED SPACE .00 00200 NEW CAP REL COSTS-INTEREST .00 00200 NEW CAP REL COSTS-INTEREST .00 00200 NEW CAP REL COSTS-MVBLE EQUIP .00 00400 EMPLOYEE BENEFITS DEPARTMENT .01 00540 NONPATI ENT TELEPHONES .02 00550 DATA PROCESSI NG .03 00560 PURCHASI NG RECEI VI NG AND STORES .04 00570 ADMI TTI NG SENTIAL .00 00600 MAI NTENANCE & REPAI RS O .00 00700 OPERATION OF PLANT O .00 00900 HAUNDRY & LI NEN SERVICE O .00 00900 ILUNDRY & LI	201, 626, 366 5, 559, 227 8, 473, 886 128, 965 5, 875, 611 1, 730, 434 2, 896, 721 4, 585, 017 10, 416, 635 5, 486, 927 108, 482 75, 646	471, 270 75, 282 0 6, 341 2, 718 16, 338 10, 649 18, 126 8, 050 950	395, 988 0 6, 341 2, 718 16, 338 10, 649 18, 126 8, 050 950	31, 844 0 0 0 0 0 0 0 0 0 0 0	389, 647 2, 718 16, 338 10, 649 18, 126 8, 050 950	11. 13. 14. 15. 16.
7. 00 01700 SOCI AL SERVICE 3. 00 01850 PATIENT TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS 0. 00 03000 ADULTS & PEDIATRICS	755, 340 298, 591 24, 777, 284	660 0 88, 255	0	0	660 0 88, 255	
.00 03400 SURGICAL INTENSIVE CARE UNIT .01 03401 PEDIATRIC INTENSIVE CARE UNIT .02 03402 PREMATURE INTENSIVE CARE UNIT .03 04300 NURSERY	0 1, 733, 627 5, 073, 960 1, 943, 514	8, 343		558	0 8, 343 22, 191 10, 301	
ANCI LLARY SERVI CE COST CENTERS 0.00 05000 OPERATI NG ROOM 1.00 05100 RECOVERY ROOM 2.00 05200 DELI VERY ROOM & LABOR ROOM 4.00 05400 RADI OLOGY - DI AGNOSTI C 5.00 05500 RADI OLOGY - THERAPEUTI C 5.00 05600 RADI OLOGY - THERAPEUTI C 5.00 05600 RADI OLOGY - THERAPEUTI C 5.00 05600 RADI OLOGY - THERAPEUTI C 5.00 06600 LABORATORY 5.00 06600 PHYSI CAL THERAPY 5.00 06600 PHYSI CAL THERAPY 5.00 06600 SPEECH PATHOLOGY 7.00 06700 OCCUPATI ONAL THERAPY 8.00 06800 SPEECH PATHOLOGY 9.00 06900 ELECTROCARDI OLOGY 9.00 07000 ELECTROENCEPHALOGRAPHY 1.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 2.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 3.00 07300 DRUGS CHARGED TO PATI ENTS	11, 098, 785 3, 490, 041 5, 748, 224 10, 180, 075 6, 295, 175 435, 976 9, 588, 142 2, 994, 642 2, 781, 638 382, 324 193, 562 1, 109, 209 650, 938 6, 285, 642 11, 206, 390 38, 331, 203 0 3, 132, 913	9, 278 28, 559 15, 038 39, 880 1, 083 11, 109 1, 889 349 0 0 2, 182 734 0 0 2, 182 734 0 0 0 13, 485	9, 278 28, 559 15, 038 39, 880 1, 083 11, 109 1, 889 349 0 0 2, 182 734 0 0 0 2, 182 734 0 0 0 13, 485		47, 092 9, 278 28, 559 15, 038 39, 880 1, 083 11, 109 1, 889 349 0 0 2, 182 734 0 0 0 2, 182 734 0 0 0 13, 485	51 52 54 55 66 67 68 69 70 71 72 73 75 75
.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	4, 770, 070	11, 027	11, 027	0	11, 027	92
3. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	198, 527, 798	450, 709	375, 427	31, 844	369, 086	118
2. 0019200PHYSICIANS' PRIVATE OFFICES2. 0119201OTHER NON-REIMBURSABLE2. 0219202CHILDBIRTH EDUCATION2. 0319203PHYSICIANS' PRIVATE OFFICES2. 0419204PHYSICIANS' PRIVATE OFFICES2. 0519205PHYSICIANS' PRIVATE OFFICES2. 0619206TIPTON HOSPITAL2. 0719207WEST HOSPITAL2. 0819208SAXONY HOSPITAL0. 00Cross Foot Adjustments	0 837, 043 152, 365 0 297, 945 1, 315, 553 71, 707 338, 575 85, 380	0 0 16, 898 0 132 972	0 0 16, 898 0 132	0 0 0 0	2, 308 0 16, 898 0 132 972 251	192 192 192 192 192 192 192 200
11.00Negative Cost Centers12.00Cost to be allocated (per Wkst. B,	34, 300, 642	6, 504, 963	10, 954, 584	150, 905	7, 138, 112	201 202
 Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Part II) 	0. 170120 1, 743, 118				18. 319433 408, 155	

Health Fin	ancial Systems	IU HEALTH NOF	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	COST ALLOCATION - STATISTICAL BASIS		Provider C	Provider CCN: 15-0161		Worksheet B-1	
					rom 01/01/2020 o 12/31/2020		
	Cost Center Description	OTHER	MAINTENANCE &			HOUSEKEEPI NG	
		ADMI NI STRATI V	REPAI RS	PLANT	LINEN SERVICE	(SQUARE	
		E & GENERAL	(SQUARE	(SQUARE	(TOTAL	FEET)	
		(ACCUM.	FEET)	FEET)	PATI ENT DAYS)		
		COST)					
		5.05	6.00	7.00	8.00	9.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 008645	0. 857869	8.833298	0. 035014	1.047499	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems	IU HEALTH NORT		01 15 01/1		u of Form CMS-2	
COSTA	LLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2020	Worksheet B-1	
				T	o 12/31/2020	Date/Time Pre 7/9/2021 10:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL SERVI CES &	PHARMACY	
		(MEALS SERVED)	(FTEs)	ADMI NI STRATI O N	SUPPLY	(COSTED REQUIS.)	
				(NURSI NG	(COSTED		
		10.00	11.00	FTEs) 13.00	REQUISITIONS) 14.00	15.00	
	GENERAL SERVICE COST CENTERS	10100		10100	1	10100	
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST						1.00
1.01	00102 MOB LEASED SPACE						1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES						4.00 5.01
5.01	00550 DATA PROCESSING						5.01
5.03	00560 PURCHASING RECEIVING AND STORES						5.03
5.04							5.04
5.05 6.00	00590 OTHER ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.05 6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	70, 980					9.00 10.00
11.00	01100 CAFETERI A	0	73, 275				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	3, 431				13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	2, 203 2, 771			38, 179, 832	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	2, 771			0	16.00
17.00	01700 SOCIAL SERVICE	0	527			0	
18.00	01850 PATIENT TRANSPORTATION	0	682	0	0	0	18.00
30.00	03000 ADULTS & PEDIATRICS	63, 629	20, 712	13, 550	1, 369, 290	169, 409	30.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	1, 370	1, 169			43	34.01
34.02 43.00	03402 PREMATURE INTENSIVE CARE UNIT 04300 NURSERY	0	3, 714 1, 503			11, 431 0	34.02 43.00
	ANCILLARY SERVICE COST CENTERS	-	.,		-	-	
50.00	05000 OPERATING ROOM	0	6, 376			148,060	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	296 3, 718	2, 699 3, 695			37, 370 33, 705	51.00 52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	4, 883			42, 032	54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	0	3, 545			60, 895	55.00
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	0	291 3, 082			237 46	56.00 60.00
65.00	06500 RESPIRATORY THERAPY	Ő	1, 680			7, 483	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 322			0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	323 152		4, 031 2, 911	0	67.00 68.00
	06900 ELECTROCARDI OLOGY	0	491			8	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	198		.,	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		0	71.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0		37, 576, 673	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	-	0	75.00
75.01	07501 CARDIAC CATHERIZATION LABORATORY OUTPATIENT SERVICE COST CENTERS	1, 414	1, 489	874	20, 356	18, 306	75.01
91.00	09100 EMERGENCY	553	3, 622	2, 509	368, 855	74, 131	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	70, 980	71, 560	24 122	23, 124, 978	20 170 000	110 00
110.UL	NONREIMBURSABLE COST CENTERS	70, 980	/1, 560	34, 132	23, 124, 978	38, 179, 829	110.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
	19201 OTHER NON-REIMBURSABLE	0	329				192.01
	19202 CHI LDBI RTH EDUCATI ON 19203 PHYSI CI ANS' PRI VATE OFFI CES	0	136 0				192.02 192.03
192.04	19204 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.04
192.05	19205 PHYSI CI AN PRACTI CE	0	984		1, 978		192.05
	19206 TI PTON HOSPI TAL 19207 WEST HOSPI TAL	0	44 178		0		192.06 192.07
192.06	I ZOT WEDT HOUT IAL	0	44		0		192.07
192.06 192.07	19208 SAXONY HOSPI TAL	0		1			200.00
192.06 192.07 192.08 200.00	19208 SAXONY HOSPITAL Cross Foot Adjustments	0					
192.06 192.07 192.08 200.00 201.00	19208 SAXONY HOSPITAL Cross Foot Adjustments Negative Cost Centers	2 107 245	4 347 364	4 004 100	10 400 (70)		201.00
192.06 192.07 192.08 200.00	19208 SAXONY HOSPITAL Cross Foot Adjustments Negative Cost Centers	2, 187, 315	4, 366, 301	6, 206, 132	13, 403, 673		201.00
192. 06 192. 07 192. 08 200. 00 201. 00 202. 00 203. 00	19208 SAXONY HOSPITAL Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	30. 815934	59. 587868	181. 561407	0. 579569	7, 241, 561 0. 189670	201. 00 202. 00 203. 00
192.06 192.07 192.08 200.00 201.00 202.00	19208 SAXONY HOSPITAL Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)			181. 561407	0. 579569	7, 241, 561	201. 00 202. 00 203. 00

Health Financial Systems		IU HEALTH NORTH HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provider C		Period:	Worksheet B-1		
					rom 01/01/2020 o 12/31/2020			
						7/9/2021 10:0	<u>8 am</u>	
Cost Center Description		DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY		
		(MEALS	(FTEs)	ADMI NI STRATI O	SERVICES &	(COSTED		
		SERVED)		N	SUPPLY	REQUIS.)		
				(NURSI NG	(COSTED			
				FTEs)	REQUISITIONS)			
		10.00	11.00	13.00	14.00	15.00		
205.00 Unit cost multiplier (Wk	st. B, Part	2. 527388	13. 292951	20. 125154	0. 060968	0. 017975	205.00	
11)								
206.00 NAHE adjustment amount t (per Wkst. B-2)	o be allocated						206.00	
207.00 NAHE unit cost multiplie Parts III and IV)	er (Wkst. D,						207.00	

COST ALLO	ancial Systems CATION - STATISTICAL BASIS	TO HEALTH NOR	Provider C	CN: 15-0161	Period:	u of Form CMS-2552- Worksheet B-1
					From 01/01/2020 To 12/31/2020	
				OTHER GENERA	L	1/ 9/ 2021 10. 08 am
	Cost Center Description	MEDI CAL	SOCI AL	SERVI CE PATI ENT	_	
	cost center bescription	RECORDS &	SERVI CE	TRANSPORTATIO	o	
		LI BRARY	(TOTAL	N		
		(GROSS	PATIENT DAYS)	(GROSS		
		CHARGES) 16.00	17.00	CHARGES) 18.00	_	
GEN	ERAL SERVICE COST CENTERS	10.00	17.00	10.00		
	00 NEW CAP REL COSTS-BLDG & FIXT					1.
	01 NEW CAP REL COSTS-INTEREST 02 MOB LEASED SPACE					1.
	00 NEW CAP REL COSTS-MVBLE EQUIP					2.
	00 EMPLOYEE BENEFITS DEPARTMENT					4.
	40 NONPATIENT TELEPHONES					5.
	50 DATA PROCESSING 60 PURCHASING RECEIVING AND STORES					5.
	70 ADMI TTI NG					5.
	90 OTHER ADMINI STRATI VE & GENERAL					5.
	DO MAINTENANCE & REPAIRS					6.
	00 OPERATION OF PLANT 00 LAUNDRY & LINEN SERVICE					7.
	00 HOUSEKEEPING					9.
0. 00 010	DO DI ETARY					10.
						11.
	00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY					13.
	00 PHARMACY					15.
	00 MEDICAL RECORDS & LIBRARY	1, 018, 881, 519				16.
	DO SOCIAL SERVICE	0				17.
	50 PATIENT TRANSPORTATION ATIENT ROUTINE SERVICE COST CENTERS	0	0	1,018,881,51	9	
	00 ADULTS & PEDIATRICS	85, 580, 620	22, 984	85, 580, 62	20	30.
	DO SURGICAL INTENSIVE CARE UNIT	0			0	34.
	01 PEDIATRIC INTENSIVE CARE UNIT	3, 287, 630				34.
	02 PREMATURE INTENSIVE CARE UNIT 00 NURSERY	21, 294, 202 6, 521, 780				34.
	I LLARY SERVICE COST CENTERS	0, 321, 700	5,701	0, 321, 70		43.
	00 OPERATI NG ROOM	192, 880, 427				50.
	DO RECOVERY ROOM	25, 678, 779				51.
	00 DELIVERY ROOM & LABOR ROOM 00 RADIOLOGY-DIAGNOSTIC	34, 456, 542 59, 281, 438				52. 54.
	00 RADIOLOGY - THERAPEUTIC	56, 754, 513				55.
	DO RADI OI SOTOPE	8, 074, 851				56.
	00 LABORATORY 00 RESPI RATORY THERAPY	45, 188, 525				60. 65.
	00 PHYSICAL THERAPY	12, 462, 262 8, 262, 730				66.
	00 OCCUPATI ONAL THERAPY	1, 831, 385				67.
	00 SPEECH PATHOLOGY	747, 781				68.
	00 ELECTROCARDI OLOGY 00 ELECTROENCEPHALOGRAPHY	12, 867, 323 3, 049, 651				69. 70.
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 903, 782				70.
	OO IMPL. DEV. CHARGED TO PATIENT	87, 259, 185				72.
	DO DRUGS CHARGED TO PATIENTS	210, 505, 337				73.
	00 ASC (NON-DI STI NCT PART) 01 CARDI AC CATHERI ZATI ON LABORATORY	0 32, 601, 026			0	75.
	PATIENT SERVICE COST CENTERS	32,001,020		<u> </u>	.0	75.
91.00 091	00 EMERGENCY	75, 391, 750	0	75, 391, 75	i0	91.
	00 OBSERVATION BEDS (NON-DISTINCT PART)					92.
18.00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1 010 001 510	21 0//	1, 018, 881, 51	0	118.
	REIMBURSABLE COST CENTERS	1,018,881,319	31, 044	1,018,881,51	7	110.
92.00 192	00 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.
	01 OTHER NON-REI MBURSABLE	0	0		0	192.
	02 CHI LDBI RTHEDUCATI ON 03 PHYSI CI ANS'PRI VATEOFFI CES	0	0		0	192. 192.
	04 PHYSICIANS' PRIVATE OFFICES	0			0	192.
92.05 192	05 PHYSICIAN PRACTICE	0	0		0	192.
	D6 TI PTON HOSPI TAL	0	0		0	192.
	07 WEST HOSPITAL 08 SAXONY HOSPITAL	0	0		0	192. 192.
200.00	Cross Foot Adjustments					200.
201.00	Negative Cost Centers					2001
202.00	Cost to be allocated (per Wkst. B,	183, 740	954, 753	390, 02	26	202.
202 00	Part I)	0.000100	20 002104	0.00000	2	202
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000180	29. 982194	0.00038	10	203.

