Health Financial Systems IU HEALTH	ARNETT HOSPI TAL	In Lieu of Form CMS-2552	2-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)	). Failure to report can re	sult in all interim FORM APPROVED	
payments made since the beginning of the cost reporting period	being deemed overpayments		
		EXPI RES 03-31-202	22
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC.	ATION Provider CCN: 15-017:	3 Period: Worksheet S From 01/01/2021 Parts I-III	
AND SETTLEMENT SUMMARY		To 12/31/2021 Date/Time Prepare	ed:
		5/26/2022 3:42 pm	
PART I – COST REPORT STATUS			
Provider 1. [X] Electronically prepared cost report		Date: 5/26/2022 Time: 3:42	pm
use only 2. [] Manually prepared cost report			
3.[ 0 ]If this is an amended report enter the n 4.[ F ]Medicare Utilization. Enter "F" for full	or "I" for low	resubmitted this cost report	
Contractor 5. [1] Cost Report Status 6. Date Received:		0.NPR Date:	
use only (1) As Submitted 7. Contractor No.	1	1. Contractor's Vendor Code:	4
(2) Settled without Audit 8. [ N ] Initial Rep	ort for this Provider CCN 1	2.[ 0]If line 5, column 1 is 4: Enter	r
(3) Settled with Addit	t for this Provider CCN	number of times reopened = 0-9.	
(4) Reopened			
(5) Amended			
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OR PROVIDER(S)		
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINE	D IN THIS COST REPORT MAY B	E PUNISHABLE BY CRIMINAL, CIVIL AND	
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL			
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTL	Y OF A KICKBACK OR WERE OTH	ERWISE ILLEGAL, CRIMINAL, CIVIL AND	
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PROVIDER(S)		
I HEREBY CERTIFY that I have read the above certificat	ion statement and that I ha	ive examined the accompanying	
electronically filed or manually submitted cost report			
Statement of Revenue and Expenses prepared by IU HEALT			
period beginning 01/01/2021 and ending 12/31/2021 and			
statement are true, correct, complete and prepared fro			
applicable instructions, except as noted. I further ce			
regarding the provision of health care services, and t provided in compliance with such laws and regulations.	hat the services identified	In this cost report were	
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
1	2 5	IGNATURE STATEMENT	

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

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	1, 616, 551	132, 495	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	1, 616, 551	132, 495	0	0	200.00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA		ier CCN:		Period: From 01/01/ To 12/31/	2021	Workshe Part I Date/Ti 5/26/20	me Pre	pared
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co									
00	Street: 6165 MCCARTY LANE	PO Box:								1.
00	City: LAFAYETTE	State: IN	Zip Cod			y: TI PPECAN				2.
		Component Name	CCN	CBSA	Provi der			nt Syst		
			Number	Number	r Type	Certified	-	0, or	1 1	4
							V	XVIII	-	4
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen									
00	Hospi tal	IU HEALTH ARNETT	150173	29200	1	11/10/2008	N	P	P	3.
~		HOSPITAL								
0	Subprovider - IPF									4.
00	Subprovider - IRF									5.
00	Subprovider - (Other)									6.
00	Swing Beds - SNF									7.
0	Swing Beds - NF						1		1	8.
0	Hospi tal -Based SNF									9.
00	Hospi tal -Based NF									10.
00	Hospital-Based OLTC								-	11.
00	Hospital-Based HHA									12.
00	Separately Certified ASC									13.
00	Hospi tal -Based Hospi ce									14.
00	Hospital-Based Health Clinic - RHC									15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis				1					18
	Other									19
		I			1	From:		То		
						1.00		2. (		1
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31		20.
	Type of Control (see instructions)					2	~~ '	12/01/	-021	20.
55	is a control (see that detrolls)					2				21.
					1.00	2.00		3. (	00	1
	Inpatient PPS Information							0.1		
00	Does this facility qualify and is it	currently receiving p	avments for		Y	N				22.
	disproportionate share hospital adju									
	§412.106? In column 1, enter "Y" fo			`						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo		lenument							
01		3	to for thi	_	Y	Y				1 22
01	Did this hospital receive interim un				T	T				22.
	cost reporting period? Enter in colu									
	the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N	" for no for the portion	on of the c	cost						
	reporting period occurring on or aft	er October 1. (see ins <sup>.</sup>	ructions)							
02	Is this a newly merged hospital that	requires final uncompe	ensated car	re	N	N				22.
	payments to be determined at cost re	port settlement? (see i	nstructior	is)						
	Enter in column 1, "Y" for yes or "N	" for no, for the porti	on of the							
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th									
	October 1.									
03	Did this hospital receive a geograph	ic reclassification fro	om urhan to	,	Ν	N		N	I	22
55	rural as a result of the OMB standar					IN IN		IN IN		~~
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin			н.						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	2.105)? Enter in column	n 3, "Y" fo	or						
	yes or "N" for no.									
04	Did this hospital receive a geograph				N	N		N		22
	rural as a result of the revised OMB	delineations for stati	stical are	eas						
	adopted by CMS in FY 2021? Enter in	column 1, "Y" for yes (	or "N" for	no						
	for the portion of the cost reportin	g period prior to Óctol	oer 1. Ente	er						
	in column 2, "Y" for yes or "N" for	no for the portion of	the cost							
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	z. robje Enter in Colur	ш э, т Т							
	yes or "N" for no.		1 and / 05	.		2				0
00						3 N				23.
00	Which method is used to determine Me						1			201
00	Which method is used to determine Me below? In column 1, enter 1 if date	of admission, 2 if cens	sus days, c	or 3						201
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method	of admission, 2 if cens of identifying the days	sus days, c s in this c	or 3						
00	Which method is used to determine Me below? In column 1, enter 1 if date	of admission, 2 if cens of identifying the days method used in the pric	sus days, c s in this c or cost	or 3						

From 01/07/2021         State (Mark State (Mark State)         State (Mark State)         Out of (Mark State)         Description (Mark State) <thdescription (Mark State)         <thdescription (Mark State</thdescription </thdescription 	2	TH ARNETT		N 45 0470		In Lie	u of Fo		
Medicaid         State         State         Matrix         State         We dicaid	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	N: 15-0173			Part I Date/T	ime Pre	epared:
24.00       If this provider is an IPPS heapital, unter the in-state Medical paid days in colum 2. In-state Medical paid days in colum 2. In colum 2. In colum 3. In colum 4. In colum 5. In colum		Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO da	ays Me	di cai d days	_
in-state Medicaid paid days in column 2, column 3, column 4, Medicaid Medicaid paid days in column 5, column 4, Medicaid Medicaid Medicaid Paid days in column 5, column 6, Medicaid Medicaid Paid days in column 6, Medicaid Medicaid Medicaid Paid days in column 6, Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Medicaid Paid days in column 6, Medicaid Medi	24.00 If this provider is an IPPS bosnital enter the								24.00
Urban/Rural S         Date of Geogr 1.00         Z.00         Ison         Z.00         Z.00 <thz.00< th="">         Z.00         <thz.00< th=""> <thz< td=""><td><ul> <li>in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.</li> <li>25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid</li> </ul></td><td></td><td></td><td></td><td></td><td></td><td></td><td>30</td><td>24.00</td></thz<></thz.00<></thz.00<>	<ul> <li>in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.</li> <li>25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid</li> </ul>							30	24.00
26.00       Fnter your standard geographic classification (not weige) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. if applicable, enter the effective date of the geographic classification (not weige) status at the end of the cost reporting period.       1       27.00       Fnter your standard geographic classification (not weige) status at the end of the cost reporting period.       1       27.00       Fnter your standard geographic classification in column 2.       35.00         26.00       Inter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods MDH status is is a flex ost reporting period.       86.00       1.00       2.00       36.00         37.00       If this is a Madi care dependent hospital (MDH), enter the number of periods MDH status is is in Ffort in the cost reporting period.       87.00       1.00       2.00       38.00         37.01       It this is a Madi care dependent hospital (MDH), enter the number of periods MDH status is instructions)       90.01       11.00       2.00       39.00         37.01       It this is a facility qualify for the inpatient hospital payment adjustment for low volume in the origo requirements in accordance with H 2016 0PPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)       N       N       40.00         00       Does this facility qualify for the inpatient hospital payment adjustment? Finer 'N' for yes or 'N' for no. (see instructions)       N       N       40.00         1.00       2.00		1	1						
cost réporting period. Énter '11' for urban or '2' for 'ural.       27.00         Con Enter your standard georgaphic classification (not wage) status at the end of the cost exporting period. Enter in colum 1, "1" for urban or '2" for rural. If applicable, enter the effective date of the geographic classification in colum 2.       0         25.00       If this is a sole commanity hospital (SCM), enter the number of periods SCH status in effect in the cost reporting period.       0       36.00         26.00       Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods MDH status       0       36.00         37.00       If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status       0       37.00         37.01       Is this hospital a Tormar MDH that is eligible for the MDH transitional payment in accordance with FY 2016 0PPS final rule? Enter 'Y" for yes or "N" for no. (see instructions)       38.00       If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is a gract that, subscript this line for the number of periods in excess of one and enter subsequent dates.       Y/N       Y/N         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume N       N       40.00         no in colum 2, for discharges prior to botober 1. Enter ''' for yes or 'N' for no. (see instructions)       N       N       40.00         10.00       2.00       39.00       Ioses this facility qualify dor che inpatient hospital payment for dispropo	26.00 Enter your standard geographic classification (not wa	ade) status	at the bec	ninning of t		00	2.	00	26.00
IFrect in the cost reporting period.       Beginning:       Ending:         60       Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number       1,00       2,00         61       Stinis a Medicare dependent hospital (MBH), enter the number of periods MDH status       0       37.00         7.01       Stinis a Medicare dependent hospital (MBH), enter the number of periods MDH status       0       37.01         8.00       If Tine 37 is 1, enter the beginning and ending dates of MDH status. If fine 37 is greater than 1, subscript this line for the number of periods in excess of one and penter subsequent dates.       38.00         8.00       If fine 37 is 1, enter the beginning and ending dates of MDH status. If fine 37 is greater than 1, subscript this line for the number of periods in excess of one and penter subsequent dates.       7/N       V/N       38.00         9.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume hospital payment adjustment? Enter in column 1. Yr for yes or "N" for no. (see instructions)       N       N       N       39.00         9.00       Is this shapital subject to the H&C program reduction adjustment? Enter "Y" for yes or "N" for no. (see instructions)       V       XVIII       XIX         10.0       2.00       10       2.00       100       2.00       100       2.00       100       2.00       100       100	cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. age) status "2" for r	at the end ural. If ap	d of the cos		1			27.00
Beginning:         Ending:           36.00         Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.         36.00           37.00         If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.         37.00           37.01         Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)         38.00           39.01         Disting are the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.         Y/N         Y/N           39.00         Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (ii)? Enter in column         N         N         N         39.00           30.01         Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in colum 2, Tor discharges on or affer October 1. Enter "Y" for yes or "N" for no in colum 2, Tor discharges on or affer October 1. Enter "Y" for yes or "N" for no in colum 2, Tor discharges on or affer October 1. Enter "Y" for yes or "N" for no in colum 2, Tor discharges on or affer October 1. Enter "Y" for yes or "N" for no. In columa 1, for or discharges on or affer October 1. Enter "Y" for yes or "N" for no.         N         N         N         40.00           45.00 <td></td> <td>e number of</td> <td>periods SC</td> <td>CH status ir</td> <td>1</td> <td>C</td> <td></td> <td></td> <td>35.00</td>		e number of	periods SC	CH status ir	1	C			35.00
36.00       Enter applicable beginning and ending dates of SCH status. Subscript I ine 36 for number of periods in excess of one and enter subsequent dates.       36.00       Sis in effect in the cost reporting period.       37.00       If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.       37.01       Sis in effect in the cost reporting period.       37.01       Sis in effect in the cost reporting period.       37.01       Sis in effect in the cost reporting period.       37.01       Sis in effect in the cost reporting period.       38.00       Sis in effect in the cost reporting period.       38.00       Sis in effect in the solution of the number of periods in excess of one and enter subsequent dates.       V/N       V/N       38.00         38.00       If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       N       N       38.00         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume naccordance with 42 CFR 412.01(b)(2)(1), (1), or (11)? Enter in column 2"r for yes or "N" for no. In column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no. N       N       40.00         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR 412.300(b) PS capital? Enter "Y" for yes or "N" for no. N       N       N	errect in the cost reporting perrod.				Begi n	ni ng:	End	i ng:	
of prefids in excess of one and enter subsequent dates.       37.00         00       If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.       37.00         10       Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FV 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)       38.00       If fline 37 is 1, enter the beginning and ending dates of MDH status. If fline 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       Y/N       Y/N       38.00         30       00       Does this facility qualify for the inpatient hospital payment adjustment for low volume hospital sin accordance with 42 CFR \$412.101(b)(2)(1), (11), or (111)? Enter in column 1. 'V" for yes or "N" for no. Does the facility meet them ileage requirements in accordance with 42 CFR \$412.101(b)(2)(1), (11), or (111)? Enter in column 2. "Y" for yes or "N" for no in column 1, for discharges on or after October 1. Enter "Y" for yes or "N" for no.       N       N       40.00         10.00       Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no.       N       N       40.00         11.00       Is this facility qualify and receive Capital payment for disproportionate share in accordance N       N       N       N       45.00         10.00       Is this facility qualify and receive Capital payment for disproportionate share in accordance N       N       N       N       45.	36.00 Enter applicable beginning and ending dates of SCH st	tatus Subs	crint line	36 for numb		00	2.	00	36.00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38.00 If fine 37 is 1, enter the beginning and ending dates of MDH status. If fine 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412, 101(b)(2)(1), (11), or (111)? Enter in column 1 'Y' for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 10(b)(2)(1), (11), or (111)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. (see instructions) 40.00 Is this facility qualify and receive Capital 45.00 Does this facility eligible for additional payment? Enter "Y" for yes or "N" for no. 45.00 Does this facility eligible for additional payment? Enter "Y" for yes or "N" for no. 46.00 Is this facility eligible for additional payment? Enter "Y" for yes or "N" for no. 56.00 Is this an env hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no. 57.00 The facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 57.00 If this sapital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no	of periods in excess of one and enter subsequent date	es.	·			C			
38.00       If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.       38.00         90.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume N       N       N       39.00         39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume N       N       N       39.00         30.01       I*Y for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)       N       N       40.00         40.00       Is is hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)       N       N       40.00         45.00       Does this facility qualify and receive Capital       Prospective Payment System (PPS)-Capital       N       N       N       45.00         45.00       Is this facility and receive Capital payment exception for extraordinary circumstances pursuant to 42 CFR \$412.302 (see instructions)       N       N       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR \$412.302 (see instructions)       N       N	<ul> <li>is in effect in the cost reporting period.</li> <li>Is this hospital a former MDH that is eligible for thaccordance with FY 2016 OPPS final rule? Enter "Y" for</li> </ul>	ne MDH tran	sitional pa	ayment in					37.01
39.00         Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(1), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 12.101(b)(2)(1), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)         N         39.00           40.00         Is is hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. (see instructions)         V         XVIII         XIX           45.00         Does this facility qualify and receive Capital Does this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.320? (see instructions)         N         N         N         45.00           6.00         Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.         N         N         N         46.00           7.00         Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no. Is this a hospital s         N         N         N         47.00           7.01         Is this a hospital s         Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1.         Y         Y         Y         S6.00	38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.00
39.00       Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after 0ctober 1. (see instructions)       V       XVIII       XIX         40.00       Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to 0ctober 1. (see instructions)       V       XVIIII       XIX         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR §412.300(b) PPS capital       N       N       N       N       45.00         46.00       Is this facility electing full federal capital payment exception for extraordinary circumstances pursuant to 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.       N       N       N       46.00         46.00       Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.       N       N       N       47.00         46.00       Is the facility electing full federal capital payment? Enter "Y" for yes									-
"N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)       V       XVIII       XIX         1.00       2.00       3.00         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)       N       Y       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       N       46.00         48.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.       N       N       N       N       47.00         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no ic column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRS) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 1.       S7.00       S7.00       If line 56 is yes, is this the first cost reporting period during which residents in approved (ME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1.       S7.00       S7.00       S7.00       S7.00       S7.00       S7.00 <t< td=""><td>hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)</td><td>), (İi), or the mileage i)? Enter</td><td>(iii)? Ent requiremer in column 2</td><td>ter in colum nts in 2 "Y" for ye</td><td>ine f in is</td><td></td><td></td><td></td><td>39.00</td></t<>	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (İi), or the mileage i)? Enter	(iii)? Ent requiremer in column 2	ter in colum nts in 2 "Y" for ye	ine f in is				39.00
V       XVIII       XIX         1.00       2.00       3.00         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)       N       Y       N       45.00         66.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       46.00         77.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.       N       N       N       48.00         Teaching Hospitals         Teaching Hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       N       N       N       48.00         S6.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.       N       N       N       48.00         S6.00       Is this a nor column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column?       S6.00       S6.00       S6.00       If line 56 is yes, is this the first cost reporting period during which residents in approved N       S7.00       S7.00       If line 56 is yes, is this the first cost rep	"N" for no in column 1, for discharges prior to Octob	per 1. Ente	r"Y" for y			J		N	40.00
Prospective Payment System (PPS)-Capital         45.00       Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)       N       Y       N       45.00         46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       A       46.00         15 this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.       N       N       N       46.00         48.00       Is the facility electing full federal capital payment? Enter "Y for yes or "N" for no.       N       N       N       46.00         48.00       Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.       N       N       N       48.00         7       Was involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs? Enter "Y" for yes or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.       57.00       For one in column 1. If column 1 is "Y", or if this hospital approved N       57.00         6ME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1			,				_	_	_
with 42 CFR Section §412.320? (see instructions)       N       N       N       N       A6.00         Is this facility eligible for additional payment exception for extraordinary circumstances       N       N       N       A6.00         pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through       N       N       N       A6.00         1s this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.       N       N       N       46.00         48.00       Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.       N       N       N       48.00         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital       S6.00         57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved       N       S7.00         GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1       S7.00       If simproved at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1       S7.00         GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       S8.00         S8.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>. 2.00</td><td>3.00</td><td></td></t<>							. 2.00	3.00	
46.00       Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.       N       N       N       46.00         47.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N       N       N       46.00         48.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.       N       N       N       57.00         GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N       58.00         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       N       S8.00 <td>51 5 1 1 3</td> <td>nt for disp</td> <td>roporti onat</td> <td>e share in</td> <td>accordance</td> <td>N</td> <td>Y</td> <td>N</td> <td>45.00</td>	51 5 1 1 3	nt for disp	roporti onat	e share in	accordance	N	Y	N	45.00
47.00       Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.       N       N       N       47.00         48.00       Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.       N       N       N       48.00         Teaching Hospitals         56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes, otherwise, enter "N" for no in column 2.       Y       Y       Y         57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", or if to column 2 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N       58.00         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as N       N       58.00	46.00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1					N	N	N	46.00
56.00       Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.       Y       Y       Y         57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N       58.00         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       N       58.00	47.00 Is this a new hospital under 42 CFR §412.300(b) PPS o								47.00
57.00       If line 56 is yes, is this the first cost reporting period during which residents in approved       N       57.00         GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1       Is column 1       1         is "Y" did residents start training in the first month of this cost reporting period? Enter "Y"       For yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.       N       58.00         58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       N       58.00	56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic	e to column rograms in cable CRs)	1 is "Y", the prior y	or if this /ear or penu	hospital Iltimate		Y		56.00
58.00       If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.       N       58.00	57.00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	period duri yes or "N th of this (", complet	" for no ir cost report e Worksheet	n column 1. ing period?	lf column P Enter "Y	1			57.00
	58.00   fline 56 is yes, did this facility elect cost reimb	oursement f	or physicia	ans' service	es as	N			58.00
				Pt. I		N			59.00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	IU HEALTH ARNE DENTIFICATION DATA	Provider C		eriod: rom 01/01/2021	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 5/26/2022 3:43	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
<ul> <li>60.00 Are you claiming nursing and allied any programs that meet the criteria instructions) Enter "Y" for yes or is "Y", are you impacted by CR 11642 adjustement? Enter "Y" for yes or "</li> <li>60.01 If line 60 is yes, complete columns</li> </ul>	under 42 CFR 413.85? ( "N" for no in column 1. (or subsequent CR) NAH N" for no in column 2.	see If column 1 E MA payment	Y	Y 23. 00	1	60. 00 60. 01
i nstructi ons)	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
51.00 Did your hospital receive FTE slots section 5503? Enter "Y" for yes or " column 1. (see instructions)				0.00		61.00
1.01 Enter the average number of unweight. FTEs from the hospital's 3 most rece ending and submitted before March 23 instructions)	nt cost reports					61. 0
1.02 Enter the current year total unweigh FTE count (excluding OB/GYN, general and primary care FTEs added under se ACA). (see instructions)	surgery FTEs,					61.02
51.03 Enter the base line FTE count for pr and/or general surgery residents, wh determining compliance with the 75% instructions)	ich is used for					61. 0
51.04 Enter the number of unweighted prima surgery allopathic and/or osteopathic current cost reporting period. (see i	c FTEs in the					61.0
A1.05 Enter the difference between the base and/or general surgery FTEs and the primary care and/or general surgery 61.04 minus line 61.03). (see instru-	current year's FTE counts (line					61.0
1.06 Enter the amount of ACA §5503 award used for cap relief and/or FTEs that care or general surgery. (see instru-	that is being are nonprimary ctions)					61.0
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
11.10 Of the FTEs in line 61.05, specify expecial ty, if any, and the number of for each new program. (see instruction column 1, the program name. Enter in program code. Enter in column 3, the unweighted count. Enter in column 4, FTE unweighted count.	FTE residents ons) Enter in column 2, the IME FTE			0.00	0.00	61. 1
51.20 Of the FTEs in line 61.05, specify eprogram specialty, if any, and the minimum residents for each expanded program. instructions) Enter in column 1, the Enter in column 2, the program code. 3, the IME FTE unweighted count. Entitle direct GME FTE unweighted count.	umber of FTE (see program name. Enter in column			0. 00	0. 00	61. 2
				<b>.</b>	1 00	
ACA Provisions Affecting the Health					1.00	
2.00 Enter the number of FTE residents the your hospital received HRSA PCRE fun	ding (see instructions)					62.0
22.01 Enter the number of FTE residents the during in this cost reporting period Teaching Hospitals that Claim Reside	of HRSA THC program. (	see instructio		your nospi tal	0.00	62. 0 <sup>.</sup>
3.00 Has your facility trained residents		during this c			Y	63. 0

PITAL AND HOSPITAL HEALTH CARE CO		LTH ARNETT HOSPITAL ATA Provider C		eriod:	Worksheet S-2	2
			FI To	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre 5/26/2022 3:4	
			Unweighted	Unweighted	Ratio (col. 1/	/
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Y	ear FTF Residents in N	lonnrovider Settings				
period that begins on or after			This base year	rs your cost i	eportring	
00 Enter in column 1, if line 63 in the base year period, the r resident FTEs attributable to settings. Enter in column 2 t resident FTEs that trained in of (column 1 divided by (colum	is yes, or your facili umber of unweighted no rotations occurring in he number of unweighte your hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0. 00	0. 00	0. 000000	64.
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	/
	-		FTĔs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te			
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter i column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	n		0.00 Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 1/ (col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1.00	2.00	3.00	1
Section 5504 of the ACA Currer	t Year FTE Residents i	n Nonprovider Setting				
beginning on or after July 1, 00 Enter in column 1 the number of	2010		0.00			0 66
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hosp (column 1 divided by (column 1	occurring in all nonp f unweighted non-prima ital. Enter in column	rovider settings. ry care resident 3 the ratio of				00.
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	/
			FTEs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Site			-
00 Enter in column 1, the program	1.00 FAMILY MEDICINE	2.00	3.00	4.00 2 10.99	5.00 0.232006	
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributabl to rotations occurring in all non-provider settings. Enter i column 4, the number of	e		3. 32			

Heal th	Financial Systems IU HEALTH ARNETT HOSPITAL	l i	n Lieu	of For	m CMS-	2552-10
HOSPI T	F	Period: From 01/01/ To 12/31/	2021	Workshe Part I Date/Ti	me Pre	pared:
				5/26/20		
	Inpatient Psychiatric Facility PPS			2.00	3.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub Enter "Y" for yes or "N" for no.	provi der?	N			70.00
	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	no. (see hi ng no.			0	71.00
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in	the most			0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42				70.00
			_	1. 0	10	
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting	period? Ei	nter	N N		80.00
	"Y" for yes and "N" for no. TEFRA Providers	•				
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85. 00 86. 00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI 2		
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Y		90.00
	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N		N		91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N		N		93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		N		94.00
95.00	applicable column. If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0. C	00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 N		0. C Y	10	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98. 01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98. 02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98.03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Ν		98.04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98.06
105 00	Rural Providers Does this hospital qualify as a CAH?	N				105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment					106.00
107.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R					107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train l&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

Health Financial Systems IU HEALTH ARNET	T_HOSPI TAL		In Lieu	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2021 p 12/31/2021	Worksheet S- Part I Date/Time Pr 5/26/2022 3:	epared:
			V	XI X	42 pm
			1.00	2.00	100.00
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	JRNA TEE SCHE	dulle? See 42	N		108.00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00	3.00	4.00	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				1.00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "\ complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	Y" for yes or	"N" for no. If	yes,	N	110.00
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in th	ne Frontier C	ommunity	1.00 N	2.00	111.00
Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting    umn 1 is Y, o ticipating in	period? Enter enter the column 2.			
		1.00	2.00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p 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 ceas participation in the demonstration, if applicable.	oeriod? "Y", enter e	N			112.00
Miscellaneous Cost Reporting Information 115.00[Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers	or E only) 3" percent includes	N			0115.00
the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	N			116.00
117.00 s this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	ance? Enter	Ν			117.00
118.00 s the malpractice insurance a claims-made or occurrence poli lif the policy is claim-made. Enter 2 if the policy is occurre	5	1			118.00
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	-
118.01 List amounts of malpractice premiums and paid losses:		976, 614	0		0118.01
			1.00	2.00	-
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.			N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 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 qua Hold Harmless provision in ACA \$3121 and applicable amendment	column 1, "Y alifies for t	" for yes or he Outpatient	Ν	Ν	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implar	ntable device	s charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defi 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.			Y	5.06	122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	r yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, ent					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter					127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter					128.00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter					129.00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, educed to the in column 1 and termination date, if applicable, in column 1		tification			130.00

ter, enter the cer column 2. enter the certific n 2.			1.00	2.00	121.00
column 2. enter the certific			1.00	2.00	101 00
enter the certific	ation date		1		131.00
n 2.					132.00
					133.00
the OPO number in	column 1				134.00
lf yes, and home o er. (see instructi	office costs	;	Y	15H059	140. 00
2.00	h 142 the			-6 +6 -	
		name and	address	or the	
WPS		or's Nu	mber: 0810	1	141.00
					142.00
1 N	Zip Code	<u>:</u>	4620	2	143.00
				1.00	-
t A?				Y	144.00
			1 00	2 00	-
74, are the costs	for		Y	2.00	145.00
in column 1. If co	olumn 1 is				
		-	Ν		146. 0
				1.00	4
r yes or "N" for n				N 1.00	147.00
for yes or "N" for	no.			N	148.0
			itle V		149.0
1.00	2.00			4.00	-
onent for Part A a	and Part B.		2 CFR §413	3. 13)	
					155. 0 156. 0
N	N		N	N	157.0
					158. 0
	N		N	N	159.0
N					160.0
				1.00	-
ope or more campus	os in diffe	pront CP	SAc2	N	165.0
and of more campus	co in unite	I GITE UB	SUDS (	IN	105.0
County			CBSA	FTE/Campus	
1.00	2.00	3.00	4.00		0 166. 00
				0.00	0100.0
ican Recovery and	Reinvestme	ot Act		1.00	
and Recovery and		IL AUL			-1/7 -
"Y" for ves or "N	" for no.		1	Y	167.0
"Y" for yes or "N ingful user (line		, enter	the	Y	167. 0 168. 0
	167 is "Y")			Y	
	f yes, and home o er. (see instructi .00 I lines 141 throug contractor number WPS IN E A? 74, are the costs n column 1. If co on for this cost r ously filed cost 15-2, chapter 40 F yes or "N" for n for pert A N N N N N N 1.00	er. (see instructions)       .00	f yes, and home office costs pr. (see instructions) 00 I lines 141 through 143 the name and contractor number. MPS Contractor's Nur IN Zip Code: Contractor's Nur IN Zip Code: Code	f yes, and home office costs pr. (see instructions) 3.00 1 lines 141 through 143 the name and address contractor number. WPS Contractor's Number: 0810 IN Zip Code: 4620 IN Zip Code: 4620 Accelent the costs for n column 1. If column 1 is on for this cost reporting ously filed cost report? 15-2, chapter 40, \$4020) If Y 15-2, chapter 40, \$4020) If Y 15-2, chapter 40, \$4020) If Part A Part B Title V 1.00 2.00 3.00 an exemption from the application of the lowe ponent for Part A and Part B. (See 42 CFR §413 N N N N N N N N N N N N N N N N	f yes, and home office costs       3.00         .00       3.00         n lines 141 through 143 the name and address of the contractor number.         WPS       Contractor's Number: 08101         IN       Zip Code:       46202         IN       Zip Code:       Y         IN       Intervention       N         In Column 1. If column 1 is on for this cost reporting       N         Ously filed cost report?       N         In Coo       2.00       3.00       4.00         In Coo       2.00       3.00       4.00         In coo       Zoo       3.00       4.00         In coo       In Coo       N       N         In Coo       N       N       N         N       N

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	CATION DATA		Period:	Worksheet S-2	
				Part I Date/Time Pre	narod
			10 12/31/2021	5/26/2022 3:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning daperiod respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have a section 1876 Medicare cost plans reported on "Y" for yes and "N" for no in column 1. If co 1876 Medicare days in column 2. (see instruct	Wkst. S-3, Pt. I, plumn 1 is yes, en	line 2, col. 6? Enter	Y N	2, 154	171.00

)SPI T	Financial Systems IU HEALTH ARNI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	TT HOSPITAL Provider C	CN: 15-0173	Peri od:	worksheet S-2	
				From 01/01/2021 To 12/31/2021	Part II	epare
				Y/N	Date	
		Fair all NO in	<b>F</b> -+	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	TOT ALL NU FE	esponses. Ent	er all dates in "	the	-
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in c	orumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, including management Y contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3.
			Y/N	Туре	Date	
	Einancial Data and Daparts		1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	A		4.		
00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N	Y/N	Legal Oper.	5
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: IT yes, Is	s the provide	r N		6
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		ved during th	e N		7 8
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		cal education	Y		9
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		the current	Ν		10
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11
					Y/N 1.00	_
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12   13
. 00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	°yes, see in	structions.	N	14
. 00	Bed Complement Did total beds available change from the prior cost reporti	V 1			N	15
		Par Y/N	-t A Date	Par Y/N	t B Date	_
		1.00	2.00	3.00	4.00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2022	Y	04/01/2022	17
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		Ν		18
. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19

Health Financial Systems

### IU HEALTH ARNETT HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems IU HEALTH ARN	ETT_HOSPITAL		In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2021 To 12/31/2021		Prepared:
	Deceri	pti on	Y/N	5/26/2022 3 Y/N	3:42 pm
		)	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:		5	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	1		1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00	
Capital Related Cost					
22.00 Have assets been relifed for Medicare purposes? If yes, see				N	22.00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made durir	ng the cost	N	23.00
24.00 Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost repo	orting period?	N	24.00
25.00 Have there been new capitalized leases entered into during instructions.	the cost repor	ting period? I	f yes, see	Ν	25.00
26.00 Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? If	yes, see	Ν	26.00
27.00 Has the provider's capitalization policy changed during the copy.	e cost reportin	ng period?lfy	ves, submit	Ν	27.00
Interest Expense 28.00 Were new Loans, mortgage agreements or letters of credit er	N	28.00			
period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or	N	29.00			
treated as a funded depreciation account? If yes, see instr	N				
Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.					30.00
instructions.	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				
Purchased Services 32.00 Have changes or new agreements occurred in patient care ser		d through cont	ractual	N	32.00
arrangements with suppliers of services? If yes, see instru 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 app		ng to competiti	ve bidding? If	N	33.00
no, see instructions. Provider-Based Physicians					
34.00 Are services furnished at the provider facility under an ar	rrangement with	nrovi der_base	d physicians?	Y	34.00
If yes, see instructions.	i angement with				54.00
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the pr	rovi der-based	Ν	35.00
			Y/N	Date	
			1.00	2.00	
Home Office Costs			1		
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Y Y		36.00 37.00
If yes, see instructions. 38.00  If line 36 is yes , was the fiscal year end of the home off			N		38.00
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to othe			Y		39.00
see instructions. 40.00 If line 36 is yes, did the provider render services to the	home office?	lf yes, see	N		40.00
i nstructi ons.					
Cast Banart Branarar Contact Information	1.	00	2.	00	_
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
respectively. 42.00 Enter the employer/company name of the cost report	IU HEALTH				42.00
43.00 Enter the telephone number and email address of the cost	317-962-1093		RUTTER@I UHEALT	H. ORG	43.00
report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems IU HEA	ALTH ARNE	TT HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	AI RE	Provider CC	CN: 15-0173	Peri od:	Worksheet S-2	
					From 01/01/2021 To 12/31/2021	Part II Date/Time Pre 5/26/2022 3:4	
		L					
			3. (	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/posit	ion [	DI RECTOR, GOVT	PROGRAMS			41.00
	held by the cost report preparer in columns 1, 2, a	nd 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the	cost					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	IU HEALTH ARNE	Provider CC	N. 15_0172	Peri od:	eu of Form CMS-2 Worksheet S-3	
позетт	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	N. 15-0175	From 01/01/2021	Part I	
					To 12/31/2021	Date/Time Pre	
						5/26/2022 3: 4	
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Visits / Trips Title V	
	Component	Line Number	NO. OI DEUS	Avai I abl e	CAR HOULS	nue v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	154	56, 2		0.00	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		154	56, 2	10 0.00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	14	5, 1	10 0.00	0	
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT	33.00	0		0 0.00	0	
10.01	BURN INTENSIVE CARE UNIT	33. 01	0		0 0.00	0	
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	17	6, 20	0.00	0	12.00
13.00	NURSERY	43.00	105	(7.5		0	
14.00	Total (see instructions)		185	67, 53	25 0.00	0	14.00
15.00	CAH visits					0	15.00 16.00
16.00 17.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						17.00
17.00	SUBPROVIDER - TRF						17.00
19.00	SUBPROVIDER SKILLED NURSING FACILITY						18.00
20.00	NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY						21.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30, 00					24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)	07100	185				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		7	2, 5	55		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33 01	LTCH site neutral days and discharges						33.01

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0173	Peri From To	iod: m 01/01/2021 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/26/2022 3:4	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		[
	Component	Title XVIII	Title XIX	Total All Patients		otal Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	15, 372 10, 517 0 0	623 8, 968 0 0	41, 76	55			1.00 2.00 3.00 4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	o	0		0			5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	15, 372	623	41, 76	55			7.00
. 00	INTENSI VE CARE UNI T	1,000	723	3, 54	17			8.00
. 00	CORONARY CARE UNI T							9.00
0. 00 0. 01	BURN INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	0	0		0 0			10.00
1.00	SURGICAL INTENSIVE CARE UNIT	0	0		0			10.01
2.00	NEONATAL INTENSIVE CARE UNIT	0	265	2, 96	52			12.00
3.00	NURSERY	Ŭ	1, 338	2, 46				13.00
4.00	Total (see instructions)	16, 372	2, 949	50, 73		14.31	1, 014. 19	
5.00	CAH visits	0	0	,	0		.,	15.00
6.00	SUBPROVIDER - IPF							16.00
7.00	SUBPROVIDER - IRF							17.0
8.00	SUBPROVI DER							18.0
9.00	SKILLED NURSING FACILITY							19.0
0.00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY							22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
4.00	HOSPICE							24. C
4.10	HOSPICE (non-distinct part)			26	51			24.1
5.00	CMHC - CMHC							25.0
6.00	RURAL HEALTH CLINIC	0			0	0.00	0.00	26.0 26.2
6.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	14.31	0.00 1,014.19	
8.00	Total (sum of lines 14-26) Observation Bed Days		80	4,80	0	14. 51	1,014.19	27.0
9.00	Ambul ance Trips	0	00	4, 00				29.0
0.00	Employee discount days (see instruction)	Ŭ			0			30.0
1.00	Employee discount days - IRF				0			31.0
2.00	Labor & delivery days (see instructions)	11	30	95				32.0
2.00	Total ancillary labor & delivery room		50		0			32.0
	outpatient days (see instructions)							
3.00	LTCH non-covered days	0						33.0

	_Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	<u>IU HEALTH ARNET</u> AL DATA	Provider CO	CN: 15-0173	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/26/2022 3:4	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 10.01 11.00 12.00 13.00 14.00 15.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT NURSERY Total (see instructions) CAH visits	0.00	<u>    12. 00                                   </u>	3, 2	15 255 48 1, 814 0 0	11, 677 11, 677	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 10.01 11.00 12.00 13.00 14.00
16.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.00 24.10 25.00 26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.01 33.00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00			0		16.00         17.00         18.00         19.00         20.00         21.00         22.00         23.00         24.10         25.00         26.00         27.00         28.00         29.00         30.00         31.00         32.01

ITAL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 To 12/31/2021		epar
	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	-
PART I I – WAGE DATA SALARI ES							
Total salaries (see	200.00	82, 487, 210	3, 172, 456	85, 659, 66	6 2, 109, 512. 50	40. 61	1 .
instructions)						0.00	
Non-physician anesthetist Part		(	0	(	0.00	0.00	
Non-physician anesthetist Part		C	0	(	0.00	0.00	
B		774 074		774 07		1/0 5/	
Physician-Part A - Administrative		774, 871	0	774, 87	1 4, 569. 79	169. 56	, I
Physicians - Part A - Teaching	1	20, 193	3 0	20, 19	3 171.43	117. 79	
Physician and Non		922, 110	0	922, 110	9, 600. 02	96.05	5
Physician-Part B Non-physician-Part B for		ſ			0.00	0.00	
hospital -based RHC and FQHC		(		,	0.00	0.00	
servi ces							
Interns & residents (in an	21.00	C	0 0	(	0.00	0.00	
approved program) Contracted interns and		1,000,111	0	1,000,11	1 27, 040. 00	36. 99	,
residents (in an approved		1,000,111		1,000,11	27,010.00		
programs)							
Home office and/or related organization personnel		(	0	(	0.00	0.00	
SNF	44.00	C	0	(	0.00	0.00	
0 Excluded area salaries (see		709, 796	2, 434, 984	3, 144, 780	0 66, 869. 57	47.03	3 1
instructions) OTHER WAGES & RELATED COSTS							-
0 Contract Labor: Direct Patient	-	1, 732, 734		1, 732, 73	4 18, 362.00	94. 37	1
Care		1,702,70		1,702,70	10,002.00	,,	Ι.
0 Contract Labor: Top Level		C	0	(	0.00	0.00	1
management and other management and administrative							
servi ces							
0 Contract Labor: Physician-Part	-	1, 277, 645	ō 0	1, 277, 64	5 8, 626. 00	148. 12	1
A - Administrative 0 Home office and/or related		C	0		0.00	0.00	1
organization salaries and		C		·	0.00	0.00	1.
wage-related costs							
<ol> <li>Home office salaries</li> <li>Related organization salaries</li> </ol>		27, 629, 923		27, 629, 92	3 661, 014. 29 0 0. 00		
2 Related organization salaries 0 Home office: Physician Part A		(			0.00		
- Administrative							
0 Home office and Contract		(	0 0	(	0.00	0.00	1
Physicians Part A - Teaching Home office Physicians Part A		C		(	0.00	0.00	1
- Teachi ng							
2 Home office contract		C	0 0	(	0.00	0.00	1
Physicians Part A - Teaching WAGE-RELATED COSTS							
0 Wage-related costs (core) (see		19, 022, 406	0	19, 022, 40	6		1
instructions)							
0 Wage-related costs (other) (see instructions)							1
0 Excluded areas		676, 470	0	676, 470	D		1
0 Non-physician anesthetist Part		C	o o	(	C		2
A  0  Non-physician anesthetist Part		r					2
0 Non-physician anesthetist Part B		t	<u></u>	,			2
0 Physician Part A -		78, 495	5 0	78, 49	5		2
Administrative		2, 519		0 F1			
1 Physician Part A - Teaching 0 Physician Part B		2, 519 131, 032		2, 51 131, 03			2
Wage-related costs (RHC/FQHC)		(		,	c		2
0 Interns & residents (in an		C		(	C		2
approved program) O Home office wage-related		16, 267, 015		16, 267, 01	5		2
(core)		10, 207, 015	, U	10, 207, 01			2
1 Related organization		C	0	(	D		2
wage-related (core)							
2 Home office: Physician Part A - Administrative -		(	ן ע	(			2
wage-rel ated (core)							1