Health Fi	nancial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C	CN: 15-0161	Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020		
				OTHER GENERA	L		
	Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	SERVI CE PATI ENT TRANSPORTATI	0		
		LI BRARY	(TOTAL	N	0		
		(GROSS	PATIENT DAYS)	(GROSS			
		CHARGES)		CHARGES)			
		16.00	17.00	18.00			
204.00	Cost to be allocated (per Wkst. B, Part II)	52, 787	51, 563	13, 93	33		204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000052	1. 619238	0.0000	14		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/9/2021 10:0	pared: 8 am
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	41, 595, 915		41, 595, 91	5 0	41, 595, 915	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0 0	0	34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	2, 871, 829		2, 871, 82	9 0	2, 871, 829	34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT	8, 332, 722		8, 332, 72	2 0	8, 332, 722	34.02
43. 00 04300 NURSERY	3, 316, 959		3, 316, 95	9 0	3, 316, 959	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	19, 091, 015		19, 091, 01		19, 091, 015	
51.00 05100 RECOVERY ROOM	5, 370, 181		5, 370, 18	1 0	5, 370, 181	
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 495, 914		9, 495, 91		9, 495, 914	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 414, 244		13, 414, 24	4 0	13, 414, 244	
55. 00 05500 RADI OLOGY – THERAPEUTI C	10, 404, 484		10, 404, 48	4 0	10, 404, 484	
56. 00 05600 RADI OI SOTOPE	597, 705		597, 70	0	597, 705	
60. 00 06000 LABORATORY	12, 220, 441		12, 220, 44	1 0	12, 220, 441	
65. 00 06500 RESPI RATORY THERAPY	3, 855, 907	0	3, 855, 90	07 0	3, 855, 907	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 430, 054	0	3, 430, 05	4 0	3, 430, 054	66.00
67.00 06700 OCCUPATI ONAL THERAPY	469, 979	0	469, 97	9 0	469, 979	67.00
68.00 06800 SPEECH PATHOLOGY	237, 656	0	237,65	6 0	237, 656	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 466, 998		1, 466, 99	8 0	1, 466, 998	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	823, 244		823, 24	4 0	823, 244	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 725, 343		10, 725, 34	3 0	10, 725, 343	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 087, 006		19, 087, 00	6 0	19, 087, 006	
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 097, 882		52, 097, 88	2 0	52, 097, 882	
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	4, 796, 713		4, 796, 71	3 0	4, 796, 713	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	7, 257, 433		7, 257, 43	3 0	7, 257, 433	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 966, 453		2, 966, 45	3	2, 966, 453	92.00
200.00 Subtotal (see instructions)	233, 926, 077	0	233, 926, 07	7 0	233, 926, 077	
201.00 Less Observation Beds	2, 966, 453		2, 966, 45		2, 966, 453	
202.00 Total (see instructions)	230, 959, 624	0	230, 959, 62	4 0	230, 959, 624	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period: From 01/01/2020	Worksheet C Part I	
				To 12/31/2020		epared:
		Title	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
		·	+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	72, 385, 086		72, 385, 08	36		30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	3, 287, 630		3, 287, 63	30		34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT	21, 294, 202		21, 294, 20)2		34.02
43. 00 04300 NURSERY	6, 521, 780		6, 521, 78	30		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	61, 959, 913	130, 920, 514	192, 880, 42		0. 000000	
51.00 05100 RECOVERY ROOM	5, 483, 533	20, 195, 246	25, 678, 77	0. 209129	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	27, 616, 293	6, 840, 249			0. 000000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	10, 110, 267	49, 171, 171			0. 000000	
55. 00 05500 RADI OLOGY – THERAPEUTI C	293, 778	56, 460, 735			0. 000000	
56. 00 05600 RADI OI SOTOPE	893, 413	7, 181, 438	8, 074, 85	0. 074021	0. 000000	56.00
60. 00 06000 LABORATORY	19, 718, 956	25, 469, 569	45, 188, 52	0. 270432	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	8, 941, 471	3, 520, 791	12, 462, 26	0. 309407	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 809, 074	4, 453, 656	8, 262, 73	0. 415124	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 623, 879	207, 506	1, 831, 38	0. 256625	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	474, 946	272, 835	747, 78	0. 317815	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	4, 391, 662	8, 475, 661	12, 867, 32		0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 566, 879	1, 482, 772	3, 049, 65	0. 269947	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 623, 441	20, 280, 341			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	42, 546, 514	44, 712, 671	87, 259, 18	0. 218739	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	38, 123, 679	172, 381, 658	210, 505, 33	0. 247490	0. 000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0. 000000	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	14, 905, 778	17, 695, 248	32, 601, 02	0. 147134	0. 000000	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	16, 755, 286	58, 636, 464				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	109, 092	13, 086, 442			0. 000000	
200.00 Subtotal (see instructions)	377, 436, 552	641, 444, 967	1, 018, 881, 51	9		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	377, 436, 552	641, 444, 967	1, 018, 881, 51	9		202.00

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0161	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/9/2021 10:0	epared: 08 am
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT					34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT					34.02
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 098978				50.00
51.00 05100 RECOVERY ROOM	0. 209129				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 275591				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 226281				54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 183324				55.00
56. 00 05600 RADI OI SOTOPE	0. 074021				56.00
60. 00 06000 LABORATORY	0. 270432				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 309407				65.00
66.00 06600 PHYSI CAL THERAPY	0. 415124				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 256625				67.00
68.00 06800 SPEECH PATHOLOGY	0. 317815				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 114010				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 269947				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 307283				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 218739				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 247490				73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 147134				75.01
OUTPATIENT SERVICE COST CENTERS					1
91. 00 09100 EMERGENCY	0. 096263				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 224807				92.00
200.00 Subtotal (see instructions)	0.22.007				200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narod
				10 12/31/2020	7/9/2021 10:0	
		Titl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)		0.00	1.00		
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	11 505 015	I	11 505 01		11 505 015	
30. 00 03000 ADULTS & PEDIATRICS	41, 595, 915		41, 595, 91		41, 595, 915	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0		0.071.07	0 0	0	
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 34.02 03402 PREMATURE INTENSIVE CARE UNIT	2, 871, 829		2, 871, 82		2, 871, 829	
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	8, 332, 722 3, 316, 959		8, 332, 72 3, 316, 95		8, 332, 722	
ANCI LLARY SERVICE COST CENTERS	3, 310, 959		3, 310, 93	0	3, 316, 959	43.00
50. 00 05000 OPERATING ROOM	19, 091, 015		19,091,0	5 0	19, 091, 015	50.00
51. 00 05100 RECOVERY ROOM	5, 370, 181		5, 370, 18		5, 370, 181	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 495, 914		9, 495, 9		9, 495, 914	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 414, 244		13, 414, 24		13, 414, 244	1
55. 00 05500 RADI OLOGY - THERAPEUTI C	10, 404, 484		10, 404, 48		10, 404, 484	
56. 00 05600 RADI OI SOTOPE	597, 705		597, 70		597, 705	1
60. 00 06000 LABORATORY	12, 220, 441		12, 220, 44		12, 220, 441	1
65. 00 06500 RESPI RATORY THERAPY	3, 855, 907		3, 855, 90		3, 855, 907	1
66. 00 06600 PHYSI CAL THERAPY	3, 430, 054		3, 430, 05		3, 430, 054	66.00
67.00 06700 OCCUPATI ONAL THERAPY	469, 979	0	469, 97	⁷ 9 0	469, 979	67.00
68.00 06800 SPEECH PATHOLOGY	237, 656	0	237, 65	6 0	237, 656	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 466, 998		1, 466, 99	98 0	1, 466, 998	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	823, 244		823, 24	4 0	823, 244	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 725, 343		10, 725, 34		10, 725, 343	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	19, 087, 006		19, 087, 00		19, 087, 006	
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 097, 882		52, 097, 88	32 0	52, 097, 882	
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	4, 796, 713		4, 796, 71	3 0	4, 796, 713	75.01
OUTPATIENT SERVICE COST CENTERS		I		-1 -1		
91. 00 09100 EMERGENCY	7, 257, 433		7, 257, 43		7, 257, 433	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 966, 453		2, 966, 45		2, 966, 453	
200.00 Subtotal (see instructions)	233, 926, 077		,,		233, 926, 077	
201.00 Less Observation Beds	2, 966, 453		2, 966, 45		2, 966, 453	
202.00 Total (see instructions)	230, 959, 624	0	230, 959, 62	24 0	230, 959, 624	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Peri od:	Worksheet C	
				From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	epared:
					7/9/2021 10:0	
			e XIX	Hospi tal	PPS	
		Charges	1			
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	6.00	7.00	8.00	9,00	Ratio 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	72, 385, 086		72, 385, 08	26		30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	72, 303, 000		72, 303, 00	0		34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	3, 287, 630		3, 287, 63			34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	21, 294, 202		21, 294, 20			34.02
43. 00 04300 NURSERY	6, 521, 780		6, 521, 78			43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	61, 959, 913	130, 920, 514	192, 880, 42	0. 098978	0. 000000	50.00
51.00 05100 RECOVERY ROOM	5, 483, 533	20, 195, 246		0. 209129	0. 000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	27, 616, 293	6, 840, 249	34, 456, 54	0. 275591	0. 000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 110, 267	49, 171, 171			0. 000000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	293, 778	56, 460, 735	56, 754, 51	3 0. 183324	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	893, 413	7, 181, 438	8, 074, 85	0. 074021	0. 000000	56.00
60. 00 06000 LABORATORY	19, 718, 956	25, 469, 569	45, 188, 52	0. 270432	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	8, 941, 471	3, 520, 791			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	3, 809, 074	4, 453, 656			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	1, 623, 879	207, 506			0. 000000	
68.00 06800 SPEECH PATHOLOGY	474, 946	272, 835			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	4, 391, 662	8, 475, 661			0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 566, 879	1, 482, 772			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 623, 441	20, 280, 341			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	42, 546, 514	44, 712, 671			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	38, 123, 679	172, 381, 658			0.00000	
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0.000000	0.00000	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	14, 905, 778	17, 695, 248	32, 601, 02	0. 147134	0.00000	75.01
OUTPATIENT SERVICE COST CENTERS	44 755 004		75 004 75		0.00000	
91.00 09100 EMERGENCY	16, 755, 286	58, 636, 464				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	109, 092	13,086,442			0.00000	
200.00 Subtotal (see instructions)	377, 436, 552	041, 444, 967	1, 018, 881, 51	9		200.00 201.00
201.00 Less Observation Beds	277 424 552	641 444 047	1 010 001 5	0		201.00
202.00 Total (see instructions)	377, 436, 552	041, 444, 967	1, 018, 881, 51	7		202.00

Health Financial Systems	IU HEALTH NORTH	H HOSPI TAL	In Lieu	u of Form CMS-2552-1
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0161	Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prepared: 7/9/2021 10:08 am
	_	Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT				34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT				34.02
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATI NG ROOM	0. 098978			50.00
51.00 05100 RECOVERY ROOM	0. 209129			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 275591			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 226281			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 183324			55.00
56, 00 05600 RADI 0I SOTOPE	0. 074021			56.00
60. 00 06000 LABORATORY	0. 270432			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 309407			65.00
66. 00 06600 PHYSI CAL THERAPY	0, 415124			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 256625			67.00
68.00 06800 SPEECH PATHOLOGY	0. 317815			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 114010			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 269947			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 307283			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 218739			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 247490			73.00
75.00 07500 ASC (NON-DI STI NCT PART)	0. 000000			75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 147134			75.01
OUTPATIENT SERVICE COST CENTERS	0.147134			73.01
91. 00 09100 EMERGENCY	0. 096263			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 224807			92.00
200.00 Subtotal (see instructions)	0.224007			200.00
201.00 Less Observation Beds				200.00
202.00 Total (see instructions)				201.00
				1202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF		Provider C	CN: 15-0161	Period:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY				From 01/01/2020 To 12/31/2020	Part Date/Time Pre	narod
				10 12/31/2020	7/9/2021 10:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operating	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
	Part I, col.	Part II col.	Capital Cos [.]	t	Reducti on	
	26)	26)	(col. 1 -		Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	10 001 015	4 9 4 9 4 7 9	44.050.0			
50.00 O5000 OPERATING ROOM	19,091,015				0	
51.00 05100 RECOVERY ROOM	5, 370, 181				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 495, 914				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 414, 244				0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	10, 404, 484				0	
56. 00 05600 RADI 0I SOTOPE	597, 705				0	
60. 00 06000 LABORATORY	12, 220, 441				0	
65. 00 06500 RESPI RATORY THERAPY	3, 855, 907				0	
66.00 06600 PHYSI CAL THERAPY	3, 430, 054				0	
67.00 06700 OCCUPATI ONAL THERAPY	469, 979				0	
68.00 06800 SPEECH PATHOLOGY	237, 656				0	
69.00 06900 ELECTROCARDI OLOGY	1, 466, 998				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	823, 244				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 725, 343				0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 087, 006				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 097, 882	1, 152, 557	50, 945, 32	25 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	, s		0 0	0	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	4, 796, 713	1, 248, 371	3, 548, 34	12 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						-
91. 00 09100 EMERGENCY	7, 257, 433				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 966, 453				0	
200.00 Subtotal (sum of lines 50 thru 199)	177, 808, 652					200.00
201.00 Less Observation Beds	2, 966, 453					201.00
202.00 Total (line 200 minus line 201)	174, 842, 199	21, 987, 857	152, 854, 34	12 0	0	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lieu	u of Form CMS.	-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part II Date/Time Prepared: 7/9/2021 10:08 am	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
	Capital and	(Worksheet C,	Cost to			
	Operating	Part I,	Charge Rati	c		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	19, 091, 015	192, 880, 427	0. 0989	78		50.00
51.00 05100 RECOVERY ROOM	5, 370, 181	25, 678, 779	0. 2091:	29		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 495, 914	34, 456, 542	0. 2755	91		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 414, 244	59, 281, 438	0. 2262	31		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	10, 404, 484	56, 754, 513	0. 1833	24		55.00
56. 00 05600 RADI 0I SOTOPE	597, 705	8, 074, 851	0. 07402	21		56.00
60. 00 06000 LABORATORY	12, 220, 441	45, 188, 525	0. 27043	32		60.00
65. 00 06500 RESPI RATORY THERAPY	3, 855, 907	12, 462, 262	0. 30940	07		65.00
66. 00 06600 PHYSI CAL THERAPY	3, 430, 054	8, 262, 730	0. 4151:	24		66.00
67.00 06700 OCCUPATI ONAL THERAPY	469, 979	1, 831, 385	0. 2566	25		67.00
68.00 06800 SPEECH PATHOLOGY	237, 656	747, 781	0. 3178 [.]	15		68.00
69.00 06900 ELECTROCARDI OLOGY	1, 466, 998		0. 1140	10		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	823, 244	3, 049, 651	0. 2699	47		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 725, 343		0. 3072	33		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 087, 006	87, 259, 185	0. 21873	39		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	52, 097, 882	210, 505, 337	0. 2474	90		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0					75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	4, 796, 713	32, 601, 026				75.01
OUTPATIENT SERVICE COST CENTERS			i			
91. 00 09100 EMERGENCY	7, 257, 433	75, 391, 750	0.0962	53		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 966, 453					92.00
200.00 Subtotal (sum of lines 50 thru 199)	177, 808, 652	915, 392, 821				200.00
201.00 Less Observation Beds	2, 966, 453					201.00
202.00 Total (line 200 minus line 201)	174, 842, 199					202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020		pared: 8 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 367, 885	0	6, 367, 88	5 24, 749	257.30	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
34. 01 PEDIATRIC INTENSIVE CARE UNIT	548, 909		548, 90	9 558	983.71	34.01
34.02 PREMATURE INTENSIVE CARE UNIT	1, 499, 262		1, 499, 26	2 4, 521	331.62	34.02
43. 00 NURSERY	653, 302		653, 30	2 3, 781	172. 79	43.00
200.00 Total (lines 30 through 199)	9, 069, 358		9, 069, 35	8 33, 609		200.00
Cost Center Description	Inpati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	7, 399	1, 903, 763				30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	69	67, 876				34.01
34.02 PREMATURE INTENSIVE CARE UNIT	0	0				34.02
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	7,468	1, 971, 639				200.00

Health Financial Systems	IU HEALTH NOF	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPI TAL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/9/2021 10:0	pared: 8 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		1	1			
50.00 05000 OPERATING ROOM	4, 840, 670					•
51.00 05100 RECOVERY ROOM	719, 252					•
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 041, 172				3, 874	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 780, 657					
55. 00 05500 RADI OLOGY - THERAPEUTI C	2, 949, 821				9, 435	
56. 00 05600 RADI 0I SOTOPE	78, 712					
60. 00 06000 LABORATORY	786, 853	45, 188, 525	0.01741	3 5, 622, 913	97, 912	60.00
65. 00 06500 RESPI RATORY THERAPY	265, 282	12, 462, 262	0. 02128	7 1, 998, 254	42, 537	65.00
66. 00 06600 PHYSI CAL THERAPY	105, 195	8, 262, 730	0. 01273	1 1, 363, 785	17, 362	66.00
67.00 06700 OCCUPATI ONAL THERAPY	10, 456	1, 831, 385	0.00570	9 617, 769	3, 527	67.00
68.00 06800 SPEECH PATHOLOGY	6, 782	747, 781	0.00907	0 183, 063	1, 660	68.00
69. 00 06900 ELECTROCARDI OLOGY	385, 207	12, 867, 323	0. 02993	7 1, 764, 692	52, 830	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	94, 867	3, 049, 651	0. 03110	7 329, 856	10, 261	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 559, 832	34, 903, 782	0. 01603	9 5, 026, 949	80, 627	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,008,445	87, 259, 185	0. 01155	7 15, 390, 053	177, 863	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 152, 557	210, 505, 337	0.00547	5 11, 807, 642	64, 647	73.00
75.00 07500 ASC (NON-DISTINCT PART)	C	0	0. 00000	0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 248, 371	32, 601, 026	0. 03829	2 5, 707, 877	218, 566	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	953, 726	75, 391, 750	0. 01265	0 6, 645, 857	84, 070	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART) 454, 131			6 39, 129	1, 347	92.00
200.00 Total (lines 50 through 199)	22, 441, 988			83, 922, 660	1, 760, 992	200 00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/9/2021 10:0	epared:)8 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	School	School	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	0		0 0	0	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0	0		0 0	0	34.02
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	l o		0 0	l o	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem	I npati ent	
· ·	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)		
		minus col. 4)		í í		
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	24, 74	19 0.00	7, 399	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T		0		0 0.00	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT		0	5!	0.00	69	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT		0	4, 52	0.00	0	34.02
43.00 04300 NURSERY		0				43.00
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS		I				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0					34.01
34. 02 03402 PREMATURE I NTENSI VE CARE UNI T	0					34.02
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	0	I				200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0161	Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursing		Allied Health	
	Anestheti st	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments		3		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	1	0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0		0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS			_		_	
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PAS	S Provider C		Period: From 01/01/2020 To 12/31/2020			
		Title	XVIII	Hospi tal	PPS		
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges		
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷		
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)		
			and 4)		(see		
					instructions)		
	4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS							
50.00 O5000 OPERATING ROOM	0	0		0 192, 880, 427	0.00000	50.00	
51.00 05100 RECOVERY ROOM	0	0		0 25, 678, 779	0.000000	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 34, 456, 542	0.000000	52.00	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 59, 281, 438	0.00000	54.00	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 56, 754, 513	0.00000	55.00	
56. 00 05600 RADI 0I SOTOPE	0	0		0 8, 074, 851	0.00000	56.00	
60. 00 06000 LABORATORY	0	0		0 45, 188, 525	0.00000	60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 462, 262	0.00000	65.00	
66.00 06600 PHYSI CAL THERAPY	0	0		0 8, 262, 730	0.000000	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 831, 385	0. 000000	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0		0 747, 781	0. 000000	68.00	
69.00 06900 ELECTROCARDI OLOGY	0	0	1	0 12, 867, 323	0. 000000	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 3, 049, 651	0. 000000	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 34, 903, 782	0. 000000	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	0 87, 259, 185	0. 000000	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 210, 505, 337	0.000000	73.00	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	75.00	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0		0 32, 601, 026	0.000000	75.01	
OUTPATIENT SERVICE COST CENTERS			•				
91.00 09100 EMERGENCY	0	0		0 75, 391, 750	0. 000000	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 13, 195, 534	0. 000000	92.00	
200.00 Total (lines 50 through 199)	0	0		0 915, 392, 821		200. 00	

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0161	Period: From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	h Charges	Pass-Through	
	(col. 6 ÷	0	Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	21, 111, 236		0 22, 790, 316	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 854, 952		0 3, 714, 665	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	65, 391		0 112, 485	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 831, 483		0 8, 706, 778	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 000000	181, 531		0 18, 832, 962	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	380, 228		0 2, 393, 534	0	56.00
60. 00 06000 LABORATORY	0. 000000	5, 622, 913		0 2, 920, 038	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 998, 254		0 954, 416	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 363, 785		0 65, 754	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	617, 769		0 3, 764	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	183, 063		0 245	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1, 764, 692		0 2,069,203	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	329, 856		0 112, 799	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	5, 026, 949		0 4, 284, 788	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	15, 390, 053		0 10, 011, 047	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 807, 642		0 51, 985, 858	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 000000	5, 707, 877		0 5, 376, 375	0	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 000000	6, 645, 857		0 8, 223, 398	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	39, 129		0 2,069,731	0	92.00
200.00 Total (lines 50 through 199)		83, 922, 660		0 144, 628, 156	0	200.00