Heal th	Financial Systems		IU HEALTH ARNE	ETT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II	pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col	. Salaries in	col. 5)	
				A-6)	3)	col. 4		
		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 SALARII							
26.00	Employee Benefits Department	4.00	-77, 343					
27.00	Administrative & General	5.00	5, 688, 625					
28.00	Administrative & General under		74, 997	0	74, 99	801.00	93.63	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	1, 507, 324	-97, 151	1, 410, 17			
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		
32.00	Housekeepi ng	9.00	1, 313, 904	-7, 810	1, 306, 09	77, 790. 51	16. 79	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Di etary	10.00	1,015,089	-428, 729	586, 36	33, 766. 78	17 36	34.00
35.00	Dietary under contract (see	10.00	1,010,007	420, 727	500, 50	0 0.00		
55.00	instructions)		0	0		0.00	0.00	33.00
36.00	Cafeteri a	11.00	0	424, 018	424, 01	8 25, 406. 64	16.69	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	9, 922, 920	-155, 494	9, 767, 42	89, 621. 81	108.98	38.00
39.00	Central Services and Supply	14.00	483, 335					
40.00	Pharmacy	15.00	4, 785, 731	-646, 610				
41.00	Medical Records & Medical	16.00	0	0		0 0.00		
	Records Library	. 51 00	0					
42.00	Social Service	17.00	587, 565	-9, 726	577, 83	19, 916, 16	29.01	42.00
43.00	Other General Service	18.00	585, 329					
	1							

Heal th	Financial Systems		IU HEALTH ARN	ETT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC		Period: From 01/01/2021 Fo 12/31/2021		pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	· · · · ·	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				1		
1.00	Net salaries (see		80, 619, 793	3, 172, 456	83, 792, 24	2,073,502.05	40. 41	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		709, 796	2, 434, 984	3, 144, 78	66, 869. 57	47.03	2.00
3.00	Subtotal salaries (line 1		79, 909, 997	737, 472	80, 647, 46	2,006,632.48	40. 19	3.00
	minus line 2)							
4.00	Subtotal other wages & related		30, 640, 302	0	30, 640, 30	688, 002. 29	44. 54	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		35, 367, 916	0	35, 367, 91	6 0.00	43.85	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		145, 918, 215	737, 472	146, 655, 68	7 2, 694, 634. 77	54.43	6.00
7.00	Total overhead cost (see		25, 887, 476	969, 104	26, 856, 580	589, 571. 63	45.55	7.00
	instructions)							

	Financial Systems AL WAGE RELATED COSTS		HOSPITAL Provider CCN	I: 15-0173	Peri od:	worksheet S-3	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
						Amount	z pii
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						1
	RETIREMENT COST						1
00	401K Employer Contributions					3, 017, 646	1.
00	Tax Sheltered Annuity (TSA) Employer Contrib	oution				0	2
00	Nonqualified Defined Benefit Plan Cost (see					0	3.
00	Qualified Defined Benefit Plan Cost (see ins					0	4.
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
00	401K/TSA Plan Administration fees					0	
00	Legal /Accounting/Management Fees-Pension Pla					0	6
00	Employee Managed Care Program Administration	i Fees				0	7
~	HEALTH AND INSURANCE COST						
0	Heal th Insurance (Purchased or Self Funded)		- +>			0	
1	Health Insurance (Self Funded without a Thir Health Insurance (Self Funded with a Third P					0 9, 978, 903	-
12 13	Heal th Insurance (Purchased)	arty Auministrato	()			9, 978, 903	
0	Prescription Drug Plan						
00	Dental, Hearing and Vision Plan					229, 295	
00	Life Insurance (If employee is owner or bene	oficiary)				227, 275	
00	Accident Insurance (If employee is owner or					0	
00	Disability Insurance (If employee is owner of					417, 691	
00	Long-Term Care Insurance (If employee is own		)			0	
00	'Workers' Compensation Insurance	ion on bonion or any				539, 493	
00	Retirement Health Care Cost (Only current ye	ar, not the extra	ordi narv accr	ual require	ed by FASB 106.	0	
	Non cumulative portion)		, <u>,</u>				
	TAXES						
	FICA-Employers Portion Only					5, 727, 894	17
00	Medicare Taxes - Employers Portion Only					0	
00	Unemployment Insurance					0	
00	State or Federal Unemployment Taxes					0	20
	OTHER				· · · ·		
00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost R	eported on li	nes 1 throu	ugh 4 above. (see	0	21
00	Day Care Cost and Allowances					0	22
00	Tui ti on Rei mbursement					0	
	Total Wage Related cost (Sum of lines 1 -23)					19, 910, 922	
	Part B - Other than Core Related Cost					, , ,,,==	1
00	OTHER WAGE RELATED COSTS (SPECIFY)						25

Heal th Fi	nancial Systems	IU HEALTH ARNETT	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI TAL	CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0173		ri od:	Worksheet S-3	
					om 01/01/2021	Part V	
				То	12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Cost Center Description			C	ontract Labor	Benefit Cost	
	Cost center bescription				1.00	2.00	
PA	RT V - Contract Labor and Benefit Cost				1.00	2.00	
	spital and Hospital-Based Component Identi	fi cati on:					
	otal facility's contract labor and benefit				1, 732, 734	19, 910, 922	1.00
2.00 Ho	ospi tal				1, 732, 734	19, 022, 406	2.00
3.00 Su	ubprovider - IPF						3.00
4.00 Su	ubprovider – IRF						4.00
5.00 Su	ubprovider - (Other)				0	0	5.00
6.00 Sw	ving Beds - SNF				0	0	6.00
7.00 Sw	ving Beds - NF				0	0	7.00
8.00 Ho	ospital-Based SNF						8.00
9.00 Ho	ospital-Based NF						9.00
10.00 Ho	ospital-Based OLTC						10.00
11.00 Ho	ospital-Based HHA						11.00
	eparately Certified ASC						12.00
13.00 Ho	ospital-Based Hospice						13.00
14.00 Ho	ospital-Based Health Clinic RHC						14.00
	ospital-Based Health Clinic FQHC						15.00
	ospital-Based-CMHC						16.00
	enal Dialysis				0	0	17.00
18. 00   Ot	ther				0	888, 516	18.00

		LTH ARNETT HOSPITAL			eu of Form CMS-	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0173	Period: From 01/01/2021	Worksheet S-1	0
				To 12/31/2021	Date/Time Pre	pared:
					5/26/2022 3:4	2 pm
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 (	column 3 divided by li	ne 202 column	8)	0. 182951	1 1.00
	Medicaid (see instructions for each line)	1				
2.00	Net revenue from Medicaid				34, 845, 061	
3.00	Did you receive DSH or supplemental payments from Me				N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or			i d?	0	4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental Medicaid charges	payments from medical	u		256, 117, 868	
7.00	Medicaid cost (line 1 times line 6)				46, 857, 020	
8.00	Difference between net revenue and costs for Medical	id program (line 7 mir	nus sum of lir	es 2 and 5; if	12, 011, 959	
	< zero then enter zero)			,	,	
	Children's Health Insurance Program (CHIP) (see inst	tructions for each lir	ne)		1	
9.00	Net revenue from stand-al one CHIP				0	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-a	alone CHIP (line 11 mi	nus line 0 i	f < zero then		
12.00	enter zero)		nus rine 7, 1			12.00
	Other state or local government indigent care progra	am (see instructions f	°or each line)			1
13.00	Net revenue from state or local indigent care progra				12, 473	
14.00	Charges for patients covered under state or local in	ndigent care program (	(Not included	in lines 6 or	212, 248	14.00
15 00	10) State on Local indigent care program cost (Line 1 ti	imaa lina 14)			20.021	15 00
15.00 16.00	State or local indigent care program cost (line 1 ti Difference between net revenue and costs for state of		program (lir	o 15 minus lino	38, 831 26, 358	•
10.00	13; if < zero then enter zero)	or rocar rhargent care			20, 330	10.00
	Grants, donations and total unreimbursed cost for Me	edicaid, CHIP and stat	e/local indig	ent care progra	ms (see	1
47.00	instructions for each line)					1 1 7 00
17.00 18.00	Private grants, donations, or endowment income rest Government grants, appropriations or transfers for				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and sta			(sum of lines	12, 038, 317	
	8, 12 and 16)	to and roodi rhargone			12,000,017	
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the	e entire facility	31, 399, 36	3, 954, 847	35, 354, 209	20.00
	(see instructions)					
21.00	Cost of patients approved for charity care and uning	sured discounts (see	5, 744, 54	5 3, 954, 847	9, 699, 392	21.00
22.00	instructions)					
22.00	Payments received from patients for amounts previous charity care	siy written orr as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		5, 744, 54	5 3, 954, 847	9, 699, 392	23.00
			1			
					1.00	
24.00	Does the amount on line 20 column 2, include charges		ond a length	of stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or other ind If line 24 is yes, enter the charges for patient day		coro progran	's longth of	0	25.00
25.00	stay limit	ys beyond the thurgen	L care program	is religiti of	0	25.00
26.00	Total bad debt expense for the entire hospital compl	lex (see instructions)	1		15, 431, 878	26.00
27.00	Medicare reimbursable bad debts for the entire hospi	ital complex (see inst	tructions)		622, 315	
27.01	Medicare allowable bad debts for the entire hospital	l complex (see instruc	ctions)		957, 408	•
28.00	Non-Medicare bad debt expense (see instructions)	· · · · · · · · · · · · · · · · · · ·			14, 474, 470	
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare I Cost of uncompensated care (line 23 column 3 plus li		instructions)		2, 983, 212 12, 682, 604	
30.00	Total unreimbursed and uncompensated care cost (line				24, 720, 921	
01.00					1 21, 720, 721	1 31.00

CLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CO		eriod: rom 01/01/2021	Worksheet A	
					o 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
				+ COL 2)	UNS (See A-0)	(col . 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
00	00100 CAP REL COSTS-BLDG & FLXT		0	0		5, 343, 348	
01 02	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE		0	0	510, 289 0	510, 289 0	
00	00200 CAP REL COSTS-MVBLE EQUIP		0	0	6, 514, 615	6, 514, 615	
01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP		0	0	560, 623	560, 623	
)0 )0	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	-77, 343	0 705, 594	0 628, 251	0 13, 718, 111	0 14, 346, 362	1 1
)1	00570 ADMI TTI NG	316, 515	840, 117	1, 156, 632	-224, 827	931, 805	
)6	00590 OTHER ADMINISTRATIVE & GENERAL	5, 372, 110	55, 303, 125	60, 675, 235		58, 140, 409	
)0 )1	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL	1, 507, 324	15, 219, 588 1, 051, 652	16, 726, 912 1, 051, 652		10, 820, 503 659, 074	
00	00800 LAUNDRY & LINEN SERVICE	Ö	0	0	0/2/0/0	0	
00	00900 HOUSEKEEPING	1, 313, 904	1, 798, 514	3, 112, 418		2, 737, 918	
00 00	01000 DI ETARY 01100 CAFETERI A	1, 015, 089 0	1, 535, 187 0	2, 550, 276 0		1, 357, 414 856, 641	
00	01300 NURSING ADMINISTRATION	9, 922, 920	3, 171, 451	13, 094, 371	-989, 536	12, 104, 835	1:
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	483, 335	137, 703	621, 038	9, 803, 009	10, 424, 047	
	01600 MEDICAL RECORDS & LIBRARY	4, 785, 731 0	9, 944, 790 0	14, 730, 521 0	-9, 134, 447 0	5, 596, 074 0	
00	01700 SOCIAL SERVICE	587, 565	159, 843	747, 408		620, 930	
	01850 PATIENT TRANSPORT SERVICES	585, 329	161, 354	746, 683		636, 906	
00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD 02200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0 72, 489	0 1, 174, 637	0 1, 247, 126	1, 000, 111 -1, 005, 977	1, 000, 111 241, 149	
	02300 PARAMED ED PRGM - PHARMACY	90, 879	28, 323	119, 202	107, 379	226, 581	
~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		10 ( 10 01 (	40.044.454	( 004 (04	00.055.000	
00 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	20, 698, 635 3, 647, 788	19, 648, 016 3, 509, 377	40, 346, 651 7, 157, 165	-6, 991, 621 -1, 133, 632	33, 355, 030 6, 023, 533	
	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
01	03301 BURN I NTENSI VE CARE UNI T	0	0	0	0	0	
. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	1, 975, 378 0	1, 545, 880 0	3, 521, 258 0		2, 992, 079 796, 477	
	ANCILLARY SERVICE COST CENTERS		-				1
00 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 947, 515 793, 431	17, 311, 154 350, 462	22, 258, 669 1, 143, 893		6, 668, 083 885, 453	
00	05200 DELIVERY ROOM & LABOR ROOM	2, 541, 971	1, 312, 210	3, 854, 181	-908, 609	2, 945, 572	
00	05300 ANESTHESI OLOGY	161, 483	6, 846, 134	7, 007, 617		6, 523, 303	
01 00	05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	1, 616 4, 075, 328	143, 492 6, 688, 273	145, 108 10, 763, 601	-135, 296 -5, 709, 006	9, 812 5, 054, 595	
	05500 RADI OLOGY-THERAPEUTI C	4,073,320	0,000,273	0	0	0,004,070	
	05600 RADI OI SOTOPE	292, 796	996, 550	1, 289, 346		433, 339	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 318, 974 6, 548	5, 459, 563 11, 344, 332	6, 778, 537 11, 350, 880		1, 650, 607 11, 282, 420	
00	06300 BLOOD STORING, PROCESSING & TRANS.	0,010	880, 580	880, 580	10, 628	891, 208	
00	06500 RESPI RATORY THERAPY	2, 212, 413	1,827,177	4, 039, 590		2, 675, 651	
00 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	580, 894 369, 471	155, 723 167, 888	736, 617 537, 359	-90, 807 -65, 828	645, 810 471, 531	
00	06800 SPEECH PATHOLOGY	282, 852	76, 892	359, 744	-28, 660	331, 084	
00	06900 ELECTROCARDI OLOGY	1, 192, 852	1,048,344	2, 241, 196	-860, 924	1, 380, 272	
00 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	82, 120	34, 489 0	116, 609 0	-28, 443 7, 857, 614	88, 166 7, 857, 614	
00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8, 574, 931	8, 574, 931	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	39, 293, 201	39, 293, 201	
00 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	745, 498	745, 498	-19, 216	726, 282 0	
	07501 ASC (NON-DI STINCT PART)	3, 220, 417	5, 537, 702	8, 758, 119	-4, 186, 585	4, 571, 534	
00	03950 CARDI AC CATHERI ZATI ON	0	0	0	0	0	70
01 97	03951 OUTPATIENT WOUND CARE CENTER 07697 CARDIAC REHABILITATION	147, 822 532	1, 019, 647 6, 327	1, 167, 469 6, 859		838, 300 558	
	OUTPATIENT SERVICE COST CENTERS		0, 327				1 ''
	09000 CLI NI C	0	0	0	0	0	
01 02	04950 SLEEP CLINIC 09001 ANTICOAGULATION CLINIC	416, 068 101, 010	363, 780 29, 016	779, 848 130, 026	-254, 705 -46, 838	525, 143 83, 188	
02	09002 ARNETT CANCER CARE CENTER	975, 914	29, 774, 632	30, 750, 546	-29, 290, 197	1, 460, 349	
	09003 OUTPATIENT INFUSION CENTER	45, 811	14, 155	59, 966	-8, 622	51, 344	90
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 802, 807	7, 251, 097	13, 053, 904	-2, 131, 423	10, 922, 481	91
01	09201 OBSERVATION BEDS (NON-DISTINCT PART)	О	0	0	0	0	
	04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS						

Health Financial Systems	IU HEALTH ARNET	T HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Period:	Worksheet A	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2.00	2.00	4.00	col. 4)	
	1.00	2.00	3.00	4.00	5.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	34, 682	86, 108	120, 79	0 -9, 896	110, 894	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	583, 227	171, 563	754, 79	0 -71, 731	683, 059	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 RETAIL PHARMACY	1,008	130, 609	131, 61	7 -40	131, 577	193.01
193. 02 19302 WHI TE HOSPI TAL	0	0		2, 120, 998	2, 120, 998	193. 02
193. 03 19303 HOSPI CE	0	5, 280	5, 28	0 0	5, 280	193.03
193. 04 19304 FRANKFORT HOSPI TAL	0	0		0 1, 510, 646	1, 510, 646	193.04
194.0007950 MARKETI NG/PUBLIC RELATIONS	0	0		0 0	0	194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	82, 487, 210	215, 713, 828	298, 201, 03	в о	298, 201, 038	200. 00

ECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-017		Α
				From 01/01/2021 To 12/31/2021 Date/Time	
	Cost Center Description		Net Expenses	5/26/2022	3:42 pm
		(See A-8) F 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS		·		
00	00100 CAP REL COSTS-BLDG & FLXT	597, 969	5, 941, 317		1.
01 02	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE	0 10, 516, 715	510, 289 10, 516, 715		1.
02	00200 CAP REL COSTS INTEREST EXTENSE	1, 334, 633	7, 849, 248		2.
01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	560, 623		2
00	00300 OTHER CAP REL COSTS	0	o		3
00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 526, 908	15, 873, 270		4
01	00570 ADMI TTI NG 00590 OTHER ADMI NI STRATI VE & GENERAL	-140, 399	791, 406		5
06 00	00700 OPERATION OF PLANT	-3, 180, 412 -4, 968	54, 959, 997 10, 815, 535		5
01	00701 OPERATION OF PLANT - NONHOSPITAL	-165	658, 909		7
00	00800 LAUNDRY & LINEN SERVICE	0	0		8
00	00900 HOUSEKEEPI NG	0	2, 737, 918		9
0.00	01000 DI ETARY	0	1, 357, 414		10
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	-257, 490 -137, 368	599, 151 11, 967, 467		11
	01400 CENTRAL SERVICES & SUPPLY	-4, 450	10, 419, 597		14
	01500 PHARMACY	-111, 210	5, 484, 864		15
5.00	01600 MEDI CAL RECORDS & LI BRARY	0	o		16
	01700 SOCI AL SERVI CE	0	620, 930		17
	01850 PATI ENT TRANSPORT SERVICES 02100 I & R SERVICES-SALARY & FRINGES APPRVD	0	636, 906		18
2.00	02200 I &R SERVICES-SALART & FRINGES APPRVD	757, 231	1, 000, 111 998, 380		21
3.00	02300 PARAMED ED PRGM - PHARMACY	0	226, 581		23
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
D. 00	03000 ADULTS & PEDI ATRI CS	-338, 398	33, 016, 632		30
1.00	03100 I NTENSI VE CARE UNI T	-373, 821	5, 649, 712		31
3.00 3.01	03300 BURN INTENSIVE CARE UNIT 03301 BURN INTENSIVE CARE UNIT	0	0		33
5.00	02060 NEONATAL INTENSIVE CARE UNIT	-9, 684	2, 982, 395		35
3.00	04300 NURSERY	0	796, 477		43
	ANCILLARY SERVICE COST CENTERS				
0.00	05000 OPERATING ROOM	-2, 198	6, 665, 885		50
1.00 2.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	-8, 485 -106	876, 968 2, 945, 466		51 52
3.00	05300 ANESTHESI OLOGY	-3, 168	6, 520, 135		53
3.01	05301 ASC ANESTHESI OLOGY	0,100	9, 812		53
4.00	05400 RADI OLOGY-DI AGNOSTI C	-19, 400	5, 035, 195		54
5.00	05500 RADI OLOGY-THERAPEUTI C	0	0		55
6.00 9.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	0	433, 339 1, 650, 607		56 59
9.00 D.00	06000 LABORATORY	0	11, 282, 420		60
	06300 BLOOD STORING, PROCESSING & TRANS.	0	891, 208		63
	06500 RESPI RATORY THERAPY	0	2, 675, 651		65
6.00	06600 PHYSI CAL THERAPY	0	645, 810		66
7.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	471, 531		67
8.00 9.00	06900 ELECTROCARDI OLOGY	0 -152	331, 084 1, 380, 120		68 69
	07000 ELECTROENCEPHALOGRAPHY	0	88, 166		70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,857,614		71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	8, 574, 931		72
	07300 DRUGS CHARGED TO PATIENTS	0	39, 293, 201		73
4.00 5.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	726, 282		74
	07501 ASC (NON-DISTINCT PART)	-5,000	4, 566, 534		75
	03950 CARDI AC CATHERI ZATI ON	0	0		76
5. 01	03951 OUTPATIENT WOUND CARE CENTER	-16	838, 284		76
5. 97	07697 CARDIAC REHABILITATION	0	558		76
			0		
). 00 ). 01	09000 CLINIC 04950 SLEEP CLINIC	0	0 525, 143		90 90
	09001 ANTI COAGULATI ON CLINIC	0	83, 188		90
	09002 ARNETT CANCER CARE CENTER	0	1, 460, 349		90
0. 04	09003 OUTPATIENT INFUSION CENTER	0	51, 344		90
	09100 EMERGENCY	-699, 219	10, 223, 262		91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_			92
2.01 3.00	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92
s. UU	04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	0	0		93
18.00		9, 437, 347	303, 075, 931		118
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	110, 894		190

Health Financial Systems	IU HEALTH ARNE	TT_HOSPITAL		In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0173	Peri od:	Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared:
				10 12/01/2021	5/26/2022 3: 42 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7.00			
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	683, 059			192.00
193.00 19300 NONPALD WORKERS	0	0			193.00
193. 01 19301 RETAIL PHARMACY	6, 595, 398	6, 726, 975			193.01
193. 02 19302 WHI TE HOSPI TAL	0	2, 120, 998			193.02
193. 03 19303 HOSPI CE	0	5, 280			193.03
193. 04 19304 FRANKFORT HOSPI TAL	0	1, 510, 646			193.04
194.00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0			194.00
200.00 TOTAL (SUM OF LINES 118 through 199)	16, 032, 745	314, 233, 783			200.00

# Health Financial Systems RECLASSIFICATIONS

# IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173 Period:

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

RECLAS	SI FI CATI ONS			Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet A-6 Date/Time Pre	
						10 12/31/2021	5/26/2022 3:4	
	Cast Contor	Li ne #	Salary	Other				
	Cost Center 2.00	3.00	Salary 4.00	5.00				
	A - NONBILLABLE SUPPLIES							
1.00	CENTRAL SERVICES & SUPPLY	14.00		10, 398, 951				1.00
2.00 3.00	ADMI TTI NG OTHER ADMI NI STRATI VE &	5. 01 5. 06		225 155, 506				2.00
0.00	GENERAL	0.00		100,000				0.00
4.00	HOUSEKEEPING	9.00		886				4.00
5.00 6.00	DI ETARY SOCI AL SERVI CE	10. 00 17. 00		96 14				5.00 6.00
7.00	PARAMED ED PRGM - PHARMACY	23.00		4				7.00
8.00	RADI OI SOTOPE	56.00		21, 180				8.00
9.00	BLOOD STORING, PROCESSING & TRANS.	63.00		10, 628				9.00
10.00	PHYSICAL THERAPY	66.00		264				10.00
11.00	ELECTROCARDI OLOGY	69.00		279				11.00
12.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00		9				12.00
13.00	o, ut lett	0.00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0.00 0.00	0	0				15.00 16.00
17.00		0.00	0	0				17.00
18.00		0.00	О	0				18.00
19. 00 20. 00		0.00 0.00	0	0				19.00 20.00
20.00		0.00	0	0				20.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
24. 00 25. 00		0.00 0.00	0	0				24.00 25.00
26.00		0.00	0	0				26.00
			0	10, 588, 042				
1.00	B - BILLABLE SUPPLIES MEDICAL SUPPLIES CHARGED TO	71.00	0	7, 857, 614				1.00
	PATI ENTS			1,001,011				
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0				3.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00	0	0				7.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11. 00 12. 00		0.00 0.00	0	0				11.00 12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0.00 0.00	0	0				15.00 16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20. 00 21. 00		0.00 0.00	0	0				20.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
24. 00 25. 00		0.00 0.00		0				24.00 25.00
26.00		0.00	ŏ	0				26.00
27.00		0.00	0	0				27.00
28.00	<u> </u>		0	00 7, 857, 614				28.00
	C - IMPLANTS		- 1					1
1.00	IMPL. DEV. CHARGED TO	72.00	0	8, 574, 931				1.00
2.00	PATI ENTS RADI OLOGY-DI AGNOSTI C	54.00	0	16, 803				2.00
3.00	ARNETT CANCER CARE CENTER	90.03	0	11, 865				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9. 00 10. 00		0.00 0.00	0	0 0				9.00 10.00
10.00	I	0.00	Ч	0				1 10.00

ASSI FI	ancial Systems CATIONS		IU HEALTH ARNE	Provi der CCN: 15-0	173 Peri od:	eu of Form CMS-2552 Worksheet A-6
					From 01/01/2021 To 12/31/2021	Date/Time Prepare 5/26/2022 3:42 pr
	Cost Center	Increases Line #	Solory	Other		<u>- 572072022 5.42 pr</u>
	2. <u>00</u>	3.00	Sal ary 4.00	5.00		
0			0	<u> </u>		11
	- DRUGS					
	JGS CHARGED TO PATIENTS /SICIANS' PRIVATE OFFICES	73.00 192.00	0 0	39, 293, 201		1
)	ISICIANS FRIVATE UTTCES	0.00	0	3, 320 0		3
		0.00	0	0		4
		0.00 0.00	0	0		5
		0.00	o	0		7
		0.00	0	0		8
0		0.00 0.00	0	0		9
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		0.00	0	0		20
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0		0.00 0.00	0	0		23
5		0.00	0	0		25
0		0.00 0.00	0	0		26
0		0.00	0			27
	- BENEFITS	4.00		12, 257, 004		
EMF	PLOYEE BENEFITS DEPARTMENT	4.00 0.00	0 0	13, 357, 994 0		1
		0.00	О	0		3
		0.00 0.00	0	0		4
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		0.00	0	0		7
		0.00 0.00	0	0		8
o		0.00	Ő	0		10
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		0.00 0.00	0	0		12
)		0.00	О	0		14
) )		0.00 0.00	0 0	0		15
5		0.00	0	0		17
		0.00	0	0		18
		0.00 0.00	0	0		19
D		0.00	О	0		21
		0.00 0.00	0 0	0		22
		0.00	0	0		24
		0.00	0	0		25
2   2		0.00 0.00	0	0		26
5		0.00	О	0		28
2   2		0.00 0.00	0	0		29
		0.00	0	0		31
0		0.00	О	0		32
0		0.00 0.00	0	0		33
5		0.00	0	0		34
D		0.00	О	0		36
0		0.00 0.00	0	0		37
0		0.00	О	0		39
0		0.00	0	0		40
0		0.00	0	000000		41

	Financial Systems IFICATIONS		IU HEALTH ARNE	TT HOSPITAL Provider CCN: 15-0	173 Period: From 01/01/2021	worksheet A-6
		Increases			To 12/31/2021	Date/Time Prepared: 5/26/2022 3:42 pm
	Cost Center	Line #	Salary	Other		
	2.00 F - CAFETERIA	3.00	4.00	5.00		
			424,018	432,623		1.0
	0 G - PROPERTY TAX		424, 018	432, 623		
0	CAP REL COSTS-BLDG & FIXT	1.00		2, 719		1.0
	CAP REL COSTS-BLDG & FIXT - NONHOSP	1.01		1, 860		2.0
L L	0 H - PROPERTY INSURANCE		0	4, 579		
0	CAP REL COSTS-BLDG & FIXT	1.00		219, 364		1.0
	CAP REL COSTS-BLDG & FIXT - NONHOSP	1.01		34, 265		2.0
- F	CAP REL_COSTS-MVBLE_EQUIP			1 <u>1, 2</u> 46 264, 875		3. C
t	I - LEASE EXPENSE		<u> </u>	204, 875		
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT -	1.00 1.01		654, 180 86, 086		1.0
ļ	NONHOSP					
	CAP REL COSTS-MVBLE EQUIP OUTPATIENT WOUND CARE CENTER	2.00 76.01		479, 004 2, 023		3. 0
		0.00	0	0		5.
)		0.00	0	0 0		6. 7.
)		0. 00 0. 00	0	0		8. 9.
0		0.00	0	0		10.
0		0.00 0.00	0	0		11.
οļ		0.00	0	0		13.
L	0 J - INTEREST EXPENSE		0	1, 221, 293		
	CAP REL COSTS-MVBLE EQUIP -	2.01		1, 579		1. (
ľ	NONHOSP	0.00	0	O		2.
	TOTALS K - HOUSEKEEPING SUPPLIES		0	1, 579		
)	HOUSEKEEPI NG	9.00	0	34, 476		1.
	CARDIAC CATHETERIZATION	59.00 0.00	0	6, 046 0		2.
		0.00 0.00	0	0		4.
		0.00	0	0		6.
		0.00 0.00	0	0		7.
		0.00	0	0		9.
0 0		0. 00 0. 00	0	0		10. 11.
0		0. 00 0. 00	0	0 0		12.
0		0.00	0	0		13.
0		0. 00 0. 00	0	0		15. 16.
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0 0		0. 00 0. 00	0	0 0		18. 19.
0		0.00	0	0		20.
0		0. 00 0. 00	0	0 0		21.
0		0.00	0	0		23.
0		0. 00 0. 00	0	0 0		24. 25.
0			<u>o</u>	0 40, 522		26.
	0 - TELEPHONE RECLASS		L			
	OTHER ADMINISTRATIVE & GENERAL	5.06	0	656		1. (
)		0.00	0	0		2.0
			0_	00		3. (
	0					
)	P - DEPRECIATION EXPENSE	1 00		4 467 095		
	8	1. 00 1. 01	0 0	4, 467, 085 388, 078		1. (

# Heal th Financial Systems RECLASSIFICATIONS

# U HEALTH ARNETT HOSPITAL Provider CCN: 15-0173 Period:

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

RECLAS	SIFICATIONS			Provider (	CCN: 15-0173	Peri od:	Worksheet A	-6
						From 01/01/2021 To 12/31/2021	Date/Time Pr	
		Increases					5/26/2022 3:	42 pm
	Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00				
4.00	CAP REL COSTS-MVBLE EQUIP -	2.01	0	560, 005				4.00
5.00	NONHOSP	0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00 9.00		0.00 0.00	0	0				8.00 9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12. 00 13. 00		0.00 0.00	0	0				12.00 13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16. 00 17. 00		0.00 0.00	0	0 0				16.00 17.00
17.00		0.00	0	0				17.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21. 00 22. 00		0.00 0.00	0	0				21.00 22.00
23.00		0.00	0	0				23.00
24.00		0.00	0	0				24.00
25. 00 26. 00		0.00 0.00	0	0				25.00 26.00
27.00	L	0.00	0	0				27.00
	O Q - FMLA RECLASS		0	11, 439, 533				-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		350				1.00
2.00	OTHER ADMI NI STRATI VE &	5.06		18, 381				2.00
3.00	GENERAL OPERATION OF PLANT	7.00		872				3.00
4.00	HOUSEKEEPI NG	9.00		5, 880				4.00
5.00	DI ETARY	10.00		2, 042				5.00
6.00 7.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00		37, 491 518				6. 00 7. 00
8.00	PHARMACY	15.00		5, 805				8.00
9.00	SOCI AL SERVI CE	17.00		2, 761				9.00
10. 00 11. 00	PATIENT TRANSPORT SERVICES ADULTS & PEDIATRICS	18.00 30.00		6, 414 114, 582				10. 00 11. 00
12.00	INTENSIVE CARE UNIT	31.00		6, 541				12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00		10, 728				13.00
14. 00 15. 00	OPERATING ROOM RECOVERY ROOM	50.00 51.00		22, 653 10, 656				14.00 15.00
16.00	DELIVERY ROOM & LABOR ROOM	51.00		20, 627				16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00		27, 518				17.00
18.00	CARDIAC CATHETERIZATION RESPIRATORY THERAPY	59.00 65.00		11, 732 16, 110				18.00 19.00
19. 00 20. 00	OCCUPATIONAL THERAPY	67.00		2, 679				20.00
21.00	ELECTROCARDI OLOGY	69.00		5, 535				21.00
22.00	ASC (NON-DI STI NCT PART)	75.01		25, 622				22.00
23. 00 24. 00	ARNETT CANCER CARE CENTER EMERGENCY	90.03 91.00		13, 111 51, 404				23.00 24.00
	0 — — — — — —		0	420, 012				
1.00	R - NURSERY NURSERY	43.00	702, 341	94, 136				1.00
2.00		0.00	0	0				2.00
	O X - ARNETT TO WHITE ALLOCATIO	DN	702, 341	94, 136				-
1.00	WHITE HOSPITAL	193.02	1, 356, 016	764, 982				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0				3.00 4.00
5.00		0.00	Ő	0				5.00
6.00		0.00	0	0				6.00
7.00 8.00		0.00 0.00		0				7.00 8.00
9.00		0.00	o	0				9.00
10.00				0				10.00
	0 Y - ARNETT TO FRANKFORT ALLOO		1, 356, 016	764, 982				-
1.00	FRANKFORT HOSPITAL	193.04	943, 519	567, 127				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0 0				3.00 4.00
	1	0.00	<i>ч</i>	0	1			1

	Financial Systems SIFICATIONS		IU HEALTH ARNET	Provider CCN: 15-0	173 Period:	worksheet A-6
					From 01/01/2021 To 12/31/2021	Date/Time Prepared 5/26/2022 3:42 pm
		Increases				0/20/2022 0. 12 pm
	Cost Center	Line #	Sal ary	Other		
	2.00	3.00	4.00	5.00		
5.00		0.00	0	0		5.0
. 00		0.00	0	0		6.0
. 00		0.00	0	0		7.0
. 00		0.00	0	0		8.0
0.00		0.00	0	U		9.0
0.00		0.00	0	0		10.0
1.00		0.00	042 510	<u>567, 127</u>		11. (
	Z - RESIDENCY STAFF		943, 519	567, 127		
00	I &R SERVICES-OTHER PRGM.	22.00	707 227	0		1.0
1.00	COSTS APPRVD	22.00	727, 337	U		1.0
		+	727, 337			
	AB - INTERNS AND RESIDENTS		121, 331	U		
1.00	I &R SERVICES-SALARY &	21.00	0	1,000,111		1.0
1.00	FRINGES APPRVD	21.00	0	1,000,111		1.0
		+		1,000,111		
	AC - PARAMEDICAL EDUCATION	I		1,000,111		
1.00	PARAMED ED PRGM - PHARMACY	23.00	114,060	8, 726		1.0
			114,060	8,726		
	AD - ACCRUED PTO	<b>I</b>		-,		
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	360, 909	0		1.0
2.00	ADMI TTI NG	5.01	167	ō		2.0
3.00	OPERATION OF PLANT	7.00	3, 473	0		3.0
4.00	RECOVERY ROOM	51.00	10, 588	ō		4. 0
5.00	ANESTHESI OLOGY	53.00	160	0		5.0
5.00	PHYSICAL THERAPY	66.00	6, 822	0		6.0
7.00	OCCUPATI ONAL THERAPY	67.00	14, 945	ō		7.0
3.00	SPEECH PATHOLOGY	68.00	3, 547	0		8.0
9.00	ELECTROCARDI OLOGY	69.00	10, 292	0		9.0
10.00	ELECTROENCEPHALOGRAPHY	70.00	1, 464	0		10.0
1.00	ARNETT CANCER CARE CENTER	90.03	1, 431	0		11.0
12.00	EMERGENCY	91.00	14, 626	0		12.0
13.00	GIFT, FLOWER, COFFEE SHOP &	190.00	564	0		13.0
	CANTEEN					
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	21, 088	0		14.0
15.00		0.00	0	0		15.0
16.00		0.00	0	0		16.0
17.00		0.00	0	0		17.0
8.00		0.00	0	0		18.0
9.00		0.00	0	0		19.0
0. 00		0.00	0	0		20.0
1. 00		0.00	О	0		21.0
2.00		0.00	0	0		22.0
3.00		0.00	o	- <u> </u>		23.0
	o		450, 076	Ō		
	AE - PRACTICE MANAGEMENT					
. 00	OTHER ADMI NI STRATI VE &	5.06	2, 753, 486	0		1. (
	<u>GENERAL</u>					
	TOTALS		2, 753, 486	0		
	AF - HR ADMIN					
. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	111, 645	0		1. (
	TOTALS	T	111, 645	0		
00 00	Grand Total: Increases		7, 582, 498	95, 964, 524		500.0

Provider CCN: 15-0173

In Lieu of Form CMS-2552-10

In Lieu	u of Form CMS-2552-10
Peri od:	Worksheet A-6 Date/Time Prepared:
From 01/01/2021	
To 12/31/2021	Date/Time Prepared:

		Decreases	C-1-	0+1		
	Cost Center	Line #	<u>Sal ary</u> 8.00	0ther 9.00	Wkst. A-7 Ref.	
	6.00 A - NONBILLABLE SUPPLIES	7.00	8.00	9.00	10.00	
00	OPERATION OF PLANT	7.00		145, 547	0	1.
00	NURSI NG ADMI NI STRATI ON	13.00		31, 808	0	2.
00	PHARMACY	15.00		140, 744	0	3.
00	PATIENT TRANSPORT SERVICES	18.00		8, 220	0	4.
0C	ADULTS & PEDIATRICS	30.00		878, 418	0	5.
0C	INTENSIVE CARE UNIT	31.00		176, 325	0	6.
00	NEONATAL INTENSIVE CARE UNIT	35.00		64, 802	О	7.
00	OPERATING ROOM	50.00		4, 830, 551	0	8.
00	RECOVERY ROOM	51.00		38, 955	0	9.
00	DELIVERY ROOM & LABOR ROOM	52.00		199, 337	0	10.
00	ANESTHESI OLOGY	53.00		258, 934	0	11.
00	ASC ANESTHESI OLOGY	53.01		73, 048	0	12.
00	RADI OLOGY-DI AGNOSTI C	54.00		1, 179, 148	0	13.
00	CARDIAC CATHETERIZATION	59.00		692, 927	0	14.
00		60.00		67, 179	0	15.
00	RESPIRATORY THERAPY	65.00		744, 851	0	16.
00	OCCUPATIONAL THERAPY	67.00		47	0	17.
00 00	SPEECH PATHOLOGY RENAL DI ALYSI S	68.00 74.00		866 3, 634	0	18.
00	ASC (NON-DISTINCT PART)	74.00		639, 698	0	20.
00	OUTPATIENT WOUND CARE CENTER	76.01		14, 318	0	21
00	SLEEP CLINIC	90.01		27, 187	0	22
00	ARNETT CANCER CARE CENTER	90.03		32, 632	0	23
00	OUTPATIENT INFUSION CENTER	90.04		726	0	24.
00	EMERGENCY	91.00		334, 834	0	25.
00	PHYSICIANS' PRIVATE OFFICES	192,00		3, 306	0	26.
			o			
	B - BILLABLE SUPPLIES	I				
00	EMPLOYEE BENEFITS DEPARTMENT	4.00	C	358	0	1.
00	OTHER ADMINISTRATIVE &	5.06	0	317	o	2.
	GENERAL					
00	OPERATION OF PLANT	7.00	0	98	0	3.
00	NURSING ADMINISTRATION	13.00	C	.,	0	4
00	CENTRAL SERVICES & SUPPLY	14.00	0		0	5.
00	PHARMACY	15.00	0	1, 550	0	6.
00	ADULTS & PEDIATRICS	30.00	0	,	0	7.
00	INTENSIVE CARE UNIT	31.00	0	00, 101	0	8
00	NEONATAL INTENSIVE CARE UNIT	35.00	0		0	9
00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	-, ,	0	10
00 00	DELIVERY ROOM & LABOR ROOM	51.00	0	384	0	11.
00	ANESTHESI OLOGY	53.00	0		0	13
00	ASC ANESTHESI OLOGY	53.00	0		0	14
00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 959, 757	0	15
00	RADI OI SOTOPE	56.00	0		0	16
00	CARDI AC CATHETERI ZATI ON	59.00	0		o	17
00	RESPI RATORY THERAPY	65.00	0	11, 630	0	18
00	PHYSI CAL THERAPY	66.00	0		0	19
00	ELECTROCARDI OLOGY	69.00	C	717	0	20
00	RENAL DI ALYSI S	74.00	C	8, 853	О	21
00	ASC (NON-DISTINCT PART)	75.01	C	533, 448	О	22
00	OUTPATIENT WOUND CARE CENTER	76.01	C	261, 381	0	23
00	SLEEP CLINIC	90.01	0	253	0	24
00	ARNETT CANCER CARE CENTER	90.03	0	1, 470	0	25
00	OUTPATIENT INFUSION CENTER	90.04	C	53	0	26
00	EMERGENCY	91.00	C	52, 275	0	27
00	PHYSICIANS' PRIVATE OFFICES	192.00	0		0	28
			0	7, 857, 614		
0	C - IMPLANTS	7 00		(00		1
0	OPERATION OF PLANT	7.00		600	0	1
0	NURSING ADMINISTRATION	13.00		180	0	2
0	CENTRAL SERVICES & SUPPLY	14.00		8, 683	0	3
0	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00		1, 275	0	4
0	OPERATING ROOM	50.00		4, 559, 841	0	5
0	DELIVERY ROOM & LABOR ROOM	52.00		4, 559, 841	0	6
0	ANESTHESI OLOGY	52.00		2, 350	0	8
00	CARDIAC CATHETERIZATION	59.00		2, 350	0	9
00	ASC (NON-DISTINCT PART)	75.01		1, 837, 286	0	10
00	OUTPATIENT WOUND CARE CENTER	76.01		1, 837, 286	0	11.
50	CARE CENTER	<u>70.01</u>	— — — ā	8, 603, 599		I I I.