Health Fina	ncial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
					From 01/01/2020 To 12/31/2020		pared:
					10 12/01/2020	7/9/2021 10:0	
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Servi ces (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		<u>9</u> 1.00	2.00	(see inst.) 3.00	(see inst.)	5.00	
ANCLI	LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	O OPERATING ROOM	0. 098978	22, 790, 316		0 0	2, 255, 740	50.00
	D RECOVERY ROOM	0. 209129			0 0	776, 844	•
	D DELIVERY ROOM & LABOR ROOM	0. 209129	112, 485		0 0	31,000	•
	D RADI OLOGY-DI AGNOSTI C	0. 275391	8, 706, 778		0 0	1, 970, 178	•
	D RADIOLOGY - THERAPEUTIC	0. 220201			0 0	3, 452, 534	
	D RADI OLOGIT - THERAPEOTIC	0. 074021	2, 393, 534		0 0	177, 172	•
	DLABORATORY	0. 270432			0 0	789, 672	•
	D RESPIRATORY THERAPY	0. 309407	954, 416		0 0	295, 303	•
	D PHYSI CAL THERAPY	0. 415124			0 0	27, 296	•
	D OCCUPATI ONAL THERAPY	0. 256625			0 0	966	•
	D SPEECH PATHOLOGY	0. 317815			0 0	78	
	D ELECTROCARDI OLOGY	0. 114010			0 0	235, 910	
	DELECTROENCEPHALOGRAPHY	0. 269947			0 0	30, 450	•
	D MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 307283			0 0	1, 316, 643	
	DIMPL. DEV. CHARGED TO PATIENT	0. 218739			0 0	2, 189, 806	
	D DRUGS CHARGED TO PATIENTS	0. 247490			0 48, 917		
	OASC (NON-DISTINCT PART)	0. 000000			0 0	0	•
	CARDIAC CATHERIZATION LABORATORY	0. 147134		21, 12	0 0	791, 048	
	ATIENT SERVICE COST CENTERS						
	DEMERGENCY	0. 096263	8, 223, 398		0 0	791, 609	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 224807			0 0	465, 290	
200.00	Subtotal (see instructions)		144, 628, 156	21, 12	48, 917		
201.00	Less PBP Clinic Lab. Services-Program			,	0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		144, 628, 156	21, 12	48, 917	28, 463, 519	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CON: 15-0161 Period: Provider CON: 15-0161 Period: 17/2/20100 Period: 17/2/201000 Period: 17/2/20100 <t< th=""><th>Health Financial Systems</th><th>IU HEALTH NOR</th><th>TH HOSPI TAL</th><th></th><th>In Lieu</th><th>」of Form CMS-</th><th>-2552-10</th></t<>	Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lieu	」of Form CMS-	-2552-10
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0 50.00 05000 OPERATING ROOM 05000 OPERATING ROOM 05000 OPERATING ROOM 051.00 0 0 50.00 05000 OPERATING ROOM 051.00 0 0 50.00 50.00 05000 OPERATING ROOM 051.00 0 0 50.00 50.00 05000 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 50.00 05500 RODIOLOGY - THERAPEUTIC 0 0 0 54.00 50.00 05500 RODIOLOGY - THERAPEUTIC 0 0 0 55.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 66.00 67.00 06500 RESPIRATORY THERAPY 0 0 0 67.00 68.00 06800 SEECH PATHOLOGY 0 0 0 68.00 69.00 68.00 69.00 0000 LLCETROENCEPHALOGRAPHY 0 0 0 0 71.00 71.00 0000 LLCETROENCEPHALOGRAPHY 0 0 0	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0161	From 01/01/2020	Part V Date/Time Pr	epared: 08 am
Cost Center Description Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS Ded. & Coins. (see inst.) 50.00 50.00 05000 IDERATING ROOM 0 50.00 05000 IDERATING ROOM 0 50.00 05100 RECOVERY ROOM 0 51.00 05100 RECOVERY ROOM 0 52.00 05200 IDELIVERY ROOM 0 54.00 05000 RADIOLOGY - DIAGNOSTIC 0 0 0 0 56.00 05600 RADIOLOGY - THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Title	XVIII	Hospi tal	PPS	
ANCILLARY SERVICE COST CENTERS Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 50.00 05000 (DEFRATING ROOM 0 0500 (DEFRATING ROOM 50.00 0 0 0 50.00 05200 (DEL) VERY ROOM 51.00 0 0 0 0 50.00 05200 (DEL) VERY ROOM 50.00 0 0 0 0 50.00 05200 (DEL) VERY ROOM 50.00 0 0 0 0 50.00 05200 (DEL) VERY ROOM 50.00 0 0 0 51.00 50.00 05200 (DEC) VERY ROOM 50.00 0 0 0 55.00 50.00 0500 (ADI LOGY - THERAPEUTI C 0 0 0 55.00 50.00 0500 (DABORATORY 0 0 0 66.00 66.00 60.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 66.00 60.00 06600 SPECH PATHOLOGY 0 0 0 66.00 71.00 72.00		Cos	sts				
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Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) 6.00 7.00 50.00 05000 OPERATI NG ROOM 0 51.00 05100 RECOVERY ROOM 0 52.00 05200 DEL/VERY ROOM & LABOR ROOM 0 52.00 05200 DEL/VERY ROOM & LABOR ROOM 0 54.00 05400 RADI 0LOGY - J AGNOSTI C 0 55.00 05500 RADI 0LOGY - THERAPEUTI C 0 50.00 05600 RADI 0LOGY - THERAPEUTI C 0 50.00 05600 RADI 0LOGY - THERAPEUTI C 0 50.00 06000 LABORATORY 0 0 60.00 06000 CUPATI NAL THERAPY 0 0 61.00 06000 CUPATI NAL THERAPY 0 0 62.00 06800 SPECH PATHORY THERAPY 0 0 63.00 06800 SPECH PATHOLOGY 0 0 64.00 06800 SPECH PATHOLOGY 0 0 65.00 00 0 0 0 71.00 07100 MELCARARPHY 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
Ded. & Coins. (see inst.) Ded. & Coins. (see inst.) ANCI LLARY SERVICE COST CENTERS 6.00 7.00 50.00 05000 0PERATI NC ROOM 0 0 51.00 05100 000 05100 REOVERY ROOM 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 51.00 52.00 05500 RADI OLOGY - 1 ARONSTI C 0 0 52.00 55.00 05500 RADI OLOGY - 1 ARONSTI C 0 0 0 60.00 0 0 0 0 55.00 56.00 05600 RADI OLOGY - 1 ARONSTI C 0 0 0 60.00 0 0 0 0 0 61.00 05000 RADI OLOGY - 1 ARONSTI C 0 0 0 0 62.00 05600 RADI OLOGY - 1 ARONSTI C 0 0 0 0 0 0 64.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 55.00 RSDI OLOGY - DI AGNOSTI C 0 0 55.00 60.00 OS600 RADI OLOGY - THERAPEUTI C 0 0 55.00 60.00 OS600 RADI OLOGY - THERAPEUTI C 0 0 0 60.00 OS600 RADI OLOGY - THERAPEUTI C 0 0 0 60.00 OS600 RADI OLOGY - THERAPEUTI C 0 0 0 60.00 DS600 RESPI RATORY THERAPY 0 0 66.00 60.00 RESPI RATORY THERAPY 0 0 0 66.00 67.00 06600 PLECTROCARDI OLOGY 0 0 68.00 69.00 ELECTROCARDI OLOGY 0 0 0 69.00 70.00 OT200 IMELC TROCARDI TO PATI ENTS 0 0 71.00 73.00 OT300 RUEGS CHARGED TO PATI ENTS 0 12,106 75.01 75.01 OT500 ASC (NON-DI STI NCT PART)<		0					
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 0 55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 56.00 05600 RADI OLOGY - THERAPEUTI C 0 0 56.00 06000 LABORATORY 0 0 06100 06500 RESPI RATORY THERAPY 0 0 06100 06600 PHYSI CAL THERAPY 0 0 0700 06700 0CCUPATI ONAL THERAPY 0 0 06700 06700 0CCUPATI ONAL THERAPY 0 0 06800 SPEECH PATHOLOGY 0 0 68.00 069.00 06900 ELECTROCARDI OLOGY 0 0 07000 DELECTROENCEPHALOGRAPHY 0 0 71.00 72.00 07000 DATI ENT 0 0 72.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0 12,106 73.00 75.01 07500 ASC (NON-DI STI NCT PART) 0 0 75.01 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
55.00 05500 RADI OLOGY - THERAPEUTI C 0 0 55.00 56.00 05600 RADI OL SOTOPE 0 0 56.00 60.00 06000 LABORATORY 0 0 60.00 65.00 05600 RESPI RATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 68.00 70.00 07000 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71.00 72.00 07200 IMUL, DEV. CHARGED TO PATI ENTS 0 12,106 73.00 75.01 07500 ASC (NON-DI STI NCT PART) 0 0 75.00 75.01 75.01 07100 EMERGENCY 0 0 0 91.00 92.00		0	0				
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65.00 06500 RESPI RATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 0CCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 68.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 12,106 73.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 3,107 0 75.01 75.01 70501 CARDI AC CATHERI ZATI ON LABORATORY 3,107 0 75.01 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 (DBSERVATION BEDS (NON-DI STI NCT PART) 0 0 92.00 200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 201.00 Less		0	0				
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 68.00 69.00 07000 ELECTROCARDI OLOGY 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 12,106 73.00 75.01 07501 CATHERI ZATI ON LABORATORY 3,107 0 75.01 00TPATI ENT SERVICE COST CENTERS 0 0 0 91.00 92.00 92.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 200.00 200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 201.00 201.00		0	0				
67.00 06700 OCUPATI ONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70.00 OTODO ELECTROCARDI OLOGY 0 0 69.00 70.00 OTODO ELECTROCARDI OLOGY 0 0 69.00 71.00 OTODO ELECTROCARGED TO PATI ENTS 0 0 70.00 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 12,106 73.00 75.01 O7500 ASC (NON-DI STI NCT PART) 0 0 75.00 0 OTS00 ASC (NON-DI STI NCT PART) 0 0 75.01 0 OTS01 CARDI AC CATHERI ZATI ON LABORATORY 3,107 0 75.01 0 OTS00 ASC (NON-DI STI NCT PART) 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 200.00 Subtotal (see instructions) 3,107		0	0				
68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 12,106 73.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 75.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 3,107 0 75.01 017501 CARDI AC CATHERI ZATI ON LABORATORY 3,107 0 91.00 91.00 OPICO DSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 92.00 092000 DSERVATI ON SEDS (NON-DI STI NCT PART) 0 0 200.00 200.00 200.00 Subtotal (see instructi ons) 3, 107 </td <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>		0	0				
69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENT 0 0 73.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.01		0	0				
70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 12,106 73.00 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 75.00 75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY 3,107 0 75.01 01700 DIPATI ENT SERVI CE COST CENTERS 0 0 91.00 92.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 200.00 0 Subtotal (see instructions) 3,107 12,106 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00		0	0				
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 12,106 73.00 75.00 07500 ASC (NON-DI STINCT PART) 0 0 75.00 075.01 ORDIAC CATHERIZATION LABORATORY 3,107 0 75.01 0175.01 OP100 EMERGENCY 0 0 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00		0	0				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 12,106 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07501 CARDI AC CATHERIZATION LABORATORY 3,107 0 75.01 0100 EMERGENCY 0 0 91.00 91.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00		0	0				•
73.00 07300 DRUGS CHARGED TO PATIENTS 0 12,106 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.01 07501 CARDIAC CATHERIZATION LABORATORY 3,107 0 75.01 0100 EMERGENCY 0 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 91.00 92.00 92.00 200.00 200.00 200.00 200.00 200.00 0 200.00 200.00 201.00 0 201.00 201.00 0 0 201.00 201.00 0 0 201.00 0 0 201.00 0 201.00 201.00 201.00 201.00 0 201.00		0	0				•
75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.01 07501 CARDIAC CATHERIZATION LABORATORY 3,107 0 75.01 0UTPATI ENT SERVICE COST CENTERS 0 0 91.00 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 91.00 200.00 Subtotal (see instructions) 3,107 12,106 200.00 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00 0 201.00 201.00 0 201.00 0		0	•				
75.01 07501 CARDIAC CATHERIZATION LABORATORY 3,107 0 75.01 0UTPATI ENT SERVICE COST CENTERS 0 0 91.00 91.00 91.00 92.00 92.00 0000 EMERGENCY 0 0 92.00<		0		1			
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0 0 92.00 92.00 200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00		0					
91. 00 09100 EMERGENCY 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92. 00 92. 00 200. 00 Subtotal (see instructions) 3, 107 12, 106 200. 00 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 201. 00 201. 00		3, 107	0				/5.01
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 201.00							
200.00 Subtotal (see instructions) 3,107 12,106 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 201.00							
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 0nl y Charges 0 0			-				
Only Charges		3, 107	12, 106				
		0					201.00
202.00 Net charges (The 200 - The 201) 3, 107 12, 106 [202.00		2 107	10 10/				
	202.00 Net Charges (Tine 200 - Tine 201)	3, 107	12, 106	I			J202. 00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020		epared:)8 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	-	Related Cost	-	col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 367, 885	0	6, 367, 88	5 24, 749	257.30	30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	548, 909		548, 90	9 558	983.71	34.01
34.02 PREMATURE INTENSIVE CARE UNIT	1, 499, 262		1, 499, 26	2 4, 521	331.62	34.02
43.00 NURSERY	653, 302		653, 30	2 3, 781	172.79	43.00
200.00 Total (lines 30 through 199)	9, 069, 358		9, 069, 35	8 33, 609		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 177	302, 842				30.00
34.00 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
34. 01 PEDIATRIC INTENSIVE CARE UNIT	26	25, 576				34.01
34. 02 PREMATURE INTENSIVE CARE UNIT	0	0				34.02
43.00 NURSERY	735					43.00
200.00 Total (lines 30 through 199)	1, 938	455, 419				200.00

Health Financial Systems	IU HEALTH NO	RTH_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPITAL COSTS	Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/9/2021 10:0	pared: 8 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col . 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	I	1		
50.00 05000 OPERATING ROOM	4, 840, 670					50.00
51.00 05100 RECOVERY ROOM	719, 252					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 041, 172					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 780, 657					
55.00 05500 RADIOLOGY - THERAPEUTIC	2, 949, 821				44	55.00
56. 00 05600 RADI OI SOTOPE	78, 712					56.00
60. 00 06000 LABORATORY	786, 853					
65. 00 06500 RESPI RATORY THERAPY	265, 282					
66.00 06600 PHYSI CAL THERAPY	105, 195					
67.00 06700 OCCUPATI ONAL THERAPY	10, 456					
68.00 06800 SPEECH PATHOLOGY	6, 782	2 747, 781				
69. 00 06900 ELECTROCARDI OLOGY	385, 207					
70.00 07000 ELECTROENCEPHALOGRAPHY	94, 867	3, 049, 651	0. 03110	7 8, 678	270	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 559, 832	2 34, 903, 782	0. 01603	9 121, 412	1, 947	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1,008,445	87, 259, 185	0. 01155	7 63, 143	730	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 152, 557	210, 505, 337	0.00547	5 573, 180	3, 138	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0		0. 00000	0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 248, 371	32, 601, 026	0. 03829	2 86, 228	3, 302	75.01
OUTPATIENT SERVICE COST CENTERS]
91.00 09100 EMERGENCY	953, 726	75, 391, 750	0. 01265	0 173, 147	2, 190	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT F	PART) 454, 131			6 0	0	92.00
200.00 Total (lines 50 through 199)	22, 441, 988			2, 847, 086	58, 880	200 00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C	CN: 15-0161	Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		narod
				10 12/31/2020	7/9/2021 10:0)8 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		h Allied Health	All Other	
	School	School	Post-Stepdow		Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0 0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0)	0 0	0	
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	0)	0 0	0	
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0	0)	0 0	0	
43.00 04300 NURSERY	0	0)	0 0	0	
200.00 Total (lines 30 through 199)	U Curi na Dad	Total Costs	Total Patien	t PerDiem		200.00
Cost Center Description	Swing-Bed Adjustment	(sum of cols.	Days	(col. 5 ÷	Inpatient Program Days	
	Amount (see	1 through 3,	Days	col. 6)	Frogram Days	
		minus col. 4)		COI. 0)		
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	24, 74	0.00	1, 177	30.00
34,00 03400 SURGI CAL I NTENSI VE CARE UNI T		0		0 0.00		1
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT		0	55	0.00	26	34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT		0	4, 52	0.00	0	34.02
43.00 04300 NURSERY		0	3, 78	0.00	735	43.00
200.00 Total (lines 30 through 199)		0	33, 60)9	1, 938	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						1 00 00
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T	0					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0					34.01 34.02
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
	0	1				I∠00.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0161	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2020 To 12/31/2020		nared
				10 12/31/2020	7/9/2021 10:0	8 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments	0.00		0.00	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			[0	0	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	0	0		0 0	0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	51.00
54. 00 105200 DELIVERY ROOM & LABOR ROOM 54. 00 105400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	52.00
55. 00 105500 RADI OLOGY - THERAPEUTI C	0	0		0 0	0	55.00
56. 00 105500 RADI 01 SOTOPE	0	0		0 0	0	56.00
60. 00 06000 LABORATORY	0	0			0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0			0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0		0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS	S Provider C		Period: From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 192, 880, 427		
51.00 05100 RECOVERY ROOM	0	0		0 25, 678, 779		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 34, 456, 542		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 59, 281, 438		
55. 00 05500 RADI OLOGY – THERAPEUTI C	0	0		0 56, 754, 513		55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 8, 074, 851	0. 000000	56.00
60. 00 06000 LABORATORY	0	0		0 45, 188, 525		60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 12, 462, 262		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 8, 262, 730		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 831, 385		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 747, 781	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 12, 867, 323		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 3, 049, 651		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 34, 903, 782		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 87, 259, 185		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 210, 505, 337		73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0		0 32, 601, 026	0. 000000	75.01
OUTPATIENT SERVICE COST CENTERS			1	_		
91.00 09100 EMERGENCY	0	0		0 75, 391, 750		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 13, 195, 534		
200.00 Total (lines 50 through 199)	0	0	1	0 915, 392, 821		200.00

Health Financial Systems	IU HEALTH NORTH	H HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre	nared
				10 12/31/2020	7/9/2021 10:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpatient	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	392, 807		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	30, 256		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	64, 358		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	109, 765		0 0	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 000000	844		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	7,859		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	335, 326		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	649, 357		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	78, 600		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	49, 623		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	9, 696		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	92, 807		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	8, 678		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	121, 412		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	63, 143		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	573, 180		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0. 000000	86, 228		0 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	0. 000000	173, 147		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		2, 847, 086		0 0	0	200. 00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0161	Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020	Part V Date/Time Pre	pared:
					7/9/2021 10:0	8 am
		Titl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		Servi ces (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col. 9		Ded. & Coins			
	1,00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	0. 098978	0	917, 14	4 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 209129		161, 52		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 275591		18, 3		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 226281		320, 63		0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 183324		481, 85		0	55.00
56. 00 05600 RADI OI SOTOPE	0. 074021		26, 90		0	56.00
60. 00 06000 LABORATORY	0. 270432		183, 10		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 309407		29, 52		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 415124		137, 22		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 256625		2		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 317815		15, 17		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 114010		33, 36		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 269947		18, 19		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 307283		209, 98		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 218739		295, 42		0	72.00
73.00 07300 DRUGS CHARGED TO PATI ENTS	0. 247490		957, 53		0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 147134	0	146, 79	04 0	0	75.01
OUTPATIENT SERVICE COST CENTERS		•				1
91.00 09100 EMERGENCY	0. 096263	0	511, 20	04 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 224807	0	149, 96	0 8	0	92.00
200.00 Subtotal (see instructions)		0	4, 614, 14	2 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	4, 614, 14	2 0	0	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0161	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V Date/Time Pre 7/9/2021 10:0	epared: 08 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	90, 777					50.00
51.00 05100 RECOVERY ROOM	33, 780					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 048					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	72, 553	0				54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	88, 335	0				55.00
56. 00 05600 RADI 0I SOTOPE	1, 991	0				56.00
60. 00 06000 LABORATORY	49, 516					60.00
65. 00 06500 RESPI RATORY THERAPY	9, 135	0				65.00
66. 00 06600 PHYSI CAL THERAPY	56, 964	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	70	0				67.00
68.00 06800 SPEECH PATHOLOGY	4, 823	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 804	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	4, 912	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	64, 525	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	64, 620	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	236, 979	0				73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0				75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	21, 598	0				75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	49, 210	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 714	0				92.00
200.00 Subtotal (see instructions)	892, 354	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	892, 354	0				202.00

	Financial Systems IU HEALTH NORTH ATION OF INPATIENT OPERATING COST III IIII III III III III IIII IIIIIIIIIIIII IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII	Provider CCN: 15-0161	Period: From 01/01/2020	u of Form CMS-2 Worksheet D-1	
		T	To 12/31/2020	7/9/2021 10:0	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s, excluding newborn)		24, 749	1 1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days,	24, 749 0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b			22, 984	4
00	Total swing-bed SNF type inpatient days (including private ro reporting period		er 31 of the cost	22, 984	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	7, 399	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI			0	13
00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr	ear, enter O on this li am (excluding swing-bed	ne) days)	0	14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	os through Docombor 21	of the cost	0.00	
00	reporting period	U U			
	Medicare rate for swing-bed SNF services applicable to servic reporting period			0.00	
00	Medicaid rate for swing-bed NF services applicable to service reporting period	C		0.00	
00	Medicaid rate for swing-bed NF services applicable to service reporting period		the cost	0.00	
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	41, 595, 915 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost report	ing period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		41, 595, 915	
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed c	harges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)	nue line 22) (con inctor	ctions)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
. 00	Adjusted general inpatient routine service cost per diem (see	-		1, 680. 71	
~~	Program general inpatient routine service cost (line 9 x line	< <u> < > 1</u>		12, 435, 573	39
	Medically necessary private room cost applicable to the Progr	-		12, 435, 575	

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST		TH HOSPITAL Provider C	CN: 15-0161	Period:	worksheet D-1	
				From 01/01/2020 To 12/31/2020		phare
					7/9/2021 10:0	
Cost Center Description	Total		Average Per	Hospital Program Days	PPS Program Cost	
cost center bescription	Inpatient	Inpatient	Diem (col.		(col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	10
.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Uni	0	0	0. (000	0	42.
. 00 INTENSIVE CARE UNIT					1	43.
. OO CORONARY CARE UNI T						44.
. OO BURN INTENSIVE CARE UNIT						45.
. 00 SURGI CAL I NTENSI VE CARE UNI T	0	0			-	
01 PEDIATRIC INTENSIVE CARE UNIT	2, 871, 829	558	1			
02 PREMATURE INTENSIVE CARE UNIT	8, 332, 722	4, 521	1, 843. 1	0	0	
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	
00 Program inpatient ancillary service cost (Wkst. D-3, col. 3	3. line 200)			15, 957, 634	48
00 Total Program inpatient costs (sum of line			ons)		28, 748, 326	
PASS THROUGH COST ADJUSTMENTS		•				
00 Pass through costs applicable to Program i	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	1, 971, 639	50
					4 7/0 000	
.00 Pass through costs applicable to Program i and IV)	npatient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	1, 760, 992	51
.00 Total Program excludable cost (sum of line	es 50 and 51)				3, 732, 631	52
.00 Total Program inpatient operating cost exc		elated, non-ph	vsician anest	hetist, and	25, 015, 695	
medical education costs (line 49 minus lin		fination, non pri		notrot, and	20,010,070	
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program di scharges					0	
.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient oper	ating cost and ta	arget amount (line 56 minus	TINE 53)	0	
.00 Bonus payment (see instructions) .00 Lesser of lines 53/54 or 55 from the cost	roporting poriod	onding 1006	undated and c	ompounded by the	0.00	
market basket	reporting period	enuring 1990,	upuateu anu c	ompounded by the	0.00	09
.00 Lesser of lines 53/54 or 55 from prior yea	ır cost report, um	dated by the	market basket		0.00	60
.00 If line 53/54 is less than the lower of li	nes 55, 59 or 60	enter the les	ser of 50% of	the amount by	0	
which operating costs (line 53) are less t	han expected cost	ts (lines 54 x	60), or 1% c	f the target		
amount (line 56), otherwise enter zero (se	e instructions)					
.00 Relief payment (see instructions)					0	
.00 Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	iyment (see instru	uctions)			0	63
.00 Medicare swing-bed SNF inpatient routine c	osts through Dece	omber 31 of th	e cost report	ing period (See	0	64
instructions)(title XVIII only)	losts through beet			ing period (bee		
.00 Medicare swing-bed SNF inpatient routine c	osts after Decemb	per 31 of the	cost reportin	g period (See	0	65
instructions)(title XVIII only)						
.00 Total Medicare swing-bed SNF inpatient rou	itine costs (line	64 plus line	65)(title XVI	ll only). For	0	66
CAH (see instructions)		D 1 01	C 11			
.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31	of the cost r	eporting period	0	67
(line 12 x line 19) .00 Title V or XIX swing-bed NF inpatient rout	ino coste aftor [locombor 21 of	the cost ror	orting poriod	0	68
(line 13 x line 20)		beceniber 31 01	the cost rep	or tring period	0	00
.00 Total title V or XIX swing-bed NF inpatien	nt routine costs ((line 67 + lin	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER		•				
.00 Skilled nursing facility/other nursing fac)		70
.00 Adjusted general inpatient routine service		ine 70 ÷ line	2)			71
.00 Program routine service cost (line 9 x lin	,		ing 25)			72
.00 Medically necessary private room cost appl .00 Total Program general inpatient routine se	U	•				73
.00 Capital-related cost allocated to inpatien	•			Part II. column		75
26, line 45)						'
.00 Per diem capital-related costs (line 75 ÷	line 2)					76
00 Program capital-related costs (line 9 x li	ne 76)					77
00 Inpatient routine service cost (line 74 mi						78
00 Aggregate charges to beneficiaries for exc			· · · · · · · · · · · · · · · · · · ·			79
00 Total Program routine service costs for co		cost limitatio	n (Iıne 78 mi	nus line 79)		80
00 Inpatient routine service cost per diem li						81
00 Inpatient routine service cost limitation00 Reasonable inpatient routine service costs	•	· .				82
.00 Reasonable inpatient routine service costs .00 Program inpatient ancillary services (see		1 <i>3 j</i>				84
.00 Utilization review - physician compensatio		ons)				85
.00 Total Program inpatient operating costs (s						86
PART IV - COMPUTATION OF OBSERVATION BED P						
.00 Total observation bed days (see instructio					1, 765	
.00 Adjusted general inpatient routine cost pe	er diem (line 27 ÷	÷line 2)			1, 680. 71	
.00 Observation bed cost (line 87 x line 88) (2, 966, 453	

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		pared: 8 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 367, 885	41, 595, 915	0. 15308	9 2, 966, 453	454, 131	90.00
91.00 Nursing School cost	0	41, 595, 915	0.00000	0 2, 966, 453	0	91.00
92.00 Allied health cost	0	41, 595, 915	0.00000	0 2, 966, 453	0	92.00
93.00 All other Medical Education	0	41, 595, 915	0.00000	2, 966, 453	0	93.00

)MPUT		er CCN: 15-0161	Period: From 01/01/2020 To 12/31/2020	J of Form CMS-2 Worksheet D-1 Date/Time Pre 7/9/2021 10:0	pare
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed days, exclu			24, 749	1.
00	Inpatient days (including private room days, excluding swing-bed and	newborn days)		24, 749	2.
00	Private room days (excluding swing-bed and observation bed days). If do not complete this line.	you nave only	private room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation bed days))		22, 984	4.
00	Total swing-bed SNF type inpatient days (including private room days)) through Deceml	ber 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private room days)) after Decembe	r 31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			J. J	
00	Total swing-bed NF type inpatient days (including private room days)	through Decembe	er 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room days)	after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)		ST OF the cost	0	
00	Total inpatient days including private room days applicable to the Pr	rogram (excludiı	ng swing-bed and	1, 177	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (inc	cluding private	room days)	0	10
	through December 31 of the cost reporting period (see instructions)	0.1	5 -	J. J	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (inc		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, enter 0 of Swing-bed NF type inpatient days applicable to titles V or XIX only (ate room days)	0	12
	through December 31 of the cost reporting period	(including prive		J. J	
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (0	13
. 00	after December 31 of the cost reporting period (if calendar year, ent Medically necessary private room days applicable to the Program (excl			0	14
	Total nursery days (title V or XIX only)	daring swiring bec		3, 781	
. 00	Nursery days (title V or XIX only)			735	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services throu	ugh December 31	of the cost	0.00	1 1 7
. 00	reporting period	agri December 51	of the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to services after	December 31 of	f the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through	ah December 31 (of the cost	0.00	19
	reporting period	<u>.</u>			
. 00	Medicaid rate for swing-bed NF services applicable to services after	December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructions)			41, 595, 915	21
	Swing-bed cost applicable to SNF type services through December 31 of	F the cost repo	rting period (line	0	22
00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of 1	the east report	ing ported (line (0	1 22
. 00	x line 18)	the cost report	ing period (inne o	0	23
. 00	Swing-bed cost applicable to NF type services through December 31 of	the cost report	ting period (line	0	24
. 00	7 x line 19)	a cast reporti	ag pariod (line 9	0	25
. 00	Swing-bed cost applicable to NF type services after December 31 of th x line 20)	le cost reportin	ng period (inne o	0	25
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost (line 21 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	1 minus line 26))	41, 595, 915	27
. 00	General inpatient routine service charges (excluding swing-bed and ob	oservation bed (charges)	0	28
	Private room charges (excluding swing-bed charges)		0,	0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 2	201		0 0. 000000	30
. 00	Average private room per diem charge (line 29 ÷ line 3)	20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 minus line	e 33)(see instru	uctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)			0.00 0	35 36
	General inpatient routine service cost net of swing-bed cost and priv	ate room cost o	differential (line	41, 595, 915	37
. 00	27 minus line 36)				1
. 00					-
. 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD JUSTMENTS	3			
. 00 . 00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instruct			1, 680. 71	38
. 00 . 00 . 00 . 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	ctions)		1, 680. 71 1, 978, 196 0	