Heal th	Financial Systems		IU HEALTH ARM	IETT HOSPI TAL		In Li	eu of Form CN	IS-2552-10
	SIFICATIONS				CCN: 15-0173	Peri od:	Worksheet A	
						From 01/01/202 To 12/31/202	I   Date/Time F	Prepared:
		Decreases					5/26/2022 3	<u>3:42 pm</u>
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref	:		
	6. 00	7.00	8.00	9.00	10.00			
1 00	D - DRUGS	4.00		434	1	0		1.00
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE &	4.00 5.06		434 66		0		1.00 2.00
2.00	GENERAL	0.00						2.00
3.00	OPERATION OF PLANT	7.00		23		0		3.00
4.00 5.00	HOUSEKEEPI NG NURSI NG ADMI NI STRATI ON	9.00 13.00		1, 012 2, 499		0		4.00 5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00		2, 477 3, 115		0		6.00
7.00	PHARMACY	15.00		7, 185, 450		0		7.00
8.00	ADULTS & PEDIATRICS	30.00		378, 025		0		8.00
9. 00 10. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 35.00		119, 885 17, 549		0		9.00 10.00
11.00	OPERATING ROOM	50.00		488, 711		0		11.00
12.00	RECOVERY ROOM	51.00		3, 808		0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00		50, 944		0		13.00
14.00 15.00	ANESTHESI OLOGY ASC ANESTHESI OLOGY	53.00 53.01		80, 544 10, 963		0		14.00 15.00
16.00	RADI OLOGY-DI AGNOSTI C	54.00		527, 136		0		16.00
17.00	RADI OI SOTOPE	56.00		589, 053		0		17.00
18.00	CARDIAC CATHETERIZATION	59.00		107, 578		0		18.00
19. 00 20. 00	LABORATORY RESPI RATORY THERAPY	60.00 65.00		181 29, 818		0		19.00 20.00
20.00	ELECTROCARDI OLOGY	69.00		129, 616		0		20.00
22.00	RENAL DI ALYSI S	74.00		6, 246		0		22.00
23.00	ASC (NON-DISTINCT PART)	75.01		146, 495		0		23.00
24.00 25.00	OUTPATIENT WOUND CARE CENTER	76.01 90.03		879		0		24.00 25.00
26.00	ARNETT CANCER CARE CENTER OUTPATIENT INFUSION CENTER	90. 03 90. 04		29, 028, 801 2, 239		0		25.00
27.00	EMERGENCY	91.00		385, 603		0		27.00
	0		0	39, 296, 521		1		_
1.00	E - BENEFITS ADMITTING	5.01		52, 106		0		1.00
2.00	OTHER ADMINISTRATIVE &	5.06		580, 524		0		2.00
	GENERAL							
3.00	OPERATION OF PLANT	7.00		281, 336		0		3.00
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00		403, 506 284, 390		0		4.00 5.00
6.00	NURSING ADMINISTRATION	13.00		387, 136		0		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00		100, 856		o		7.00
8.00	PHARMACY SOCI AL SERVI CE	15.00		685, 852		0		8.00
9. 00 10. 00	PATIENT TRANSPORT SERVICES	17.00 18.00		119, 527 98, 918		0		9.00 10.00
11.00	I &R SERVICES-OTHER PRGM.	22.00		5, 320		0		11.00
	COSTS APPRVD							
12.00	PARAMED ED PRGM - PHARMACY ADULTS & PEDIATRICS	23.00 30.00		15, 148 4, 135, 847		0		12.00
13.00 14.00	INTENSIVE CARE UNIT	31.00		4, 135, 847 530, 829		0		13.00 14.00
15.00	NEONATAL INTENSIVE CARE UNIT	35.00		298, 811		0		15.00
16.00	OPERATING ROOM	50.00		848, 714		0		16.00
17.00 18.00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00		163, 805 488, 532		0		17.00 18.00
19.00	ANESTHESI OLOGY	53.00		25, 540		0		19.00
20.00	ASC ANESTHESI OLOGY	53.01		184		0		20.00
21.00	RADI OLOGY-DI AGNOSTI C	54.00		674, 595		0		21.00
22. 00 23. 00	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	56.00 59.00		28, 569 249, 484		0		22.00 23.00
24.00	LABORATORY	60.00		1, 100		0		23.00
25.00	RESPI RATORY THERAPY	65.00		307, 564		0		25.00
26.00	PHYSICAL THERAPY	66.00		96, 729		0		26.00
27.00 28.00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67.00 68.00		80, 726 31, 341		0		27.00 28.00
29.00	ELECTROCARDI OLOGY	69.00		357, 379		0		29.00
30.00	ELECTROENCEPHALOGRAPHY	70.00		29, 907	,	0		30.00
31.00	ASC (NON-DI STI NCT PART)	75.01		450, 777		0		31.00
32. 00 33. 00	OUTPATIENT WOUND CARE CENTER CARDIAC REHABILITATION	76. 01 76. 97		24, 465 21		0		32.00 33.00
33.00 34.00	SLEEP CLINIC	78. 97 90. 01		122, 416		0		33.00
35.00	ANTI COAGULATI ON CLINIC	90. 02		20, 800		0		35.00
36.00	ARNETT CANCER CARE CENTER	90.03		232, 601		0		36.00
37.00 38.00	OUTPATIENT INFUSION CENTER	90.04 91.00		5, 604 1, 034, 947		0		37.00 38.00
38.00 39.00	EMERGENCY GIFT, FLOWER, COFFEE SHOP &	190.00		1, 034, 947 10, 469		0		38.00
	CANTEEN							
40.00	PHYSICIANS' PRIVATE OFFICES	192.00	l	91, 579	1	0		40.00

CLAS	SEFECATIONS			Provider (	CCN: 15-0173	Period: From 01/01/2021	Worksheet A-6
						To 12/31/2021	Date/Time Prepar 5/26/2022 3:42 p
		Decreases					5/20/2022 5.42
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	_	
00	6.00 RETAIL PHARMACY	7.00	8.00	9.00	10.00	2	4
00			— — — <sub>d</sub>			2	4
	F - CAFETERIA		- 1				
00	<u>DIETARY</u>	10.00	42 <u>4, 0</u> 18	43 <u>2, 6</u> 23		2	
			424, 018	432, 623			
0	G - PROPERTY TAX OTHER ADMINISTRATIVE &	5.06		2, 719	1;	2	
0	GENERAL	5.00		2,717			
00	OPERATION OF PLANT -	7.01		1, 860	1:	3	
		+				_	
	U H – PROPERTY INSURANCE		0	4, 579	1		
00	OTHER ADMINI STRATI VE &	5.06		264, 875	1:	2	
	GENERAL						
00		0.00	0	0			
00		0.00	0	0		2	
	I - LEASE EXPENSE		0	264, 875			
00	CAP REL COSTS-MVBLE EQUIP -	2.01		961	1(	D	
_	NONHOSP						
00	OPERATION OF PLANT	7.00		580, 422			
00	OPERATION OF PLANT - NONHOSPITAL	7.01		11, 954	10	1	
00	NURSI NG ADMI NI STRATI ON	13.00		82, 225	10	b	
00	CENTRAL SERVICES & SUPPLY	14.00		156, 429		b	
00	PHARMACY	15.00		30, 847			
00	ADULTS & PEDIATRICS	30.00		18, 202			
)0 )0	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 35.00		2, 897 7, 116			
00	OPERATI NG ROOM	50.00		108, 846			1
00	ANESTHESI OLOGY	53.00		9, 788			1
00	RESPI RATORY THERAPY	65.00		123, 189			1
00	SLEEP_CLINIC	<u>90.</u> 01		88, 417		2	1
	0 J - INTEREST EXPENSE		0	1, 221, 293			
00	OTHER ADMINISTRATIVE &	5.06		240	1	1	
	GENERAL	74.04		4			
00	OUTPATIENT WOUND CARE CENTER	<u>76.01</u>		<u>1, 3</u> 39 1, 579			
	K - HOUSEKEEPING SUPPLIES	I	0	1, 377			
00	ADMI TTI NG	5.01		15		D	
00	OTHER ADMINISTRATIVE &	5.06		17	(	D	
00	GENERAL OPERATION OF PLANT	7.00		1, 027			
00	DI ETARY	10.00		1, 027			
00	NURSING ADMINISTRATION	13.00		324			
00	CENTRAL SERVICES & SUPPLY	14.00		1, 261			
00	PHARMACY	15.00		3, 264			
00 00	PATIENT TRANSPORT SERVICES ADULTS & PEDIATRICS	18.00 30.00		18 17, 525			
00	INTENSIVE CARE UNIT	31.00		960			1
00	NEONATAL INTENSIVE CARE UNIT	35.00		775			1
00	OPERATING ROOM	50.00		3, 815			1
00	RECOVERY ROOM	51.00		115			1
00 00	DELIVERY ROOM & LABOR ROOM	52.00 53.00		880 35			1
00	RADI OLOGY – DI AGNOSTI C	53.00 54.00		35 2, 051			1
00	RADI OI SOTOPE	56.00		41			1
00	RESPI RATORY THERAPY	65.00		52		p	1
00	ELECTROCARDI OLOGY	69.00		55			1
00 00	RENAL DI ALYSI S ASC (NON-DI STI NCT PART)	74.00 75.01		348 2, 058			2
00	OUTPATIENT WOUND CARE CENTER	75.01		2, 058			2
00	SLEEP CLINIC	90.01		166			2
00	ARNETT CANCER CARE CENTER	90.03		1, 608	. (		2
00	EMERGENCY	91.00		2, 965			2
00	PHYSICIANS' PRIVATE OFFICES	<u>192.00</u>		<u>900</u> 40, 522			2
	0 - TELEPHONE RECLASS			+0, 522	·I	I	
00	OPERATING ROOM	50.00	0	178			
00	RADI OLOGY-DI AGNOSTI C	54.00	0	287		C	
0	PHYSICIANS' PRIVATE OFFICES	192.00	0	191			

### Health Financial Systems RECLASSIFICATIONS

#### IU HEALTH ARNETT HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0173

 Period:
 Worksheet A-6

 From 01/01/2021
 Date/Time Prepared:

 To
 12/31/2021
 Date/Time Prepared:

						2 3:42 pm
	Cost Conton	Decreases	Colory	Othors	kat A 7 Daf	
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther W 9.00	kst. A-7 Ref. 10.00	
	P - DEPRECIATION EXPENSE	7.00	0.00	7.00	10.00	
1.00	OTHER ADMI NI STRATI VE &	5.06	0	37, 454	9	1.00
2.00	GENERAL OPERATION OF PLANT	7.00	0	4, 769, 837	9	2.00
3.00	OPERATION OF PLANT -	7.00	0	378, 764	9	3.00
	NONHOSPI TAL					
4.00 5.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	3, 414 31, 562	9	4.00 5.00
6.00	NURSING ADMINISTRATION	13.00	0	299, 849	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	100, 008	0	7.00
8.00	PHARMACY	15.00	0	288, 341	0	8.00
9. 00 10. 00	ADULTS & PEDIATRICS	30.00 31.00	0	302, 702 178, 794	0	9.00 10.00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	101, 010	0	11.00
12.00	OPERATING ROOM	50.00	0	1, 463, 966	o	12.00
13.00	RECOVERY ROOM	51.00	0	61, 961	0	13.00
14. 00 15. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52.00 53.00	0	12, 129 82, 297	0	14.00 15.00
16.00	ASC ANESTHESI OLOGY	53.01	0	46, 530	Ö	16.00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 368, 376	0	17.00
18. 00 19. 00	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	56.00 59.00	0	252, 811 601, 931	0	18.00 19.00
20.00	RESPIRATORY THERAPY	65.00	0	125, 695	0	20.00
21.00	ELECTROCARDI OLOGY	69.00	0	226, 565	0	21.00
22.00	RENAL DI ALYSI S	74.00	0	135	0	22.00
23.00 24.00	ASC (NON-DISTINCT PART) CARDIAC REHABILITATION	75. 01 76. 97	0	468, 159 6, 280	0	23.00 24.00
24.00	SLEEP CLINIC	90.01	0	9, 141	0	24.00
26.00	ARNETT CANCER CARE CENTER	90.03	0	6, 381	0	26.00
27.00	EMERGENCY	91.00	<u>0</u>	215, 441	0	27.00
	Q – FMLA RECLASS		U	11, 439, 533		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	350	0	0	1.00
2.00	OTHER ADMINI STRATI VE &	5.06	18, 381	0	0	2.00
3.00	GENERAL OPERATION OF PLANT	7.00	872	0	0	3.00
4.00	HOUSEKEEPING	9.00	5, 880	0	0	4.00
5.00	DIETARY	10.00	2, 042	0	0	5.00
6.00 7.00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13.00 14.00	37, 491 518	0	0	6.00 7.00
8.00	PHARMACY	15.00	5, 805	0	0	8.00
9.00	SOCI AL SERVI CE	17.00	2, 761	0	0	9.00
10.00	PATIENT TRANSPORT SERVICES	18.00	6, 414	0	0	10.00
11. 00 12. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30.00 31.00	114, 582 6, 541	0	0	11.00 12.00
13.00	NEONATAL INTENSIVE CARE UNIT	35.00	10, 728	0	0	13.00
14.00	OPERATING ROOM	50.00	22, 653	0	0	14.00
15.00	RECOVERY ROOM	51.00 52.00	10, 656	0	0	15.00
16. 00 17. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	54.00	20, 627 27, 518	0	0	16.00 17.00
18.00	CARDI AC CATHETERI ZATI ON	59.00	11, 732	0	0	18.00
19.00	RESPIRATORY THERAPY	65.00	16, 110	0	0	19.00
20. 00 21. 00	OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY	67.00 69.00	2, 679 5, 535	0	0	20.00 21.00
21.00	ASC (NON-DISTINCT PART)	75.01	25, 622	0	0	22.00
23.00	ARNETT CANCER CARE CENTER	90.03	13, 111	0	О	23.00
24.00	EMERGENCY	91.00	51, 404	0	0	24.00
	0 R – NURSERY		420, 012	0		
1.00	ADULTS & PEDIATRICS	30.00	678, 679	90, 004	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	23, 662	4, 132	<u>0</u>	2.00
	O X - ARNETT TO WHITE ALLOCATIO		702, 341	94, 136		
1.00	ADMITTING	5.01	23, 684	62, 865	0	1.00
2.00	OTHER ADMI NI STRATI VE &	5.06	701, 001	363, 898	Ō	2.00
2 00	GENERAL	7.00	E0 340	17 510		2.00
3.00 4.00	OPERATION OF PLANT DIETARY	7.00 10.00	58, 340 0	17, 513 17, 694	0	3.00 4.00
5.00	NURSING ADMINISTRATION	13.00	47, 588	38, 783	0	5.00
6.00	PHARMACY	15.00	301, 406	88, 891	o	6.00
7.00	ADULTS & PEDIATRICS	30.00	47, 993	57, 249	0	7.00
8.00 9.00	OPERATI NG ROOM ELECTROCARDI OLOGY	50.00 69.00	87, 360 52, 518	26, 650 47, 592	0	8.00 9.00
10.00	EMERGENCY	91.00	36, 126	43, 847	0	10.00
	•		•		1	·

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

	Financial Systems		IU HEALTH ARNE	IT HUSPITAL		In Lie	u of Form CMS-2552	
RECLASSI FI CATI ONS				Provider (	CCN: 15-0173	Period: From 01/01/2021	Worksheet A-6	
						To 12/31/2021	Date/Time Prepare	
							5/26/2022 3:42 pm	
		Decreases				1		
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	_		
	6.00	7.00	8.00	9.00	10.00			
	Y - ARNETT TO FRANKFORT ALLOCA		1, 356, 016	764, 982				
00	ADMITTING	5.01	23, 684	62, 865	0		1.	
00	OTHER ADMINI STRATI VE &	5.06	474, 085	228, 626			2.	
00	GENERAL	5.00	474,000	220, 020			2.	
00	OPERATION OF PLANT	7.00	41, 412	13, 727	(		3.	
00	NURSING ADMINISTRATION	13.00	47, 464	26, 924	(		4.	
00	CENTRAL SERVICES & SUPPLY	14.00	42, 122	73, 743	(		5.	
00	PHARMACY	15.00	204, 067	59, 977	(		6.	
00	ADULTS & PEDIATRICS	30.00	10, 588	25, 364	(		7.	
00	OPERATING ROOM	50.00	43, 707	13, 333	(	ן	8.	
00	ELECTROCARDI OLOGY	69.00	30, 010	27, 195	(		9.	
	ASC (NON-DISTINCT PART)	75.01	8, 306	13, 436			10.	
. 00	EMERGENCY	<u>91.</u> 00	1 <u>8, 0</u> 74	2 <u>1,9</u> 37		2	11.	
	0		943, 519	567, 127				
	Z - RESIDENCY STAFF							
00	I &R SERVICES-OTHER PRGM.	22.00	0	727, 337	(		1.	
	COSTS APPRVD	+		727, 337	— — ·	-		
	AB - INTERNS AND RESIDENTS		U	121, 331				
00	I &R SERVICES-OTHER PRGM.	22.00	0	1,000,111			1.	
00	COSTS APPRVD	22.00	0	1,000,111			1.	
		+		1,000,111		1		
	AC - PARAMEDICAL EDUCATION			.,				
00	PHARMACY	15.00	114, 060	8, 726	(	כו בי בי בי בי בי בי בי בי בי בי בי בי בי	1.	
			114,060	8, 726		1		
	AD - ACCRUED PTO							
00	OTHER ADMINISTRATIVE &	5.06	37, 166	0	(	)	1.	
	GENERAL							
00	HOUSEKEEPI NG	9.00	1, 930	0	(	)	2.	
	DI ETARY	10.00	2, 669	0	(		3.	
00	NURSING ADMINISTRATION	13.00	22, 951	0	(		4.	
00	CENTRAL SERVICES & SUPPLY	14.00	5, 575	0		ן ע	5.	
00	PHARMACY	15.00	21, 272	0	(		6.	
00	SOCIAL SERVICE	17.00	6, 965	0			7.	
00	PATIENT TRANSPORT SERVICES	18.00	2, 621	0	(		8.	
00	I&R SERVICES-OTHER PRGM.	22.00	546	0	(		9.	
00	COSTS APPRVD	22 00	262	0	(		10.	
	PARAMED ED PRGM - PHARMACY ADULTS & PEDIATRICS	23. 00 30. 00	263 56, 290	0			10.	
	INTENSIVE CARE UNIT	31.00	57, 446	0			12.	
	NEONATAL INTENSIVE CARE UNIT	35.00	24, 777	0			13.	
	OPERATING ROOM	50.00	20, 706	0	(		13.	
	DELIVERY ROOM & LABOR ROOM	52.00	18, 269	0	(		14.	
	RADI OLOGY-DI AGNOSTI C	54.00	14, 459	0			16.	
	RADI OI SOTOPE	56.00	5, 405	0	(		17.	
	CARDI AC CATHETERI ZATI ON	59.00	66	0			18.	
	RESPI RATORY THERAPY	65.00	21, 140	0	(		19.	
	ASC (NON-DISTINCT PART)	75.01	86, 922	0	(	b	20.	
	OUTPATIENT WOUND CARE CENTER	76.01	9, 475	0	(	o	21.	
	SLEEP CLINIC	90.01	7, 125	0	0		22.	
00	ANTI COAGULATI ON CLINIC	<u>90.</u> 02	26, 038	0		<u>)</u>	23.	
	0		450, 076	0				
	AE - PRACTICE MANAGEMENT							
00	OTHER ADMINISTRATIVE &	5.06	0	2, 753, 486	(	ס	1.	
	GENERAL				L	4		
	TOTALS		0	2, 753, 486				
	AF - HR ADMIN				1	-1		
00	EMPLOYEE BENEFITS DEPARTMENT		• •	<u>111, 6</u> 45 111, 645	<u> </u>	2	1.	

Health Financial Systems		IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173			Do		u of Form CMS-2 Worksheet A-7	
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CC	N: 15-01/3	Period: From 01/01/2021			
					To		Date/Time Pre	pared:
							5/26/2022 3:4	2 pm
			Acqui si ti		s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	3, 859, 566	0		0	0	.,	1.00
2.00	Land Improvements	394, 836	497, 007		0	497, 007		2.00
3.00	Buildings and Fixtures	191, 138, 584	0		0	0	20, 476, 101	3.00
4.00	Building Improvements	31, 113, 477	0		0	0	18, 215, 488	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	103, 143, 540	6, 060, 795		0	6, 060, 795	28, 778, 997	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	329, 650, 003	6, 557, 802		0	6, 557, 802	69, 410, 439	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	329, 650, 003	6, 557, 802		0	6, 557, 802	69, 410, 439	10.00
		Endi ng Bal ance	Fully					
		-	Depreciated					
			Assets					
		6.00	7.00				-	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	2, 221, 220	0					1.00
2.00	Land Improvements	590, 336	0					2.00
3.00	Buildings and Fixtures	170, 662, 483	0					3.00
4.00	Building Improvements	12, 897, 989	1, 281, 709					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	80, 425, 338	39, 926, 590					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	266, 797, 366	41, 208, 299					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	266, 797, 366	41, 208, 299					10.00

Health Financial Systems	IU HEALTH ARNE	ETT_HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part II Date/Time Pre 5/26/2022 3:4	pared:
		S	UMMARY OF CAF	PITAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	(	D	0 0	0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - NONHOSP	0	(	D	0 0	0	1.01
1.02 CAP REL COSTS INTEREST EXPENSE	0	(	D	0 0	0	1.02
2.00 CAP REL COSTS-MVBLE EQUIP	0	(	D	0 0	0	2.00
2.01 CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	(	D	0 0	0	2.01
3.00 Total (sum of lines 1-2)	0	(	D	0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1) (sum	n			
	Capi tal -Rel ate	of cols. 9				
	d Costs (see	through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORE	SHEET A, COLUM	N 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	(	C			1.00
1.01 CAP REL COSTS-BLDG & FIXT - NONHOSP	0	(	C			1.01
1.02 CAP REL COSTS INTEREST EXPENSE	0	(	C			1.02
2.00 CAP REL COSTS-MVBLE EQUIP	0	(	C			2.00
2.01 CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	(	C			2.01
3.00  Total (sum of lines 1-2)	0	(	)			3.00

Heal th	Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS	1	Provider C		Period: From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 3:42	pared: 2 pm
		COME	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		<b>I</b>	-	-		
1.00 1.01 1.02	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - NONHOSP CAP REL COSTS INTEREST EXPENSE	186, 372, 028 0 0			B         0.698553           0.00000         0.00000           0.000000         0.000000	0	1. 00 1. 01 1. 02
2. 00 2. 01	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - NONHOSP	80, 425, 339 0	0	80, 425, 33	0. 000000	0	2. 00 2. 01
3.00	Total (sum of lines 1-2)	266, 797, 367		2001111100			3.00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
-	PART III - RECONCILIATION OF CAPITAL COSTS CI				-		
1.00	CAP REL COSTS-BLDG & FIXT	0	-		5, 065, 054		1.00
1.01	CAP REL COSTS-BLDG & FIXT - NONHOSP CAP REL COSTS INTEREST EXPENSE	0	0		388, 078		1.01
1.02 2.00	CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP	0			0 7,358,998	0 479, 004	1.02 2.00
2.00	CAP REL COSTS-MVBLE EQUIP - NONHOSP	0			5 7, 338, 998 560, 005		2.00
3.00	Total (sum of lines 1-2)	0	0		13, 372, 135		3.00
			SL	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		r	1	1		
1.00	CAP REL COSTS-BLDG & FLXT	0				5, 941, 317	1.00
1.01	CAP REL COSTS-BLDG & FLXT - NONHOSP	0	01/200			510, 289	1.01
1.02	CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP	10, 516, 715			0 0	10, 516, 715	1.02
2.00 2.01	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - NONHOSP	1, 579				7, 849, 248 560, 623	2.00 2.01
2.01	Total (sum of lines 1-2)	10, 518, 294		4, 57		25, 378, 192	2.01
0.00		1 10,010,274	201,075	1 7, 57		20, 0, 0, 172	0.00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL
ADJUSTMENTS TO EXPENSES	Provider CCN: 15-01

In Lieu of Form CMS-2552-10 Worksheet A-8

	Financial Systems		IU HEALTH ARN			eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2021	Worksheet A-8	
					To 12/31/2021		
				Expense Classification of To/From Which the Amount is		5/26/2022 3: 42	2 pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
1.00	COSTS-BLDG & FLXT (chapter 2)		U	CAP REL COSTS-BEDG & FIXI	1.00	0	1.00
1.01	Investment income - CAP REL COSTS-BLDG & FIXT - NONHOSP (chapter 2)		0	CAP REL COSTS-BLDG & FIXT - NONHOSP	1.01	0	1. 01
1. 02	Investment income - CAP REL COSTS INTEREST EXPENSE (chapter 2)	В	116, 782	CAP REL COSTS INTEREST EXPENSE	1.02	11	1. 02
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
2. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - NONHOSP		C	CAP REL COSTS-MVBLE EQUIP - NONHOSP	2. 01	О	2. 01
3.00	(chapter 2) Investment income - other (chapter 2)		C		0.00	0	3.00
4.00	Trade, quantity, and time		0		0.00	0	4.00
5.00	di scounts (chapter 8) Refunds and rebates of expenses (chapter 8)		C		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)		C		0.00	О	7. OC
8.00	Television and radio service (chapter 21)		O		0.00		
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 562, 115		0.00	0 0	9. 00 10. 00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	39, 538, 792			0	
13.00 14.00	Laundry and linen service Cafeteria-employees and guests		0 0		0.00		
15.00	Rental of quarters to employee		0		0.00	0	15.00
16. 00	and others Sale of medical and surgical supplies to other than		O		0.00	0	16. OC
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18. 00	patients Sale of medical records and		0		0.00	0	18.00
	abstracts		0				
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		O		0.00	0	19. OC
20.00	Vending machines Income from imposition of		0		0.00		20.00 21.00
21.00	interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		O		0.00	0	22.00
23. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	O	RESPI RATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
26. 01	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1.01	0	26. 01
26. 02	COSTS-BLDG & FIXT - NONHOSP Depreciation - CAP REL COSTS		0	NONHOSP CAP REL COSTS INTEREST	1.02	0	26. 02
	INTEREST EXPENSE			EXPENSE			
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		U	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00

Heal th	Fi nanci al	Systems	
	MENTS TO D		

## 

Heal th	Financial Systems		IU HEALTH ARN	ETT HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:43	pared:
				Expense Classification on	Worksheet A	572072022 3.4.	
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.01	Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP -	2.01	0	27.01
20.00	COSTS-MVBLE EQUIP - NONHOSP			NONHOSP	10.00		20.00
28.00 29.00	Non-physician Anesthetist Physicians'assistant		(	*** Cost Center Deleted ***	19.00 0.00		28.00 29.00
	Adjustment for occupational	A-8-3	(	OCCUPATI ONAL THERAPY	67.00	0	30.00
	therapy costs in excess of		_				
	limitation (chapter 14)						
30.99	Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.99
31.00	instructions) Adjustment for speech	A-8-3	C	SPEECH PATHOLOGY	68.00		31.00
31.00	pathology costs in excess of	A-0-3	L. L. L.	SFEEdit FATTOLOGI	08.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		C		0.00	0	32.00
	Depreciation and Interest						
33.00	EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT		0	
33.01	HAF OFFSET	A	-18, 378, 894	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.01
33. 02	MI SCELLANEOUS I NCOME	В	-324, 959	OTHER ADMINISTRATIVE &	5.06	0	33. 02
00102		5	0217707	GENERAL	0.00	0	00102
33.03	MI SCELLANEOUS I NCOME	В	-4,573	OPERATION OF PLANT	7.00	0	33.03
33.04	MI SCELLANEOUS I NCOME	В	-165	OPERATION OF PLANT -	7.01	0	33.04
22 OF		D	257 400	NONHOSPI TAL	11 00	0	22.05
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		CAFETERIA NURSING ADMINISTRATION	11.00 13.00	0	
	MI SCELLANEOUS I NCOME	B		CENTRAL SERVICES & SUPPLY	14.00	-	
	MI SCELLANEOUS I NCOME	В		PHARMACY	15.00	0	
	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00	0	
	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69.00	0	
33. 11	MI SCELLANEOUS I NCOME	В		EMERGENCY	91.00	0	
33.12	TELEPHONE EXPENSE	Ā		OTHER ADMINI STRATI VE &	5.06	0	
				GENERAL			
33.13	NON-ALLOWABLE MARKETING	A		EMPLOYEE BENEFITS DEPARTMENT		0	
33.14	NON-ALLOWABLE MARKETING	A	-14, 501	OTHER ADMINISTRATIVE &	5.06	0	33.14
33. 15	NON-ALLOWABLE MARKETING	А	222	GENERAL PHARMACY	15.00	0	33. 15
33. 15 33. 16	NON-ALLOWABLE MARKETING	A		DELIVERY ROOM & LABOR ROOM	52.00	0	
33.10	UNWONTED SI TUATI ONS	A		OTHER ADMINISTRATIVE &	52.00	0	
55.17		~	-1,212	GENERAL	5.00	0	55.17
33. 18	UNWONTED SI TUATI ONS	А	-3, 972	ADULTS & PEDIATRICS	30.00	0	33. 18
	UNWONTED SITUATIONS	А		OPERATING ROOM	50.00	0	
33.20	UNWONTED SITUATIONS	A	-985	RECOVERY ROOM	51.00	0	33.20
33.21	UNWONTED SITUATIONS	A	-16	OUTPATIENT WOUND CARE CENTER	76.01	0	33. 21
33.22	UNWONTED SITUATIONS	A	-1, 131	EMERGENCY	91.00	0	33. 22
33.23	CONTRI BUTI ON EXPENSE	A	-958, 597	OTHER ADMINISTRATIVE &	5.06	0	33.23
22 24		Δ	201	GENERAL	7.00	~	22.24
33.24	CONTRI BUTI ON EXPENSE	A		OPERATION OF PLANT	7.00	0	
33. 25 33. 26	CONTRIBUTION EXPENSE	A A		PHARMACY	15.00	0	
33.20 33.27	RECRUI TMENT	A		OTHER ADMINISTRATIVE &	5.06	0	
55.21			2,0,007	GENERAL	0.00	0	
33. 28	RECRUI TMENT	А	-20,000	ADULTS & PEDIATRICS	30.00	0	33. 28
33. 29	RECRUI TMENT	А		INTENSIVE CARE UNIT	31.00	0	33. 29
	RECRUI TMENT	A		NEONATAL INTENSIVE CARE UNI		0	
33.31	RECRUITMENT	A		RECOVERY ROOM	51.00	0	
33.32	RECRUITMENT	A		ASC (NON-DISTINCT PART)	75.01	0	
33.33		A		EMERGENCY	91.00	0	
33.34	PRACTICE MGMT	A	4, 303, 044	OTHER ADMINISTRATIVE & GENERAL	5.06	0	33.34
33.35	RETAIL PHARMACY	А	6, 595, 398	RETAIL PHARMACY	193.01	0	33.35
	PRECEPTORS	A		I &R SERVICES-OTHER PRGM.	22.00	0	
				COSTS APPRVD			
	PRECEPTORS	A		EMPLOYEE BENEFITS DEPARTMENT	Г 4.00	0	
50.00	TOTAL (sum of lines 1 thru 49)		16, 032, 745				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)	1		1	1		1

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).

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

Health Financial Systems		IU HEALTH ARNI	ETT HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-0173	Period: From 01/01/2021	Worksheet A-8	
				To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
			Expense Classification c			
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	

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

Heal th	Financial Systems	IU HEALTH AR	NETT HOSPI TAL	In Lie	eu of Form CMS-:	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0173	Period: From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00		2.22		5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	IRANSACIIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1, 096, 472	498, 503	1.00
2.00	1. 02	CAP REL COSTS INTEREST EXPEN	HOME OFFICE ALLOCATION	10, 399, 933	0	2.00
3.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	1, 334, 633	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	14, 862, 394	0	4.00
4.01		ADMI TTI NG	HOME OFFICE ALLOCATION	0	140, 399	4.01
4.02	5.06	OTHER ADMINISTRATIVE & GENER	HOME OFFICE ALLOCATION	43, 683, 296	31, 199, 034	4.02
4.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	41, 818	41, 818	4.03
4.04	5.06	OTHER ADMINISTRATIVE & GENER	RELATED PARTY	277, 694	277, 694	4.04
4.05	13.00	NURSING ADMINISTRATION	RELATED PARTY	30, 739	30, 739	4.05
4.06	30.00	ADULTS & PEDIATRICS	RELATED PARTY	226	226	4.06
4.07	35.00	NEONATAL INTENSIVE CARE UNIT	RELATED PARTY	60, 000	60, 000	4.07
4.08	50.00	OPERATING ROOM	RELATED PARTY	381, 498	381, 498	4.08
4.09	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	17, 500	17, 500	4.09
4.10	59.00	CARDI AC CATHETERI ZATI ON	RELATED PARTY	132	132	4.10
4.11	60.00	LABORATORY	RELATED PARTY	11, 273, 746	11, 273, 746	4.11
4.12	63.00	BLOOD STORING, PROCESSING &	RELATED PARTY	13, 102	13, 102	4.12
4.13	66.00	PHYSI CAL THERAPY	RELATED PARTY	4,076	4, 076	4.13
4.14	70.00	ELECTROENCEPHALOGRAPHY	RELATED PARTY	12,000	12,000	4.14
4.15	76.01	OUTPATIENT WOUND CARE CENTER	RELATED PARTY	14	14	4.15
4.16	91.00	EMERGENCY	RELATED PARTY	228, 861	228, 861	4.16
5.00	0		0	83, 718, 134	44, 179, 342	5.00

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

			Related Organization(s) and/	or Home Office			
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 B I U HEALT	H 100. 00 I U HEALTH	100.00	6.00
7.00	0.00	0.00	7.00
8.00	0.00	0.00	8.00
9.00	0.00	0.00	9.00
10.00	0.00	0.00	10.00
100.00 G. Other (financial or		1	00.00
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 ARNETT	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED	O ORGANI ZATI ONS AND HOME	Provider CCN: 15-0173	From 01/01/2021	Worksheet A-8-1 Date/Time Prepared: 5/26/2022 3:42 pm
Net Wkst. A-7 Ref.				

	Net	WKST. A-/ Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CC	STS:		
1.00	597, 969	9		1.00
2.00	10, 399, 933	11		2.00
3.00	1, 334, 633	9		3.00
4.00	14, 862, 394	0		4.00
4.01	-140, 399	0		4.01
4.02	12, 484, 262	0		4.02
4.03	C	0		4.03
4.04	C	0		4.04
4.05	C	0		4.05
4.06	C	0		4.06
4.07	C	0		4.07
4.08	C	0		4.08
4.09	C	0		4.09
4.10	C	0		4.10
4.11	C	0		4.11
4.12	C	0		4.12
4.13	C	0		4.13
4.14	C	0		4.14
4.15	C	0		4.15
4.16	C	0		4. 16
5.00	39, 538, 792			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 no	been posted to worksheet A,	corumnis i and/or z, the amount arrowable should be thur cated th corumni 4 or this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	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.

i ei iibui			
6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10. 00 100. 00			10.00
100.00		1	00.00
(1) 1100	the following symbols to inc	licate interrelationship to related ergenizations:	

(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.