alth Financial Systems MPUTATION OF INPATIENT OPERATING COST	IU HEALIH NOR	TH HOSPITAL Provider C	N: 15 0161	In Lie Period:	u of Form CMS- Worksheet D-1	
MPUTATION OF INPATIENT OPERATING COST		Provider C		From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/9/2021 10:0	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	
.00 NURSERY (title V & XIX only)	3, 316, 959	3, 781	877.2	7 735	644, 793	42.
Intensive Care Type Inpatient Hospital Uni .00 INTENSIVE CARE UNIT	ts					43.
. 00 CORONARY CARE UNIT						43
. OO BURN INTENSIVE CARE UNIT						45.
. 00 SURGICAL INTENSIVE CARE UNIT	0	0	0.0	0 0	0	46
. 01 PEDIATRIC INTENSIVE CARE UNIT	2, 871, 829	558				
. 02 PREMATURE INTENSIVE CARE UNIT	8, 332, 722	4, 521	1, 843. 1	1 0	0	
. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
					1.00	
00 Program inpatient ancillary service cost (663, 817	48
00 Total Program inpatient costs (sum of line	s 41 through 48)	(see instructi	ons)		3, 420, 619	49
PASS THROUGH COST ADJUSTMENTS .00 Pass through costs applicable to Program i	nationt routing	convigos (fro		of Dorte L one	455, 419	50
		Services (IIU	II WKSL. D, SUI	ii Ui Faits i and	455,419	1 50
.00 Pass through costs applicable to Program i	npatient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	58, 880	51
and IV)	a EQ and E1)				E14 000	^
.00 Total Program excludable cost (sum of line .00 Total Program inpatient operating cost exc	,	elated non-ph	vsician anesti	netist and	514, 299 2, 906, 320	
medical education costs (line 49 minus lin		area, non-pri			2, 700, 320	
TARGET AMOUNT AND LIMIT COMPUTATION						
. 00 Program di scharges					0	
.00 Target amount per discharge .00 Target amount (line 54 x line 55)					0.00	
.00 Difference between adjusted inpatient oper	ating cost and ta	arget amount (ine 56 minus	line 53)	0	
. 00 Bonus payment (see instructions)	atting obot and to	anger amount (0	
.00 Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and co	ompounded by the	0.00	59
market basket					0.00	
.00 Lesser of lines 53/54 or 55 from prior yea .00 If line 53/54 is less than the lower of li				the amount by	0. 00 0	
which operating costs (line 53) are less t	han expected cost	ts (lines 54 x	60), or 1% of	f the target	0	
amount (line 56), otherwise enter zero (se				-		
. 00 Relief payment (see instructions)		· • • • • • • • • • • • • • • • • • • •			0	
. 00 Allowable Inpatient cost plus incentive pa PROGRAM INPATIENT ROUTINE SWING BED COST	yment (see finstru	uctions)			0	63
. 00 Medicare swing-bed SNF inpatient routine c	osts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64
instructions)(title XVIII only)						
.00 Medicare swing-bed SNF inpatient routine c	osts after Decemb	per 31 of the	cost reporting	g period (See	0	65
instructions)(title XVIII only) .00 Total Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	55)(title XVII	l only). For	0	66
CAH (see instructions)		- p			_	
.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	n December 31	of the cost re	eporting period	0	67
(line 12 x line 19) .00 Title V or XIX swing-bed NF inpatient rout	ino coste after [Jocombor 21 of	the cost rop	orting poriod	0	68
(line 13 x line 20)	The costs after t	December 31 01	the cost repo	bitting period	0	00
.00 Total title V or XIX swing-bed NF inpatien	t routine costs	(line 67 + lin	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER						
.00 Skilled nursing facility/other nursing fac .00 Adjusted general inpatient routine service)		70
.00 Program routine service cost (line 9 x lin		ine /u - IIIe	<i>_</i>)			72
. 00 Medically necessary private room cost appl		m (line 14 x l	ne 35)			73
.00 Total Program general inpatient routine se						74
.00 Capital-related cost allocated to inpatien	t routine service	e costs (from	Worksheet B, I	art II, column		75
26, line 45) .00 Per diem capital-related costs (line 75 ÷	line 2)					76
.00 Program capital -related costs (line 9 x li						77
.00 Inpatient routine service cost (line 74 mi						78
00 Aggregate charges to beneficiaries for exc				us line 70)		79
00 Total Program routine service costs for co 00 Inpatient routine service cost per diem li	•	LUST IIMITATIO	i (iine /8 mii	ius i i ne 79)		80
.00 Inpatient routine service cost per drem in		1)				82
.00 Reasonable inpatient routine service costs						83
.00 Program inpatient ancillary services (see						84
.00 Utilization review - physician compensatio						85
.00 Total Program inpatient operating costs (s PART IV - COMPUTATION OF OBSERVATION BED PA		n ougit 85)				86
.00 Total observation bed days (see instructio	ns)				1, 765	87
.00 Adjusted general inpatient routine cost pe					1, 680. 71	
.00 Observation bed cost (line 87 x line 88) (2, 966, 453	1 00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2020	Worksheet D-1	
				To 12/31/2020		pared: 8 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 367, 885	41, 595, 915	0. 15308	9 2, 966, 453	454, 131	90.00
91.00 Nursing School cost	0	41, 595, 915	0.00000	0 2, 966, 453	0	91.00
92.00 Allied health cost	0	41, 595, 915	0.00000	0 2, 966, 453	0	92.00
93.00 All other Medical Education	0	41, 595, 915	0.00000	0 2, 966, 453	0	93.00

Health Financial Systems IU HEALTH NORTH				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0161	Period: From 01/01/2020	Worksheet D-3	3
			To 12/31/2020	Date/Time Pre	epared:
				7/9/2021 10:0	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			00.055.000		
30. 00 03000 ADULTS & PEDIATRICS			22, 855, 989		30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T			0		34.00
34. 01 O3401 PEDIATRIC INTENSIVE CARE UNIT			426, 347		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT			0		34.02
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS		0.0000	70 04 444 004	0.000 540	
50. 00 05000 OPERATING ROOM		0.0989			
51.00 OS100 RECOVERY ROOM		0. 2091			
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 2755			
54.00 O5400 RADI OLOGY-DI AGNOSTI C		0. 2262			
55. 00 O5500 RADI OLOGY - THERAPEUTI C		0. 1833			
56. 00 05600 RADI OI SOTOPE		0.07402			
		0. 2704			
65. 00 06500 RESPI RATORY THERAPY		0. 30940			
66.00 O6600 PHYSI CAL THERAPY		0. 41512			
67.00 06700 OCCUPATI ONAL THERAPY		0. 2566			
68. 00 06800 SPEECH PATHOLOGY		0. 3178			
69. 00 06900 ELECTROCARDI OLOGY		0. 1140			
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 2699			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3072			
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 21873			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 2474			
75.00 O7500 ASC (NON-DI STI NCT PART)		0.0000			
75. 01 O7501 CARDI AC CATHERI ZATI ON LABORATORY		0. 1471:	34 5, 707, 877	839, 823	75.01
OUTPATIENT SERVICE COST CENTERS		0.0515		(00	
91.00 09100 EMERGENCY		0.0962			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 22480			92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			83, 922, 660		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		l	83, 922, 660	l	202.00

Health Financial Systems IU HEALTH NORTH				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0161	Period: From 01/01/2020	Worksheet D-3	3
			To 12/31/2020	Date/Time Pre	epared:
				7/9/2021 10:0	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1 017 170		1 00 00
30. 00 03000 ADULTS & PEDIATRICS			1, 017, 472		30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			124.010		34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT			124, 918		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT			2, 795, 731		34.02
43.00 04300 NURSERY			113, 340		43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0, 0989	78 392, 807	38, 879	50.00
51.00 05100 RECOVERY ROOM		0. 0989			
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 2091			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2755			
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1833			
56. 00 05600 RADI 0I SOTOPE		0. 07402			
60. 00 06000 LABORATORY		0. 2704			
65. 00 06500 RESPIRATORY THERAPY		0. 30940			
66. 00 06600 PHYSI CAL THERAPY		0. 41512			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2566			
68. 00 06800 SPEECH PATHOLOGY		0. 3178			
69. 00 06900 ELECTROCARDI OLOGY		0. 1140			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 2699	47 8, 678	2, 343	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3072			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 2187	39 63, 143	13, 812	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2474	90 573, 180	141, 856	73.00
75.00 07500 ASC (NON-DISTINCT PART)		0.0000	0 00	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY		0. 1471	34 86, 228	12, 687	75.01
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0.0962		16, 668	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 22480		Ű	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 847, 086	663, 817	
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			2, 847, 086		202.00

	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0161	Period:	u of Form CMS-2 Worksheet E	2002-10
5200L			From 01/01/2020 To 12/31/2020	Part A Date/Time Pre	pared.
				7/9/2021 10:0	
		Title XVIII	Hospi tal	PPS	
				1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments			0	1.00
1.00	DRG amounts other than outlier payments for discharges occur	rring prior to October 1	(see	12, 461, 356	
1. 02	instructions) DRG amounts other than outlier payments for discharges occur instructions)	ring on or after October	1 (see	4, 337, 853	1.02
1. 03	DRG for federal specific operating payment for Model 4 BPCI 1 (see instructions)	for discharges occurring	prior to October	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI October 1 (see instructions)	for discharges occurring	on or after	0	1.04
2.00	Outlier payments for discharges. (see instructions)			0	2.00
2.01 2.02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruc	rtions)		0	2.01 2.02
2.02	Outlier payments for discharges occurring prior to October 1			605,073	
2.04	Outlier payments for discharges occurring on or after Octobe			140, 266	
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost rep Indirect Medical Education Adjustment	oorting period (see instr	uctions)	155.83	4.00
5.00	FTE count for allopathic and osteopathic programs for the mo	ost recent cost reporting	period ending or	0.00	5.00
6.00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet	the criteria for an add-	on to the cap for	0.00	6.00
	new programs in accordance with 42 CFR 413.79(e)				
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00	7.00
	cost report straddles July 1, 2011 then see instructions.		, , , , , ,		
8.00	Adjustment (increase or decrease) to the FTE count for allop affiliated programs in accordance with 42 CFR 413.75(b), 413			0.00	8.00
	1998), and 67 FR 50069 (August 1, 2002).				
8. 01	The amount of increase if the hospital was awarded FTE cap s report straddles July 1, 2011, see instructions.	slots under § 5503 of the	ACA. If the cost	0.00	8.01
8. 02	The amount of increase if the hospital was awarded FTE cap s under § 5506 of ACA. (see instructions)	slots from a closed teach	ing hospital	0.00	8. 02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus li instructions)	nes (8, 8,01 and 8,02)	(see	0.00	9.00
	FTE count for allopathic and osteopathic programs in the cur	rrent year from your reco	rds	0.00	
	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00	
13.00	Total allowable FTE count for the prior year.			0.00	
14.00	Total allowable FTE count for the penultimate year if that y otherwise enter zero.	vear ended on or after Se	ptember 30, 1997,	0.00	
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
	Adjustment for residents displaced by program or hospital cl	osure		0.00	
18.00 19.00	Adjusted rolling average FTE count				18.00
	Current year resident to bed ratio (line 18 divided by line Prior year resident to bed ratio (see instructions)	4).		0.000000 0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22.01
23.00	Indirect Medical Education Adjustment for the Add-on for § 4 Number of additional allopathic and osteopathic IME FTE resi		CFR 412.105	0.00	23.00
24.00	(f)(1)(iv)(C). IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
	If the amount on line 24 is greater than -0-, then enter the instructions)	e lower of line 23 or lin	e 24 (see		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
	IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	1
	IME add-on adjustment amount - Managed Care (see instruction	IS)		0	1
	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.	01)		0	1
20.00	Disproportionate Share Adjustment	notiont days (and init	ati ana)	4.05	20.00
	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	cuons)	1.85	
	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			21. 31 23. 16	
	Allowable disproportionate share percentage (see instruction	าร)		8. 32	
33.00					

	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0161	Period:	u of Form CMS-2 Worksheet E	
			From 01/01/2020 To 12/31/2020	Part A Date/Time Pre 7/9/2021 10:03	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment			0.000.014.504	
	Total uncompensated care amount (see instructions)			8, 290, 014, 521	
	Factor 3 (see instructions) Hospital uncompensated care payment (Ifline 34 is zero, ente	or zoro on this line) (se	0. 000113212 945, 388	0. 000131680 1, 091, 625	
33. UZ	instructions)		e 940, 500	1, 071, 025	55. UZ
35.03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	707, 750	275, 150	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		982, 900	.,	36.00
	Additional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu	gh 46)		
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 6	584 and 685. (see	0		40.00
	instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.00
41.01	instructions) Total ESRD Medicare covered and paid discharges excluding MS-	DDCc 652 692 692 694	0		41.01
41.UI	an 685. (see instructions)	-0103 032, 002, 003, 084	U		41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not quali	fv for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68				43.00
	instructions)				
44.00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0.000000		44.00
45 00	days)	- >	0.00		45 00
45.00 46.00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00		45.00 46.00
48.00	Subtotal (see instructions)	1.01)	18, 876, 871		48.00
48.00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	10, 070, 071		48.00
101 00	only. (see instructions)		0		101.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions			18, 876, 871	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I ar			1, 591, 762	
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Li			0	51.00 52.00
53.00	Nursing and Allied Health Managed Care payment	ne 47 see mstructrons).		0	53.00
54.00	Special add-on payments for new technologies			52, 397	
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intr			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 11 line 200)		0	58.00
59.00 60.00	Total (sum of amounts on lines 49 through 58) Primary payer payments			20, 521, 030	
61.00	Total amount payable for program beneficiaries (line 59 minus	sline 60)		9, 398 20, 511, 632	
62.00	Deductibles billed to program beneficiaries			1, 802, 856	
63.00	Coinsurance billed to program beneficiaries			27, 104	
64.00	Allowable bad debts (see instructions)			91, 361	
65.00	Adjusted reimbursable bad debts (see instructions)			59, 385	
66.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		13, 149	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			18, 741, 057	67.00
68.00	Credits received from manufacturers for replaced devices for			0	68.00
69.00 70.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(FOR SCH SEE INSTRUCTION	5)	0	69.00
717 181	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (soo	instructions)	0	70.00 70.50
	Demonstration payment adjustment amount before sequestration			0	70.30
70.50				0	70.88
	SCH or MDH volume decrease adjustment (contractor use only)				
70. 50 70. 87		tructions)			70.89
70. 50 70. 87 70. 88	SCH or MDH volume decrease adjustment (contractor use only)	tructions)		0	
70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions)		0	70. 90 70. 91
70. 50 70. 87 70. 88 70. 89 70. 90 70. 91 70. 92	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	tructions)		0	70.89 70.90 70.91 70.92
70. 50 70. 87 70. 88 70. 89 70. 90 70. 91	SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	tructions)		0	70. 90 70. 91 70. 92 70. 93

	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0161	Peri od:	u of Form CMS-2 Worksheet E	2002-
		TTOWIGET C	UN. 13-0101	From 01/01/2020 To 12/31/2020	Part A Date/Time Pre	
		Title	XVIII	Hospi tal	7/9/2021 10:0 PPS	18 am
		intre		(yyyy)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
ľ	the corresponding federal year for the period prior to 10/1)					
0. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.
0 00	the corresponding federal year for the period ending on or af	ter 10/1)			0	70
0. 98 0. 99	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	70.
	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			18, 840, 054	
1.01	Sequestration adjustment (see instructions)	o, a , o,			124, 344	
1. 02	Demonstration payment adjustment amount after sequestration				0	
1.03	Sequestration adjustment-PARHM pass-throughs					71.
	Interim payments				18, 686, 692	
	Interim payments-PARHM				0	72.
3.00 3.01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)				0	73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0)2 72 and			29, 018	
4.00	73)	<i>12, 12, and</i>			29,010	/4.
4.01	Balance due provider/program-PARHM (see instructions)					74.
5.00	Protested amounts (nonallowable cost report items) in accorda	ance with			435, 129	75.
I	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	- 5 0 0 0			0	
D. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	OT 2.03			0	90.
1.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
	Capital outlier reconciliation adjustment amount (see instruc	,			0	
4.00	The rate used to calculate the time value of money (see instr	ructions)			0.00	
5.00	Time value of money for operating expenses (see instructions)				0	95.
6.00	Time value of money for capital related expenses (see instruc	ctions)		Dui au ta 10/1	0	96.
				Prior to 10/1	UN/AFTER 10/1	
				1 00		
	HSP Bonus Payment Amount			1.00	2.00	
	HSP Bonus Payment Amount HSP bonus amount (see instructions)			1.00	2.00	100.
00.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	2.00	
00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)			0. 0000000000	2.00 0 0.000000000	101.
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior	ns)		0	2.00 0 0.000000000	101.
00. 00 01. 00 02. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructior HRR Adjustment for HSP Bonus Payment	ns)		0. 0000000000	2.00 0 0.000000000 0	101. 102.
00. 00 01. 00 02. 00 03. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)			0.0000000000000000000000000000000000000	2.00 0 0.000000000 0 0.0000	101. 102. 103.
00. 00 01. 00 02. 00 03. 00 04. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	5)	ustment	0. 0000000000	2.00 0 0.000000000 0 0.0000	101. 102. 103.
00.00 01.00 02.00 03.00 04.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	s) ration) Adju	ustment the 21st	0.0000000000000000000000000000000000000	2.00 0 0.000000000 0 0.0000 0	101. 102. 103. 104.
00. 00 01. 00 02. 00 03. 00 04. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	s) ration) Adju	ustment the 21st	0.0000000000000000000000000000000000000	2.00 0 0.000000000 0 0.0000 0	101. 102. 103. 104.
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	š) rration) Adji eriod under	ustment the 21st	0.0000000000000000000000000000000000000	2.00 0 0.000000000 0 0.0000 0	102. 103. 104. 200.
00. 00 01. 00 02. 00 03. 00 04. 00 00. 00 01. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir	š) rration) Adji eriod under	ustment the 21st	0.0000000000000000000000000000000000000	2.00 0.000000000 0 0.0000 0	101. 102. 103. 104. 200.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions)	š) rration) Adji eriod under	ustment the 21st	0.0000000000000000000000000000000000000	2.00 0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	s) ration) Adju eriod under ne 49)	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0 0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions)	s) ration) Adju eriod under ne 49)	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0 0.000000000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	s) ration) Adju eriod under ne 49)	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	s) cration) Adji eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 203. 204. 205.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 03.00 04.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	s) cration) Adji eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 04.00 05.00 05.00 06.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment factor (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	s) rration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 05.00 06.00 07.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	s) rration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0 0.000000000 0 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206.
00.00 01.00 02.00 03.00 04.00 01.00 02.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) rration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 05.00 06.00 06.00 07.00 08.00 09.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lir Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	s) rration) Adju eriod under ne 49) n first year	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment for HSP Bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	s) rration) Adji eriod under ne 49) n first year ructions) line 59)	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0 0.0000 0 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204.
00.00 01.00 02.00 03.00 04.00 00.00 02.00 03.00 05.00 06.00 06.00 07.00 08.00 09.00 10.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) rration) Adju eriod under ne 49) n first year first year ructions) line 59)	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0 0.0000 0 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
00.00 01.00 02.00 03.00 04.00 00.00 02.00 03.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A ir period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	s) rration) Adju eriod under ne 49) n first year first year ructions) line 59)	the 21st	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0.0000 0 trati on	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 211. 2212.
00.00 01.00 02.00 03.00 04.00 00.00 01.00 02.00 03.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00 11.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iir Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	s) rration) Adji eriod under ne 49) first year first year i rructions) line 59)	of the curre	0. 0000000000 0 0. 0000000000 0 0. 00000 0	2.00 0.000000000 0.0000 0 0.0000 0	101. 102. 103. 104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 210. 211.

	Financial Systems		IU HEALTH NOR	Provider C	1	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	t 4 pare
						llooni tol	7/9/2021 10:0	8 am
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Hospital Period On/After 10/01	PPS Total (Col 2 through 4)	
	DDC amounts at here there out live	0	1.00	2.00	3.00	4.00	5.00	1
00	DRG amounts other than outlier payments	1.00	0	0		0 0	0	1.
)1	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	12, 461, 356	0	12, 461, 35	6	12, 461, 356	1.
)2	DRG amounts other than outlier payments for discharges occurring on or after October	1.02	4, 337, 853	0		4, 337, 853	4, 337, 853	1
3	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	0	0		D	0	1.
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.
00	Outlier payments for	2.00						2
)1	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0		0 0	0	2
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	605, 073	0	605, 07	3	605, 073	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	140, 266	0		140, 266	140, 266	2
0	Operating outlier reconciliation	2.01	0	0		0 0	0	3
00	Managed care simulated payments	3.00	0	0		0 0	0	4.
	Indirect Medical Education Adju	ustment			N			
00	Amount from Worksheet E, Part	21.00	0. 000000	0.00000	0.00000	0 0.000000		5
0	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0 0	0	6
)1	instructions) IME payment adjustment for managed care (see	22.01	0	0		0 0	0	6
	instructions) Indirect Medical Education Adju	istment for th	Add_on for S	action 122 of	the MMA			
0	IME payment adjustment factor	27.00	0. 000000			0.000000		7
0	(see instructions) IME adjustment (see instructions)	28.00	0	0		o 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	0	0		o 0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9
	Disproportionate Share Adjustme		ı		·			
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0832	0. 0832	0. 083	2 0. 0832		10
00	Disproportionate share adjustment (see instructions)	34.00	349, 423	0	259, 19	6 90, 227	349, 423	11
01	Uncompensated care payments	36.00	982, 900	0	707, 75	0 275, 150	982, 900	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	<u>rcentage of ES</u> 46.00	KD beneficiary 0	di scharges 0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	18, 876, 871 0	0	14, 033, 37	5 4, 843, 496 0 0	18, 876, 871 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	18, 876, 871	0	14, 033, 37	5 4, 843, 496	18, 876, 871	15

	Financial Systems		IU HEALTH NOR	Provider C	°N· 15_0161	Peri od:	u of Form CMS-2 Worksheet E	2552-1
	LOWE CALCOLATION EXHIBIT 4					From 01/01/2020 To 12/31/2020	Part A Exhibi Date/Time Pre 7/9/2021 10:0	pared
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prion to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 591, 762	0	1, 204, 18	33 387, 579	1, 591, 762	16.0
17.00	Special add-on payments for new technologies	54.00	52, 397	0		0 52, 397	52, 397	
17.01 17.02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.0 17.0
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.0
19.00	SUBTOTAL			0	15, 237, 5	58 5, 283, 472	20, 521, 030	19.0
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		1, 307, 286 0	0		29 327,657 0 0	1, 307, 286 0	
21.00 21.01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2.00 2.01	221, 726 0	0 0		32 44, 194 0 0		
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000	0.000	0. 0000		22.0
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0		
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0480	0. 0480	0. 048	0. 0480		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	62, 750	0	47, 02	22 15, 728	62, 750	25.0
26.00	Total prospective capital payments (see instructions)	12.00	1, 591, 762	0	1, 204, 18	33 387, 579	1, 591, 762	26.0
		W/S E, Part A						
		line	E, Part A)	0.00				
7.00	Law veloce addresses Contract	0	1.00	2.00	3.00	4.00	5.00	07.0
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0. 00000	0 0. 000000 0	0	27.0 28.0
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. C
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. C

OSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2020 To 12/31/2020 Hospital		pared:
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
. 00 . 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	12, 461, 356	12, 461, 35		12, 461, 356	1.00 1.01
. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 02	4, 337, 853		4, 337, 853	4, 337, 853	1.02
. 03	discharges occurring on or after October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1.03
. 04	I DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0		0	0	1.04
. 00	October 1 Outlier payments for discharges (see instructions)	2.00					2.00
. 01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.01
. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	605, 073	605, 07	3	605, 073	2.02
. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	140, 266		140, 266	140, 266	2.03
00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0 0 0	0	3.00 4.00
. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0 0.000000		5.00
. 00	(see instructions) IME payment adjustment (see instructions)	22. 00	0		0 0	0	6.00
. 01	IME payment adjustment for managed care (see instructions)		0		0 0	0	6. 01
	Indirect Medical Education Adjustment for the						
00	IME payment adjustment factor (see instructions)	27.00	0. 000000				7.00
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0 0 0	0 0	8. 00 8. 01
00 01	care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		0 0 0 0	0	9. 00 9. 01
	lines 6.01 and 8.01) Disproportionate Share Adjustment						
0. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0832	0. 083	2 0. 0832		10.00
1.00	Disproportionate share adjustment (see instructions)	34.00	349, 423	259, 19	6 90, 227	349, 423	11.00
. 01	Uncompensated care payments Additional payment for high percentage of ESI	36.00	982, 900	707, 75	0 275, 150	982, 900	11.01
. 00	Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12.00
. 00 . 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	18, 876, 871 0	14, 033, 37	5 4, 843, 496 0 0	18, 876, 871 0	13.00 14.00
. 00	instructions) Total payment for inpatient operating costs	49.00	18, 876, 871	14, 033, 37	5 4, 843, 496	18, 876, 871	15.00
. 00	(see instructions) Payment for inpatient program capital (from	50.00	1, 591, 762	1, 204, 18	3 387, 579	1, 591, 762	16.00
. 00	Wkst. L, Pt. I, if applicable) Special add-on payments for new technologies	54.00	52, 397		0 52, 397	52, 397	
. 01 . 02	Net organ acquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.01 17.02
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		о о	0	18.00
9.00	SUBTOTAL			15, 237, 55	8 5, 283, 472	20, 521, 030	19.00

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2020 To 12/31/2020	Date/Time Pre 7/9/2021 10:0	pared:
				XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1, 307, 286	979, 62	9 327, 657	1, 307, 286	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0	0	20.01
21.00	Capital DRG outlier payments	2.00	221, 726	177, 53	2 44, 194	221, 726	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0 0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0480	0. 048	0 0. 0480		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	62, 750	47, 02	2 15, 728	62, 750	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 591, 762	1, 204, 18	3 387, 579	1, 591, 762	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	106, 474	72, 46	5 34,009	106, 474	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70. 94	-7, 477	-7,47	7 0	-7, 477	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
	· · · · · ·					(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70. 99			0 0		32.00
100. 00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

	I Financial Systems IU HEALTH NORTH HOSPITAL ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0161 Per	In Lie	u of Form CMS-2 Worksheet E	2552-10
		01/01/2020 12/31/2020	Part B	
	Title XVIII	Hospi tal	PPS	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)		15, 213	
2.00	OPPS payments		28, 463, 519 19, 619, 553	
4.00	Outlier payment (see instructions)		84, 843	
4.01	Outlier reconciliation amount (see instructions)		0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	•
8.00	Transitional corridor payment (see instructions)		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		15, 213	•
	COMPUTATION OF LESSER OF COST OR CHARGES			
12.00	Reasonable charges Ancillary service charges		70, 037	12 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0,037	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		70, 037	14.00
15 00	Customary charges	hanga haai a	0	15 00
15.00 16.00	Aggregate amount actually collected from patients liable for payment for services on a c Amounts that would have been realized from patients liable for payment for services on a	0	0	15.00 16.00
101.00	had such payment been made in accordance with 42 CFR §413. 13(e)	onal gobaol o		10100
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 line	11) (see	70, 037 54, 824	
17.00	instructions)	(300	54, 024	17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line	18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)		15, 213	21.00
22.00			0	
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT		19, 704, 396	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		4, 224	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instruct	i ons)	3, 507, 130	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 an instructions)	d 23] (see	16, 208, 255	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	
30.00 31.00	Subtotal (sum of lines 27 through 29)		16, 208, 255	
31.00			14, 972 16, 193, 283	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			
	Composite rate ESRD (from Wkst. I-5, line 11)		0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		128, 613 83, 598	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		90, 442	
37.00			16, 276, 881	•
38.00 39.00			-319	1
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructio	ns)	2, 100	
39.99 40.00			0 16, 277, 200	
40.01	Sequestration adjustment (see instructions)		107, 430	
40.02			0	
40.03	Sequestration adjustment-PARHM pass-throughs Interim payments		16, 218, 462	40.03
	Interim payments-PARHM		10, 210, 402	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		40.700	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)		-48, 692	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, cha	pter 1,	2,009	1
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)		0	90.00
			0	
92.00	The rate used to calculate the Time Value of Money			92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)		0	93.00 94.00
74.00			. 0	1 / 4.00