Heal th Financial	Systems	
	UNICL OL AN	

IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10

PROVIDER BASED PHYSICIAN ADJUSTMENT         Provider CCR: 15-013         Peroid Provider CR: 15-013         Peroid From 10/10/203         Dirksheet A.8-2 bit CR: 2023 242 pm           Image: State CR: 15-013         Cost Center/Physician Letter From 2000         Total Remueration         Provider CR: 15-013         REE anout Component         REE anout Received and 2000         The properties of 2000           1.00         2.00         3.00         4.00         5.00         6.00         7.00		D BASED DHVSICI		TO HEALTH AR	Provider (	CCN: 15-0173	Period:	Worksheet A-8	
To         12/31/2021         Date:/Time Prepared: // 000         To         12/31/2022         Date:/Time Prepared: // 000         Date:/Time Prepared:// 000         Date:/Time Prep	TROVIDE				i i ovidei (				
WKST. A Line #         Cost Center/Physician         Total Identifier         Total Returnation         Professional Component         Provident         REC Amount         Physician/Provi Identifier           1.00         2.00         3.00         4.00         5.00         6.00         7.20         7.30           1.00         5.00         0.00         2.00         13.00µU851KATUR         111,196         3.60         5.00         6.00         7.20         7.30         0         2.00         1.00         0.00         7.00         1.00         0							To 12/31/2021	Date/Time Pre	epared:
Ident IT år         Renuneration         Component         Component         i dår Component         i dår Component           1.00         5.06 (OTHER ADMINI STRATIVE & (EMERAL)         141.965         36.994         105.369         211.500         7.00         1.00           2.00         13.00 (MESK ADMINI STRATIVE & (EMERAL)         113.118         113.118         0.01         2.00         1.00         2.00         1.00         2.00         1.00         2.01         2.01         0.00<		Wkst Aline #	Cost Center/Physician	Total	Professional	Provi der	RCE Amount	Physician/Prov	+ <u>z pili</u>
Image: constraint of the second sec		WRSt. A LINC #							
1.00         2.00         3.00         4.00         5.00         6.00         7.00         7.34           2.00         13.00         000         141.965         36.596         105.06         211.500         0         2.00           3.00         22.00         13.00         000         13.00         113.118         0         211.500         0         2.00         171         3.00           4.00         30.00         20.01 & SERVI CES-OTHER PROM.         20.193         113.118         0         211.500         4.00         4.00           5.00         31.00         NETRIN VE CARE UNIT         2.114         20.193         115.00         4.00			r don't i r oi	Remarker are on	oomponent	oomponente			
1.00         5.06[0]HER ADMINISTRATIVE &         141,965         36,596         105,369         211,500         734         1.00           2.00         13.00NURSING ADMINISTRATION         113,118         0         211,500         0         2.00           3.00         22.00 [AS SERVICES-OTHER PROM COSTS APPRVD         20,193         114,426         0         211,500         0         0         2.00         173,000         173,000         173,000         0         0         0         2.01 [AS SERVICES-OTHER PROM COSTS APPRVD         20,193         179,000         171,500         <		1.00	2.00	3.00	4.00	5.00	6.00		
2.00         13.00/NURSI NG ADMINI STRATION COSTS APPRVD         113,118         113,118         113,118         0         211,500         0         2.00         0         2.00         177         3.00           4.00         30.00 (ADULTS & PEDIATRICS         314,426         314,426         0         211,500         4.380         5.00           5.00         31.00 (INTENSI VE CARE UNIT         811,691         357,891         453,800         2211,500         4.380         5.00         6.00         7.00         5.00 (ADULTS & PEDIATRICS         314,426         314,426         0         211,500         4.380         5.00         6.00         9.11,500         4.380         5.00         6.00         9.11,500         4.380         5.00         6.00         9.11,500         4.380         5.00         6.00         9.11,500         0         7.00         8.00         9.00         1.050,33         359,564         600,79         9         1.050         8.282         200.00         8.282         200.00         1.270,151         Provider         Physician         1.00         8.282         200.00         1.300         14.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00         10.00	1.00		OTHER ADMINISTRATIVE &	141, 965	36, 596	105, 369	211, 500		1.00
3.00         22.00 Irak SERVICES-OTHER PRGM. COSTS APPRVD         20.193         0         20.193         179,000         171         3.00           4.00         30.00[ADULTS & PEPLO ATRICS         314,426         314,426         314,426         0         211,500         0         4.00           6.00         35.00[ADULTS & PEDI ATRICS         811,601         35.00         211,500         0         6.00           7.00         55.00[ADURTAL INTENSI VE CARE UNI T         2.184         0         2211,500         0         0         0         0         0         0.00         3.50.012         3.543         8.00         9.00         0.00         0			GENERAL						
-         COSTS APPRVD         314,426         314,426         0         211,500         0 <th< td=""><td>2.00</td><td>13.00</td><td>NURSING ADMINISTRATION</td><td>113, 118</td><td>113, 118</td><td>C</td><td>211, 500</td><td>0</td><td>2.00</td></th<>	2.00	13.00	NURSING ADMINISTRATION	113, 118	113, 118	C	211, 500	0	2.00
4.00         30.00/ADULTS & PEDIATRICS         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         314, 426         317, 400         211, 500         0.0         4, 300         5.00           6.00         33.00/HEONATAL INTENSIVE CARE UNIT         2, 184         2, 184         0         211, 500         0         6.00         7.00         3, 543         8, 00         9.00         0	3.00			20, 193	0	20, 193	179, 000	171	3.00
5.00         33.00         INTENSIVE CARE UNIT         811.691         35.7.891         453.800         211.500         4.38.00         5.00           7.00         35.00         ONENTAL INTENSIVE CARE UNIT         2.184         0.211.500         0.600         0.00         0.00         0.00         0.00         0.00         239.400         0.700         0.00         0									
6.00         35.00NEONATAL INTERSIVE CARE UNIT 53.00AMESTHESI LOLOGY         2.184 3.166 0.00         0         0         211.500 0.00         0.00 <th< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>,</td><td></td><td></td></th<>							,		
7.00         53.00 [AMESTHES] OLOGY         3.166         3.166         0         239,400         0.0         7.00         7.00         200,00         201,000         0.00									
8.00         91.00[EMERGENCY         1,050,353         359,564         690,799         211,500         3,543         8.00         9.00         0.00         0									
9.00         0.00         0<									
10.00         0.00         0			EMERGENCY	1, 050, 353	359, 564				
200.00				0	0		-	, i i i i i i i i i i i i i i i i i i i	
West.         A Line         Cost Center/Physician Identifier         Unadjusted RCE Limit         5 Percent of Unadjusted RCE Limit         Cost of Component Continuing Education         Provider Share of col.         Prysician Cost of Mal practice Insurance           1.00         2.00         8.00         9.00         12.00         13.00         14.00           2.00         13.00 UNRSING ADMINISTRATION         0		0.00		0 457 000	1 104 047	-	-		
Identi fi or         Li mi t         Unadj usita RCE Li mi t         Membershi ps & Continuing Education         Component Share of col.         of 1.00         Mal practi ce Insurance           1.00         2.00         8.00         9.00         12.00         13.00         14.00           2.00         13.00 NURSI NA SDMI NI STRATI VE & GENERAL         74.635         3.732         0 <td< td=""><td></td><td>Wkct Alipo #</td><td>Cost Contor/Dhysician</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>		Wkct Alipo #	Cost Contor/Dhysician						
Linit         Continuing Education         Share of col Education         Insurance Education           1.00         2.00         8.00         9.00         12.00         13.00         14.00           1.00         5.06         OTHER ADMINISTRATIVE & GENERAL         74.635         3.732         0		WKSL A LINE #							
Image: Note of the second s			rdentifier						
1.00         2.00         8.00         9.00         12.00         13.00         14.00           1.00         5.06 OTHER ADMI NI STRATI VE & GENERAL         74,635         3,732         0								i nour unee	
1.00         5.06         OTHER ADMINI STRATI VE & GENERAL         74,635         3,732         0         0         0         1.00           2.00         13.00         AUNRSI MG ADMINI STRATI ON COSTS APPRVD         0		1.00	2.00	8,00	9,00			14.00	
2.00         13.00         NURSI NG ADMI NI STRATI ON COSTS APPRVD COSTS APPRVD         0	1.00	5.06		74, 635	3, 732	(	0 0	0	1.00
3.00         22.00         L&R SERVICES-OTHER PRGM. COSTS APPRVD         14,716         736 (0)         0         0         0         3.00           4.00         30.00         ADULTS PEDIATRICS         0 <td></td> <td></td> <td>GENERAL</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>			GENERAL						
4.00         30.00         AUDITS & PEDIATRICS         0 </td <td>2.00</td> <td>13.00</td> <td>NURSING ADMINISTRATION</td> <td>0</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td>2.00</td>	2.00	13.00	NURSING ADMINISTRATION	0	0	C	0	0	2.00
4.00         30.00         ADULTS & PEDIATRICS         0 </td <td>3.00</td> <td></td> <td></td> <td>14, 716</td> <td>736</td> <td>C</td> <td>0 0</td> <td>0</td> <td>3.00</td>	3.00			14, 716	736	C	0 0	0	3.00
5.00         31.00         INTENSI VE CARE UNIT         445, 370         22, 269         0         0         0         5.00           6.00         35.00         NEONATAL INTENSI VE CARE UNIT         0									
6.00         35.00         NEONATAL I NTENSI VE CARE UNI T         0				0	0	-	-	-	
7.00         53.00 ANESTHESI OLOGY         0         0         0         0         7.00           8.00         91.00 EMERGENCY         360,262         18,013         0         0         8.00           9.00         0.00         0 </td <td></td> <td></td> <td></td> <td>445, 370</td> <td>22, 269</td> <td></td> <td>·   ·</td> <td>-</td> <td></td>				445, 370	22, 269		·   ·	-	
8.00         91.00         EMERGENCY         360,262         18,013         0         0         0         8.00           9.00         0.00         0.00         0				0	0	-	-	-	
9.00         0.00 <th< td=""><td></td><td></td><td></td><td></td><td>10 010</td><td>-</td><td></td><td>-</td><td></td></th<>					10 010	-		-	
10.00 200.00         0.00 0         0.00 894,983         0 44,750         0 0         0			EMERGENCY	360, 262	18, 013			-	
200.00         Cost Center/Physician Identifier         Provider Component Share of col.         Adjusted RCE Limit         RCE Disal Iowance         Adjustment         Adjustment           1.00         2.00         15.00         16.00         17.00         18.00         100         1.00				0	0		0	-	
Wkst. A Line #         Cost Center/Physician Identifier         Provider Component Share of col.         Adjusted RCE Limit         RCE Disal Iowance         Adjustment           1.00         2.00         15.00         16.00         17.00         18.00           1.00         5.06         OTHER ADMINISTRATIVE & GENERAL         0         74,635         30,734         67,330         1.00           2.00         13.00         NURSI NG ADMINISTRATI ON GENERAL         0         0         0         113,118         2.00           3.00         22.00         I&R SERVI CES-OTHER PRGM. COSTS APPRVD         0         14,716         5,477         5,477         3.00           4.00         30.00         ADULTS & PEDI ATRICS         0         0         0         3445,370         8,430         366,321         5.00           6.00         35.00         NEONATAL INTENSI VE CARE UNIT         0         0         0         2,184         6.00           7.00         53.00         ARSTHESI OLOGY         0         360,262         330,527         690,091         80.00           9.00         0         0         0         0         0         0         9.00         0         0         0         0         0         0		0.00		001 002	44 750	-		-	
Identifier         Component Share of col.         Limit         Disal I owance         Image: Component Share of col.         Limit         Disal I owance         Image: Component Share of col.         Limit         Disal I owance         Image: Component Share of col.         Limit         Disal I owance         Image: Component Share of col.         Limit         Disal I owance         Image: Component Share of col.         Limit         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owance         Image: Component Share of col.         Limit Share of col.         Disal I owan		Wkst Aline #	Cost Center/Physician				-	0	200.00
Image: Constraint of the image: Constraint of th		WRSt. A EINC #					Auj us tiliont		
Image: Note of the state of the st			r denti i i ei		Li ili c	Disarromanee			
1.00         5.06         OTHER ADMINISTRATIVE & GENERAL         0         74,635         30,734         67,330         1.00           2.00         13.00         NURSING ADMINISTRATION         0         0         0         113,118         2.00           3.00         22.00         I&R SERVICES-OTHER PRGM. COSTS APPRVD         0         14,716         5,477         5,477         3.00           4.00         30.00         ADULTS & PEDIATRICS         0         0         0         314,426         4.00           5.00         31.00         INTENSI VE CARE UNIT         0         445,370         8,430         366,321         5.00           6.00         35.00         NEONATAL INTENSI VE CARE UNIT         0         0         0         3.168         7.00           7.00         53.00         ANSTHESI OLOGY         0         360,262         330,527         690,091         8.00           9.00         0.00         0         0         0         0         0         9.00           10.00         0         0         0         0         0         0         9.00									
GENERAL         General <t< td=""><td></td><td>1.00</td><td>2.00</td><td>15.00</td><td>16.00</td><td>17.00</td><td>18.00</td><td>1</td><td></td></t<>		1.00	2.00	15.00	16.00	17.00	18.00	1	
2.00         13.00         NURSI NG ADMI NI STRATI ON         0         0         0         113, 118         2.00           3.00         22.00         I & SERVI CES-OTHER PRGM. COSTS APPRVD         0         14, 716         5, 477         5, 477         3.00           4.00         30.00         ADULTS & PEDI ATRI CS         0         0         0         314, 426         4.00           5.00         31.00         INTENSI VE CARE UNI T         0         445, 370         8, 430         366, 321         5.00           6.00         35.00         NEONATAL INTENSI VE CARE UNI T         0         0         0         2, 184         6.00           7.00         53.00         ANESTHESI OLOGY         0         0         31, 168         7.00           8.00         91.00         EMERGENCY         0         360, 262         330, 527         690, 091         8.00           9.00         0.00         0         0         0         0         9.00         10.00	1.00			0	74, 635	30, 734	67, 330		1.00
3. 00         22. 00         I &R SERVICES-OTHER PRGM. COSTS APPRVD         0         14, 716         5, 477         5, 477         3. 00           4. 00         30. 00 ADULTS & PEDI ATRICS         0         0         0         314, 426         4.00           5. 00         31. 00 I NTENSI VE CARE UNIT         0         445, 370         8, 430         366, 321         5.00           6. 00         35. 00 NEONATAL I NTENSI VE CARE UNIT         0         0         0         2, 184         6.00           7. 00         53. 00 ADUETS I OLOGY         0         0         31, 168         7.00           8. 00         91. 00 EMERGENCY         0         360, 262         330, 527         690, 091         8.00           9. 00         0. 00         0         0         0         0         9.00         10.00         10.00									
COSTS APPRVD         COSTS APPRVD           4.00         30.00 ADULTS & PEDI ATRI CS         0         0         314,426         4.00           5.00         31.00 INTENSI VE CARE UNI T         0         445,370         8,430         366,321         5.00           6.00         35.00 NEONATAL INTENSI VE CARE UNI T         0         0         0         2,184         6.00           7.00         53.00 ANESTHESI OLOGY         0         0         3,168         7.00           8.00         91.00 EMERGENCY         0         360,262         330,527         690,091         8.00           9.00         0.00         0         0         0         0         9.00         10.00         9.00           10.00         0.00         0         0         0         0         0         9.00				-	-	-			
4.00       30.00       ADULTS & PEDIATRICS       0       0       314,426       4.00         5.00       31.00       INTENSI VE CARE UNIT       0       445,370       8,430       366,321       5.00         6.00       35.00       NEONATAL INTENSI VE CARE UNIT       0       0       0       2,184       6.00         7.00       53.00       ANESTHESI OLOGY       0       0       3,168       7.00         8.00       91.00       EMERGENCY       0       360,262       330,527       690,091       800         9.00       0.00       0       0       0       0       9.00       10.00       10.00	3.00			0	14, 716	5, 477	5, 477		3.00
5.00         31.00         INTENSI VE CARE UNIT         0         445,370         8,430         366,321         5.00           6.00         35.00         NEONATAL INTENSI VE CARE UNIT         0         0         0         2,184         6.00           7.00         53.00         ANESTHESI OLOGY         0         0         0         3,168         7.00           8.00         91.00         EMERGENCY         0         360,262         330,527         690,091         8.00           9.00         0.00         0         0         0         0         9.00         10.00	1 00				_				1.00
6.00         35.00         NEONATAL INTENSIVE CARE UNIT         0         0         2,184         6.00           7.00         53.00         ANESTHESI OLOGY         0         0         0         3,168         7.00           8.00         91.00         EMERGENCY         0         360,262         330,527         690,091         8.00           9.00         0.00         0         0         0         0         9.00           10.00         0.00         0         0         0         0         10.00				0		-			
7.00         53.00         ANESTHESI OLOGY         0         0         3,168         7.00           8.00         91.00         EMERGENCY         0         360,262         330,527         690,091         8.00           9.00         0.00         0         0         0         9.00         10.00         9.00					445, 3/0				
8.00         91.00         EMERGENCY         0         360, 262         330, 527         690, 091         8.00           9.00         0.00         0         0         0         0         9.00           10.00         0.00         0         0         0         0         9.00						C C			
9.00         0.00         0         0         0         9.00           10.00         0.00         0         0         0         0         10.00					260 262				
10.00 0.00 0 0 0 10.00								1	
							-		
		0.00		n	894 983	-	-		
	_00.00	I I		. 0		0,0,100	., 552, 115	I	

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH ARNE	Provi der C		eri od:	u of Form CMS-2 Worksheet B	2552-10
				F T	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	
				CAPITAL RE	LATED COSTS	5/26/2022 3:4	<u>2 pm</u>
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT -	CAP REL COSTS	MVBLE EQUIP	
		for Cost Allocation		NONHOSP	I NTEREST EXPENSE		
		(from Wkst A			LAFLINGL		
		col. 7) 0	1.00	1.01	1. 02	2.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	5 041 217	E 041 217	1			1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP	5, 941, 317 510, 289	5, 941, 317 0				1.00
1.02 2.00	00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP	10, 516, 715	0	0	10, 516, 715	7 940 249	1.02 2.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	7, 849, 248 560, 623				7, 849, 248 0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 873, 270	0	0	0	0	4.00
5.01 5.06	00570 ADMI TTI NG 00590 OTHER ADMI NI STRATI VE & GENERAL	791, 406 54, 959, 997	17, 941 196, 206		31, 758 347, 304	23, 703 259, 213	
7.00	00700 OPERATION OF PLANT	10, 815, 535	1, 093, 857		1, 936, 235	1, 445, 127	
7.01 8.00	00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE	658, 909 0	0	7,839 0	0	0	
9.00	00900 HOUSEKEEPI NG	2, 737, 918	76, 583		135, 559	101, 175	
10.00 11.00	01000 DI ETARY 01100 CAFETERI A	1, 357, 414 599, 151	120, 952 93, 255		214, 098 165, 071	159, 794 123, 202	
13.00	01300 NURSING ADMINISTRATION	11, 967, 467	67, 627	0	119, 706	89, 344	13.00
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	10, 419, 597 5, 484, 864	303, 385 67, 461		537, 022 119, 412	400, 811 89, 125	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
	01700 SOCIAL SERVICE 01850 PATIENT TRANSPORT SERVICES	620, 930 636, 906	0 19, 270	0	0 34, 110	0 25, 458	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	1, 000, 111	19,270	0	0	23, 430	
22.00 23.00	02200 I & SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM - PHARMACY	998, 380 226, 581	0 2, 099	82, 629 5	0 3, 716	0 2, 773	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	220, 581	2,099	ή <u>5</u>	3,710	2,113	23.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	33, 016, 632	1, 690, 377		2, 992, 127	2, 233, 205	
33.00	03300 BURN INTENSIVE CARE UNIT	5, 649, 712 0	169, 219 0	0	299, 534 0	223, 560 0	1
33.01	03301 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
35.00 43.00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	2, 982, 395 796, 477	134, 952 64, 501		238, 878 114, 173	178, 289 85, 214	
50.00	ANCI LLARY SERVI CE COST CENTERS	6, 665, 885	459, 329	0	813, 058	606, 833	50.00
51.00	05100 RECOVERY ROOM	876, 968	439, 329 69, 756		123, 476	92, 157	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2, 945, 466	216, 020		382, 376 32, 506	285, 390	
53.00	05301 ASC ANESTHESI OLOGY	6, 520, 135 9, 812	18, 364 0	691	32, 500 0	24, 261 0	53.00 53.01
	05400 RADI OLOGY-DI AGNOSTI C	5, 035, 195 0	257, 294	0	455, 435	339, 918	
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	433, 339	31, 865	-	0 56, 405	0 42, 098	
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 650, 607	95, 475		169, 001	126, 135	
60.00 63.00	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	11, 282, 420 891, 208	136, 281 9, 711		241, 231 17, 189	180, 045 12, 829	1
65.00	06500 RESPI RATORY THERAPY	2, 675, 651	13, 229	0	23, 417	17, 478	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	645, 810 471, 531	8, 653 6, 373		15, 318 11, 281	11, 432 8, 420	
68.00	06800 SPEECH PATHOLOGY	331, 084	4, 969	0	8, 795	6, 564	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	1, 380, 120 88, 166	36, 894 0	0	65, 307 0	48, 742 0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 857, 614	0	0	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	8, 574, 931 39, 293, 201	0	0	0	0	
	07400 RENAL DI ALYSI S	726, 282	23, 302	0	41, 248	30, 786	
	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
	07501 ASC (NON-DI STINCT PART) 03950 CARDI AC CATHERI ZATI ON	4, 566, 534 0	0	199, 738 0	0	0 0	
76.01	03951 OUTPATIENT WOUND CARE CENTER	838, 284	0	0	0	0	76.01
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	558	0	15, 125	0	0	76.97
	09000 CLI NI C	0	0	0	0	0	
	04950 SLEEP CLINIC 09001 ANTI COAGULATI ON CLINIC	525, 143 83, 188	0 0	18, 080 6, 861	0	0	
90.03	09002 ARNETT CANCER CARE CENTER	1, 460, 349	0	67, 446	0	0	90.03
90.04	09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY	51, 344 10, 223, 262	8, 940 311, 993		15, 825 552, 259	11, 811 412, 184	
91,00			011, //0		002,207	112, 104	1 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92.00 92.01

Health Financial Systems	IU HEALTH ARNE	TT_HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
					5/26/2022 3:4	
			CAPITAL RE	LATED COSTS		
Cost Center Description	Net Expenses	BLDG & FIXT		CAP REL COSTS	MVBLE EQUIP	
	for Cost		NONHOSP	INTEREST		
	Allocation			EXPENSE		
	(from Wkst A col. 7)					
	0	1.00	1, 01	1. 02	2.00	
SPECIAL PURPOSE COST CENTERS	-					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	303, 075, 931	5, 826, 133	497, 683	10, 312, 830	7, 697, 076	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	110, 894	34, 554	. C	61, 163	45, 650	190. 00
191. 00 19100 RESEARCH	0	0	) (	0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	683, 059	0		0 0	-	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
193.01 19301 RETALL PHARMACY	6, 726, 975			32, 292		193. 01
193. 02 19302 WHI TE HOSPI TAL	2, 120, 998		6, 096	60, 227		193. 02
193. 03 19303 HOSPI CE	5, 280			0 0		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	1, 510, 646	28, 362	6, 510	50, 203		193. 04
194.0007950 MARKETI NG/PUBLIC RELATIONS	0	C	0 0	0 0	0	194.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0 0	0 0		201.00
202.00   TOTAL (sum lines 118 through 201)	314, 233, 783	5, 941, 317	510, 289	10, 516, 715	7, 849, 248	202.00

ST ALI	LOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre	par
					10 12/01/2021	5/26/2022 3:4	
	Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP -	EMPLOYEE	ADMI TTI NG	Subtotal	OTHER	
		NONHOSP	BENEFI TS DEPARTMENT			ADMI NI STRATI VE & GENERAL	
		2.01	4.00	5.01	5A. 01	5.06	-
	ENERAL SERVICE COST CENTERS				l		
	0100 CAP REL COSTS-BLDG & FIXT						1
	0101 CAP REL COSTS-BLDG & FIXT - NONHOSP 0102 CAP REL COSTS INTEREST EXPENSE						1
	0200 CAP REL COSTS INTEREST EXTENSE						2
01 0	0201 CAP REL COSTS-MVBLE EQUIP - NONHOSP	560, 623					2
	0400 EMPLOYEE BENEFITS DEPARTMENT	0	15, 873, 270				4
		3,089	50, 137	920, 84			
	0590 OTHER ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	104, 314	1, 283, 594 262, 523		0 57, 245, 576 0 15, 553, 277	57, 245, 576 3, 464, 586	
	0701 OPERATION OF PLANT - NONHOSPITAL	8, 612	202, 020		0 675, 360	150, 440	
0 0	0800 LAUNDRY & LINEN SERVICE	0	0		0 0	0	8
	10900 HOUSEKEEPI NG	905	243, 148		0 3, 296, 112	734, 229	
	11000 DI ETARY 11100 CAFETERI A	0	109, 159 78, 937		0 1, 961, 417 0 1, 059, 616	436, 917 236, 036	
	1300 NURSI NG ADMI NI STRATI ON	0	1, 818, 343		0 14, 062, 487	3, 132, 503	
	1400 CENTRAL SERVICES & SUPPLY	461	81, 004		0 11, 742, 700	2, 615, 757	
	1500 PHARMACY	292	770, 555		0 6, 531, 975	1, 455, 037	15
	1600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16
	11700 SOCIAL SERVICE 11850 PATIENT TRANSPORT SERVICES	0	107, 573 107, 285		0 728, 503 0 823, 029	162, 278 183, 335	
	12100 I &R SERVICES-SALARY & FRINGES APPRVD	0	107, 285		0 1,000,111	222, 781	
	2200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	90, 780	148, 797		0 1, 320, 586	294, 168	
	2300 PARAMED ED PRGM - PHARMACY	6	38, 103		0 273, 283	60, 875	23
	NPATIENT ROUTINE SERVICE COST CENTERS		0.404.044		0 40 745 005	0 707 7//	
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	0	3, 684, 311 667, 175	98, 68 14, 95		9, 737, 766 1, 564, 672	30
	3300 BURN INTENSIVE CARE UNIT	0	007, 173		0 7,024,131	1, 304, 072	33
01 0	3301 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33
	2060 NEONATAL INTENSIVE CARE UNIT	0	361, 135	8, 63		869, 702	
	14300 NURSERY NCI LLARY SERVI CE COST CENTERS	0	130, 751	2, 08	5 1, 193, 201	265, 793	43
	5000 OPERATI NG ROOM	0	888, 577	92, 40	4 9, 526, 086	2, 121, 993	50
	5100 RECOVERY ROOM	0	147, 696	7, 59		293, 514	51
	5200 DELIVERY ROOM & LABOR ROOM	0	461, 577	14, 51		959, 040	
	15300 ANESTHESI OLOGY 15301 ASC ANESTHESI OLOGY	0 759	30, 092 301	5, 23 2, 41		1, 477, 004 3, 114	
	15400 RADI OLOGY-DI AGNOSTI C	0	750, 865	62, 34		1, 537, 251	54
	5500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55
	15600 RADI OI SOTOPE	0	53, 502	9, 21		139, 539	
	5900 CARDI AC CATHETERI ZATI ON	0	243, 349	38, 11			
	6000 LABORATORY 6300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	1, 219	49, 25 3, 05		2, 648, 669 208, 052	
	6500 RESPI RATORY THERAPY	0	404, 937	13, 30		701, 239	
00 0	6600 PHYSI CAL THERAPY	0	109, 412	2, 15		176, 597	66
	6700 OCCUPATIONAL THERAPY	0	71, 066	1, 35		126, 977	
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	53, 317	1, 05 21 10		90, 391 392, 017	
	17000 ELECTROENCEPHALOGRAPHY	0	207, 588 15, 560	21, 19 36		23, 186	
00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	35, 43		1, 758, 223	
00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	68, 50		1, 925, 377	
	7300 DRUGS CHARGED TO PATIENTS	0	0	145, 55		8, 785, 220	
	17400 RENAL DIALYSIS 17500 ASC (NON-DISTINCT PART)	0	0	1, 43	9 823, 057 0 0	183, 341 0	74   75
	7501 ASC (NON-DI STINCT PART)	219, 439	577, 028	76, 11	-	1, 256, 088	
00 0	3950 CARDI AC CATHERI ZATI ON	0	0		0 0	0	76
	3951 OUTPATIENT WOUND CARE CENTER	0	25, 755	7, 13		194, 059	
	17697 CARDIAC REHABILITATION	16, 617	99		0 32, 399	7, 217	76
	UTPATI ENT SERVI CE COST CENTERS	0	0		0 0	0	90
	4950 SLEEP CLINIC	19, 863	76, 130	3, 21	-	143, 104	90
	9001 ANTI COAGULATI ON CLINIC	7, 538	13, 957	33		24, 921	90
	9002 ARNETT CANCER CARE CENTER	74, 099	179, 506	17, 61		400, 740	
	19003 OUTPATIENT INFUSION CENTER 19100 EMERGENCY	0	8, 528 1, 063, 337	45 117, 08		21, 585 2, 824, 573	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)		7,000,007	117,00	0	2, 024, 373	92
	9201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	
00 0	4951 OTHER OUTPATIENT SERVICES	0	0		0 0	0	93
	PECIAL PURPOSE COST CENTERS						

Health Financial Systems	IU HEALTH ARNE	TT HOSPITAL		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2021	Worksheet B Part I
				To 12/31/2021	Date/Time Prepared:
					5/26/2022 3:42 pm
	CAPITAL				
	RELATED COSTS				
Cost Center Description	MVBLE EQUIP - NONHOSP	EMPLOYEE BENEFITS	ADMI TTI NG	Subtotal	OTHER ADMI NI STRATI VE
	NUNHUSP	DEPARTMENT			& GENERAL
	2.01	4.00	5.01	5A. 01	5.06
NONREI MBURSABLE COST CENTERS	2.01	4.00	5.01	5A. 01	3.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 562		0 258, 823	57, 654 190. 00
191. 00 19100 RESEARCH	0	0		0 0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	112, 502		2 795, 563	177, 216 192. 00
193. 00 19300 NONPALD WORKERS	0	0		0 0	0 193.00
193. 01 19301 RETALL PHARMACY	0	188	5	6, 801, 856	1, 515, 154 193. 01
193. 02 19302 WHI TE HOSPI TAL	6, 697	252, 441		0 2, 525, 435	562, 556 193. 02
193. 03 19303 HOSPI CE	0	0		0 5, 280	1, 176 193. 03
193. 04 19304 FRANKFORT HOSPI TAL	7, 152	175, 649		0 1, 815, 991	
194.0007950 MARKETI NG/PUBLIC RELATIONS	0	0		0 0	0 194.00
200.00 Cross Foot Adjustments				0	200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00  TOTAL (sum lines 118 through 201)	560, 623	15, 873, 270	920, 84	5 314, 233, 783	57, 245, 576 202. 00

DOOT 1	Financial Systems	IU HEALTH ARNE				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: rom 01/01/2021	Worksheet B Part I	
		-		Т	o 12/31/2021	Date/Time Pre 5/26/2022 3:43	
	Cost Center Description	OPERATION OF PLANT	OPERATI ON OF PLANT - NONHOSPI TAL	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		7.00	7.01	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP						1.01
1.02	00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01 4.00	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.01 4.00
5.01	00570 ADMI TTI NG						5.01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL						5.06
7.00	00700 OPERATION OF PLANT	19, 017, 863	0.25 0.00				7.00
7.01 8.00	00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE	0	825, 800 0	0			7.01 8.00
9.00	00900 HOUSEKEEPI NG	314, 340	1, 681		4, 346, 362		9.00
10.00	01000 DI ETARY	496, 460	0		92, 158	2, 986, 952	
11.00	01100 CAFETERIA	382, 775	0	1	71,054	0	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	277, 581 1, 245, 273	857		51, 527 232, 068	0	13.00 14.00
15.00	01500 PHARMACY	276, 900	542			0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	0 0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	C	0	0	17.00
18.00 21.00	01850 PATIENT TRANSPORT SERVICES 02100 I&R SERVICES-SALARY & FRINGES APPRVD	79, 096 0	0		14, 683	0	18.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	168, 611		178, 907	0	22.00
23.00	02300 PARAMED ED PRGM - PHARMACY	8, 616	11	с с	1, 611	0	23.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	( 020 200	0		1 207 051	2 (0( 101	20.00
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	6, 938, 299 694, 574	0			2, 696, 191 228, 981	30.00 31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33.00
33.01	03301 BURN INTENSIVE CARE UNIT	0	0	C	0	0	33.01
35.00 43.00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	553, 923 264, 750	0			0	35.00 43.00
43.00	ANCI LLARY SERVICE COST CENTERS	204,730	0	1 <u> </u>	47, 145	0	43.00
50.00	05000 OPERATING ROOM	1, 885, 360	0			0	
51.00	05100 RECOVERY ROOM	286, 322	0			0	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	886, 674 75, 377	0		164, 592 13, 992	61, 780 0	52.00 53.00
53.01	05301 ASC ANESTHESI OLOGY	0	1, 410		1, 496	0	53.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 056, 086	0	C	196, 040	0	54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 130, 794	0		0 0 24, 279	0	55.00 56.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	391, 887	0		72, 746	0	59.00
60.00	06000 LABORATORY	559, 378	0	C	103, 837	0	
	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	39, 858	0	C	7, 399	0	63.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	54, 301 35, 519	0		0 10, 080 0 6, 593	0	65.00 66.00
67.00	06700 OCCUPATI ONAL THERAPY	26, 159	0		4, 856	0	67.00
68.00	06800 SPEECH PATHOLOGY	20, 394	0	C	3, 786	0	68.00
69.00		151, 436	0	C	28, 111	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	70.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	0 0	0	73.00
74.00	07400 RENAL DIALYSIS	95, 647	0	C	17, 755	0	74.00
75.00 75.01	07500 ASC (NON-DI STINCT PART) 07501 ASC (NON-DI STINCT PART)	0	0 407, 579		0 432, 469	0	75.00 75.01
	03950 CARDI AC CATHERI ZATI ON	0	-07, 379		, +32, 409	0	76.00
76.01	03951 OUTPATIENT WOUND CARE CENTER	0	0	C	0	0	76. 01
76.97	07697 CARDI AC REHABI LI TATI ON	0	30, 864	C	32, 748	0	76.97
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	l c	ol	0	90.00
90.00 90.01	04950 SLEEP CLINIC	0	36, 893		39, 146	0	90.00
90.02	09001 ANTI COAGULATI ON CLINIC	0	14, 000	C	14, 855	0	90. 02
	09002 ARNETT CANCER CARE CENTER	0	137, 628	C	146,032	0	90.03
90.03	09003 OUTPATIENT INFUSION CENTER	36, 697 1, 280, 606	0		6, 812 237, 718	0	90.04 91.00
90.04	09100 EMERGENCY	1, 200, 000	0		207,710	0	92.00
90.04	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)						
90. 04 91. 00 92. 00 92. 01	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	C	0	0	
90. 04 91. 00 92. 00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 09201 OBSERVATI ON BEDS (DI STI NCT PART) 04951 OTHER OUTPATI ENT SERVI CES	0	0		-	0 0	
90. 04 91. 00 92. 00 92. 01	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 09201 OBSERVATI ON BEDS (DI STINCT PART) 04951 OTHER OUTPATI ENT SERVI CES SPECIAL PURPOSE COST CENTERS	0	0		0	0	93.00
90. 04 91. 00 92. 00 92. 01 93. 00 118. 00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 09201 OBSERVATI ON BEDS (DI STINCT PART) 04951 OTHER OUTPATI ENT SERVICES SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONRELMBURSABLE COST CENTERS	0	-	C	4, 231, 307	0	93. 00 118. 00
90. 04 91. 00 92. 00 92. 01 93. 00 118. 00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 09201 OBSERVATI ON BEDS (DI STINCT PART) 04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	0	C	0 4, 231, 307 26, 327	0 2, 986, 952 0	93.00

Health Financial Systems	IU HEALTH ARNE	TT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part     Date/Time Pre	nared
				10 12/31/2021	5/26/2022 3: 4	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT -	LINEN SERVICE			
		NONHOSPI TAL				
	7.00	7.01	8.00	9.00	10.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 RETAIL PHARMACY	74, 881	0		0 13, 900	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	139, 659	12, 439		0 39, 123	0	193. 02
193. 03 19303 HOSPI CE	0	0		0 0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	116, 413	13, 285		0 35, 705	0	193. 04
194.00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	19, 017, 863	825, 800		0 4, 346, 362	2, 986, 952	202.00

ST AL	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH ARN	Provi der CC		eri od:	u of Form CMS-2 Worksheet B	
				F	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pare
						5/26/2022 3:4	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDICAL RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1.
	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP						1.
	00102 CAP REL COSTS INTEREST EXPENSE						1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 4.
	00570 ADMI TTI NG						5.
	00590 OTHER ADMINISTRATIVE & GENERAL						5.
	00700 OPERATION OF PLANT						7.
	00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE						7.
	00900 HOUSEKEEPI NG						9.
	01000 DI ETARY						10.
		1, 749, 481	1				11.
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	88, 289 18, 994		15, 891, 258			13.
	01500 PHARMACY	102, 672		83, 044	8, 502, 146		15.
	01600 MEDI CAL RECORDS & LI BRARY	C	-	0	0	0	
	01700 SOCIAL SERVICE	19,629		0	0	0	
	01850 PATIENT TRANSPORT SERVICES 02100 I&R SERVICES-SALARY & FRINGES APPRVD	33, 377 29, 320		4, 734 0	0	0	18.
	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	8, 298		0	0	0	
	02300 PARAMED ED PRGM - PHARMACY	5, 942		0	0	0	23.
	INPATIENT ROUTINE SERVICE COST CENTERS		0 (57 400	500.047	F ( 700		1
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	515, 654 70, 606		509, 017 105, 524	56, 702 25, 014	0	
	03300 BURN INTENSIVE CARE UNIT	,0,000		000, 024	23, 014	0	
	03301 BURN INTENSIVE CARE UNIT	C	0	0	0	0	33
	02060 NEONATAL INTENSIVE CARE UNIT	46, 285		39, 125	3, 662	0	35.
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	16, 719	276, 907	0	0	0	43.
	05000 OPERATI NG ROOM	125, 989	1, 469, 807	2, 952, 555	29, 139	0	50.
	05100 RECOVERY ROOM	21, 227		22, 698	795	0	51.
	05200 DELIVERY ROOM & LABOR ROOM	63, 763		116, 045	10, 629	0	
	05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY	6, 270	47, 791	152, 442 42, 357	16, 131 1, 375	0	53. 53.
	05400 RADI OLOGY-DI AGNOSTI C	105, 766	409, 503	755, 395	31, 909	0	54.
	05500 RADI OLOGY-THERAPEUTI C	C	0	0	0	0	55.
	05600 RADI OI SOTOPE	6, 987	1	6, 056	2, 158	0	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	34, 647 80, 830		521, 131 38, 545	9, 605 38	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	00,000	0	0	0	0	63.
. 00	06500 RESPI RATORY THERAPY	51, 838	46, 854	429, 956	0	0	65.
	06600 PHYSI CAL THERAPY	15, 183		88	0	0	66.
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	9, 999 6, 823		50 517	0	0	67
	06900 ELECTROCARDI OLOGY	37, 106		3, 291	1, 597	0	
	07000 ELECTROENCEPHALOGRAPHY	2, 110		0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	4, 506, 452	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	4, 917, 835	0 100 475	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS			2, 086	8, 198, 475 130	0	
	07500 ASC (NON-DI STI NCT PART)		0	2,000	0	0	75.
. 01	07501 ASC (NON-DI STI NCT PART)	C	0	416, 769	15, 486	0	75.
	03950 CARDI AC CATHERI ZATI ON	0	0	0	0	0	
	03951 OUTPATIENT WOUND CARE CENTER 07697 CARDIAC REHABILITATION		0	11, 789 0	0	0	
	OUTPATIENT SERVICE COST CENTERS		<u>/</u>	0	0	0	1 /0
00	09000 CLI NI C	C	0	0	0	0	
	04950 SLEEP CLINIC	C	0	16, 087	0	0	
	09001 ANTI COAGULATI ON CLINI C			0	0	0	
	09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER	28, 849		39, 322 417	30, 604 467	0	90 90
	09100 EMERGENCY	150, 064		196, 035	68, 188	0	91
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	09201 OBSERVATION BEDS (DISTINCT PART)	0		0	0	0	
	04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	93.
8. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 704, 179	17, 612, 387	15, 889, 362	8, 502, 104	0	118.
Į	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,049	0	0	0	0	190.