ANALY	I Financial Systems IU HEALTH NOR SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0161	Period: From 01/01/2020 To 12/31/2020		pared:
			XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		18, 655, 1	92 0	16, 218, 462 0	1.00 2.00 3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/19/2020	31, 5	00	0	3.0'
3. 02 3. 03				0	0	3.02 3.03
3.03				0	0	3.0
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51 3. 52				0	0	3.5 3.5
3.52				0	0	3.5
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		31, 5	00	0	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		18, 686, 6	92	16, 218, 462	4.0
	TO BE COMPLETED BY CONTRACTOR					
5.00	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			0	0	
5. 01 5. 02	TENTATI VE TO PROVI DER			0	0	5.0 5.0
5.02				0	0	
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5. 51 5. 52				0	0	5.5 5.5
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
	5. 50-5. 98)			-	Ū	. ,
o. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5.01	SETTLEMENT TO PROVIDER		29, 0	18	0	6.0
5.02	SETTLEMENT TO PROGRAM		10 715 7	0	48,692	6.0
7.00	Total Medicare program liability (see instructions)		18, 715, 7	Contractor	16, 169, 770 NPR Date	7.0
				Number	(Mo/Day/Yr)	

	I Systems IU HEALTH NOR	RTH HOSPI TAL	In Lie	」of Form CMS-	2552-10		
CALCULATION OF	REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0161	Peri od: From 01/01/2020 To 12/31/2020		epared:		
		Title XVIII	Hospi tal	PPS			
				1.00			
TO BE CO	MPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
HEALTH I	NFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT	ION					
1.00 Total ho							
2.00 Medicare	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
3.00 Medicare	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00 Total in	patient days from S-3, Pt. I col. 8 sum of lines 1	, 8-12			4.00		
5.00 Total ho	spital charges from Wkst C, Pt. I, col. 8 line 200				5.00		
6.00 Total ho	spital charity care charges from Wkst. S-10, col.	3 line 20			6.00		
7.00 CAH only line 168	- The reasonable cost incurred for the purchase o	f certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00 Cal cul a	ion of the HIT incentive payment (see instructions)			8.00		
9.00 Sequest	ation adjustment amount (see instructions)				9.00		
10.00 Cal cul a	ion of the HIT incentive payment after sequestrati	on (see instructions)			10.00		
I NPATI EN	T HOSPITAL SERVICES UNDER THE IPPS & CAH				1		
30.00 Initial,	interim HIT payment adjustment (see instructions)				30.00		
31.00 Other Ad	justment (specify)				31.00		
32.00 Bal ance	due provider (line 8 (or line 10) minus line 30 an	d line 31) (see instructio	ns)		32.00		

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2020 0 12/31/2020	Worksheet G Date/Time Pre 7/9/2021 10:0	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-1, 683, 731	0	0	0	1.0
00	Temporary investments	0	0	0	0	2.0
00	Notes receivable Accounts receivable	73, 620		0	0	3.0
00	Other receivable	347, 328, 836	0	0	0	4.
00	Allowances for uncollectible notes and accounts receivable	-15, 697, 721	0	0	0	6.
00	Inventory	5, 091, 768	0	0	0	7.
00	Prepai d expenses	1, 121, 654	0	0	0	8.
00 0. 00	Other current assets Due from other funds	-9, 919, 617	0	0	0	9. 10.
	Total current assets (sum of lines 1-10)	326, 314, 809	0	0	0	10.
. 00	FIXED ASSETS	020,011,007	0			1
	Land	0	0	0	0	12.
	Land improvements	12,041,302	0	0	0	13.
	Accumulated depreciation	-11, 951, 324	0	0	0	14.
	Buildings Accumulated depreciation	208, 357, 664 -63, 424, 506	0	0	0	15. 16.
	Leasehold improvements	554, 623	0	0	0	17.
	Accumulated depreciation	-533, 291	0	0	0	18.
	Fixed equipment	0	0	0	0	19.
	Accumulated depreciation	0	0	0	0	20.
	Automobiles and trucks	138, 887	0	0	0	21.
	Accumulated depreciation Major movable equipment	-138, 887 101, 149, 108		0	0	22.
	Accumulated depreciation	-72, 467, 538		0	0	24
	Minor equipment depreciable	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation Minor equipment-nondepreciable	0	0	0	0	28 29
	Total fixed assets (sum of lines 12-29)	173, 726, 038		0	0	30
	OTHER ASSETS			-1		
	Investments	0		0	0	31.
. 00	Deposits on Leases	0		0	0	32.
	Due from owners/officers Other assets	24, 403, 639	0	0	0	33
	Total other assets (sum of lines 31-34)	24, 403, 639		0	0	35
	Total assets (sum of lines 11, 30, and 35)	524, 444, 486		0	0	36
	CURRENT LIABILITIES					
	Accounts payable	10, 666, 863		0	0	37.
. 00 . 00	Salaries, wages, and fees payable Payroll taxes payable	6, 229, 395 0	0	0	0	38
	Notes and Loans payable (short term)	0	0	0	0	40
	Deferred income	21, 250	0	0	0	
	Accel erated payments	13, 676, 538				42
	Due to other funds	1 750 404	0	0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	1, 750, 484 32, 344, 530		0	0	
. 00	LONG TERM LIABILITIES	52, 544, 550	0	0	0	1 - 5
. 00	Mortgage payable	0	0	0	0	46.
. 00	Notes payable	0	0	0	0	47
	Unsecured Loans	0	0	0	0	48
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	374, 573 374, 573		0	0	49 50
	Total liabilities (sum of lines 45 and 50)	32, 719, 103		0	0	51
	CAPITAL ACCOUNTS	02/ / / / / / / / / / / / / / / / / / /	<u> </u>			1.
. 00	General fund balance	491, 725, 383				52
	Specific purpose fund		0	_		53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00 . 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance					55 56
. 00	Plant fund balance - invested in plant			0	0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion					
. 00	Total fund balances (sum of lines 52 thru 58)	491, 725, 383		0	0	59
. 00	Total liabilities and fund balances (sum of lines 51 and	524, 444, 486	0	0	0	60

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0161	Period: From 01/01/2020 To 12/31/2020	Worksheet G-1 Date/Time Pre 7/9/2021 10:0	epared:
	General	Fund	Speci al	Purpose Fund	Endowment Fund	
	1.00	2.00	3.00	4.00	5.00	
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 DONATED PPE 6.00 7.00 8.00 9.00 10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance sheet (line 11 minus line 18) 	0 145,000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	379, 469, 715 112, 110, 668 491, 580, 383 145, 000 491, 725, 383 0 491, 725, 383				$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
	Endowment Fund	PI ant	Fund	_		
	6.00	7.00	8.00			
 1.00 Fund balances at beginning of period 2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 4.00 Additions (credit adjustments) (specify) 5.00 DONATED PPE 6.00 7.00 8.00 9.00 	0			0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 Total additions (sum of line 4-9) 11.00 Subtotal (line 3 plus line 10) 12.00 Deductions (debit adjustments) (specify) 13.00 14.00 15.00 16.00 17.00 18.00 Total deductions (sum of lines 12-17)	000	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 Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0161	Period: From 01/0 To 12/3	1/2020 1/2020	Date/Time Pre	pared:
	Cast Cantan Description		1	0		7/9/2021 10:0	18 am
	Cost Center Description		Inpatient 1.00	0utpati 2.00		Total 3.00	
	PART I – PATIENT REVENUES		1.00	2.00	5	5.00	
	General Inpatient Routine Services						1
1.00	Hospi tal		78, 906, 8	38		78, 906, 888	1 1.0
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3.0
4.00	SUBPROVI DER						4.0
5.00	Swing bed - SNF			0		0	
5.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY						7.0
3.00	NURSING FACILITY						8.0
9.00 10.00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)		78, 906, 8	00		78, 906, 888	9.0
10.00	Intensive Care Type Inpatient Hospital Services		76, 900, 6	00		70, 900, 000	10.0
11.00	INTENSIVE CARE UNIT						111.0
12.00	CORONARY CARE UNIT						12.0
13.00	BURN I NTENSI VE CARE UNI T						13.0
14.00	SURGI CAL I NTENSI VE CARE UNI T			0		0	
14.01	PEDIATRIC INTENSIVE CARE UNIT		3, 287, 6	30		3, 287, 630	14.0
14.02	PREMATURE INTENSIVE CARE UNIT		21, 294, 7	70		21, 294, 770	14.0
15.00	OTHER SPECIAL CARE (SPECIFY)						15.0
16.00	Total intensive care type inpatient hospital services (sum of	lines	24, 582, 4	00		24, 582, 400	16.0
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16))	103, 489, 2			103, 489, 288	
18.00	Ancillary services		257,083,4		22,063	826, 805, 539	
19.00 20.00	Outpatient services		16, 864, 3	/8 /1, /2	22, 316	88, 586, 694	
20.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY			0	0	0	21.0
23.00	AMBULANCE SERVICES						23.0
24.00	CMHC						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
26.00	HOSPI CE						26.0
27.00	NONALLOWABLE REVENUE			0 90	61, 671	961, 671	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	377, 437, 1	42 642, 40	06, 050	1, 019, 843, 192	28.0
	G-3, line 1)						1
	PART II - OPERATING EXPENSES			1			
29.00	Operating expenses (per Wkst. A, column 3, line 200)				25, 867		29.0
30.00	ADD (SPECI FY)			0			30.0
1.00				0			31.0 32.0
32.00 33.00				0			32.0
34.00				0			34.0
35.00				0			35.0
36.00	Total additions (sum of lines 30-35)			-	0		36.0
37.00	DEDUCT (SPECIFY)			0			37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00				0			41.0
12.00	Total deductions (sum of lines 37-41)				0		42.0
13.00	Total operating expenses (sum of lines 29 and 36 minus line 4: to Wkst. G-3, line 4)	2)(transfer		244, 32	25, 867		43.0

	Financial Systems	IU HEALTH NORTH			u of Form CMS-2	
STATEME	NT OF REVENUES AND EXPENSES		Provider CCN: 15-0161	Peri od:	Worksheet G-3	
				From 01/01/2020 To 12/31/2020	Date/Time Pre	nared
				10 12/01/2020	7/9/2021 10:0	
					1.00	
	Total patient revenues (from Wkst. G-2, F				1, 019, 843, 192	1.00
	Less contractual allowances and discounts		ts		683, 441, 663	
	Net patient revenues (line 1 minus line 2				336, 401, 529	3.00
	Less total operating expenses (from Wkst.		43)		244, 325, 867	4.00
	Net income from service to patients (line	e 3 minus line 4)			92, 075, 662	5.00
	OTHER INCOME					
	Contributions, donations, bequests, etc				0	6.00
	Income from investments				0	7.00
	Revenues from telephone and other miscell		servi ces		0	8.00
	Revenue from television and radio service	2			0	9.00
	Purchase di scounts				0	10.00
	Rebates and refunds of expenses				0	11.00
	Parking lot receipts				0	12.00
	Revenue from laundry and linen service				0	13.00
	Revenue from meals sold to employees and	guests			0	14.00
	Revenue from rental of living quarters				0	15.00
	Revenue from sale of medical and surgical		han patients		0	16.00
	Revenue from sale of drugs to other than				0	17.00
	Revenue from sale of medical records and				0	18.00
	Tuition (fees, sale of textbooks, uniform				0	19.00
	Revenue from gifts, flowers, coffee shops	s, and canteen			0	20.00
	Rental of vending machines				0	
	Rental of hospital space				0	22.00
	Governmental appropriations				0	23.00
	MISC. INCOME				8, 966, 490	
	COVID-19 PHE Funding				11, 068, 516	
	Total other income (sum of lines 6-24)				20, 035, 006	
	Total (line 5 plus line 25)				112, 110, 668	
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and				0	28.00
29.00	Net income (or loss) for the period (line	e 26 minus line 28)			112, 110, 668	29.00

ALCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0161	Period: From 01/01/2020 To 12/31/2020		
	Title XVIII	Hospi tal	PPS	
			1.00	
PART I - FULLY PROSPECTIVE METHOD				-
CAPITAL FEDERAL AMOUNT 00 Capital DRG other than outlier			1 207 204	1
			1, 307, 286 0	
11 Model 4 BPCI Capital DRG other than outlier 10 Capital DRG outlier payments			221, 726	
01 Model 4 BPCI Capital DRG outlier payments			221,720	
0 Total inpatient days divided by number of days in the cost reporting period (see instructions)			81. 02	
0 Number of interns & residents (see instructions)			0.00	
0 Indirect medical education percentage (see instructions)			0.00	
0 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and			0	6.
1.01) (see instructions)		,		
0 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			1.85	7.
0 Percentage of Medicaid patient days to total days (see instructions)			21.31	8.
0 Sum of Lines 7 and 8			23.16	9.
00 Allowable disproportionate share percentage (see instructions)			4.80	10.
00 Disproportionate share adjustment (see instructions)			62, 750	
.00 Total prospective capital payments (see instructions)			1, 591, 762	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST				
0 Program inpatient routine capital cost (see instructions)		0		
00 Program inpatient ancillary capital cost (see instructions)			0	
00 Total inpatient program capital cost (line 1 plus line 2)			0	
00 Capital cost payment factor (see instructions)	N		0	4.
00 Total_inpatient_program_capital_cost (line 3_x line 4))		0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	1 1.
00 Program inpatient capital costs (see fistractions)	rumstances (see instructions)		0	2.
00 Net program inpatient capital costs for extraordinary circ			0	
00 Applicable exception percentage (see instructions)			0.00	
00 Capital cost for comparison to payments (line 3 x line	e 4)		0	
00 Percentage adjustment for extraordinary circumstances			0.00	
00 Adjustment to capital minimum payment level for extrac		x line 6)	0	7.
00 Capital minimum payment level (line 5 plus line 7)			0	8.
00 Current year capital payments (from Part I, line 12, a			0	
.00 Current year comparison of capital minimum payment lev	1 1 5 1	, ,	0	
00 Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)		5	0	
.00 Net comparison of capital minimum payment level to cap			0	1
	.00 Current year exception payment (if line 12 is positive, enter the amount on this line)			
		following period	0	14.
		ron owning period		
.00 Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line	e)	rorrowing perrou	0	15.
.00 Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line	e) (see instructions)		0	