Health Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	nared
				10 12/31/2021	5/26/2022 3: 4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	1, 89	6 42	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193.01 19301 RETAIL PHARMACY	0	0		0 0	0	193.01
193. 02 19302 WHI TE HOSPI TAL	25, 591	0		0 0	0	193. 02
193. 03 19303 HOSPI CE	0	0		0 0	0	193.03
193. 04 19304 FRANKFORT HOSPI TAL	17, 662	0		0 0	0	193.04
194.0007950 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	1, 749, 481	17, 612, 387	15, 891, 25	8 8, 502, 146	0	202.00

ST ALLO	nancial Systems CATION - GENERAL SERVICE COSTS	IU HEALTH ARNI		1	Period: From 01/01/2021 To 12/31/2021		epared
	· ·		OTHER GENERAL	INTERNS 8	RESI DENTS	5/26/2022 3:4	2 pm
			SERVI CE				
	Cost Center Description	SOCI AL SERVI CE			RSERVI CES-OTHER		
			TRANSPORT SERVI CES	Y & FRINGES	PRGM. COSTS	PRGM - PHARMACY	
		17.00	18.00	21.00	22.00	23.00	
	IERAL SERVICE COST CENTERS	1		l		1	
	100 CAP REL COSTS-BLDG & FLXT						1.0
	IO1 CAP REL COSTS-BLDG & FLXT - NONHOSP IO2 CAP REL COSTS INTEREST EXPENSE						1.0
	200 CAP REL COSTS INTEREST EXPENSE						2.0
	201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2.0
00 004	400 EMPLOYEE BENEFITS DEPARTMENT						4.0
	570 ADMI TTI NG						5.0
	590 OTHER ADMINI STRATI VE & GENERAL						5.0
	700 OPERATION OF PLANT 701 OPERATION OF PLANT - NONHOSPITAL						7.0
	300 LAUNDRY & LINEN SERVICE						8.0
	POO HOUSEKEEPING						9.0
	DOO DI ETARY						10.0
	100 CAFETERIA						11. (
	300 NURSI NG ADMI NI STRATI ON						13.0
	400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY						14.0
	500 MEDICAL RECORDS & LIBRARY						16.0
	700 SOCIAL SERVICE	910, 410					17.0
	350 PATIENT TRANSPORT SERVICES	0	1, 138, 254				18. (
	100 I & R SERVICES-SALARY & FRINGES APPRVD	0	C				21.
	200 I & R SERVI CES-OTHER PRGM. COSTS APPRVD	0	C		1, 970, 570		22.0
	300 PARAMED ED PRGM - PHARMACY PATIENT ROUTINE SERVICE COST CENTERS	0	C	ער ער ער ער		350, 338	23.0
	DOO ADULTS & PEDIATRICS	735, 516	122, 056	1, 031, 66	2 1, 623, 498	0	30.
	100 I NTENSI VE CARE UNI T	62, 466			0 0	0	
. 00 033	BOO BURN INTENSIVE CARE UNIT	0	C		0 C	0	33.
	BURN INTENSIVE CARE UNIT	0	C		0 0	0	
	DECONTRACTION NET THE PROVIDE CARE UNIT	52, 163					
	300 NURSERY CI LLARY SERVI CE COST CENTERS	43, 411	2, 578	3	0 0	0	43.0
	DOO OPERATI NG ROOM	0	114, 290	33, 26	5 52, 348	0	50.0
. 00 051	IOO RECOVERY ROOM	0	9, 394		o c		51.
	200 DELIVERY ROOM & LABOR ROOM	16, 854	17, 948				
	300 ANESTHESI OLOGY	0	6, 474		0 0	-	
	301 ASC ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	0	2, 989 77, 110			0	
	500 RADI OLOGY-THERAPEUTI C	0				0	
	500 RADI OI SOTOPE	0	11, 393	3	0 0	-	
. 00 059	200 CARDI AC CATHETERI ZATI ON	0	47, 142		0 C	0	59.
	DOO LABORATORY	0	60, 918		0 0	0	
	BLOOD STORING, PROCESSING & TRANS.	0	3, 779		0 0	0	
	500 RESPI RATORY THERAPY 500 PHYSI CAL THERAPY	0	16, 450 2, 669			0	
	700 OCCUPATI ONAL THERAPY	0	1, 679		0 0	0	
	BOO SPEECH PATHOLOGY	0	1, 308		0 0	0	
	POO ELECTROCARDI OLOGY	0	26, 219		0 0	0	
	DOO ELECTROENCEPHALOGRAPHY	0	447		0 0	0	
	100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	43, 821			0	
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS		84, 728 179, 345			350, 338	
	400 RENAL DI ALYSI S	0	1, 779		0 0	0	
. 00 075	500 ASC (NON-DI STINCT PART)	0	C		0 0	0	
. 01 075	501 ASC (NON-DISTINCT PART)	0	94, 137	/	o o	0	
	250 CARDI AC CATHERI ZATI ON	0		)	0	0	
	251 OUTPATIENT WOUND CARE CENTER	0	8, 825 C			0	
	597 CARDIAC REHABILITATION TPATIENT SERVICE COST CENTERS	1 0		<u>/</u>	5 0	0	70.
		0	C		0 0	0	90.
. 01 049	950 SLEEP CLINIC	0	3, 971		0 0	0	90.
	DO1 ANTICOAGULATION CLINIC	0	412		0 0	0	
	002 ARNETT CANCER CARE CENTER	0	21, 780		0 0	0	
	DO3 OUTPATIENT INFUSION CENTER	0	144 015			0	
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART)		144, 815	49, 32	7 77,625	0	91. 92.
	200 OBSERVATION BEDS (NON-DISTINCT PART) 201 OBSERVATION BEDS (DISTINCT PART)	0	C		o o	0	
	951 OTHER OUTPATIENT SERVICES	0	C		0 0		
	CIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			-		
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	910, 410	1, 138, 182	1, 252, 21	2 1, 970, 570	350, 338	1118

Health Financial Systems IU HEALTH ARNETT HOSPITAL In Lie						2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2021	Worksheet B Part I	
				To 12/31/2021	Date/Time Pre	
					5/26/2022 3:4	2 pm
		OTHER GENERAL SERVI CE	INTERNS 8	RESI DENTS		
Cost Center Description	SOCI AL SERVICE	PATI ENT	SERVI CES-SALA	RSERVI CES-OTHER	PARAMED ED	
		TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
		SERVI CES			PHARMACY	
	17.00	18.00	21.00	22.00	23.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0	0	190.00
191. 00 19100 RESEARCH	0	C	)	0 0	0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2	2	0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	C	) (	0 0	0	193.00
193.01 19301 RETAIL PHARMACY	0	70	) (	0 0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	0	0	) (	0 0	0	193. 02
193. 03 19303 HOSPI CE	0	0	) (	0 0	0	193.03
193. 04 19304 FRANKFORT HOSPI TAL	0	0		o o	0	193.04
194.0007950 MARKETI NG/PUBLIC RELATI ONS	0	0		o o	0	194.00
200.00 Cross Foot Adjustments			(	o o	0	200.00
201.00 Negative Cost Centers	0	C		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	910, 410	1, 138, 254	1, 252, 21	1, 970, 570	350, 338	202.00

ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0173		lorksheet B Part I
				To 12/31/2021 [	ate/Time Prepar
Cost Center Description	Subtotal	Intern &	Total		5/26/2022 3:42 p
·		Residents Cost			
		& Post			
		Stepdown Adjustments			
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS	1				
0 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP					
2 00102 CAP REL COSTS-BEDG & TTXT - NONNOSP					
00200 CAP REL COSTS-MVBLE EQUIP					
00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP					
00400 EMPLOYEE BENEFITS DEPARTMENT					
00570 ADMI TTI NG					
00590 OTHER ADMINI STRATI VE & GENERAL					
0 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL					
00800 LAUNDRY & LINEN SERVICE					
00900 HOUSEKEEPING					
00 01000 DI ETARY					1(
00 01100 CAFETERIA					1
00 01300 NURSING ADMINISTRATION					1:
00 01400 CENTRAL SERVICES & SUPPLY					14
00 01500 PHARMACY 00 01600 MEDICAL RECORDS & LIBRARY					15
00 01700 SOCIAL SERVICE					1
00 01850 PATIENT TRANSPORT SERVICES					18
00 02100 I&R SERVICES-SALARY & FRINGES APPRVD					2
00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD					22
00 02300 PARAMED ED PRGM - PHARMACY					23
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	77 ( )( )( )		74 071 /0		
00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT	77, 626, 846 11, 147, 238	-2, 655, 160 0	74, 971, 68 11, 147, 23		30
00 03300 BURN INTENSIVE CARE UNIT	0	0	11, 147, 20	0	3
01 03301 BURN INTENSIVE CARE UNIT	0	0		0	3
00 02060 NEONATAL INTENSIVE CARE UNIT	6, 647, 109	-103, 497	6, 543, 61	2	3!
00 04300 NURSERY	2, 112, 504	0	2, 112, 50	)4	43
ANCI LLARY SERVI CE COST CENTERS	18, 660, 810	-85, 613	18, 575, 19	17	50
00 05100 RECOVERY ROOM	2, 437, 678		2, 437, 67		5
00 05200 DELIVERY ROOM & LABOR ROOM	7, 873, 298	-251, 560	7, 621, 73		52
00 05300 ANESTHESI OLOGY	8, 426, 073	0	8, 426, 07		53
01 05301 ASC ANESTHESI OLOGY	66, 720	0	66, 72		53
00  05400  RADI OLOGY-DI AGNOSTI C 00  05500  RADI OLOGY-THERAPEUTI C	11, 070, 111	0	11, 070, 11	1	54
00 05500 RADIOLOGI - THERAPEUTIC	947, 627	0	947, 62	7	50
00 05900 CARDI AC CATHETERI ZATI ON	4, 463, 548	0	4, 463, 54		59
00 06000 LABORATORY	15, 382, 664	0	15, 382, 66		60
00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 193, 080	0	1, 193, 08	0	63
00 06500 RESPI RATORY THERAPY	4, 458, 730	0	4, 458, 73		6
00 06600 PHYSI CAL THERAPY	1,029,432	0	1, 029, 43		60
00 06700 OCCUPATIONAL THERAPY 00 06800 SPEECH PATHOLOGY	739, 749	0	739, 74		6
00 06900 ELECTROCARDI OLOGY	529, 006 2, 566, 894	0	529, 00 2, 566, 89		64
00 07000 ELECTROEARD OLOGT	129, 831	0	2, 300, 89		70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 201, 540	0	14, 201, 54	0	7
00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 571, 374	0	15, 571, 37		72
00 07300 DRUGS CHARGED TO PATIENTS	56, 952, 137	0	56, 952, 13		7:
00 07400 RENAL DIALYSIS	1, 123, 795	0	1, 123, 79	5	74
00 07500 ASC (NON-DISTINCT PART) 01 07501 ASC (NON-DISTINCT PART)	0	0	0 741 77	28	75
00 03950 CARDIAC CATHERIZATION	8, 261, 378 0	0	8, 261, 37	0	76
01 03951 OUTPATIENT WOUND CARE CENTER	1,085,847	0	1, 085, 84	.7	70
07 07697 CARDI AC REHABI LI TATI ON	103, 228	0	103, 22		70
OUTPATIENT SERVICE COST CENTERS				-	
	0	0		0	90
01   04950  SLEEP CLINIC 02   09001  ANTI COAGULATI ON CLINIC	881,627	0	881, 62		90
03 09001 ANTICOAGULATION CLINIC 03 09002 ARNETT CANCER CARE CENTER	166, 065 2, 935, 222	0	166, 06 2, 935, 22		90
04 09003 OUTPATIENT INFUSION CENTER	185, 462	0	2, 935, 22		90
00 09100 EMERGENCY	19, 675, 061	-126, 952	19, 548, 10		9
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92
01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	92
00 04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	0	0		0	93

Health Financial Systems IU HEALTH ARNETT HOSPITAL					u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period:	Worksheet B
				From 01/01/2021 To 12/31/2021	Part I Date/Time Prepared:
Cost Center Description	Subtotal	Intern &	Total		5/26/2022 3:42 pm
cost center bescription		Residents Cost	TOTAL		
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26.00		
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	486, 681	0	486, 68	1	190.00
191. 00 19100 RESEARCH	C	0		0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	974, 719	0	974, 71	9	192.00
193. 00 19300 NONPAI D WORKERS	C	0		0	193.00
193. 01 19301 RETAIL PHARMACY	8, 405, 861	0	8, 405, 86	1	193. 01
193. 02 19302 WHI TE_HOSPI TAL	3, 304, 803		3, 304, 80		193. 02
193. 03 19303 HOSPI CE	6, 456	1	6, 45		193.03
193. 04 19304 FRANKFORT HOSPI TAL	2, 403, 579	0	2, 403, 57	9	193.04
194.0007950 MARKETI NG/PUBLI C RELATI ONS	C	0		0	194.00
200.00 Cross Foot Adjustments	C	0		0	200.00
201.00 Negative Cost Centers	C	0		0	201.00
202.00  TOTAL (sum lines 118 through 201)	314, 233, 783	-3, 222, 782	311, 011, 00	1	202.00

Health Financial Systems	IU HEALTH ARNE	TT HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	F	eriod: rom 01/01/2021	Worksheet B Part II Data /Time Bro	narodi
				o 12/31/2021	Date/Time Pre 5/26/2022 3:4	
			CAPITAL RE	LATED COSTS		
Cost Center Description	Directly Assigned New	BLDG & FIXT	BLDG & FIXT - NONHOSP	I NTEREST	MVBLE EQUIP	
	Capital Related Costs			EXPENSE		
GENERAL SERVICE COST CENTERS	0	1.00	1.01	1.02	2.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP						1.01
1. 02 00102 CAP REL COSTS INTEREST EXPENSE 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.02 2.00
2.01 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4. 00   00400  EMPLOYEE BENEFITS DEPARTMENT 5. 01   00570  ADMITTING	0	C 17, 941	0 0 1 2, 811	0	0	
5.06 00590 OTHER ADMINISTRATIVE & GENERAL	0	196, 206		31, 758 347, 304	23, 703 259, 213	1
7.00 00700 OPERATION OF PLANT	0	1, 093, 857		1, 936, 235	1, 445, 127	7.00
7. 01 00701 OPERATION OF PLANT - NONHOSPITAL	0	0	,,00,	0	0	
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	76, 583	0 0 3 824	135, 559	0 101, 175	
10. 00 01000 DI ETARY	0	120, 952		214, 098	159, 794	•
11. 00 01100 CAFETERIA	0	93, 255		165, 071	123, 202	•
13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	0	67, 627 303, 385		119, 706 537, 022	89, 344 400, 811	•
15. 00 01500 PHARMACY	0	67, 461		119, 412	89, 125	•
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	°	0	0	
17. 00  01700  SOCI AL_SERVI CE 18. 00  01850  PATI ENT_TRANSPORT_SERVI CES	0	19, 270		0 34, 110	0 25, 458	17.00 18.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00 02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	(	82, 629	0	0	
23. 00 02300 PARAMED ED PRGM - PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2, 099	5	3, 716	2, 773	23.00
30. 00 03000 ADULTS & PEDIATRICS	0	1, 690, 377	7 0	2, 992, 127	2, 233, 205	30.00
31.00 03100 I NTENSI VE CARE UNI T	0	169, 219		299, 534	223, 560	•
33.00 03300 BURN INTENSIVE CARE UNIT 33.01 03301 BURN INTENSIVE CARE UNIT	0	(		0	0	33.00 33.01
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	134, 952		238, 878	178, 289	•
43. 00 04300 NURSERY	0	64, 501	1 0	114, 173	85, 214	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	0	459, 329	200	813, 058	606, 833	50.00
51. 00 05100 RECOVERY ROOM	0	69, 756		123, 476	92, 157	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	216, 020		382, 376	285, 390	1
53. 00 05300 ANESTHESI OLOGY 53. 01 05301 ASC ANESTHESI OLOGY	0	18, 364	4 0 0 691	32, 506	24, 261 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	257, 294		455, 435	339, 918	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	0 0	0	0	
56. 00 05600 RADI 0I SOTOPE 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	31, 865 95, 475		56, 405 169, 001	42, 098 126, 135	•
60. 00 06000 LABORATORY	0	136, 281		241, 231	120, 133	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	9, 711		17, 189	12, 829	•
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	13, 229 8, 653		23, 417 15, 318	17, 478 11, 432	•
67. 00 06700 OCCUPATI ONAL THERAPY	0	6, 373		11, 281	8, 420	•
68.00 06800 SPEECH PATHOLOGY	0	4, 969		8, 795	6, 564	•
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	36, 894		65, 307	48, 742 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(		0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	0 0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	0	0 23, 302		0 41, 248	0 30, 786	73.00 74.00
75. 00 07500 ASC (NON-DI STI NCT PART)	0	23, 302		41, 240	30, 788 0	75.00
75.01 07501 ASC (NON-DI STINCT PART)	0	C	199, 738	0	0	
76. 00 03950 CARDIAC CATHERIZATION	0	0	0	0	0	76.00
76. 01 03951 OUTPATIENT WOUND CARE CENTER 76. 97 07697 CARDIAC REHABILITATION	0	(	15, 125	0	0	
OUTPATIENT SERVICE COST CENTERS				-	-	
90. 00 09000 CLINIC	0	C	0	0	0	
90. 01 04950 SLEEP CLINIC 90. 02 09001 ANTICOAGULATION CLINIC	0	( (	0 18,080 0 6,861	0	0	
90. 03 09002 ARNETT CANCER CARE CENTER	0	C	67, 446	0	0	90.03
90. 04 09003 OUTPATIENT INFUSION CENTER	0	8, 940		15, 825	11, 811	•
91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	311, 993	0 ا	552, 259	412, 184	91.00 92.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	C	o o	0	0	1
93. 00 04951 OTHER OUTPATI ENT SERVICES	0	C	0 0	0	0	1
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 826, 133	3 497, 683	10, 312, 830	7, 697, 076	118 00
	۱ V	5, 020, 133	1 471,003	10, 512, 030	1,071,070	1110.00

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2021	Worksheet B Part II	
				To 12/31/2021	Date/Time Pre	
			CAPITAL R	ELATED COSTS	5/26/2022 3:4	2 pm 1
			CALL IN	LEATED 00010		
Cost Center Description	Di rectl y	BLDG & FIXT	BLDG & FIXT ·	- CAP REL COSTS	MVBLE EQUIP	
	Assigned New		NONHOSP	I NTEREST		
	Capital			EXPENSE		
	Related Costs	1.00	1.01	1. 02	2.00	
NONREI MBURSABLE COST CENTERS	0	1.00	1.01	1.02	2.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34, 554		0 61, 163	45, 650	190.00
191. 00 19100 RESEARCH	0	C		0 0	0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	C		0 0		192.00
193.00 19300 NONPALD WORKERS	0	C		0 0		193.00
193.01 19301 RETAIL PHARMACY	0	18, 243		0 32, 292		193. 01
193. 02 19302 WHI TE HOSPI TAL	0	34, 025	6, 09	6 60, 227		193.02
193. 03 19303 HOSPI CE	0	0	)	0 0		193.03
193. 04 19304 FRANKFORT HOSPI TAL	0	28, 362	6, 51	0 50, 203		193.04
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	0	U	)	0 0	0	194.00
200.00 Cross Foot Adjustments		0		0	0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	5, 941, 317	510, 28	0 0 9 10, 516, 715		201.00
202.00 TOTAL (Sum Thes Its through 201)	0	5, 941, 317	1 510, 28	10, 510, 715	7, 849, 248	1202. UU

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH ARNE	Provider C		riod: om 01/01/2021	u of Form CMS-2 Worksheet B Part II	2552-10
				Tc		Date/Time Pre	pared:
	Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - NONHOSP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	5/26/2022 3: 4 OTHER ADMI NI STRATI VE & GENERAL	
	1	2.01	2A	4.00	5.01	5.06	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	I					1.00
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 2. \ 00 \\ 2. \ 01 \\ 4. \ 00 \\ 5. \ 01 \\ 5. \ 06 \\ 7. \ 00 \\ 7. \ 01 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \\ 17. \ 00 \end{array}$	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUI P 00201 CAP REL COSTS-MVBLE EQUI P - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 3, 089 104, 314 0 8, 612 0 905 0 0 0 0 0 461 292 0 0 0	0 79, 302 1, 001, 985 4, 475, 219 16, 451 0 315, 046 494, 844 381, 528 276, 677 1, 242, 099 276, 556 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	79, 302 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 001, 985 60, 642 2, 633 0 12, 852 7, 648 4, 131 54, 830 45, 785 25, 468 0 2, 840	$\begin{array}{c} 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 01\\ 5.\ 06\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
21. 00 22. 00	01850 PATI ENT TRANSPORT SERVI CES 02100 I & SERVI CES-SALARY & FRI NGES APPRVD 02200 I & SERVI CES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM - PHARMACY INPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 90, 780 6	78, 838 0 173, 409 8, 599	0 0 0 0	0 0 0	3, 209 3, 899 5, 149 1, 066	21. 00 22. 00
33. 00 33. 01 35. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03301 BURN INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	0 0 0 0 0 0	6, 915, 709 692, 313 0 552, 119 263, 888	0 0 0 0 0 0	8, 483 1, 285 0 0 742 179	170, 431 27, 387 0 0 15, 223 4, 652	31.00 33.00 33.01 35.00
$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 53.\ 01\\ 54.\ 00\\ 55.\ 00\\ 60.\ 00\\ 63.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 76.\ 01\\ 76.\ 01\\ 76.\ 97\end{array}$	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03951 OUTPATI ENT WOUND CARE CENTER 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 759 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1,879,220\\ 285,389\\ 883,786\\ 75,131\\ 1,450\\ 1,052,647\\ 0\\ 130,368\\ 390,611\\ 557,557\\ 39,729\\ 54,124\\ 35,403\\ 26,074\\ 20,328\\ 150,943\\ 0\\ 0\\ 0\\ 0\\ 95,336\\ 0\\ 419,177\\ 0\\ 0\\ 31,742\end{array}$		7, 944 653 1, 247 450 208 5, 359 0 792 3, 277 4, 234 263 1, 143 185 117 91 1, 822 31 3, 046 5, 889 12, 654 124 0 6, 543 0 0 6, 543	46, 361 3, 642 12, 274 3, 091 2, 223 1, 582 6, 862 406 30, 775 33, 701 153, 772 3, 209 0 21, 986 0 3, 397 126	$ \begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 01\\ 54.\ 00\\ 55.\ 00\\ 65.\ 00\\ 65.\ 00\\ 63.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 01\\ 76.\ 01\\ 76.\ 97\\ \end{array} $
90. 01 90. 02 90. 03 90. 04 91. 00 92. 00 92. 01	09000 CLINIC 04950 SLEEP CLINIC 09001 ANTICOAGULATION CLINIC 09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) 04951 OTHER OUTPATIENT SERVICES	0 19, 863 7, 538 74, 099 0 0 0 0	0 37, 943 14, 399 141, 545 36, 576 1, 276, 436 0 0	0 0 0 0 0 0 0	0 276 29 1, 514 39 10, 065 0 0	2, 505 436 7, 014 378	90.01 90.02 90.03 90.04 91.00 92.00 92.01
	SPECIAL PURPOSE COST CENTERS						4

Health Financial Systems	IU HEALTH ARNET	T HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021	Worksheet B	
				To 12/31/2021	Part II Date/Time Pre 5/26/2022 3:4	
	CAPI TAL RELATED COSTS					
Cost Center Description	MVBLE EQUIP -	Subtotal	EMPLOYEE	ADMI TTI NG	OTHER	
	NONHOSP		BENEFITS		ADMI NI STRATI VE	
	2.01	2A	DEPARTMENT 4.00	5. 01	& GENERAL 5.06	
NONREI MBURSABLE COST CENTERS	2.01	28	4.00	5.01	5.00	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	141, 367		0 0	1,009	190.00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	3, 102	192.00
193. 00 19300 NONPAI D WORKERS	0	0		0 0		193.00
193. 01 19301 RETALL PHARMACY	0	74, 637		0 5	26, 520	
193. 02 19302 WHI TE HOSPI TAL	6, 697	151, 996		0 0		193. 02
193. 03 19303 HOSPI CE	0	0		0 0		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	7, 152	129, 696		0 0		193. 04
194.0007950 MARKETI NG/PUBLIC RELATIONS	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00  TOTAL (sum lines 118 through 201)	560, 623	25, 378, 192		0 79, 302	1, 001, 985	202.00

Heal th	Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0173 F	Period: From 01/01/2021	Worksheet B Part II	
					o 12/31/2021	Date/Time Pre	
	Cost Center Description	OPERATI ON OF	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	5/26/2022 3: 4 DI ETARY	
		PLANT	PLANT - NONHOSPI TAL	LINEN SERVICE			
		7.00	7.01	8.00	9.00	10.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	[					1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP						1.00
1.02	00102 CAP REL COSTS INTEREST EXPENSE						1.02
2.00 2.01	00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2.00 2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.06 7.00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	4, 535, 861					5.06 7.00
7.01	00701 OPERATION OF PLANT - NONHOSPITAL	0	19, 084				7.01
8.00	00800 LAUNDRY & LINEN SERVICE	0	0				8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	74, 972 118, 408	39 0		402, 909 8, 543	629, 443	9.00 10.00
11.00	01100 CAFETERI A	91, 294	0		6, 587	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	66, 205	0			0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	297,004 66,042	20		21, 513 4, 818	0	14.00 15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0	0	16.00
17.00	01700 SOCIAL SERVICE	0	0	C	0	0	17.00
18.00 21.00	01850 PATIENT TRANSPORT SERVICES 02100 I &R SERVICES-SALARY & FRINGES APPRVD	18, 865	0		0 1, 361 0 0	0	18.00 21.00
22.00	02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	3, 897	C	16, 585	0	22.00
23.00	02300 PARAMED ED PRGM - PHARMACY	2, 055	0	C	149	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 654, 824	0	C	119, 390	568, 171	30.00
31.00	03100 INTENSIVE CARE UNIT	165, 659	0			48, 253	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	C	-	0	33.00
33. 01 35. 00	03301 BURN INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	132, 114			-	0	33. 01 35. 00
43.00	04300 NURSERY	63, 144	0			0	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	449, 668	0	C	32, 443	0	50.00
51.00	05100 RECOVERY ROOM	68, 289	0			0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	211, 476				13, 019	
53.00 53.01	05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY	17, 978 0	0			0	53.00 53.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	251, 882	0			0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55.00
56.00 59.00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	31, 195 93, 467			2, 251 6, 744	0	56.00 59.00
60.00	06000 LABORATORY	133, 415	0	C		0	60.00
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY	9, 506 12, 951	0		686 934	0	
65.00 66.00	06600 PHYSI CAL THERAPY	8, 471	0		611	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	6, 239		C	450	0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	4, 864 36, 118			) 351 2,606	0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 2,000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	0	71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72.00 73.00
74.00	07400 RENAL DIALYSIS	22, 812	0		1, 646	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	C	0	0	75.00
75. 01 76. 00	07501 ASC (NON-DI STI NCT PART) 03950 CARDI AC CATHERI ZATI ON	0	9, 417	0	40, 090	0	75.01 76.00
76.00	03951 OUTPATIENT WOUND CARE CENTER	0	0		0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	713	C	3, 036	0	76.97
90.00	OUTPATI ENT SERVICE COST CENTERS	0	0	c		0	90.00
90.00 90.01	04950 SLEEP CLINIC	0	853		3, 629	0	90.00 90.01
90.02	09001 ANTI COAGULATI ON CLI NI C	0	324		1, 377	0	90.02
90. 03 90. 04	09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER	0 8, 752	3, 181		) 13, 537 ) 631	0	90. 03 90. 04
90.04 91.00	09100 EMERGENCY	305, 431	0		22, 037	0	90.04
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-	-	-		-	92.00
92.01 93.00	09201 OBSERVATI ON BEDS (DI STINCT PART) 04951 OTHER OUTPATI ENT SERVICES	0	0   0			0	92.01 93.00
	SPECIAL PURPOSE COST CENTERS		-				
118.00	SUBTOTALS         (SUM OF LINES 1 through 117)           NONREIMBURSABLE         COST         CENTERS	4, 423, 100	18, 490	C	392, 242	629, 443	00 .811
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	33, 827 0	0				190. 00 191. 00
191.00		1 0	ı 0	1 (	יו U	0	1171.00

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL	In Lie	Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narad
				10 12/31/2021	5/26/2022 3:4	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT -	LINEN SERVICE	Ξ		
		NONHOSPI TAL				
	7.00	7.01	8.00	9.00	10.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 RETAIL PHARMACY	17, 860	0		0 1, 289	0	193.01
193. 02 19302 WHI TE HOSPI TAL	33, 309	287		0 3, 627	0	193.02
193. 03 19303 HOSPI CE	0	0		0 0	0	193.03
193. 04 19304 FRANKFORT HOSPI TAL	27, 765	307		0 3, 310	0	193.04
194.00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	4, 535, 861	19, 084		0 402, 909	629, 443	202.00

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH ARN	ETT HOSPITAL Provider CC	N: 15-0173 Pe	In Lieu riod:	u of Form CMS-2 Worksheet B	2552-10
				Fr To	om 01/01/2021 12/31/2021	Part II Date/Time Pre	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	5/26/2022 3: 4 MEDI CAL RECORDS & LI BRARY	2 pm
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 01\\ 5.\ 06\\ 7.\ 00\\ 7.\ 01\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS INTEREST EXPENSE 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00700 OPERATION OF PLANT - NONHOSPITAL 00700 OPERATION OF PLANT - NONHOSPITAL 00700 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 PATIENT TRANSPORT SERVICES	483, 540 24, 402 5, 250 28, 378 0 5, 425 9, 225 8, 104	426, 891 863 0 0 0 0	1, 612, 534 8, 427 0 0 480	409, 702 0 0 0	0 0 0	17. 00 18. 00
	02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	8, 104 2, 294	0	0	0	0	21.00
	02200 PARAMED ED PRGM - PHARMACY	1, 642	0	0	0	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS					_	
	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	142, 520 19, 515	209, 835 29, 663	51, 651 10, 708	2, 732 1, 205	0	
	03300 BURN INTENSIVE CARE UNIT	19, 515	29,003	10, 708	1, 203	0	33.00
	03301 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.01
	02060 NEONATAL INTENSIVE CARE UNIT	12, 793		3, 970	176	0	35.00
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	4, 621	6, 712	0	0	0	43.00
	05000 OPERATING ROOM	34, 822	35, 625	299, 604	1, 404	0	50.00
51.00	05100 RECOVERY ROOM	5, 867	10, 493	2, 303	38	0	•
	05200 DELIVERY ROOM & LABOR ROOM	17,623		11, 775	512	0	52.00
	05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY	1, 733	1, 158	15, 469 4, 298	777 66	0	53.00 53.01
	05400 RADI OLOGY-DI AGNOSTI C	29, 233	9, 926	76, 652	1, 538	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	1, 931 9, 576	0 13, 242	615 52, 881	104 463	0	56.00 59.00
	06000 LABORATORY	22, 341	13, 242	3, 911	403	0	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	ō	0	
	06500 RESPI RATORY THERAPY	14, 328		43, 629	0	0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	4, 196 2, 764	0	9	0	0	66.00 67.00
	06800 SPEECH PATHOLOGY	1, 886	0	52	0	0	68.00
	06900 ELECTROCARDI OLOGY	10, 256		334	77	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	583	0	0 457, 282	0	0	70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	499, 032	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	395, 070	0	73.00
	07400 RENAL DIALYSIS	0	0	212	6	0	74.00
	07500 ASC (NON-DI STI NCT PART) 07501 ASC (NON-DI STI NCT PART)	0	0	0 42, 291	0 746	0	75.00
	03950 CARDI AC CATHERI ZATI ON	0	0	42, 271	0	0	76.00
	03951 OUTPATIENT WOUND CARE CENTER	0	0	1, 196	0	0	76.01
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	04950 SLEEP CLINIC	0	0	1, 632	0	0	
	09001 ANTI COAGULATI ON CLINIC	0	0	0	0	0	90.02
	09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER	7, 974	8, 029 511	3, 990	1, 475	0	90.03 90.04
	09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY	261 41, 476		42 19, 892	23 3, 286	0	90.04
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	,	, 002	. , , , , , , , , , , , , , , , , , , ,	5,200	0	92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	
93.00	04951 OTHER OUTPATIENT SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	93.00
<del>7</del> 3.00	GILVIAL FUREVAL GUAT GENTERA						1
93.00 118.00		471, 019	426, 891	1, 612, 342	409, 700	0	118.00
118.00		471, 019		1, 612, 342	409, 700		118.00 190.00

Health Financial Systems	IU HEALTH ARNI	ETT_HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Peri od:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II   Date/Time Pre	narod
				10 12/31/2021	5/26/2022 3:4	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	19	2 2	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
193. 01 19301 RETAIL PHARMACY	0	0		0 0	0	193.01
193. 02 19302 WHI TE HOSPI TAL	7,073	0		0 0	0	193. 02
193. 03 19303 HOSPI CE	0	0		0 0	0	193.03
193. 04 19304 FRANKFORT HOSPI TAL	4, 882	0		0 0	0	193.04
194.0007950 MARKETI NG/PUBLI C RELATI ONS	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	483, 540	426, 891	1, 612, 53	409, 702	0	202.00

OCATION (	OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2021	Worksheet B Part II	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:4	par
			OTHER GENERA	L I NTERNS	& RESI DENTS	572072022 3.4	
	Cost Center Description	SOCI AL SERVI CE	SERVI CE PATI ENT	SERVICES-SALA	RSERVI CES-OTHER	PARAMED ED	
			TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
		17.00	SERVI CES 18. 00	21.00	22.00	PHARMACY 23.00	-
GENER	AL SERVICE COST CENTERS	17.00	10.00	21.00	22.00	23.00	
	CAP REL COSTS-BLDG & FIXT						1
	CAP REL COSTS-BLDG & FIXT - NONHOSP CAP REL COSTS INTEREST EXPENSE						1
	CAP REL COSTS INTEREST EXPENSE						
	CAP REL COSTS MVBLE EQUIP - NONHOSP						
	EMPLOYEE BENEFITS DEPARTMENT						4
	ADMI TTI NG						5
	OTHER ADMINISTRATIVE & GENERAL						5
	OPERATION OF PLANT OPERATION OF PLANT - NONHOSPITAL						
	LAUNDRY & LINEN SERVICE						
	HOUSEKEEPING						9
00 01000	DI ETARY						10
	CAFETERIA						11
							13
	CENTRAL SERVICES & SUPPLY PHARMACY						14
	MEDICAL RECORDS & LIBRARY						16
	SOCIAL SERVICE	8, 265					17
00 01850	PATIENT TRANSPORT SERVICES	0	111, 97	8			18
	I &R SERVICES-SALARY & FRINGES APPRVD	0		0 12,00			21
	I &R SERVICES-OTHER PRGM. COSTS APPRVD	0		0	201, 334		22
	PARAMED ED PRGM - PHARMACY I ENT ROUTINE SERVICE COST CENTERS	0		0		13, 511	23
	ADULTS & PEDIATRICS	6,677	11, 94	.6			30
	INTENSIVE CARE UNIT	567	1, 81				31
00 03300	BURN INTENSIVE CARE UNIT	0		0			33
	BURN INTENSIVE CARE UNIT	0		0			33
	NEONATAL INTENSIVE CARE UNIT NURSERY	474	1, 04 25				35
	LARY SERVICE COST CENTERS	374	20	12			43
00 05000	OPERATING ROOM	0	11, 18	6			50
	RECOVERY ROOM	0	91				51
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	153	1, 75 63				52
	ASC ANESTHESI OLOGY	0	29				53
	RADI OLOGY-DI AGNOSTI C	0	7, 54				54
00 05500	RADI OLOGY-THERAPEUTI C	0		0			55
	RADI OI SOTOPE	0	1, 11				56
	CARDI AC CATHETERI ZATI ON LABORATORY	0	4, 61				59
	BLOOD STORING, PROCESSING & TRANS.	0	5, 96 37				60
	RESPI RATORY THERAPY	0	1, 61				65
	PHYSI CAL THERAPY	0	26				66
	OCCUPATIONAL THERAPY	0	16				67
	SPEECH PATHOLOGY	0	12				68
	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		2, 56	6			69
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 28				71
	I MPL. DEV. CHARGED TO PATIENTS	0	8, 29				72
	DRUGS CHARGED TO PATIENTS	0	18, 12	27			73
	RENAL DIALYSIS	0	17				74
	ASC (NON-DISTINCT PART) ASC (NON-DISTINCT PART)	0		0			75
	CARDIAC CATHERIZATION		9, 21	3			76
	OUTPATIENT WOUND CARE CENTER	0	86				76
97 07697	CARDI AC REHABI LI TATI ON	0		0			76
	TIENT SERVICE COST CENTERS	1					
		0		0			90
	SLEEP CLINIC ANTICOAGULATION CLINIC	0	38	.0			90
	ARNETT CANCER CARE CENTER		2, 13				90
	OUTPATIENT INFUSION CENTER	0		5			90
	EMERGENCY	0	14, 17				91
	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OBSERVATION BEDS (DISTINCT PART)	0		0			92
	OTHER OUTPATIENT SERVICES	0		0			93
INPEC.	AL PURPOSE COST CENTERS						1

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	narod
				10 12/31/2021	5/26/2022 3: 4	
		OTHER GENERAL	I NTERNS	& RESI DENTS		
		SERVI CE		_		
Cost Center Description	SOCI AL SERVI CE			RSERVI CES-OTHER		
		TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
	17.00	SERVI CES	21.00	22.00	PHARMACY	
NONREI MBURSABLE COST CENTERS	17.00	18.00	21.00	22.00	23.00	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1			190.00
191. 00 19100 RESEARCH						191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
193. 00 19300 NONPALD WORKERS	0					193.00
193. 01 19301 RETAIL PHARMACY	0	7	7			193.01
193. 02 19302 WHI TE HOSPI TAL	0	C				193.02
193. 03 19303 HOSPI CE	0	c c				193.03
193. 04 19304 FRANKFORT HOSPI TAL	0	c c				193.04
194.0007950 MARKETING/PUBLIC RELATIONS	0	C	)			194.00
200.00 Cross Foot Adjustments			12, 00	3 201, 334		200.00
201.00 Negative Cost Centers	0	C		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	8, 265	111, 978	3 12,00	201, 334	13, 511	202.00

	inancial Systems	IU HEALTH ARN	ETT HOSPITAL Provider CC	N. 15-0173	In Li Period:	eu of Form CMS-2552- Worksheet B
LLUCATI	ION OF CALIFICE RELATED COSTS			N. 13-0175	From 01/01/202 To 12/31/202	1 Part II
	Cost Center Description	Subtotal	Intern &	Total		5/26/2022 3:42 pm
		Subtotul	Residents Cost & Post	lotal		
			Stepdown Adjustments			
G	ENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
1.00 0	0100 CAP REL COSTS-BLDG & FIXT					1. (
	0101 CAP REL COSTS-BLDG & FIXT - NONHOSP 0102 CAP REL COSTS INTEREST EXPENSE					1. (
	0200 CAP REL COSTS INTEREST EXPENSE					2.0
. 01 0	0201 CAP REL COSTS-MVBLE EQUIP - NONHOSP					2.0
	0400 EMPLOYEE BENEFITS DEPARTMENT					4. (
	10570 ADMI TTI NG 10590 OTHER ADMI NI STRATI VE & GENERAL					5.0
	0700 OPERATION OF PLANT					7. (
	0701 OPERATION OF PLANT - NONHOSPITAL					7.0
	10800 LAUNDRY & LINEN SERVICE 10900 HOUSEKEEPING					8.0
	1000 DI ETARY					10. (
	1100 CAFETERI A					11.
	1300 NURSI NG ADMI NI STRATI ON 1400 CENTRAL SERVI CES & SUPPLY					13.0
	1500 PHARMACY					14.0
	1600 MEDI CAL RECORDS & LI BRARY					16. (
	1700 SOCIAL SERVICE					17.0
	1850 PATIENT TRANSPORT SERVICES 12100 I &R SERVICES-SALARY & FRINGES APPRVD					18.0
	2200 I &R SERVICES-OTHER PRGM. COSTS APPRVD					22. (
	2300 PARAMED ED PRGM - PHARMACY					23. (
	NPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS	9, 862, 369	0	9, 862, 3	369	30.
	3100 I NTENSI VE CARE UNI T	1, 010, 317	1	1, 010, 1		31.
	3300 BURN INTENSIVE CARE UNIT	0			0	33.
	13301 BURN INTENSIVE CARE UNIT 12060 NEONATAL INTENSIVE CARE UNIT	0 751, 480	-	751,	0	33.0
	4300 NURSERY	348, 398		348,		43.0
	NCILLARY SERVICE COST CENTERS		1			
	5000 OPERATING ROOM 5100 RECOVERY ROOM	2, 789, 058 384, 016		2, 789, 384,		50. ( 51. (
	5200 DELIVERY ROOM & LABOR ROOM	1, 198, 093	1	1, 198,		52.0
	5300 ANESTHESI OLOGY	140, 480	1	140,		53. (
		6, 542			542	53.0
	15400 RADI OLOGY-DI AGNOSTI C 15500 RADI OLOGY-THERAPEUTI C	1, 479, 864 0	0	1, 479,	0	55.
6.00 0	5600 RADI OI SOTOPE	170, 813		170,		56.
	5900 CARDI AC CATHETERI ZATI ON	583, 931		583,		59.0
	16000 LABORATORY 16300 BLOOD STORI NG, PROCESSI NG & TRANS.	783, 409 54, 196		783, 54,		60. 63.
	6500 RESPIRATORY THERAPY	142, 129		142,		65.0
	6600 PHYSI CAL THERAPY	52, 227		52,		66.
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	38, 036 29, 282		38, 29, 1		67.0
	6900 ELECTROCARDI OLOGY	27, 202		29,		69.
	7000 ELECTROENCEPHALOGRAPHY	1, 064	0	1, (	064	70.
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	495, 392		495,		71.
1	17200 I MPL. DEV. CHARGED TO PATIENTS 17300 DRUGS CHARGED TO PATIENTS	546, 914 579, 623		546, 579,		72. 73.
4.00 0	7400 RENAL DI ALYSI S	123, 519	1	123,		74.
	7500 ASC (NON-DI STINCT PART)	0	-	5.40	0	75.
	17501 ASC (NON-DI STI NCT PART) 13950 CARDI AC CATHERI ZATI ON	549, 463	0	549,	463 0	75.0
	3951 OUTPATIENT WOUND CARE CENTER	6, 070	0	6,	070	76.
5. 97 0	7697 CARDIAC REHABILITATION	35, 617		35,		76.
	UTPATI ENT SERVI CE COST CENTERS	0	0		0	90.
	14950 SLEEP CLINIC	47, 227	-	47,	-	90. 90.
0. 02 0	9001 ANTI COAGULATI ON CLINIC	16, 605	0	16,	605	90.
	9002 ARNETT CANCER CARE CENTER	190, 391		190,		90.
	19003 OUTPATIENT INFUSION CENTER 19100 EMERGENCY	47, 268 1, 789, 888		47, 1, 789, 1		90. 91.
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1,707,000	0	1, 707,		91.
2.01 0	9201 OBSERVATION BEDS (DISTINCT PART)	0			0	92. (
	14951 OTHER OUTPATIENT SERVICES PECIAL PURPOSE COST CENTERS	0	0		0	93.0
S	SUBTOTALS (SUM OF LINES 1 through 117)	24, 469, 319	0	24, 469,	a. al	118. (

Health Financial Systems	IU HEALTH ARN	ETT HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-0173	Period: From 01/01/2021	Worksheet B
				To 12/31/2021	Part II Date/Time Prepared:
					5/26/2022 3:42 pm
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26.00		
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	179, 210	0 0	179, 21	0	190.00
191. 00 19100 RESEARCH	0	0		0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 296	0	3, 29	96	192.00
193.00 19300 NONPALD WORKERS	0	0		0	193.00
193.01 19301 RETAIL PHARMACY	120, 318	0	120, 31	8	193. 01
193. 02 19302 WHI TE HOSPI TAL	206, 139	0	206, 13	39	193. 02
193. 03 19303 HOSPI CE	21	0	2	21	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	173,041	0	173, 04	1	193.04
194.0007950 MARKETI NG/PUBLIC RELATIONS		ol		0	194.00
200.00 Cross Foot Adjustments	226, 848	0	226, 84	8	200.00
201.00 Negative Cost Centers	0	o o		0	201.00
202.00 TOTAL (sum lines 118 through 201)	25, 378, 192	0	25, 378, 19	2	202.00

T ALLOCATION - STATISTICAL BASIS		Provider C		eri od:	u of Form CMS-2 Worksheet B-1	
			F T	rom 01/01/2021 o 12/31/2021	Date/Time Pre	
		CAP	ITAL RELATED CO	OSTS	5/26/2022 3:4	2 pn
Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - NONHOSP	CAP REL COSTS	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - NONHOSP	
	(SQUARE TEET)	(SQUARE FEET)	EXPENSE	(SQUARE TELT)	(SQUARE FEET)	
		(******************	(SQUARE FEET)		(	
GENERAL SERVICE COST CENTERS	1.00	1.01	1.02	2.00	2.01	
0 00100 CAP REL COSTS-BLDG & FIXT	393, 411					1 1
1 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP	C					1
2 00102 CAP REL COSTS INTEREST EXPENSE	C	C	393, 411			1
0 00200 CAP REL COSTS-MVBLE EQUIP				393, 411		2
1 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 0 00400 EMPLOYEE BENEFITS DEPARTMENT			o	0	96, 019 0	2
1 00570 ADMITTING	1, 188	529				5
6 00590 OTHER ADMINISTRATIVE & GENERAL	12, 992				17, 866	
0 00700 OPERATION OF PLANT	72, 431				0	
1 00701 OPERATION OF PLANT - NONHOSPITAL	C			-	1, 475	7
0 00800 LAUNDRY & LINEN SERVICE	C	-	0	-	0	
0 00900 HOUSEKEEPI NG 00 01000 DI ETARY	5,071				155 0	
00 01100 CAFETERIA	6, 175				0	
00 01300 NURSI NG ADMI NI STRATI ON	4, 478				0	13
00 01400 CENTRAL SERVICES & SUPPLY	20, 089	79	20, 089	20, 089	79	14
00 01500 PHARMACY	4, 467				50	
00 01600 MEDICAL RECORDS & LIBRARY	C	0	0	-	0	
00 01700 SOCIAL SERVICE 00 01850 PATIENT TRANSPORT SERVICES	1, 276		0 1, 276	-	0	
00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	1,2/0		1,270		0	
00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD				-	15, 548	
00 02300 PARAMED ED PRGM - PHARMACY	139		139	139		
INPATIENT ROUTINE SERVICE COST CENTERS		1		[		
00 03000 ADULTS & PEDIATRICS	111, 930					
00 03100 I NTENSI VE CARE UNI T 00 03300 BURN I NTENSI VE CARE UNI T	11, 205 C		11, 205 0		0	
01 03301 BURN INTENSIVE CARE UNIT			0	-	0	
00 02060 NEONATAL INTENSIVE CARE UNIT	8, 936	0	8, 936	8, 936	0	
00 04300 NURSERY	4, 271	0	4, 271	4, 271	0	43
ANCI LLARY SERVI CE COST CENTERS 00 05000 OPERATI NG ROOM	30, 415	0	30, 415	30, 415	0	50
00 05100 RECOVERY ROOM	4, 619					
00 05200 DELIVERY ROOM & LABOR ROOM	14, 304		14, 304			
00 05300 ANESTHESI OLOGY	1, 216	C	1, 216	1, 216	0	53
01 05301 ASC ANESTHESI OLOGY	C			-	130	
00 05400 RADI OLOGY-DI AGNOSTI C	17,037				0	
00 05500 RADI OLOGY-THERAPEUTI C 00 05600 RADI OI SOTOPE	2, 110		0 2, 110		0	
00 05900 CARDI AC CATHETERI ZATI ON	6, 322				0	
00 06000 LABORATORY	9, 024		9, 024		0	
00 06300 BLOOD STORING, PROCESSING & TRANS.	643		643			
00 06500 RESPI RATORY THERAPY	876		876			
00 06600 PHYSI CAL THERAPY	573		573		0	
00 06700 OCCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY	422		422 329		0	· · ·
00 06900 ELECTROCARDI OLOGY	2, 443		2, 443		0	
00 07000 ELECTROENCEPHALOGRAPHY	C	0	0	0	0	70
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	C	0	0	0	71
00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	C	0	-	0	72
00 07300 DRUGS CHARGED TO PATIENTS	C	0	0	-	0	
00 07400 RENAL DIALYSIS	1, 543		1, 543		0	
00 07500 ASC (NON-DI STINCT PART) 01 07501 ASC (NON-DI STINCT PART)		37, 584		-	0 37, 584	
00 03950 CARDI AC CATHERI ZATI ON		0,,004	0	-	0	
01 03951 OUTPATIENT WOUND CARE CENTER	C	0	0	-	0	
97 07697 CARDI AC REHABI LI TATI ON	C	2, 846	0	0	2, 846	76
OUTPATIENT SERVICE COST CENTERS	-		-			0.00
00 09000 CLINIC 01 04950 SLEEP CLINIC		-			3 402	
02 09001 ANTICOAGULATION CLINIC		3, 402		-	3, 402 1, 291	
03 09002 ARNETT CANCER CARE CENTER		12, 691		-	12, 691	
04 09003 OUTPATIENT INFUSION CENTER	592		592	-	0	
00 09100 EMERGENCY	20, 659		20, 659		0	91
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
01 09201 OBSERVATION BEDS (DISTINCT PART)	C	-	0		0	
00 04951 OTHER OUTPATI ENT SERVICES SPECIAL PURPOSE COST CENTERS	C	0	0	0	0	93
STECTAL FUNCOL COST CENTERS						1

Health Financial Systems	IU HEALTH ARNI	ETT_HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		CAP	ITAL RELATED C	OSTS		
Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - NONHOSP (SQUARE FEET)	CAP REL COSTS INTEREST EXPENSE (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - NONHOSP (SQUARE FEET)	
	1.00	1.01	1.02	2.00	2. 01	
NONREI MBURSABLE COST CENTERS				_	_	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 288	0	2, 288	3 2, 288		190.00
191. 00 19100 RESEARCH	0	0	(	0 0	-	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	(	0		193.00
193. 01 19301 RETAIL PHARMACY	1, 208		1, 208			193. 01 193. 02
193. 02 19302 WHI TE HOSPI TAL 193. 03 19303 HOSPI CE	2, 253	1, 147	2, 253	2, 253		193.02
193. 04 19304 FRANKFORT HOSPI TAL	1, 878	1, 225	1, 878	1,878		193.03
194. 00107950 MARKETI NG/PUBLI C RELATI ONS	1,070	1, 225	1,070	1,070		193.04
200.00 Cross Foot Adjustments	0			0	0	200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 941, 317	510, 289	10, 516, 715	5 7, 849, 248	560, 623	
203.00 Unit cost multiplier (Wkst. B, Part I)	15. 102061	5. 314459	26. 732133	19. 951776	5. 838667	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)						204.00
205.00 Unit cost multiplier (Wkst. B, Part						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

ST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2021	Worksheet B-1	
				o 12/31/2021	Date/Time Pre	
Cost Center Description	EMPLOYEE	ADMITTING F	Reconciliatior	OTHER	5/26/2022 3:4 OPERATION OF	<u> </u>
	BENEFITS	(PATI ENT		ADMI NI STRATI VE		
	DEPARTMENT	CHARGES)		& GENERAL	(SQUARE FEET)	
	(GROSS SALARI ES)			(ACCUM. COST)		
	4.00	5.01	5A. 06	5.06	7.00	
GENERAL SERVICE COST CENTERS		T			I	
00 00100 CAP REL COSTS-BLDG & FLXT						
00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 02 00102 CAP REL COSTS INTEREST EXPENSE						
00 00200 CAP REL COSTS INTEREST EXPENSE						
01 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						
00 00400 EMPLOYEE BENEFITS DEPARTMENT	85, 264, 805					
01 00570 ADMI TTI NG	269, 314	1, 614, 903, 078				1
06 00590 OTHER ADMINISTRATIVE & GENERAL	6, 894, 963	0	-57, 245, 576	256, 988, 207		1
00 00700 OPERATION OF PLANT	1, 410, 173	0	C	15, 553, 277	306, 800	
01 00701 OPERATION OF PLANT - NONHOSPITAL	0	0	C	675, 360	0	
00 00800 LAUNDRY & LINEN SERVICE	0	0	C	0 0	0	
00 00900 HOUSEKEEPING	1, 306, 094	0	C	3, 296, 112	5, 071	
00 01000 DI ETARY 00 01100 CAFETERI A	586, 360 424, 018	0	C	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	8,009	
00 01300 NURSING ADMINISTRATION	9, 767, 426	0		.,	6, 175 4, 478	
00 01400 CENTRAL SERVICES & SUPPLY	435, 120	0	C			
00 01500 PHARMACY	4, 139, 121	0	C	6, 531, 975	4, 467	
00 01600 MEDICAL RECORDS & LIBRARY	0	0	C		0	
00 01700 SOCIAL SERVICE	577, 839	0	C	728, 503	0	1
00 01850 PATIENT TRANSPORT SERVICES	576, 294	0	C	823, 029	1, 276	18
00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	C	1,000,111	0	
00 02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	799, 280	0	C	.,		
00 02300 PARAMED ED PRGM - PHARMACY	204, 676	0	C	273, 283	139	23
INPATIENT ROUTINE SERVICE COST CENTERS	40 700 500	470 400 000		40 745 005	444.000	
00 03000 ADULTS & PEDIATRICS 00 03100 INTENSIVE CARE UNIT	19, 790, 503	173, 128, 938	C		111, 930	
00 03100 INTENSIVE CARE UNIT 00 03300 BURN INTENSIVE CARE UNIT	3, 583, 801 0	26, 230, 561 0	C		11, 205 0	
01 03301 BURN INTENSIVE CARE UNIT	0	0			0	
00 02060 NEONATAL INTENSIVE CARE UNIT	1, 939, 873	15, 141, 188	C	-	8, 936	
00 04300 NURSERY	702, 341	3, 657, 080	C		4, 271	
ANCI LLARY SERVI CE COST CENTERS			-			
00 05000 OPERATI NG ROOM	4, 773, 089	162, 112, 872	C	9, 526, 086	30, 415	50
00 05100 RECOVERY ROOM	793, 363	13, 324, 314	C	1,011,010		
00 05200 DELIVERY ROOM & LABOR ROOM	2, 479, 413	25, 458, 235	C	.,,		
00 05300 ANESTHESI OLOGY 01 05301 ASC ANESTHESI OLOGY	161, 643	9, 182, 970	C	010001072	1, 216	
01 05301 ASC ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C	1,616	4, 239, 290 109, 375, 963		13, 979 6, 901, 051	0 17, 037	
00 05500 RADI OLOGY-THERAPEUTI C	4, 033, 351	109, 375, 903		0,901,031	0	
00 05600 RADI OL SOTOPE	287, 391	16, 160, 868	C	626, 421	2, 110	
00 05900 CARDI AC CATHETERI ZATI ON	1, 307, 176	66, 868, 372	C			
00 06000 LABORATORY	6, 548	86, 409, 016	C			
00 06300 BLOOD STORING, PROCESSING & TRANS.	0	5, 360, 488	C		643	
00 06500 RESPI RATORY THERAPY	2, 175, 163	23, 332, 901	C	3, 148, 012	876	65
00 06600 PHYSI CAL THERAPY	587, 716	3, 785, 233	C	792, 783	573	
00 06700 OCCUPATI ONAL THERAPY	381, 737	2, 382, 117	C	570, 029	422	
00 06800 SPEECH PATHOLOGY	286, 399	1,855,309	C	405, 787	329	
00 06900 ELECTROCARDI OLOGY	1, 115, 081	37, 190, 256	C	1, 759, 849		
00 07000 ELECTROENCEPHALOGRAPHY 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	83, 584	634, 731 62, 158, 060		0 104, 088 0 7, 893, 044	0	
00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	62, 158, 060 120, 181, 006	(			
00 07300 DRUGS CHARGED TO PATIENTS	0	254, 748, 167	C C	39, 438, 759		
00 07400 RENAL DIALYSIS	0	2, 524, 008	C		1, 543	
00 07500 ASC (NON-DI STINCT PART)	0	0	C	0 0	0	
01 07501 ASC (NON-DI STINCT PART)	3, 099, 567	133, 527, 665	C	5, 638, 850	0	
00 03950 CARDI AC CATHERI ZATI ON	0	0	C	0	0	76
01 03951 OUTPATIENT WOUND CARE CENTER	138, 347	12, 518, 056	C		0	
97 07697 CARDI AC REHABI LI TATI ON	532	0	C	32, 399	0	70
		~			^	
00 09000 CLINIC 01 04950 SLEEP CLINIC	408, 943	0 5, 632, 352	C	642, 426		90 90
02 09001 ANTI COAGULATI ON CLINIC	408, 943 74, 972	5, 632, 352 584, 422	C C	0 042, 420	0	
03 09002 ARNETT CANCER CARE CENTER	964, 234	30, 894, 116				
04 09003 OUTPATIENT INFUSION CENTER	45, 811	791, 296	ſ	96, 899		
00 09100 EMERGENCY	5, 711, 829	205, 411, 777	C			
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-, , 52 /	, ,		_, _, 2, 2, 0, 1, 20		92
01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	C	0	0	
00 04951 OTHER OUTPATIENT SERVICES	0	0	C			93
SPECIAL PURPOSE COST CENTERS						
3.00 SUBTOTALS (SUM OF LINES 1 through 117)	02 224 701	4 444 004 407	-57, 245, 576	244, 785, 259	299, 173	1111

Health Financial Systems	IU HEALTH ARNE	TT_HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021 To 12/31/2021		pared:
					5/26/2022 3:4	2 pm
Cost Center Description	EMPLOYEE	ADMI TTI NG	Reconciliatio		OPERATION OF	
	BENEFITS	(PATI ENT		ADMI NI STRATI VE		
	DEPARTMENT	CHARGES)		& GENERAL	(SQUARE FEET)	
	(GROSS			(ACCUM. COST)		
	SALARI ES)					
	4.00	5.01	5A. 06	5.06	7.00	
NONREI MBURSABLE COST CENTERS	T T		1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	35, 246	C	)	0 258, 823		190.00
191. 00 19100 RESEARCH	0	C	)	0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	604, 315	2, 775		0 795, 563		192.00
193.00 19300 NONPAI D WORKERS	0	C		0 0		193.00
193.01 19301 RETAIL PHARMACY	1,008	98, 676		0 6, 801, 856		193. 01
193. 02 19302 WHI TE HOSPI TAL	1, 356, 016	0		0 2, 525, 435		193. 02
193. 03 19303 HOSPI CE	0	C	)	0 5, 280		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	943, 519	C	)	0 1, 815, 991	1, 878	193. 04
194.0007950 MARKETI NG/PUBLIC RELATIONS	0	C	)	0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	15, 873, 270	920, 845	5	57, 245, 576	19, 017, 863	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 186164	0. 000570		0. 222756	61. 987819	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	79, 302		1, 001, 985	4, 535, 861	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000049		0. 003899	14. 784423	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 COST ALLOCATION - STATISTICAL BASIS	IU HEALTH ARN		CN: 15-0173	In Lie Period:	u of Form CMS-2 Worksheet B-1	2552-10
COST ALLOCATION - STATISTICAL DASIS		Frovider C		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
Cost Center Description	OPERATION OF PLANT - NONHOSPITAL (SQUARE FEET)	LAUNDRY & LI NEN SERVICE (PATIENT DAYS)		DI ETARY (PATI ENT DAYS)	CAFETERI A (FTES)	
	(300ARE FEET) 7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						1 00
1.00       00100       CAP       REL       COSTS-BLDG & FIXT         1.01       00101       CAP       REL       COSTS-BLDG & FIXT       -         1.02       00102       CAP       REL       COSTS-BLDG & FIXT       -       NONHOSP         1.02       00102       CAP       REL       COSTS INTEREST       EXPENSE         2.00       00200       CAP       REL       COSTS -MVBLE       EQUIP         2.01       00201       CAP       REL       COSTS -MVBLE       EQUIP         2.01       00200       CAP       REL       COSTS -MVBLE       EQUIP         3.00       00570       ADMI TTING       STATI VE       & GENERAL         7.00       00700       OPERATION OF       PLANT       -       NONHOSPI TAL         8.00       00800       LAUNDRY & LINEN       SERVICE       9.00       00900       HOUSEKEEPI NG         10.00       01000       DI ETARY	76, 149 0 155 0 0 79 50	51, 696 0 0 0 0 0 0 0 0 0 0 0 0 0 0	377, 72 8, 00 6, 17 4, 47 20, 16 4, 51	9 46,269 5 0 8 0 8 0	85, 385 4, 309 927 5, 011 0	13.00 14.00 15.00 16.00
17.00 01700 SOCIAL SERVICE 18.00 01850 PATIENT TRANSPORT SERVICES			1, 27	6 0	958 1, 629	
21.00       02100       I &R SERVI CES-SALARY & FRI NGES APPRVD         22.00       02200       I &R SERVI CES-OTHER PRGM. COSTS APPRVD         23.00       02300       PARAMED ED PRGM - PHARMACY	C 15, 548	, s	15, 54	0 0 8 0	1, 431 405 290	21.00 22.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         O30000         ADULTS & PEDI ATRI CS	0	41, 765	111, 93	0 41, 765	25, 167	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	0,011			3, 446	
33.00 03300 BURN INTENSIVE CARE UNIT 33.01 03301 BURN INTENSIVE CARE UNIT				0 0 0 0	0	33.00 33.01
35.00 02060 NEONATAL INTENSIVE CARE UNIT	C				2, 259	35.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	2,465	4, 27	1 0	816	43.00
50. 00 05000 OPERATI NG ROOM	C	C	30, 41	5 0	6, 149	50.00
51.00 05100 RECOVERY ROOM	0	, s	.,		1,036	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY					3, 112 306	
53. 01 05301 ASC ANESTHESI OLOGY	130		13		0	53.01
54. 00 05400 RADI OLOGY -DI AGNOSTI C	0	0	17, 03		5, 162	
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE			2, 11		0 341	55.00 56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	C C	6, 32	2 0	1, 691	59.00
60.00 06000 LABORATORY	0	0	9,02			60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY			64 87		0 2, 530	63.00 65.00
66. 00 06600 PHYSI CAL THERAPY	C	0	57		741	66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	0	42		488	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY			32 2,44		333 1, 811	68.00 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		2, 11	0 0	103	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS					0	72.00 73.00
74. 00 07400 RENAL DI ALYSI S	0		1, 54	3 0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	75.00
75. 01 07501 ASC (NON-DI STINCT PART) 76. 00 03950 CARDI AC CATHERI ZATI ON	37, 584		37, 58	4 0	0	75.01 76.00
76. 01 03951 OUTPATIENT WOUND CARE CENTER				0 0	0	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 846	0 0	2, 84	6 0	0	76.97
OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0				0	90.00
90. 01 04950 SLEEP CLINIC	3, 402		3, 40	2 0	0	90.00
90. 02 09001 ANTI COAGULATI ON CLINIC	1, 291		1, 29		0	90. 02
90. 03 09002 ARNETT CANCER CARE CENTER 90. 04 09003 OUTPATIENT INFUSION CENTER	12, 691		12, 69 59		1, 408 46	90. 03 90. 04
91. 00 09100 EMERGENCY			20, 65		7, 324	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 93.00 04951 OTHER OUTPATI ENT SERVICES					0	92.01 93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)		,	1			93.00 118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	2, 28	8 0	100	190.00
				· · · · · · · · · · · · · · · · · · ·		·

Health Financial Systems	IU HEALTH ARN	ETT_HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
				From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/26/2022 3:4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(FTES)	
		(PATIENT DAYS)				
	(SQUARE FEET)					
	7.01	8.00	9.00	10.00	11.00	101.00
191.00 19100 RESEARCH	0	0	(	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(	0		192.00
193.00 19300 NONPALD WORKERS	0	0	(	0		193.00
193. 01 19301 RETAIL PHARMACY	0	0	1, 208			193.01
193. 02 19302 WHI TE HOSPI TAL	1, 147	0	3, 400	0		193.02
193. 03 19303 HOSPI CE	1 005	0	2 10	0		193.03
193. 04 19304 FRANKFORT HOSPI TAL	1, 225	0	3, 103	3 U		193.04
194.00 07950 MARKETING/PUBLIC RELATIONS 200.00  Cross Foot Adjustments	0	0		0	0	194.00 200.00
						200.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	825, 800		1 246 26	2 004 052		
Part I)	825,800	0	4, 346, 362	2 2, 986, 952	1, 749, 481	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10. 844528	0. 000000	11. 506744	4 64. 556226	20. 489325	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	19, 084	0	402, 909	629, 443	483, 540	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 250614	0. 000000	1. 066678	3 13. 603990	5.663056	205. 00
)						
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)	l	I		1		

	ncial Systems TION - STATISTICAL BASIS	IU HEALTH ARNE	Provi der CC	N: 15-0173	Peri od:	worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES & SUPPLY	(COSTED REQUI S. )	RECORDS & LI BRARY	(PATIENT DAYS)	
		(FTES)	(COSTED		(PATI ENT		
			REQUIS.)		CHARGES)		
CENER	AL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	-
	CAP REL COSTS-BLDG & FIXT						1 1
	CAP REL COSTS-BLDG & FIXT - NONHOSP						1
	CAP REL COSTS INTEREST EXPENSE						1
	CAP REL COSTS-MVBLE EQUIP						2
	CAP REL COSTS-MVBLE EQUIP - NONHOSP						2
	EMPLOYEE BENEFITS DEPARTMENT						4
							5
	OTHER ADMINISTRATIVE & GENERAL						
	OPERATION OF PLANT - NONHOSPITAL						
	LAUNDRY & LINEN SERVICE						8
	HOUSEKEEPING						9
00 01000	DIETARY						10
	CAFETERIA						11
	NURSING ADMINISTRATION	37, 590					13
	CENTRAL SERVICES & SUPPLY	76	27, 708, 594	40 740 47			14
	) PHARMACY ) MEDI CAL RECORDS & LI BRARY	0	144, 799	40, 748, 61	0 1, 614, 903, 078		15
	SOCIAL SERVICE	0	0		0 1, 014, 903, 070	51, 696	
	PATIENT TRANSPORT SERVICES	0	8, 255		0 0	0 0	
	I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0 0	0	
00 02200	I&R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0 0	0	
	PARAMED ED PRGM - PHARMACY	0	0		0 0	0	23
	I ENT ROUTI NE SERVI CE COST CENTERS	10.17	007.544			44.745	
	ADULTS & PEDIATRICS	18, 477	887, 541	271, 75			
	BURN INTENSIVE CARE UNIT	2,612	183, 996 0	119, 88	35 26, 230, 561 0 0	3, 547	
	BURN INTENSIVE CARE UNIT	0	0			0	
	NEONATAL INTENSIVE CARE UNIT	2,051	68, 219	17, 54	19 15, 141, 188	-	
	NURSERY	591	0		0 3, 657, 080		
	LARY SERVICE COST CENTERS	I				1	
	OPERATING ROOM	3, 137	5, 148, 183	139, 65			
	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	924 2, 175	39, 577 202, 341	3, 80 50, 94			-
	ANESTHESI OLOGY	2, 175	265, 804	50, 92 77, 31			
	ASC ANESTHESI OLOGY	0	73, 855	6, 59			
	RADI OLOGY-DI AGNOSTI C	874	1, 317, 134	152, 93		0	
	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55
	RADI OI SOTOPE	0	10, 560	10, 34			
	CARDI AC CATHETERI ZATI ON	1, 166	908, 663	46, 03			
		0	67, 208	18			
	BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	100	0 749, 687		0 5, 360, 488 0 23, 332, 901	0	1
	PHYSI CAL THERAPY	0	153		0 3, 785, 233		
	OCCUPATI ONAL THERAPY	0	87		0 2, 382, 117	0	
00 06800	SPEECH PATHOLOGY	0	902		0 1, 855, 309	0	68
	ELECTROCARDI OLOGY	357	5, 739	7,65			
	ELECTROENCEPHALOGRAPHY	0	0		0 634, 731	0	
-	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,857,614		0 62, 158, 060		
	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	8, 574, 931 0	39, 293, 20	0 120, 181, 006 01 254, 748, 167		1
	RENAL DIALYSIS	0	3, 637	39, 293, 20			
	ASC (NON-DISTINCT PART)	0	0,007	02	0 0	0	
	ASC (NON-DI STINCT PART)	0	726, 693	74, 22	133, 527, 665	0	
	CARDIAC CATHERIZATION	0	О		0 0	0	
	OUTPATIENT WOUND CARE CENTER	0	20, 556		0 12, 518, 056		
	CARDIAC REHABILITATION	0	0		0 0	0	76
	CLINIC	0	0		0 0	0	90
	SLEEP CLINIC	0	28, 050		0 5, 632, 352	-	
	ANTI COAGULATION CLINIC	0	0		0 584, 422		
03 09002	ARNETT CANCER CARE CENTER	707	68, 564	146, 67	30, 894, 116	0	90
	OUTPATIENT INFUSION CENTER	45	727	2, 23			
	EMERGENCY	4, 196	341, 813	326, 80	05 205, 411, 777	0	
	OBSERVATION BEDS (NON-DISTINCT PART)		_		-	-	92
	OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	
	OTHER OUTPATIENT SERVICES AL PURPOSE COST CENTERS	0	0		0 0	0	93
SPECT							

Health Financial Systems	IU HEALTH ARNE	TT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 3:42	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		SUPPLY	REQUIS.)	LI BRARY	(PATIENT DAYS)	
	(FTES)	(COSTED		(PATI ENT		
		REQUIS.)		CHARGES)		
	13.00	14.00	15.00	16.00	17.00	
NONREI MBURSABLE COST CENTERS		0				100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191.00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 306	20	0 2, 775		192.00 193.00
193. 00 19300 NONPALD WORKERS 193. 01 19301 RETALL PHARMACY	0	0				193.00
193. 02 1930 WHI TE HOSPI TAL	0	0		0 98, 676		193.01
193. 03 19303 HOSPI CE	0	0		0 0		193.02
193. 04 19303 FRANKFORT HOSPI TAL	0	0		0 0		193.03
193. 04 19304 FRANKFORT HOSPITAL 194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0				193.04
200.00 Cross Foot Adjustments	0	0		0 0		200.00
201.00 Negative Cost Centers						200.00
202.00 Cost to be allocated (per Wkst. B,	17, 612, 387	15, 891, 258	8, 502, 14	6 0	910, 410	
Part I)	17,012,007	10,071,200	0,002,11		,10,110	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	468, 539159	0. 573514	0, 20864	9 0. 000000	17.610840	203.00
204.00 Cost to be allocated (per Wkst. B,	426, 891	1, 612, 534				204.00
Part II)					.,	
205.00 Unit cost multiplier (Wkst. B, Part	11. 356504	0. 058196	0. 01005	4 0. 000000	0. 159877	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH ARNE	TT HOSPITAL Provider CC		<u>In Lie</u> Period: From 01/01/2021	u of Form CMS-2552-10 Worksheet B-1
					To 12/31/2021	Date/Time Prepared: 5/26/2022 3:42 pm
		OTHER GENERAL	INTERNS &	RESI DENTS		
	Cost Center Description	SERVI CE PATI ENT	SERVI CES-SALAR	SERVI CES-OTHER	R PARAMED ED	
		TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
		SERVI CES (PATI ENT	(ASSIGNED TIME)	(ASSI GNED TI ME)	PHARMACY (ASSI GNED	
		CHARGES)	TTWE)	TTWE)	TI ME)	
	OFNERAL OFRICE ODOT OFNITERO	18.00	21.00	22.00	23.00	
1.00	GENERAL SERVICE COST CENTERS					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP					1. 01
1.02	00102 CAP REL COSTS INTEREST EXPENSE					1.02
2.00 2.01	00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00570 ADMI TTI NG					5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5.06
7.00 7.01	00701 OPERATION OF PLANT - NONHOSPITAL					7.00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9.00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00						15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE					16. 00 17. 00
18.00	01850 PATIENT TRANSPORT SERVICES	1, 614, 903, 078				18.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	10, 992			21.00
22.00 23.00	02200 I & SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM - PHARMACY	0		10, 992	100	22. 00 23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				100	20.00
30.00	03000 ADULTS & PEDIATRICS	173, 128, 938				
31.00 33.00	03100 I NTENSI VE CARE UNI T 03300 BURN I NTENSI VE CARE UNI T	26, 230, 561 0	0			31.00 33.00
33.00	03301 BURN I NTENSI VE CARE UNI T	0	0			33.00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	15, 141, 188	353	353		35.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	3, 657, 080	0	(	0 0	43.00
50.00	05000 OPERATI NG ROOM	162, 112, 872	292	292	2 0	50.00
51.00	05100 RECOVERY ROOM	13, 324, 314	0	(		51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	25, 458, 235 9, 182, 970	858 0	858		52.00 53.00
53.00	05301 ASC ANESTHESI OLOGY	4, 239, 290	0			53.00
	05400 RADI OLOGY-DI AGNOSTI C	109, 375, 963	0			54.00
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0 16, 160, 868	0			55. 00 56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	66, 868, 372	0			59.00
60.00	06000 LABORATORY	86, 409, 016	0	0	0 0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5, 360, 488			0 0	63.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	23, 332, 901 3, 785, 233	0			65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	2, 382, 117	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	1,855,309	0	0	0 0	68.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	37, 190, 256 634, 731	0			69.00 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	62, 158, 060	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	120, 181, 006	0	0	0 0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	254, 748, 167	0			73.00
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	2, 524, 008 0	0			74.00 75.00
75.01	07501 ASC (NON-DISTINCT PART)	133, 527, 665	0			75.01
76.00	03950 CARDI AC CATHERI ZATI ON	0	0	(	-	76.00
76.01 76.97	03951 OUTPATIENT WOUND CARE CENTER 07697 CARDIAC REHABILITATION	12, 518, 056 0	0			76. 01 76. 97
, , ,	OUTPATIENT SERVICE COST CENTERS		0			
	09000 CLINIC	0	0			90.00
90.01	04950 SLEEP CLINIC 09001 ANTI COAGULATI ON CLINIC	5, 632, 352 584, 422	0			90. 01 90. 02
un ni	09002 ARNETT CANCER CARE CENTER	30, 894, 116	0		-	90.02
90. 02 90. 03						90.04
90. 03 90. 04	09003 OUTPATIENT INFUSION CENTER	791, 296	0			
90. 03 90. 04 91. 00	09100 EMERGENCY	791, 296 205, 411, 777	0 433			91.00
90. 03 90. 04 91. 00 92. 00					3 0	

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B-1 Date/Time Prepared: 5/26/2022 3:42 pm
	OTHER GENERAL	INTERNS &	RESI DENTS		
	SERVI CE				
Cost Center Description		SERVI CES-SALAR			
	TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
	SERVI CES	(ASSI GNED	(ASSI GNED	PHARMACY	
	(PATI ENT	TIME)	TIME)	(ASSI GNED	
	CHARGES)			TIME)	
	18.00	21.00	22.00	23.00	
SPECIAL PURPOSE COST CENTERS	4 (44 004 (07	10.000	10.00		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 614, 801, 627	10, 992	10, 99	2 100	118.00
NONREI MBURSABLE COST CENTERS	-	-		-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190.00
191. 00 19100 RESEARCH	0	0		0 0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 775	0		0 0	192.00
193.00 19300 NONPALD WORKERS	0	0		0	193.00
193. 01 19301 RETAIL PHARMACY	98, 676	0		0	193.01
193. 02 19302 WHI TE HOSPI TAL	0	0		0	193. 02
193. 03 19303 HOSPI CE	0	0		0	193.03
193. 04 19304 FRANKFORT HOSPI TAL	0	0		0	193.04
194.0007950 MARKETING/PUBLIC RELATIONS 200.00 Cross Foot Adjustments	0	0		J 0	194. 00 200. 00
					200.00
201.00 Negative Cost Centers	1 100 054	1 050 010	1 070 57	250,220	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 138, 254	1, 252, 212	1, 970, 57	350, 338	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.000705	113. 920306	179. 27310	8 3, 503. 380000	203.00
204.00 Cost to be allocated (per Wkst. B,	111, 978				203.00
Part II)	111, 770	12,005	201, 33	+ 15, 511	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0, 000069	1. 091976	18. 31641	2 135, 110000	205.00
	0.000007	1.071770	10.01011	100.110000	200.00
206.00 NAHE adjustment amount to be allocated				0	206.00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,	1			0.000000	207.00
Parts III and IV)					
·				·	-

	ancial Systems	IU HEALTH ARNE		N 45 0470		u of Form CMS-2	2002-10
COMPUTATIO	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-01/3	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre	pared:
						5/26/2022 3:4	2 pm
			Title	XVIII	Hospi tal	PPS	-
	Cast Castas Description	Tatal Cast	The second states the second	Tatal Casta	Costs	Tatal Casta	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	Auj.		DI Sal I Owalice		
		26)					
		1.00	2.00	3.00	4.00	5.00	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	DO ADULTS & PEDIATRICS	74, 971, 686		74, 971, 6	86 0	74, 971, 686	30.00
31.00 0310	DO INTENSIVE CARE UNIT	11, 147, 238		11, 147, 2	38 8, 430	11, 155, 668	31.00
	DO BURN INTENSIVE CARE UNIT	0			0 0	0	33.00
	D1 BURN INTENSIVE CARE UNIT	0			0 0	0	
	50 NEONATAL INTENSIVE CARE UNIT	6, 543, 612		6, 543, 6		6, 543, 612	
43.00 0430	DONURSERY	2, 112, 504		2, 112, 5	04 0	2, 112, 504	43.00
ANCI	LLARY SERVICE COST CENTERS	10 575 407		10 575 4		40 575 407	
	DO OPERATING ROOM	18, 575, 197		18, 575, 1		18, 575, 197	•
	DO RECOVERY ROOM	2, 437, 678		2, 437, 6		2, 437, 678	•
	DO DELIVERY ROOM & LABOR ROOM DO ANESTHESIOLOGY	7, 621, 738 8, 426, 073		7, 621, 7 8, 426, 0		7, 621, 738 8, 426, 073	•
	DI ASC ANESTHESI OLOGY	66, 720		8, 426, 0 66, 7		66, 720	•
	DO RADI OLOGY-DI AGNOSTI C	11,070,111		11, 070, 1		11, 070, 111	
	DO RADI OLOGY-THERAPEUTI C	0		11,070,1	0 0	0	
	DO RADI OI SOTOPE	947, 627		947, 6		947, 627	
	DO CARDI AC CATHETERI ZATI ON	4, 463, 548		4, 463, 5	-	4, 463, 548	
	DO LABORATORY	15, 382, 664		15, 382, 6		15, 382, 664	•
63.00 0630	DO BLOOD STORING, PROCESSING & TRANS.	1, 193, 080		1, 193, 0		1, 193, 080	63.00
65.00 0650	DO RESPI RATORY THERAPY	4, 458, 730	0	4, 458, 7	30 0	4, 458, 730	65.00
66.00 0660	DO PHYSI CAL THERAPY	1, 029, 432				1, 029, 432	66.00
	00 OCCUPATI ONAL THERAPY	739, 749	0	739, 7		739, 749	
	DO SPEECH PATHOLOGY	529, 006	0	529, 0		529, 006	
	DO ELECTROCARDI OLOGY	2, 566, 894		2, 566, 8		2, 566, 894	
	DO ELECTROENCEPHALOGRAPHY	129, 831		129, 8		129, 831	•
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 201, 540		14, 201, 5		14, 201, 540	
	DO I MPL. DEV. CHARGED TO PATIENTS	15, 571, 374		15, 571, 3		15, 571, 374	•
	DO DRUGS CHARGED TO PATIENTS	56, 952, 137		56, 952, 1		56, 952, 137	•
	DO RENAL DIALYSIS DO ASC (NON-DISTINCT PART)	1, 123, 795		1, 123, 7	95 0 0 0	1, 123, 795 0	1
75.00 0750	DI ASC (NON-DISTINCT PART)	8, 261, 378		8, 261, 3		8, 261, 378	•
	50 CARDI AC CATHERI ZATI ON	0,201,370		0, 201, 3	0 0	0, 201, 370	1
	51 OUTPATIENT WOUND CARE CENTER	1,085,847		1, 085, 8		1, 085, 847	•
	97 CARDI AC REHABI LI TATI ON	103, 228		103, 2		103, 228	•
OUTE	PATIENT SERVICE COST CENTERS	100,220		10072		100/220	
	DO CLINIC	0			0 0	0	90.00
	50 SLEEP CLINIC	881, 627		881, 6	27 0	881, 627	90.01
90. 02 0900	D1 ANTICOAGULATION CLINIC	166, 065		166, 0	65 0	166, 065	90.02
	02 ARNETT CANCER CARE CENTER	2, 935, 222		2, 935, 2	22 0	2, 935, 222	
	O3 OUTPATIENT INFUSION CENTER	185, 462		185, 4		185, 462	
	DO EMERGENCY	19, 548, 109		19, 548, 1		19, 878, 636	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	7, 728, 192		7, 728, 1		7, 728, 192	
	01 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	
	51 OTHER OUTPATIENT SERVICES	0			0 0	0	
200.00	Subtotal (see instructions)	303, 157, 094	0			303, 496, 051	
201.00	Less Observation Beds	7, 728, 192		7, 728, 1		7, 728, 192	
202.00	Total (see instructions)	295, 428, 902	0	295, 428, 9	02 338, 957	295, 767, 859	1202.00

OMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:4	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS	140 700 5/4		140 700 54			1 20 (
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT	148, 728, 564 26, 230, 561		148, 728, 56			30.0
	00 BURN INTENSIVE CARE UNIT			26, 230, 56	0		33.0
	1 BURN INTENSIVE CARE UNIT	0			0		33.0
	O NEONATAL INTENSIVE CARE UNIT	15, 141, 188		15, 141, 18	0		35.0
	NURSERY	3, 657, 080		3, 657, 08			43.0
	LLARY SERVICE COST CENTERS	3,037,000		3,037,00			43.0
	O OPERATING ROOM	59, 657, 143	102, 455, 729	162, 112, 87	0. 114582	0.00000	50.0
	O RECOVERY ROOM	4, 411, 597	8, 912, 717			0.000000	
	DO DELIVERY ROOM & LABOR ROOM	23, 877, 489	1, 580, 746			0.000000	
	OO ANESTHESI OLOGY	3, 700, 984	5, 481, 986			0.000000	
	01 ASC ANESTHESI OLOGY	4, 541	4, 234, 749			0.000000	
	DO RADI OLOGY-DI AGNOSTI C	42, 878, 323	66, 497, 640			0.000000	
	00 RADI OLOGY-THERAPEUTI C	0	C		0 0.000000	0.000000	
	DO RADI OI SOTOPE	2,060,326	14, 100, 542	16, 160, 86		0.000000	
	OO CARDI AC CATHETERI ZATI ON	29, 329, 995	37, 538, 377			0.000000	
	DO LABORATORY	34, 763, 587	51, 645, 429			0.000000	
	DO BLOOD STORING, PROCESSING & TRANS.	3, 696, 736	1, 663, 752			0. 000000	
5.00 0650	00 RESPIRATORY THERAPY	22,099,550	1, 233, 351	23, 332, 90	0. 191092	0. 000000	65.
. 00 0660	0 PHYSI CAL THERAPY	3, 359, 850	425, 383	3, 785, 23	0. 271960	0.000000	66.
7.00 067C	O OCCUPATIONAL THERAPY	2, 141, 983	240, 134	2, 382, 1	0. 310543	0. 000000	67.
3. 00 0680	O SPEECH PATHOLOGY	1, 654, 050	201, 259	1, 855, 30	0. 285131	0. 000000	68.
9.00 0690	00 ELECTROCARDI OLOGY	19, 701, 468	17, 488, 788	37, 190, 25	0. 069021	0.000000	69.
0,00 0700	00 ELECTROENCEPHALOGRAPHY	509, 364	125, 367	634, 73	0. 204545	0. 000000	70.
. 00 0710	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 869, 635	35, 288, 425	62, 158, 06	50 0. 228475	0.000000	71.
2.00 0720	00 IMPL. DEV. CHARGED TO PATIENTS	51, 545, 365	68, 635, 641	120, 181, 00	0. 129566	0.00000	72.
	DO DRUGS CHARGED TO PATIENTS	79, 271, 988	175, 476, 179	254, 748, 16	0. 223562	0.000000	73.
	00 RENAL DIALYSIS	2, 329, 367	194, 641	2, 524, 00		0.00000	
	00 ASC (NON-DISTINCT PART)	0	C		0 0.000000	0.00000	
	1 ASC (NON-DISTINCT PART)	182, 777	133, 344, 888	133, 527, 66	0. 061870	0.00000	75.
	50 CARDI AC CATHERI ZATI ON	0	C		0 0. 000000	0. 000000	
	01 OUTPATIENT WOUND CARE CENTER	146, 244	12, 371, 812	2 12, 518, 05		0. 000000	
	27 CARDIAC REHABILITATION	0	C		0 0.000000	0.00000	76.
	ATIENT SERVICE COST CENTERS	1		i	-		4
	DO CLINIC	0	C		0 0. 000000	0.00000	
	50 SLEEP CLINIC	0	5, 632, 352			0.00000	
	1 ANTICOAGULATION CLINIC	817	583, 605			0.00000	
	2 ARNETT CANCER CARE CENTER	234, 812	30, 659, 304			0.00000	
	03 OUTPATIENT INFUSION CENTER	10, 111	781, 185			0.00000	
	00 EMERGENCY	50, 125, 143	155, 286, 634			0.00000	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	707, 906	23, 692, 468			0.00000	
	01 OBSERVATION BEDS (DISTINCT PART)	0	C	2	0 0.000000	0.000000	
	1 OTHER OUTPATIENT SERVICES	0	0		0 0.00000	0.000000	
0.00	Subtotal (see instructions)	659, 028, 544	955, 773, 083	8 1, 614, 801, 62	27		200.
01.00	Less Observation Beds	(50.000.5.)	055 330 655				201.
02.00	Total (see instructions)	659, 028, 544	955, 773, 083	3 1, 614, 801, 62	27		202

	ancial Systems	IU HEALTH ARNETT			eu of Form CMS-255	52-10
COMPUTATION	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0173	Period: From 01/01/2021	Worksheet C Part I	
				To 12/31/2021	Date/Time Prepar	
			Title XVIII	Hospi tal	5/26/2022 3: 42 p PPS	μιι
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	ATLENT ROUTINE SERVICE COST CENTERS					~~ ~~
	00 ADULTS & PEDIATRICS 00 INTENSIVE CARE UNIT					30.00
	00 BURN INTENSIVE CARE UNIT					31.00 33.00
	00 BURN INTENSIVE CARE UNIT					33.00
	60 NEONATAL INTENSIVE CARE UNIT					35.00
	00 NURSERY					43.00
	I LLARY SERVICE COST CENTERS					.0.00
	00 OPERATI NG ROOM	0. 114582			51	50.00
	OO RECOVERY ROOM	0. 182950				51.00
	OO DELIVERY ROOM & LABOR ROOM	0. 299382				52.00
	00 ANESTHESI OLOGY	0. 917576				53.00
	01 ASC ANESTHESI OLOGY	0. 015738			5.	53.01
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0. 101212			54	54.00
55.00 0550	00 RADI OLOGY-THERAPEUTI C	0. 000000			5!	55.00
	00 RADI OI SOTOPE	0. 058637			56	56.00
59.00 059C	00 CARDI AC CATHETERI ZATI ON	0. 066751			50	59.00
	00 LABORATORY	0. 178022				60.00
	00 BLOOD STORING, PROCESSING & TRANS.	0. 222569				63.00
	00 RESPI RATORY THERAPY	0. 191092				65.00
	00 PHYSI CAL THERAPY	0. 271960				66.00
	00 OCCUPATI ONAL THERAPY	0. 310543				67.00
	00 SPEECH PATHOLOGY	0. 285131				68.00
		0. 069021				69.00
		0. 204545				70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS 00 IMPL. DEV. CHARGED TO PATIENTS	0. 228475				71.00
	00 DRUGS CHARGED TO PATIENTS	0. 129566 0. 223562				72.00 73.00
	00 RENAL DIALYSIS	0. 223562				73.00 74.00
	00 ASC (NON-DISTINCT PART)	0. 000000				75.00
	01 ASC (NON-DISTINCT PART)	0. 061870				75.00 75.01
	50 CARDI AC CATHERI ZATI ON	0. 000000				76.00
	51 OUTPATIENT WOUND CARE CENTER	0. 086742				76.01
	97 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTF	PATIENT SERVICE COST CENTERS					
90.00 0900	00 CLINIC	0. 000000			90	90.00
	50 SLEEP CLINIC	0. 156529			90	90. 01
	01 ANTICOAGULATION CLINIC	0. 284153				90. 02
	02 ARNETT CANCER CARE CENTER	0. 095009				90.03
	03 OUTPATIENT INFUSION CENTER	0. 234378				90.04
	00 EMERGENCY	0. 096775				91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART)	0. 316724				92. OC
	01 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
	51 OTHER OUTPATIENT SERVICES	0. 000000				93.00
200.00	Subtotal (see instructions)					00.00
201.00 202.00	Less Observation Beds					01.00
	Total (see instructions)				202	02.00

	ancial Systems	IU HEALTH ARNE		N 15 0170		u of Form CMS-2	2552-10
COMPUTATION	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-01/3	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre	pared:
						5/26/2022 3:4	2 pm
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
	cost center bescription	(from Wkst. B,	Adj.		Disallowance	TOTAL COSTS	
		Part I, col.	Auj .		Di Sai i Owanee		
		26)					
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	0 ADULTS & PEDIATRICS	74, 971, 686		74, 971, 6			
	O INTENSIVE CARE UNIT	11, 147, 238		11, 147, 2			
	O BURN INTENSIVE CARE UNIT	0			0 0	0	33.00
	1 BURN INTENSIVE CARE UNIT	0		( 540 (	0 0	0	33.01
	0 NEONATAL INTENSIVE CARE UNIT	6, 543, 612		6, 543, 6		6, 543, 612	35.00 43.00
43.00 0430	LLARY SERVICE COST CENTERS	2, 112, 504		2, 112, 5	04 0	2, 112, 504	43.00
50.00 0500	00 OPERATING ROOM	18, 575, 197		18, 575, 1	97 0	18, 575, 197	50.00
	O RECOVERY ROOM	2, 437, 678		2, 437, 6		2, 437, 678	
	O DELIVERY ROOM & LABOR ROOM	7,621,738		7, 621, 7		7, 621, 738	
	O ANESTHESI OLOGY	8, 426, 073		8, 426, 0		8, 426, 073	
53.01 0530	1 ASC ANESTHESI OLOGY	66, 720		66, 7	20 0	66, 720	53.01
	0 RADI OLOGY-DI AGNOSTI C	11, 070, 111		11, 070, 1	11 0	11, 070, 111	54.00
	0 RADI OLOGY-THERAPEUTI C	0			0 0	0	55.00
	0 RADI OI SOTOPE	947, 627		947, 6		947, 627	
	O CARDI AC CATHETERI ZATI ON	4, 463, 548		4, 463, 5		4, 463, 548	
	O LABORATORY	15, 382, 664		15, 382, 6		15, 382, 664	
	0 BLOOD STORING, PROCESSING & TRANS.	1, 193, 080		1, 193, 0		1, 193, 080	
	0 RESPIRATORY THERAPY	4, 458, 730				4, 458, 730	
	0 PHYSI CAL THERAPY	1,029,432		.,		1, 029, 432	
	0 OCCUPATI ONAL THERAPY 0 SPEECH PATHOLOGY	739, 749 529, 006	0	739, 7 529, 0		739, 749 529, 006	
	0 ELECTROCARDI OLOGY	2, 566, 894	0	2, 566, 8		2, 566, 894	
	0 ELECTROENCEPHALOGRAPHY	129, 831		129, 8		129, 831	
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 201, 540		14, 201, 5		14, 201, 540	
	O IMPL. DEV. CHARGED TO PATIENTS	15, 571, 374		15, 571, 3		15, 571, 374	
	O DRUGS CHARGED TO PATIENTS	56, 952, 137		56, 952, 1		56, 952, 137	
74.00 0740	0 RENAL DIALYSIS	1, 123, 795		1, 123, 7	95 0	1, 123, 795	74.00
75.00 0750	O ASC (NON-DISTINCT PART)	0			0 0	0	
	ASC (NON-DISTINCT PART)	8, 261, 378		8, 261, 3		8, 261, 378	
	O CARDI AC CATHERI ZATI ON	0			0 0	0	
	1 OUTPATIENT WOUND CARE CENTER	1,085,847		1, 085, 8		1, 085, 847	76.01
76.97 0769	07 CARDI AC REHABI LI TATI ON	103, 228		103, 2	28 0	103, 228	76.97
	ATIENT SERVICE COST CENTERS	0		1	0 0	0	90.00
	O SLEEP CLINIC	881, 627		881, 6		0 881, 627	1
	ANTICOAGULATION CLINIC	166, 065		166, 0		166, 065	1
90.02 0900	2 ARNETT CANCER CARE CENTER	2, 935, 222		2, 935, 2		2, 935, 222	
	3 OUTPATIENT INFUSION CENTER	185, 462		185, 4		185, 462	
	00 EMERGENCY	19, 548, 109		19, 548, 1		19, 878, 636	
	0 OBSERVATION BEDS (NON-DISTINCT PART)	7, 728, 192		7, 728, 1		7, 728, 192	
	1 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	92.01
	1 OTHER OUTPATIENT SERVICES	0			0 0	0	
200.00	Subtotal (see instructions)	303, 157, 094	0			303, 496, 051	
201.00	Less Observation Beds	7, 728, 192		7, 728, 1		7, 728, 192	
202.00	Total (see instructions)	295, 428, 902	0	295, 428, 9	02 338, 957	295, 767, 859	202 00

OMPUTAT	FION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:4	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Inpati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	140 700 5/4		140 700 54			1 20 0
	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT	148, 728, 564 26, 230, 561		148, 728, 56			30.0
	3300 BURN INTENSIVE CARE UNIT			26, 230, 56	0		33.0
	3301 BURN I NTENSI VE CARE UNI T	0			0		33.0
	2060 NEONATAL INTENSIVE CARE UNIT	15, 141, 188		15, 141, 18	Ŭ,		35.0
	4300 NURSERY	3, 657, 080		3, 657, 08			43.0
	NCI LLARY SERVICE COST CENTERS	3,037,000		3,037,00			
	5000 OPERATING ROOM	59, 657, 143	102, 455, 729	162, 112, 87	0. 114582	0.00000	50.0
	5100 RECOVERY ROOM	4, 411, 597	8, 912, 717			0.000000	
	5200 DELIVERY ROOM & LABOR ROOM	23, 877, 489	1, 580, 746			0.000000	
	5300 ANESTHESI OLOGY	3, 700, 984	5, 481, 986			0.000000	
	5301 ASC ANESTHESI OLOGY	4, 541	4, 234, 749			0.000000	
	5400 RADI OLOGY-DI AGNOSTI C	42, 878, 323	66, 497, 640			0.000000	
	5500 RADI OLOGY-THERAPEUTI C	0	C		0 0.000000	0.000000	
	5600 RADI OI SOTOPE	2,060,326	14, 100, 542	16, 160, 86		0.000000	
	5900 CARDI AC CATHETERI ZATI ON	29, 329, 995	37, 538, 377			0.000000	
	6000 LABORATORY	34, 763, 587	51, 645, 429			0.000000	
	6300 BLOOD STORING, PROCESSING & TRANS.	3, 696, 736	1, 663, 752			0.000000	
5.00 00	6500 RESPI RATORY THERAPY	22,099,550	1, 233, 351	23, 332, 90	0. 191092	0.000000	65.
	6600 PHYSI CAL THERAPY	3, 359, 850	425, 383		0. 271960	0.000000	66.
7.00 00	6700 OCCUPATIONAL THERAPY	2, 141, 983	240, 134	2, 382, 1	0. 310543	0.000000	67.
3. 00 00	6800 SPEECH PATHOLOGY	1,654,050	201, 259	1, 855, 30	0. 285131	0.000000	68.
9.00 00	6900 ELECTROCARDI OLOGY	19, 701, 468	17, 488, 788	37, 190, 25	0. 069021	0.000000	69.
D. 00 0	7000 ELECTROENCEPHALOGRAPHY	509, 364	125, 367	634, 73	0. 204545	0. 000000	70.
1.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 869, 635	35, 288, 425	62, 158, 06	0. 228475	0. 000000	71.
2.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	51, 545, 365	68, 635, 641	120, 181, 00	0. 129566	0.000000	72.
3.00 0	7300 DRUGS CHARGED TO PATIENTS	79, 271, 988	175, 476, 179	254, 748, 16	0. 223562	0.000000	73.
4. 00 0 <sup>.</sup>	7400 RENAL DIALYSIS	2, 329, 367	194, 641	2, 524, 00	0. 445242	0. 000000	74.
5.00 0	7500 ASC (NON-DISTINCT PART)	0	C		0 0.000000	0.000000	75.
5.01 0	7501 ASC (NON-DISTINCT PART)	182, 777	133, 344, 888	3 133, 527, 66	0. 061870	0.000000	75.
6.00 03	3950 CARDI AC CATHERI ZATI ON	0	C		0 0.000000	0.000000	76.
6.01 0	3951 OUTPATIENT WOUND CARE CENTER	146, 244	12, 371, 812	2 12, 518, 05	0. 086742	0.000000	76.
	7697 CARDI AC REHABI LI TATI ON	0	C		0 0.000000	0.00000	76.
	UTPATIENT SERVICE COST CENTERS	1			- 1		
	9000 CLI NI C	0	C		0 0.000000	0. 000000	
	4950 SLEEP CLINIC	0	5, 632, 352			0. 000000	
	9001 ANTICOAGULATION CLINIC	817	583, 605			0. 000000	
	9002 ARNETT CANCER CARE CENTER	234, 812	30, 659, 304			0. 000000	
	9003 OUTPATIENT INFUSION CENTER	10, 111	781, 185			0.000000	
	9100 EMERGENCY	50, 125, 143	155, 286, 634			0. 000000	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	707, 906	23, 692, 468			0. 000000	
	9201 OBSERVATION BEDS (DISTINCT PART)	0	C	) I	0 0.000000	0. 000000	
	4951 OTHER OUTPATIENT SERVICES	0	C	ן ע	0 0.000000	0. 000000	
00.00	Subtotal (see instructions)	659, 028, 544	955, 773, 083	3 1, 614, 801, 62	27		200.
01.00	Less Observation Beds						201.
02.00	Total (see instructions)	659, 028, 544	955, 773, 083	3 1, 614, 801, 62	27		202.

	Financial Systems	IU HEALTH ARNETT			u of Form CMS-2552-
OMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0173	Period: From 01/01/2021	Worksheet C Part I
				To 12/31/2021	Date/Time Prepared 5/26/2022 3:42 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	NPATI ENT ROUTI NE SERVI CE COST CENTERS				20
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT				30. 0
	D3300 BURN INTENSIVE CARE UNIT				31.0
	03300 BURN INTENSIVE CARE UNIT				33. (
	22060 NEONATAL INTENSIVE CARE UNIT				35.0
	04300 NURSERY				43.0
	ANCI LLARY SERVI CE COST CENTERS				
	D5000 OPERATI NG ROOM	0. 114582			50.0
	D5100 RECOVERY ROOM	0. 182950			51. (
2.00 0	D5200 DELIVERY ROOM & LABOR ROOM	0. 299382			52.0
3.00 0	05300 ANESTHESI OLOGY	0. 917576			53.0
3. 01 0	05301 ASC ANESTHESI OLOGY	0. 015738			53.0
	05400 RADI OLOGY-DI AGNOSTI C	0. 101212			54.0
	05500 RADI OLOGY-THERAPEUTI C	0. 000000			55.0
	D5600 RADI OI SOTOPE	0. 058637			56.0
	05900 CARDI AC CATHETERI ZATI ON	0. 066751			59.0
	06000 LABORATORY	0. 178022			60. (
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 222569			63.0
	06500 RESPI RATORY THERAPY	0. 191092			65.0
	06600 PHYSI CAL THERAPY	0. 271960			66. (
		0. 310543			67.0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0. 285131 0. 069021			68. ( 69. (
	D7000 ELECTROENCEPHALOGRAPHY	0. 204545			70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 228475			70.0
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 129566			71.0
	D7300 DRUGS CHARGED TO PATIENTS	0. 223562			72.0
	07400 RENAL DI ALYSI S	0. 445242			74.0
	07500 ASC (NON-DISTINCT PART)	0. 000000			75. (
	07501 ASC (NON-DI STINCT PART)	0. 061870			75. (
	03950 CARDI AC CATHERI ZATI ON	0. 000000			76.0
	03951 OUTPATIENT WOUND CARE CENTER	0. 086742			76. (
	07697 CARDI AC REHABI LI TATI ON	0. 000000			76.9
	DUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	0. 000000			90. (
	04950 SLEEP CLINIC	0. 156529			90.0
	09001 ANTI COAGULATI ON CLI NI C	0. 284153			90.0
	09002 ARNETT CANCER CARE CENTER	0.095009			90. (
	09003 OUTPATIENT INFUSION CENTER	0. 234378			90. (
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	0.096775			91. (
	D9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 316724 0. 000000			92. (
	04951 OTHER OUTPATIENT SERVICES	0.000000			92.0
200.00	Subtotal (see instructions)	0.00000			200. 0
201.00	Less Observation Beds				200.0
					120

Health Financial Systems	IU HEALTH ARNE	ETT HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider CC		Period: From 01/01/2021 To 12/31/2021	5/26/2022 3:4	pared: 2 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reducti on	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
	1.00		col . 2)		5.00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	10 575 107	2 700 050	15 70/ 1/		0	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	18, 575, 197					
	2, 437, 678					
52.00 O5200 DELIVERY ROOM & LABOR ROOM	7, 621, 738					
53.00 05300 ANESTHESI OLOGY	8, 426, 073	140, 480			-	
53. 01 05301 ASC ANESTHESI OLOGY	66, 720		60, 17			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 070, 111	1, 479, 864	9, 590, 24			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	170.010	77/ 0/	0 0		55.00
56.00 05600 RADI OI SOTOPE	947, 627	170, 813				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 463, 548		3, 879, 6			59.00
60. 00 06000 LABORATORY	15, 382, 664	783, 409				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 193, 080				-	63.00
65. 00 06500 RESPI RATORY THERAPY	4, 458, 730					
66. 00 06600 PHYSI CAL THERAPY	1,029,432	52, 227	977, 20			66.00
67.00 06700 OCCUPATI ONAL THERAPY	739, 749					67.00
68.00 06800 SPEECH PATHOLOGY	529, 006	29, 282	499, 72			68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 566, 894	215, 638				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	129, 831	1, 064	128, 76			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 201, 540					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 571, 374					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	56, 952, 137				-	
74.00 07400 RENAL DIALYSIS	1, 123, 795	123, 519	1, 000, 27			
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	-	75.00
75.01 07501 ASC (NON-DISTINCT PART)	8, 261, 378	549, 463	7, 711, 91			
76.00 03950 CARDI AC CATHERI ZATI ON	0	0		0 0		76.00
76.01 03951 OUTPATIENT WOUND CARE CENTER	1, 085, 847	6, 070				
76. 97 07697 CARDI AC REHABI LI TATI ON	103, 228	35, 617	67, 6	1 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	0		0 0		•
90. 01 04950 SLEEP CLINIC	881, 627	47, 227				
90. 02 09001 ANTI COAGULATI ON CLINIC	166, 065	16, 605	149, 46			90.02
90.03 09002 ARNETT CANCER CARE CENTER	2, 935, 222	190, 391	2, 744, 83	31 0	0	90.03
90. 04 09003 OUTPATIENT INFUSION CENTER	185, 462	47, 268	138, 19			90.04
91.00 09100 EMERGENCY	19, 548, 109				-	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 728, 192	1, 016, 628	6, 711, 56	64 0	0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
93. 00 04951 OTHER OUTPATI ENT SERVI CES	0	0		0 0	0	
200.00 Subtotal (sum of lines 50 thru 199)	208, 382, 054	13, 513, 383	194, 868, 67	71 0		200.00
201.00 Less Observation Beds	7, 728, 192	1, 016, 628	6, 711, 56			201.00
202.00 Total (line 200 minus line 201)	200, 653, 862	12, 496, 755	188, 157, 10	07 0	0	202.00

CALCUL	Financial Systems ATION OF OUTPATIENT SERVICE COST TO CHARGE RA IONS FOR MEDICAID ONLY	IU HEALTH ARNI	Provi der C	CN: 15-0173	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS- Worksheet C Part II Date/Time Pro 5/26/2022 3:4	epared:
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,				
		Operating Cost	Part I, column		6		
		Reduction	8)	/ col. 7)			
		6.00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	18, 575, 197	162, 112, 872				50.00
	05100 RECOVERY ROOM	2, 437, 678	13, 324, 314	0. 1829	50		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 621, 738	25, 458, 235	0. 2993	82		52.00
53.00	05300 ANESTHESI OLOGY	8, 426, 073	9, 182, 970	0. 9175	76		53.00
53.01	05301 ASC ANESTHESI OLOGY	66, 720	4, 239, 290				53.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 070, 111	109, 375, 963	0. 1012	12		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	00		55.00
56.00	05600 RADI OI SOTOPE	947, 627	16, 160, 868	0. 0586	37		56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 463, 548	66, 868, 372	0.0667	51		59.00
	06000 LABORATORY	15, 382, 664	86, 409, 016				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 193, 080	5, 360, 488				63.00
	06500 RESPI RATORY THERAPY	4, 458, 730	23, 332, 901	0. 1910			65.00
	06600 PHYSI CAL THERAPY	1,029,432	3, 785, 233				66.00
	06700 OCCUPATI ONAL THERAPY	739, 749	2, 382, 117	0. 3105			67.00
	06800 SPEECH PATHOLOGY	529,006	1, 855, 309				68.00
	06900 ELECTROCARDI OLOGY	2, 566, 894					69.00
	07000 ELECTROENCEPHALOGRAPHY	129, 831	634, 731	0. 2045			70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	14, 201, 540	62, 158, 060				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	15, 571, 374					72.00
	07300 DRUGS CHARGED TO PATIENTS	56, 952, 137	254, 748, 167				73.00
	07400 RENAL DI ALYSI S	1, 123, 795	2, 524, 008				74.00
	07500 ASC (NON-DISTINCT PART)	0	2, 324, 000	0. 00000			75.00
	07501 ASC (NON-DISTINCT PART)	8, 261, 378	-	0.0618			75.01
	03950 CARDI AC CATHERI ZATI ON	0,201,370	133, 327, 003	0.0000			76.00
	03951 OUTPATIENT WOUND CARE CENTER	1, 085, 847	12, 518, 056				76.01
	07697 CARDI AC REHABI LI TATI ON	103, 228	12, 510, 050	0.0000			76.97
	OUTPATIENT SERVICE COST CENTERS	103, 220	0	0.0000	00		- /0. //
	09000 CLINIC	0	0	0.0000	00		90.00
	04950 SLEEP CLINIC	881, 627	5, 632, 352				90.00
							90.01
	09001 ANTI COAGULATI ON CLINI C	166, 065		0. 2841			
	09002 ARNETT CANCER CARE CENTER	2, 935, 222	30, 894, 116				90.03
	09003 OUTPATIENT INFUSION CENTER	185, 462	791, 296				90.04
	09100 EMERGENCY	19, 548, 109					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 728, 192					92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0				92.01
	04951 OTHER OUTPATI ENT SERVICES	0	0	0.0000	00		93.00
200.00	, , , , , , , , , , , , , , , , , , , ,		1, 421, 044, 234				200.00
201.00	Less Observation Beds	7, 728, 192	0				201.00
202.00	Total (line 200 minus line 201)	200, 653, 862	1, 421, 044, 234	1			202.00

Health Financial Systems	IU HEALTH ARNE	TT HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26) 1.00	2.00	2)	4, 00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS 31. 00 INTENSIVE CARE UNIT 33. 00 BURN INTENSIVE CARE UNIT 33. 01 BURN INTENSIVE CARE UNIT 35. 00 NEONATAL INTENSIVE CARE UNIT 43. 00 NURSERY 200. 00 Total (Lines 30 through 199) Cost Center Description	9,862,369 1,010,317 0 751,480 348,398 11,972,564 Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	9, 862, 36 1, 010, 31 751, 48 348, 39 11, 972, 56	7 3, 547 0 0 0 0 0 2, 962 8 2, 465	211. 80 284. 84 0. 00 0. 00 253. 71 141. 34	31.00 33.00 33.01 35.00
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00ADULTS & PEDIATRICS31.00INTENSIVE CARE UNIT33.00BURN INTENSIVE CARE UNIT33.01BURN INTENSIVE CARE UNIT35.00NEONATAL INTENSIVE CARE UNIT43.00NURSERY200.00Total (lines 30 through 199)	15, 372 1, 000 0 0 0 16, 372	284, 840 0 0 0 0 0				30.00 31.00 33.00 33.01 35.00 43.00 200.00

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 3:4	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost	Total Charges (from Wkst. C,	Ratio of Cos to Charges	t Inpatient Program	Capital Costs (column 3 x	
	(from Wkst. B, Part II, col.	Part I, col. 8)	(col. 1 ÷ col 2)	. Charges	column 4)	
	26)	2.00	2.00	4.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	2 700 050	1/2 112 072	0.0170	10 000 454	242.402	
50. 00 05000 OPERATI NG ROOM	2, 789, 058					•
51.00 O5100 RECOVERY ROOM	384,016					•
52.00 O5200 DELIVERY ROOM & LABOR ROOM	1, 198, 093					
53. 00 05300 ANESTHESI OLOGY	140, 480					53.00
53. 01 05301 ASC ANESTHESI OLOGY	6, 542					53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 479, 864				220, 356	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	-			-	55.00
56. 00 05600 RADI OI SOTOPE	170, 813					
59. 00 05900 CARDI AC CATHETERI ZATI ON	583, 931					•
60. 00 06000 LABORATORY	783, 409					
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	54, 196					
65. 00 06500 RESPI RATORY THERAPY	142, 129					
66.00 06600 PHYSI CAL THERAPY	52, 227					•
67.00 06700 OCCUPATIONAL THERAPY	38, 036					•
68. 00 06800 SPEECH PATHOLOGY	29, 282					
69.00 06900 ELECTROCARDI OLOGY	215, 638					•
70. 00 07000 ELECTROENCEPHALOGRAPHY	1,064					•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	495, 392					•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	546, 914					•
73.00 07300 DRUGS CHARGED TO PATIENTS	579, 623					
74.00 07400 RENAL DI ALYSI S	123, 519					•
75. 00 07500 ASC (NON-DI STINCT PART)	0	-			-	
75. 01 07501 ASC (NON-DI STI NCT PART)	549, 463					•
76.00 03950 CARDIAC CATHERIZATION	0	-			-	•
76. 01 03951 OUTPATIENT WOUND CARE CENTER 76. 97 07697 CARDIAC REHABILITATION	6,070					
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	35, 617	0	0.0000		0	/0.9/
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
90. 01 04950 SLEEP CLINIC	47,227					
90. 01 04930 SLEEP CEINIC 90. 02 09001 ANTI COAGULATI ON CLINIC					-	
90. 02 09001 ANTICOAGULATION CLINIC 90. 03 09002 ARNETT CANCER CARE CENTER	16, 605 190, 391				-	
90. 03 09002 ARNETT CANCER CARE CENTER 90. 04 09003 OUTPATIENT INFUSION CENTER	47, 268					
91. 00 09100 EMERGENCY	47, 268 1, 789, 888					
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 789, 888					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	1, 016, 628					
93. 00 04951 OTHER OUTPATIENT SERVICES		-				
200.00 Total (lines 50 through 199)	0	1, 421, 044, 234		150, 739, 332	-	
	13, 513, 505	1, 421, 044, 234	I	100, 137, 332	1,400,421	l≥00.00

Health Financial Systems	IU HEALTH ARNE				u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHE	R PASS THROUGH COST			Period: From 01/01/2021 To 12/31/2021	5/26/2022 3:4	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
	Program	Program	Post-Stepdow		Medi cal	
	Post-Stepdown		Adj ustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		0	J	0 0		
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	U U	
31. 00 03100 I NTENSI VE CARE UNI T	0	0	)	0 0	0	
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0	)	0 0	0	
33. 01 03301 BURN INTENSIVE CARE UNIT	0	0	)	0 0	0	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	)	0 0	0	1 00.00
43. 00 04300 NURSERY	0	0	)	0 0	0	
200.00   Total (lines 30 through 199)	0	0	)	0 0		200.00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpati ent	
	Adj ustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions) 4.00	minus col. 4) 5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	46, 56	5 0.00	15, 372	1 30. 00
31. 00 03100 I NTENSI VE CARE UNI T	_	0	3, 54			
33.00 03300 BURN INTENSIVE CARE UNIT		0		0 0.00		
33. 01 03301 BURN INTENSIVE CARE UNIT		0		0 0.00		
35. 00 02060 NEONATAL INTENSIVE CARE UNIT		0	2,96			
43. 00 04300 NURSERY		0				
200.00 Total (lines 30 through 199)		0			16, 372	
Cost Center Description	Inpati ent			-		
•	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.0
31.00 03100 INTENSIVE CARE UNIT	0					31.0
33.00 03300 BURN INTENSIVE CARE UNIT	0					33.0
33.01 03301 BURN INTENSIVE CARE UNIT	0					33.0
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0					35.00
						1 12 00
43. 00 04300 NURSERY	0					43.00

Health Financial Systems	IU HEALTH ARNE	ETT_HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PASS	S Provider C	CN: 15-0173	Period: From 01/01/2021	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2021		pared:
					5/26/2022 3:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anestheti st	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
	1.00	Adjustments			0.00	
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0		0		50.00
	0	0		0 0		
	0	0				
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0				-	
53. 00 05300 ANESTHESTOLOGY 53. 01 05301 ASC ANESTHESTOLOGY	0	0				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			-	
	0	0				
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			-	
	0	0			-	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		-	-	
60. 00 06000 LABORATORY	0	0		-	-	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	-	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	-	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	-	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0			, °	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0			, °	
70. 00 07000 ELECTROCARDI OLOGY	0	0			, °	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			-	
74. 00 07400 RENAL DIALYSIS	0	0			000,000	1
75. 00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0	
	0			0 0	0	
75. 01 07501 ASC (NON-DISTINCT PART) 76. 00 03950 CARDIAC CATHERIZATION	0	0				1
76. 01 03951 OUTPATIENT WOUND CARE CENTER	0	0			-	
76. 97 07697 CARDIAC REHABILITATION	0					
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	/0.9/
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 04950 SLEEP CLINIC	0	0		0 0		
90. 02 09001 ANTI COAGULATI ON CLINIC	0				0	
90. 03 09002 ARNETT CANCER CARE CENTER	0				0	
90. 04 09003 OUTPATIENT INFUSION CENTER	0	0		0 0	0	
91. 00 09100 EMERGENCY	0			0 0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0		0 0	-	
200.00 Total (lines 50 through 199)	0	0		0 0	-	
	1 0	1 0	I	5	1 000,000	1-00.00

Health Financial Systems	IU HEALTH ARNI				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0173	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021	Part IV Date/Time Pre	nared
				10 12/01/2021	5/26/2022 3: 4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	-	-	1			
50. 00 05000 OPERATI NG ROOM	0	0		0 162, 112, 872	0.00000	•
51.00 05100 RECOVERY ROOM	0	0		0 13, 324, 314		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 25, 458, 235	0.00000	•
53. 00 05300 ANESTHESI OLOGY	0	0		0 9, 182, 970	0.00000	
53. 01 05301 ASC ANESTHESI OLOGY	0	0		0 4, 239, 290	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 109, 375, 963	0.00000	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.00000	
56. 00 05600 RADI OI SOTOPE	0	0		0 16, 160, 868	0. 000000	
59. 00 05900 CARDIAC CATHETERIZATION	0	0		0 66, 868, 372	0. 000000	•
60. 00 06000 LABORATORY	0	0		0 86, 409, 016	0. 000000	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 5, 360, 488	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 23, 332, 901	0. 000000	•
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 785, 233	0. 000000	•
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 2, 382, 117	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 855, 309	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 37, 190, 256	0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 634, 731	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 62, 158, 060	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 120, 181, 006	0. 000000	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	350, 338	350, 33	8 254, 748, 167	0.001375	•
74.00 07400 RENAL DIALYSIS	0	0		0 2, 524, 008	0. 000000	•
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000	•
75.01 07501 ASC (NON-DISTINCT PART)	0	0		0 133, 527, 665	0. 000000	75.01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0		0 0	0. 000000	
76.01 03951 OUTPATIENT WOUND CARE CENTER	0	0		0 12, 518, 056	0. 000000	•
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0.00000	90.00
90. 01 04950 SLEEP CLINIC	0	0		0 5, 632, 352	0.00000	90.01
90. 02 09001 ANTI COAGULATI ON CLINIC	0	0		0 584, 422	0.00000	90.02
90. 03 09002 ARNETT CANCER CARE CENTER	0	0		0 30, 894, 116	0. 000000	
90. 04 09003 OUTPATIENT INFUSION CENTER	0	0		0 791, 296	0.00000	
91. 00 09100 EMERGENCY	0	0		0 205, 411, 777	0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 24, 400, 374	0.00000	92.00
AN AN ANALADOEDWATION DEDG (DICTINGT DADT)				0 0	0.000000	92.01
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0		
92.01 09201 OBSERVATION BEDS (DISTINCT PART) 93.00 04951 OTHER OUTPATIENT SERVICES 200.00 Total (lines 50 through 199)	0	0 0 350, 338		0 0 8 1, 421, 044, 234	0. 000000	

Health Financial Systems	IU HEALTH ARNE	TT_HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-0173	Period: From 01/01/2021	Worksheet D Part IV	
				To 12/31/2021	Date/Time Pre	
		Title	XVIII	Hospi tal	5/26/2022 3:4 PPS	2 piii
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	51121 g = -	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			•		•	
50. 00 05000 OPERATI NG ROOM	0. 000000	19, 902, 456		0 20, 341, 898	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 468, 256	1	0 1, 996, 585	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	129, 646	1	0 10, 536	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	1, 176, 659	1	0 998, 272	0	53.00
53. 01 05301 ASC ANESTHESI OLOGY	0. 000000	294		0 709, 197	0	53.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	16, 286, 471		0 16, 301, 789	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0. 000000	884, 393		0 4, 557, 825	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 756, 328		0 11, 410, 664	0	59.00
60. 00 06000 LABORATORY	0. 000000	11, 126, 034		0 5, 997, 612	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	1, 409, 182		0 912, 824	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	5, 686, 679		0 157, 864	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 477, 759		0 19,036	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	915, 207		0 8, 083	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	771, 333		0 18,646		68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	8, 364, 701		0 4, 917, 494	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	218, 267		0 20, 445	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	8,002,613		0 9, 600, 977	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	18, 799, 072		0 18, 619, 818	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.001375	23, 758, 568	32, 66			•
74.00 07400 RENAL DI ALYSI S	0. 000000	1, 224, 220		0 50, 086		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 ASC (NON-DI STINCT PART)	0. 000000	59, 876		0 24, 147, 196	-	75.01
76.00 03950 CARDI AC CATHERI ZATI ON	0. 000000	0		0 0	0	76.00
76.01 03951 OUTPATIENT WOUND CARE CENTER	0. 000000	112, 903		0 2, 120, 391	0	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				- <b>.</b>		
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 04950 SLEEP CLINIC	0. 000000	0		0 1, 105, 319	0	90.01
90. 02 09001 ANTI COAGULATI ON CLINIC	0. 000000	443		0 256,099	0	90.02
90.03 09002 ARNETT CANCER CARE CENTER	0. 000000	129, 613		0 10, 411, 383		90.03
90. 04 09003 OUTPATIENT INFUSION CENTER	0. 000000	2, 612		0 165, 735	0	90.04
91. 00 09100 EMERGENCY	0. 000000	18, 890, 459		0 20, 905, 013	-	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	185, 288		0 4, 777, 354		92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
93. 00 04951 OTHER OUTPATIENT SERVICES	0. 000000	0		0 0	0	93.00
200.00 Total (lines 50 through 199)		150, 739, 332	32, 66	220, 812, 746	82, 878	
	т — Т					

APPORTI ONM	ENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 3:4	pared: 2 pm
			Title	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	DO OPERATING ROOM	0. 114582	20, 341, 898		0 0	2, 330, 815	50.00
	DO RECOVERY ROOM	0. 182950			0 0		•
	DO DELIVERY ROOM & LABOR ROOM	0. 299382			0 0	3, 154	52.00
	DO ANESTHESI OLOGY	0. 917576			0 0	915, 990	•
	D1 ASC ANESTHESI OLOGY	0. 015738			0 0		53.00
	DO RADI OLOGY-DI AGNOSTI C	0. 101212			0 0		54.00
	DO RADI OLOGY-THERAPEUTI C	0. 000000			0 0	1, 049, 937	55.00
	DO RADI OI SOTOPE	0. 058637	4, 557, 825		0 0		56.00
	DO CARDI AC CATHETERI ZATI ON	0. 066751	11, 410, 664		-		•
60.00 0600	DO LABORATORY	0. 178022	5, 997, 612		0 0		
	DO BLOOD STORING, PROCESSING & TRANS.	0. 222569			0 0		•
	DO RESPIRATORY THERAPY	0. 191092			0 0	30, 167	65.00
	DO PHYSI CAL THERAPY	0. 271960			0 0	5, 177	66.00
	DO OCCUPATIONAL THERAPY	0. 310543			0 0	2, 510	
	DO SPEECH PATHOLOGY	0. 285131	18, 646		0 0	5, 317	68.00
	DO ELECTROCARDI OLOGY	0. 069021	4, 917, 494		0 0	339, 410	•
	DO ELECTROENCEPHALOGRAPHY	0. 204545			0 0	4, 182	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 228475			0 0		
	DO I MPL. DEV. CHARGED TO PATIENTS	0. 129566			0 0		•
	DO DRUGS CHARGED TO PATIENTS	0. 223562			0 30, 669		•
	DO RENAL DI ALYSI S	0. 445242			0 0		
	DO ASC (NON-DI STINCT PART)	0. 000000			0 0		75.00
	D1 ASC (NON-DI STINCT PART)	0. 061870			0 0	1, 493, 987	
	50 CARDI AC CATHERI ZATI ON	0. 000000			0 0	0	76.00
	51 OUTPATIENT WOUND CARE CENTER	0. 086742			0 0		76.01
	7 CARDI AC REHABI LI TATI ON	0.00000			0 0	0	76.97
	PATIENT SERVICE COST CENTERS	•					1
90.00 0900	DO CLINIC	0. 000000	0	I	0 0	0	90.00
90.01 0495	50 SLEEP CLINIC	0. 156529	1, 105, 319		0 0	173, 014	90.01
90.02 0900	D1 ANTICOAGULATION CLINIC	0. 284153	256, 099		0 0	72, 771	90.02
90.03 0900	2 ARNETT CANCER CARE CENTER	0. 095009	10, 411, 383		0 0	989, 175	90.03
90.04 0900	03 OUTPATIENT INFUSION CENTER	0. 234378	165, 735		0 0	38, 845	90.04
91.00 0910	DO EMERGENCY	0. 095165	20, 905, 013		0 0	1, 989, 426	91.00
92.00 0920	OO OBSERVATION BEDS (NON-DISTINCT PART)	0. 316724	4, 777, 354		0 0	1, 513, 103	92.00
92.01 0920	01 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
93.00 0495	51 OTHER OUTPATIENT SERVICES	0. 000000	0		0 0	0	93.00
200.00	Subtotal (see instructions)		220, 812, 746	30, 7	52 30, 669	32, 520, 635	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	220, 812, 746	30, 7	52 30, 669	32, 520, 635	202 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pro 5/26/2022 3:4	epared: 42 pm
			Title	e XVIII	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
	ANCILLADY SEDVICE COST CENTERS	6.00	7.00				
50.00	ANCI LLARY SERVI CE COST CENTERS	0	(				50.00
		0					
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	(				51.00 52.00
52.00	05300 ANESTHESI OLOGY	0	(	-			53.00
53.00 53.01	05301 ASC ANESTHESI OLOGY	0	(				
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(				53.01
		0	(				
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	(				55.00
56.00 59.00		2,053	(				56.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	2,053	(				59.00 60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(				63.00
65.00	06500 RESPIRATORY THERAPY	0	(				65.00
66.00	06600 PHYSI CAL THERAPY	0	(				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	(				67.00
68.00	06800 SPEECH PATHOLOGY	0	(	•			68.00
69.00	06900 ELECTROCARDI OLOGY	0	(	-			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(	•			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 856				73.00
74.00	07400 RENAL DIALYSIS	0	0,000				74.00
75.00	07500 ASC (NON-DI STINCT PART)	0	(				75.00
75.01	07501 ASC (NON-DI STINCT PART)	0	(				75.01
76.00	03950 CARDI AC CATHERI ZATI ON	0	(				76.00
76.01	03951 OUTPATIENT WOUND CARE CENTER	0	(				76.01
	07697 CARDI AC REHABI LI TATI ON	0					76.97
	OUTPATIENT SERVICE COST CENTERS			-			
90.00	09000 CLI NI C	0	(	D			90.00
90.01	04950 SLEEP CLINIC	0					90.01
90. 02	09001 ANTI COAGULATI ON CLINIC	0	(	b			90.02
90. 03	09002 ARNETT CANCER CARE CENTER	0	(	b			90.03
90.04	09003 OUTPATIENT INFUSION CENTER	0	(				90.04
91.00	09100 EMERGENCY	0	(				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	(	b			92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	(	•			92.01
93.00	04951 OTHER OUTPATIENT SERVICES	0	(	b			93.00
200.00		2,053	6, 856	5			200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	2,053	6, 856	5			202.00

Health Financial Systems	IU HEALTH ARNI	ETT_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 01/01/2021	Worksheet D Part I	
				To 12/31/2021	Date/Time Pre	
					5/26/2022 3:4	2 pm
	1		e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1		
30. 00 ADULTS & PEDIATRICS	9, 862, 369	0	9, 862, 36		211.80	30.00
31.00 INTENSIVE CARE UNIT	1, 010, 317		1, 010, 31	7 3, 547	284.84	31.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.00
33.01 BURN INTENSIVE CARE UNIT	0			0 0	0.00	33.01
35.00 NEONATAL INTENSIVE CARE UNIT	751, 480		751, 48	0 2, 962	253.71	35.00
43.00 NURSERY	348, 398		348, 39	8 2, 465	141.34	43.00
200.00 Total (lines 30 through 199)	11, 972, 564		11, 972, 56	4 55, 539		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	623	131, 951				30.00
31.00 INTENSIVE CARE UNIT	723	205, 939				31.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
33. 01 BURN INTENSIVE CARE UNIT	0	0				33.01
35.00 NEONATAL INTENSIVE CARE UNIT	265	67, 233				35.00
43. 00 NURSERY	1, 338					43.00
200.00 Total (lines 30 through 199)	2, 949		1			200.00
	1 2,747	1 374, 230	1			1200.00

	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col.	e XIX		Worksheet D Part II Date/Time Prep 5/26/2022 3:43 PPS Capital Costs	pared: 2 pm
	Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col.	Ratio of Cos	t Inpatient		
	Related Cost (from Wkst. B, Part II, col. 26)	(from Wkst. C, Part I, col.			Capital Costs	
	(from Wkst. B, Part II, col. 26)	Part I, col.	to Charges	<b>D</b>		
	Part II, col. 26)			Program	(column 3 x	
	26)		(col. 1 ÷ col	. Charges	column 4)	
		8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 789, 058		0.01720		9, 091	
51.00 05100 RECOVERY ROOM	384, 016	13, 324, 314	0. 02882		1, 523	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 198, 093	25, 458, 235	0.04706		12, 616	52.00
53. 00 05300 ANESTHESI OLOGY	140, 480	9, 182, 970	0. 01529		476	53.00
53. 01 05301 ASC ANESTHESI OLOGY	6, 542	4, 239, 290			0	53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 479, 864	109, 375, 963	0.01353		8, 683	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55.00
56. 00 05600 RADI 0I SOTOPE	170, 813	16, 160, 868	0. 01057		158	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	583, 931	66, 868, 372	0.00873		1, 803	59.00
60. 00 06000 LABORATORY	783, 409	86, 409, 016			6, 120	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	54, 196	5, 360, 488	0. 01011		418	63.00
65. 00 06500 RESPI RATORY THERAPY	142, 129		0.00609		3, 535	65.00
66.00 06600 PHYSI CAL THERAPY	52, 227	3, 785, 233	0. 01379	42, 622	588	66.00
67.00 06700 OCCUPATI ONAL THERAPY	38, 036	2, 382, 117	0. 01596		499	67.00
68.00 06800 SPEECH PATHOLOGY	29, 282	1, 855, 309	0. 01578	40, 483	639	68.00
69. 00 06900 ELECTROCARDI OLOGY	215, 638	37, 190, 256	0.00579		1, 695	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 064	634, 731	0. 00167	22, 331	37	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	495, 392	62, 158, 060	0.00797		2, 411	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	546, 914	120, 181, 006	0.00455	62, 619	285	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	579, 623	254, 748, 167	0.00227	75 1, 376, 574	3, 132	73.00
74.00 07400 RENAL DIALYSIS	123, 519	2, 524, 008	0. 04893	93, 728	4, 587	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
75.01 07501 ASC (NON-DISTINCT PART)	549, 463	133, 527, 665	0. 00411		0	75.01
76.00 03950 CARDI AC CATHERI ZATI ON	0	0	0.0000		0	76.00
76.01 03951 OUTPATIENT WOUND CARE CENTER	6, 070	12, 518, 056	0. 00048		0	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	35, 617	0	0.0000	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				- T		
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
90. 01 04950 SLEEP CLINIC	47, 227	5, 632, 352	0. 00838		0	90.01
90. 02 09001 ANTI COAGULATI ON CLINIC	16, 605	584, 422	0. 02841	3 0	0	90.02
90. 03 09002 ARNETT CANCER CARE CENTER	190, 391	30, 894, 116	0. 00616		33	90.03
90. 04 09003 OUTPATIENT INFUSION CENTER	47, 268	791, 296	0.05973		0	90.04
91.00 09100 EMERGENCY	1, 789, 888	205, 411, 777	0.00871	4 899, 194	7, 836	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 016, 628	24, 400, 374	0. 04166		1, 165	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.00000	0 0	0	92.01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	0.00000		0	93.00
200.00 Total (lines 50 through 199)	13, 513, 383	1, 421, 044, 234		6, 237, 344	67, 330	200.00

Health Financial Systems	IU HEALTH ARNE	TT HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST		CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 3:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Healt	h Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adj ustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	C	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	C		0 0	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	C		0 0	0	33.00
33.01 03301 BURN INTENSIVE CARE UNIT	0	C		0 0	0	33.01
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	C		0 0	0	1
43. 00 04300 NURSERY	0	(		0 0	0	
200.00 Total (lines 30 through 199)	0	(		0 0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patien	t Per Diem (col.	Inpati ent	200100
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,	Julio	0 00000000	l logi am bajo	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1100	0100	0.00	1100	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	(	46, 56	5 0.00	623	30.00
31. 00 03100 I NTENSI VE CARE UNI T		(	3, 54			1
33. 00 03300 BURN INTENSIVE CARE UNIT		0	5,0	0 0.00		
33. 01 03301 BURN INTENSIVE CARE UNIT				0 0.00		1
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			2,96			
43. 00 04300 NURSERY						
200.00 Total (lines 30 through 199)						200.00
Cost Center Description	Inpatient	<u> </u>	J 55, 50	7	2, 747	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33.00
33. 01 03300 BURN INTENSIVE CARE UNIT	0					33.00
	0					
35. 00 02060 NEONATAL INTENSIVE CARE UNIT						35.00
43.00 04300 NURSERY	0					43.00
200.00  Total (lines 30 through 199)	0					200.00

74.00       07400       RENAL DI ALYSI S       0       0       0       0       0       74.00       75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.00       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       0       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01       07697       CARDI AC CATHERI ZATION       0       0       0       0       0       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       76.01       <	Health Financial Systems	IU HEALTH ARNE	ETT_HOSPITAL		In Lie	eu of Form CMS-	2552-10
To         12/31/2021         Date/Time Prepared           Title XIX         Hospital         Program           Title XIX         Hospital           Title XIX         Hospital           Program         Program         Program         Program         Program           Nursing         Nursing         Nursing         Program         Program           Title XIX         Hospital         Program           Program         Program           Program         Program           Date/Time Prepared           Title XIX         Hospital           Nursing         Program           Date/Time Prepared		RVICE OTHER PASS	6 Provider C	CN: 15-0173			
Cost Center Description         Non Physician Anesthetian         Nursing Program Astistant         Nursing Program Adjustments         Nursing Program Adjustments         Nursing Program Adjustments         Nursing Program Adjustments         Nursing Program Adjustments         Nursing Program Adjustments         Nursing Program Adjustments         Nursing Program Adjustments           50.00         05000 (PERATING ROM 05000 (PERATING ROM Adjustments)         0 <td< td=""><td>THROUGH COSTS</td><td></td><td></td><td></td><td></td><td></td><td>epared:</td></td<>	THROUGH COSTS						epared:
Cost Center Description         Non Physician AnestHetist Cost         Nursing Program Post-Stepdom Adjustments         Nursing Program Post-Stepdom Adjustments         Allied Health Program Post-Stepdom Adjustments           50:00         05000         PERMICE COST CENTERS         0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Anesthetist         Program Cost         Program Post-Stepdom Adjustments         Program Post-Stepdom Adjustments         Program Post-Stepdom Adjustments           NACILLARY SERVICE COST CENTERS         1.00         2         0         3A         3.00           NACILLARY SERVICE COST CENTERS         0			Titl	e XIX	Hospi tal	PPS	
Cost         Post-Stepdow         Adj ustments           Adj ustments         Adj ustments         Adj ustments           1.00         2A         2.00         3A         3.00           50.00         05000 (PERDVERY ROOM         0         0         0         0         0         0         0         51.00         0         0         0         0         0         0         0         0         0         0         52.00         0 <td>Cost Center Description</td> <td>Non Physician</td> <td>Nursi ng</td> <td>Nursi ng</td> <td>Allied Health</td> <td>Allied Health</td> <td></td>	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
Adjustments         Adjustments         Adjustments           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           S0.00         OSCOO DEEDATING ROM         0         0         0         0         0         50.00           S1.00         OSCOO DEEDATING ROM         0         0         0         0         50.00 <td></td> <td></td> <td></td> <td>Program</td> <td></td> <td></td> <td></td>				Program			
Incomposition         Incompos		Cost			Adjustments		
ANCI LLARY SERVICE COST CENTERS         Image: Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control of Control Contecontrol Control Control Control Control Contrel Cont							
50.00         OSDOOL OPERATING ROOM         0 <td></td> <td>1.00</td> <td>2A</td> <td>2.00</td> <td>3A</td> <td>3.00</td> <td></td>		1.00	2A	2.00	3A	3.00	
51.00         OSIOO RECOVERY ROOM         O         O         O         O         51.00           52.00         05300 DELLIVERY ROOM & LABOR ROOM         O         O         O         O         S3.00           53.00         05300 ANESTHESI OLOGY         O         O         O         O         S3.00           53.01         05301 ASC ANESTHESI OLOGY         O         O         O         O         S3.00           54.00         05400 RADIOLOGY-DI AGNOSTI C         O         O         O         O         S5.00           55.00         05500 RADI OLOGY-THERAPEUTI C         O         O         O         O         S5.00           56.00         05600 RADI OLOGY-THERAPEUT         O         O         O         O         S5.00           60.00         06000 LABORATORY         O         O         O         O         S5.00           63.00         05000 RADI OLSTRING, PROCESSI NG & TRANS.         O         O         O         O         O         S5.00           66.00         06000 PHYSI CAL THERAPY         O         O         O         O         O         S5.00         S5.00           67.00         05700 OCUPATI ONAL THERAPY         O         O         O			0		0		50.00
52.00         OS200         DELIVERY ROM & LABOR ROM         0         0         0         52.00           53.00         05301         ASC ANESTHESI OLOGY         0         0         0         0         53.00           53.01         05301         ASC ANESTHESI OLOGY         0         0         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         0         53.00           55.00         05500         RADI OLOGY-DI AGNOSTI C         0         0         0         0         55.00           55.00         05600         RADI OLOGY-DI AGNOSTI C         0		-					
53.00         OS300         ANESTHESI OLOGY         O         O         O         S3.00           53.01         OS301         ASC ANESTHESI OLOGY         O         O         O         O         S3.01           54.00         OS400         RADI OLOGY-THERAPEUTI C         O <td< td=""><td></td><td>0</td><td>0</td><td></td><td></td><td></td><td></td></td<>		0	0				
53.01       0S301       ASC ANESTHESI OLOGY       0       0       0       54.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       54.00         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0       0       0       55.00         56.00       05600       RADI OLOGY-THERAPEUTI C       0       0       0       0       0       55.00         50.00       05000       CARDI AC CATHETERI ZATION       0       0       0       0       0       56.00       0       0       0       0       0       0       0       60.00       <		0	0		-	-	
54.00         05400         RADIOLOGY-DIAGNOSTIC         0		0	0		0	, i i i i i i i i i i i i i i i i i i i	
55 00         05500         RADIOLOGY-THERAPEUTIC         0         0         0         0         55 00           56 00         05600         RADIOLOGY-THERAPEUTIC         0		0	0		-	-	
56.00         05600         CARDI AC CATHETERI ZATI ON         0		0	0		0	, i i i i i i i i i i i i i i i i i i i	•
59.00       05900       CARDI AC CATHETERI ZATI ON       0		0	0		-	-	•
60.00       LABORATORY       0		0	0		-	-	•
63.00       66300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       63.00         65.00       06500       RESPIRATORY THERAPY       0       0       0       0       65.00         66.00       6600       6600       PHYSICAL THERAPY       0       0       0       0       66.00         67.00       0CCUPATIONAL THERAPY       0       0       0       0       66.00         68.00       SPECH PATHOLOGY       0       0       0       0       66.00         69.00       06400       ELECTROCARDIOLOGY       0       0       0       67.00         70.00       ELECTROCARDIOLOGY       0       0       0       0       67.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       70.00         71.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       71.00         75.00       07500 ASC (NON-DISTINCT PART)       0       0       0       0       75.00         76.00       03951       OUTPATIENT SAUTON       0       0       0       0       75.00         76.00       03950       ARDIA DIALYSIS <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>-</td> <td></td>		0	0		-	-	
65.00       06500       RESPI RATORY THERAPY       0       0       0       0       65.00         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         70.00       06700       00       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.00       0       0       0       69.00       0       0       0       0       69.00       0       0       0       0       0       0       69.00       0       0       0       0       0       69.00       0		0	0		-	-	
66.00       06600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       0CCUPATI ONAL THERAPY       0       0       0       0       67.00         68.00       0SECE PATHOLOGY       0       0       0       0       68.00         68.00       0SECE PATHOLOGY       0       0       0       0       68.00         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       71.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       72.00       73.00       73.00       73.00       07300       RUSS CHARGED TO PATI ENTS       0       0       0       73.00       73.00       73.00       75.00		0	0		-	-	
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0       67.00         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       68.00         70.00       07000       ELECTROCARDIOLOGY       0       0       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       71.00       71.00       71.00       73.00       07300       RENAL DI ALYSI S       0       0       0       72.00       74.00       74.00       74.00       75.00       75.00       75.00       75.00       75.00       75.00       0       0       0       75.00       75.00       75.00       75.01       75.01       75.02       (NON-DI STINCT PART)       0       0       0       75.00       76.00		0	0		-	-	
68.00       06800       SPEECH PATHOLOGY       0       0       0       0       68.00         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       69.0         70.00       07000       ELECTROCARDI OLOGY       0		0	0		-	-	
69.00       06900       ELECTROCARDI OLOGY       0		0	0		0	u u	
70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0       70.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       71.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       350,338       73.00         74.00       07400       RENAL DIALYSIS       0       0       0       0       74.00         75.01       07501 ASC (NON-DI STINCT PART)       0       0       0       0       75.00         76.00       03950       CARDI AC CATHERI ZATION       0       0       0       76.00         76.01       03951       OUTPATIENT WOUND CARE CENTER       0       0       0       76.00         76.02       07697       CARDI AC CATHERI ZATION       0       0       0       76.00         76.03       03951       OUTPATIENT WOUND CARE CENTER       0       0       0       76.00         76.02       0450       SLEEP CLINIC       0       0       0       0       90.00         9		0	0		0	u u	
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       73.00       73.00       0       0       0       0       73.00       73.00       0       0       0       0       73.00       0       0       0       0       0       73.00       73.00       0       0       0       0       73.00       0       0       0       0       0       0       73.00       0       0       0       0       0       0       0       73.00       0		0	0		0	u u	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       350, 338       73.00         74.00       O7400       RENAL DI ALYSI S       0       0       0       0       74.00       75.00       75.00       75.00       75.00       75.00       0       0       0       0       75.00       75.01       75.01       75.01       75.01       75.01       75.02       75.00       0       0       0       0       0       75.01       75.		0	0		0	u u	
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       350, 338       73.00         74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       75.00         75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       75.00         76.00       03950       CARDI AC CATHERI ZATION       0       0       0       0       75.00         76.01       03951       OUTPATIENT WOUND CARE CENTER       0       0       0       0       76.00         76.97       OR697       CARDI AC REHABILITATION       0       0       0       0       76.00         70.00       09000       CLINIC       0		0	0		0		
74.00       07400       RENAL DI ALYSI S       0       0       0       0       74.00         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       75.00         75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01         76.00       03950       CARDI AC CATHERI ZATI ON       0       0       0       0       0       76.00         76.01       03951       OUTPATI ENT WOUND CARE CENTER       0       0       0       0       76.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       0       76.00         00000       CLINIC       0       0       0       0       0       0       76.00         90.00       09000       CLINIC       0       0       0       0       90.00       90.		0	0		0	-	
75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       0       75.01         75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       75.01         76.00       03950       CARDI AC CATHERIZATION       0       0       0       0       0       76.00         76.01       03951       OUTPATI ENT WOUND CARE CENTER       0       0       0       0       76.00         76.97       7697       CARDI AC REHABILITATION       0       0       0       0       76.00         76.97       07697       CARDI AC REHABILITATION       0       0       0       0       76.00         00100       CLINIC       0       0       0       0       0       0       90.00         90.00       09000       CLINIC       0       0       0       0       90.00 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>а С</td><td>000,000</td><td></td></td<>		0	0		а С	000,000	
75.01       07501       ASC (NON-DI STINCT PART)       0       0       0       0       75.01         76.00       03950       CARDI AC CATHERI ZATION       0       0       0       0       76.00         76.01       03951       OUTPATI ENT WOUND CARE CENTER       0       0       0       0       76.00         76.01       03951       OUTPATI ENT WOUND CARE CENTER       0       0       0       0       76.00         76.07       7ARDI AC REHABILI TATION       0       0       0       0       0       76.00         76.97       OT697       CARDI AC REHABILI TATION       0       0       0       0       76.00         00000       CLINIC       0       0       0       0       0       90.00         90.00       09000       CLINIC       0       0       0       0       90.00         90.01       04950       SLEEP CLINIC       0       0       0       0       90.00         90.02       09001       ANTICOAGULATION CLINIC       0       0       0       90.00       90.00         90.03       09002       ARNETT CANCER CARE CENTER       0       0       0       90.00       90.00		0	0			, i i i i i i i i i i i i i i i i i i i	
76.00       03950       CARDÍAC CATHERIZATION       0       0       0       0       76.00         76.01       03951       OUTPATI ENT WOUND CARE CENTER       0       0       0       0       76.00         76.97       07697       CARDIAC REHABILITATION       0       0       0       0       76.00         0UTPATI ENT SERVICE COST CENTERS       0       0       0       0       0       0       76.00         00.00       09000       CLINIC       0       0       0       0       0       90.00         90.01       04950       SLEEP CLINIC       0       0       0       0       90.00         90.02       09001       ANTI COAGULATION CLINIC       0       0       0       90.00         90.03       09002       ARNETT CANCER CARE CENTER       0       0       0       90.00         90.04       09003       OUTPATI ENT INFUSION CENTER       0       0       0       90.00         90.04       09020       OBERVATION BEDS (NON-DI STINCT PART)       0       0       0       92.00         92.00       09200       OBERVATION BEDS (DI STINCT PART)       0       0       0       0       92.00		0	0			-	
76.01       03951       OUTPATI ENT WOUND CARE CENTER       0       0       0       0       0       76.07         76.97       07697       CARDI AC REHABILI TATI ON       0       0       0       0       0       0       76.07         OUTPATI ENT SERVICE COST CENTERS       0		0	0		0 0		
76.97         07697         CARDI AC REHABILITATION         0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td></t<>		0	0		0	-	
OUTPATIENT SERVICE COST CENTERS           90.00         09000         CLINIC         0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
90.00       09000       CLINIC       0       0       0       0       0       0       90.00         90.01       04950       SLEEP CLINIC       0       0       0       0       0       90.00         90.02       09001       ANTICOAGULATION CLINIC       0       0       0       0       90.00         90.03       09002       ARNETT CANCER CARE CENTER       0       0       0       0       90.00         90.04       09003       OUTPATIENT INFUSION CENTER       0       0       0       0       90.00         91.00       09100       EMERGENCY       0       0       0       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       92.00         92.01       09201       OBSERVATION BEDS (DISTINCT PART)       0       0       0       0       92.00         93.00       04951       OTHER OUTPATIENT SERVICES       0       0       0       0       93.00					-1 -1	-	
90.01       04950       SLEEP CLINIC       0		0	0		0 0	0	90.00
90.02       09001       ANTI COAGULATION CLINIC       0		0					
90.03       09002       ARNETT CANCER CARE CENTER       0		0	0		0 0		
90.04       09003       OUTPATIENT INFUSION CENTER       0       0       0       0       90.0         91.00       09100       EMERGENCY       0       0       0       0       91.0         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0       0       0       0       92.0         92.01       09201       OBSERVATION BEDS (DISTINCT PART)       0       0       0       0       92.0         93.00       04951       OTHER OUTPATIENT SERVICES       0       0       0       0       93.00		0	0		0 0	0	
91.00       09100       EMERGENCY       0       0       0       0       91.00         92.00       09200       DBSERVATI ON BEDS (NON-DISTINCT PART)       0       0       0       0       92.00         92.01       09201       DBSERVATI ON BEDS (DISTINCT PART)       0       0       0       0       92.00         93.00       04951       OTHER OUTPATIENT SERVICES       0       0       0       0       93.00		0	0		0 0	0	
92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         0         0         0         92.00         92.01         09201         0BSERVATI ON BEDS (DI STI NCT PART)         0         0         0         0         92.00         93.00         04951         OTHER OUTPATI ENT SERVICES         0         0         0         0         0         93.00         0         0         0         0         93.00         0         0         0         0         93.00         0         0         0         0         0         0         0         93.00         93.00         0         0         0         0         0         0         93.00		0	0		0 0	0	
92. 01         09201         0BSERVATI ON BEDS (DI STINCT PART)         0         0         0         0         92. 0           93. 00         04951         0THER OUTPATIENT SERVICES         0         0         0         0         93. 0	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
		0	0		0 0	0	92.01
200.00 Total (lines 50 through 199) 0 0 0 0 350.338/200.0	93. 00 04951 OTHER OUTPATIENT SERVICES	0	0		0 0	0	93.00
	200.00 Total (lines 50 through 199)	0	0		0 0	350, 338	200.00

APPORT OMMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0173         Period: From 01/01/2021 To 12/31/2021         Period: Date/Time Pres 5/26/2022         Period: Size/2022         Size/2022         Period: Size/2022         Period: Size/2022         Period: Size/2022         Period: Size/2022         Size/2022         Period: Size/2022         Size/2022         Size/2022         Size/2022         Size/2022         Size/2022         Size/2022	2552-1
Antional object         To         12/31/2021         Date/Time Preg 5/2022         Date/Time Preg 5/202         Date/TimePreg 5/202	
It Ite         XIX         Hospital         PPS           Cost Center Description         All Other Medical Education Cost         Total Cost         Total Cost         Total Cost         Total Cost         Cost Center Description         Total Cost         Total Cost         Cost Center Description         Total Cost         Total Cost         Cost Center Description         Total Cost         Cost Cost         Part 1, col.	pared:
Cost Center Description         All Other Medical Education Cost         Total (sum of cols. 4)         Total Outpatient (sum of cols. 2, 3, and 4)         Total Outpatient (col. 3, and 4)         Total Outpatient (col. 8)         Total Cost (col. 8)         Ratio of Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (col. 8)         Ratio Cost (co	2 pm
Medical Education Cost         (sum of cols. 4)         Outpatient (ost (sum of 4))         (from West C cols. 2, 3, and 4)         to charges (col. 5 + col. 7)           50.00         05000         OPERATING ROOM         0<	
ANCILLARY SERVICE COST CENTERS         Education Cost         1, 2, 3, and 4)         Cost (sum of cols, 2, 3, and 4)         Part I, col 8)         (col, 5, 2, col, 7)         (col, 5, 2, col, 7)           ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           0         05000 0PERATI MG ROOM         0         0         162,112,872         0.000000           51.00         05000 0PERATI MG ROOM         0         0         13,324,314         0.000000           52.00         05200 DELIVERY ROOM & LABOR ROOM         0         0         9,182,970         0.000000           53.00         05300 RADI LUCCY -DI AGNOSTI C         0         0         0         9,9132,976         0.000000           55.00         05500 RADI LOCY-THEARDEUTIC         0         0         0         109,9375,963         0.000000           55.00         05500 RADI LOCY-THARDRUTIC         0         0         0         0         0         0         0         0.000000           50.00         05600 RADI LOSOTIRING, PROCESSI NG & TRANS.         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td< td=""><td></td></td<>	
ANCI LLARY SERVICE COST CENTERS         A)         Col s 2, 3, and 4)         8)         7) (see instructions)           50.00         05000         0FERATI NG ROOM         0         162, 112, 872         0.000000           51.00         05100         RECOVERY ROOM         0         0         0         0         25, 458, 235         0.000000         0	
ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           ANCILLARY SERVICE COST CENTERS         0         0         0         0.00         0         0         0         0         0         0.00         0         0         0         0         0.00         0         0         0         0         0         0         0         0         0         0.00         0         0         0         0         0         0         0         0         0.00         0         0         0         0         0         0.00         0	
ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000         OPERATING ROOM         0         0         0         162,112,872         0.000000           51.00         05100         RECOVERY ROOM         0         0         13,24,314         0.000000           52.00         05200         DELI VERY ROOM & LABOR ROOM         0         0         13,24,314         0.000000           53.01         05301         ASE STHESI OLOGY         0         0         0         9,182,970         0.000000           54.00         05400         RADI OLOGY-THERAPEUTI C         0         0         0         0,00000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         <	
ANCILLARY SERVICE COST CENTERS         4.00         5.00         6.00         7.00         8.00           50.00         05000         OPERATING ROM         0         0         0         162,112,872         0.000000           51.00         05100         RECOVERY ROM         0         0         0         13,324,314         0.000000           52.00         05200         DELIVERY ROM & LABOR ROOM         0         0         25,458,235         0.000000           53.00         05301         ASC ANESTHESI OLOGY         0         0         0         4,239,290         0.000000           53.00         05500         RADI OLOGY-THARNOSTI C         0         0         0         109,375,963         0.000000           54.00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         0         0.000000           55.00         05500         RADI OLOGY-THARNOSTI C         0         0         0         0.000000           56.00         05600         RADI OLOGY-THERAPEUTI C         0         0         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0	
ANCI LLARY SERVI CE COST CENTERS           50. 00         05000         OPERATI NG ROOM         0         0         162, 112, 872         0.000000           51. 00         05100         RCOVERY ROOM         0         0         13, 324, 314         0.000000           52. 00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         25, 458, 235         0.000000           53. 01         05300         ANESTHESI OLOGY         0         0         0         4, 239, 290         0.000000           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         0         0         0         0.000000           55. 00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0.000000         <	
50.00         05000         OPERATI NG ROOM         0         0         162, 112, 872         0.000000           51.00         RECOVERY ROOM         0         0         0         0         13, 324, 314         0.000000           52.00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         25, 458, 235         0.000000           53.01         05301         ASC ANESTHESI OLOGY         0         0         0         4, 239, 290         0.000000           54.00         05400         RADI OLOGY - DI AGNOSTI C         0         0         0         0         0.000000           55.00         05500         RADI OLOGY - THERAPEUTI C         0         0         0         0         0.000000           56.00         05600         RADI OLOGY - THERAPEUTI C         0         0         0         0.000000           56.00         05500         CARDI AC CATHETERI ZATI ON         0         0         0         0         0.000000           57.00         05000         CARDI AC CATHETERI ZATI ON         0         0         0         0         0.000000           63.00         06300         BLODD STORI NG, PROCESSI NG & TRANS.         0         0         0 <t< td=""><td></td></t<>	
51.00       05100       RECOVERY ROOM       0       0       13, 324, 314       0.000000         52.00       05200       DELIVERY ROOM & LABOR ROOM       0       0       0       25, 458, 235       0.0000000         53.00       05301       ASC ANESTHESI OLOGY       0       0       0       9, 182, 970       0.000000         54.00       05400       RADI OLOGY - DI AGNOSTI C       0       0       0       4, 239, 290       0.000000         55.00       05500       RADI OLOGY - THERAPEUTI C       0       0       0       0       0.000000         56.00       05600       RADI OLOGY - THERAPEUTI C       0       0       0       0.000000         56.00       05600       RADI OLOGY - THERAPEUTI C       0       0       0       66, 868, 372       0.000000         63.00       06300       LADOR - ATHETREI ZATI ON       0       0       0       86, 409, 016       0.000000         63.00       06300       BLODD STORI NG, PROCESSI NG & TRANS.       0       0       0       3,785, 233       0.000000         64.00       06300       SESPI RATORY THERAPY       0       0       0       2, 382, 117       0.000000         67.00       06600	50.00
53.00         05300         ANESTHESI OLOGY         0         0         9, 182, 970         0.00000           53.01         05301         ASC ANESTHESI OLOGY         0         0         4, 239, 290         0.000000           54.00         05500         RADI OLOGY-DI AGNOSTI C         0         0         109, 375, 963         0.000000           55.00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         0.000000           56.00         05600         RADI OL SOTOPE         0         0         0         0.000000           56.00         05600         CARDI AC CATHETERI ZATI ON         0         0         0         66, 868, 372         0.000000           63.00         06300         LABORATORY         0         0         0         5, 60, 488         0.000000           65.00         06300         RESPI RATORY THERAPY         0         0         0         3, 785, 233         0.000000           65.00         06400         PHYSI CAL THERAPY         0         0         0         3, 785, 233         0.000000           66.00         06600         PHYSI CAL THERAPY         0         0         0         3, 7190, 256         0.000000           67	51.00
53.01       05301       ASC ANESTHESI 0LOGY       0       0       4, 239, 290       0.00000         54.00       05400       RADI 0LOGY-DI AGNOSTI C       0       0       109, 375, 963       0.000000         55.00       05500       RADI 0LOGY-THERAPEUTI C       0       0       0       0.000000         55.00       05600       RADI 0LOGY-THERAPEUTI C       0       0       0       0.000000         56.00       05600       CARDI AC CATHETERI ZATI ON       0       0       0       66, 868, 372       0.000000         60.00       06000       LABORATORY       0       0       0       66, 868, 372       0.000000         63.00       06000       STORI NG, PROCESSI NG & TRANS.       0       0       0       53.00, 000000         65.00       06500       RESPI RATORY THERAPY       0       0       0       23, 332, 901       0.000000         66.00       06600       PHYSI CAL THERAPY       0       0       0       2, 382, 117       0.000000         66.00       06600       PHYSI CAL THERAPY       0       0       0       1, 855, 309       0.000000         67.00       067000       ELECTROCARDI 0LOGY       0       0       0	52.00
53.01       05301       ASC ANESTHESI OLOGY       0       0       4, 239, 290       0.000000         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       109, 375, 963       0.000000         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0.000000         56.00       05600       RADI OLOGY-THERAPEUTI C       0       0       0       0.000000         59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       66, 868, 372       0.000000         60.00       LABORATORY       0       0       0       66, 868, 372       0.000000         63.00       06500       RESPI RATORY       0       0       0       5, 360, 488       0.000000         65.00       06500       RESPI RATORY THERAPY       0       0       0       3, 785, 233       0.000000         66.00       06600       PHYSI CAL THERAPY       0       0       0       3, 785, 233       0.000000         67.00       06700       CCUPATI ONAL THERAPY       0       0       0       1, 855, 309       0.000000         68.00       06800       SPECH PATHOLOGY       0       0       0       37, 190, 256<	53.00
54.00       05400       RADI OLOGY - DI AGNOSTI C       0       0       109, 375, 963       0.00000         55.00       05500       RADI OLOGY - THERAPEUTI C       0       0       0       0.00000         56.00       0500       RADI OLOGY - THERAPEUTI C       0       0       0       0.00000         56.00       05900       CARDI AC CATHETERI ZATI ON       0       0       066, 868, 372       0.000000         60.00       06000       LABORATORY       0       0       0       66, 868, 372       0.000000         63.00       06300       BLODD STORI NG, PROCESSI NG & TRANS.       0       0       0       23, 332, 901       0.000000         65.00       06500       RESPI RATORY THERAPY       0       0       0       3, 785, 233       0.000000         66.00       06400       PHYSI CAL THERAPY       0       0       0       3, 785, 233       0.000000         67.00       06700       OCUPATI ONAL THERAPY       0       0       0       1, 855, 309       0.000000         68.00       SPEECH PATHOLOGY       0       0       0       0       0, 000000       0       0.000000         70.00       OT200       LECTROCARDI OLOGY       0 <td>53.01</td>	53.01
56.00         05600         RADI 01 SOTOPE         0         0         16, 160, 868         0.00000           59.00         05900         CARDI AC CATHETERI ZATI 0N         0         0         0         66, 868, 372         0.000000           60.00         D6000         LABORATORY         0         0         86, 409, 016         0.000000           63.00         O6000         LABORATORY         0         0         0         5, 360, 488         0.000000           65.00         06500         RESPI RATORY THERAPY         0         0         0         23, 332, 901         0.000000           66.00         06600         PHYSI CAL THERAPY         0         0         0         3, 785, 233         0.000000           67.00         06700         CCUPATI ONAL THERAPY         0         0         0         1, 855, 309         0.000000           68.00         SPEECH PATHOLOGY         0         0         0         1, 855, 309         0.000000           70.00         0700         ELCTROCARDI OLOGY         0         0         0         0.000000           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0.000000           72.00         <	54.00
59.00         05900         CARDI AC CATHETERI ZATI ON         0         0         66, 868, 372         0.00000           60.00         06000         LABORATORY         0         0         0         86, 409, 016         0.00000           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0         0         0         5, 360, 488         0.000000           65.00         06500         RESPI RATORY THERAPY         0         0         0         23, 332, 901         0.000000           66.00         06400         PHYSI CAL THERAPY         0         0         0         2, 3785, 233         0.000000           67.00         06700         0CCUPATI ONAL THERAPY         0         0         0         2, 382, 117         0.000000           68.00         06800         SPEECH PATHOLOGY         0         0         0         37, 190, 256         0.000000           69.00         06900         ELECTROCARDI OLOGY         0         0         0         634, 731         0.000000           71.00         OTIO0         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         120, 181, 006         0.000000           73.00         07300         DRUGS CHARGED TO PATI ENTS	55.00
59.00         05900         CARDI AC CATHETERI ZATI ON         0         0         66, 868, 372         0.00000           60.00         06000         LABORATORY         0         0         0         86, 409, 016         0.00000           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0         0         0         5, 360, 488         0.000000           65.00         06600         PHYSI CAL THERAPY         0         0         0         3, 32, 901         0.000000           67.00         06C00         PHYSI CAL THERAPY         0         0         0         2, 332, 901         0.000000           67.00         06CUPATI ONAL THERAPY         0         0         0         2, 382, 117         0.000000           68.00         06800         SPEECH PATHOLOGY         0         0         0         1, 855, 309         0.000000           69.00         06900         ELECTROCARDI OLOGY         0         0         0         64, 731         0.000000           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         120, 181, 006         0.000000           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0 <td>56.00</td>	56.00
63.00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         5,360,488         0.00000           65.00         06500         RESPIRATORY THERAPY         0         0         0         23,332,901         0.000000           66.00         06600         PHYSICAL THERAPY         0         0         0         3,785,233         0.000000           67.00         06700         0CCUPATIONAL THERAPY         0         0         0         2,382,117         0.000000           68.00         06800         SPEECH PATHOLOGY         0         0         0         1,855,309         0.000000           69.00         ELECTROCARDIOLOGY         0         0         0         37,190,256         0.000000           71.00         07100         BEDCTROCARDIOLOGY         0         0         0         62,158,060         0.000000           72.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         0         120,181,006         0.000000           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0         0.000000           74.00         07400         RENAL DI ALYSIS         0         0         0         0.0000000 <td>59.00</td>	59.00
63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       5, 360, 488       0.00000         65.00       06500       RESPIRATORY THERAPY       0       0       0       23, 332, 901       0.000000         66.00       06600       PHYSI CAL THERAPY       0       0       0       3, 785, 233       0.000000         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       2, 382, 117       0.000000         68.00       06800       SPEECH PATHOLOGY       0       0       0       1, 855, 309       0.000000         69.00       06900       ELECTROCARDI OLOGY       0       0       0       37, 190, 256       0.000000         71.00       07000       ELECTROCARDI OLOGY       0       0       0       634, 731       0.000000         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       120, 181, 006       0.000000         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       2, 524, 008       0.000000         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0.000000         74.00       07400 <td>60.00</td>	60.00
65.00         06500         RESPI RATORY THERAPY         0         0         23, 332, 901         0.00000         66.00         66.00         06600         PHYSI CAL THERAPY         0         0         0         3, 785, 233         0.000000         67.00         06700         0CCUPATI ONAL THERAPY         0         0         0         2, 382, 117         0.000000         68.00         06800         SPEECH PATHOLOGY         0         0         0         1, 855, 309         0.000000         69.00         0.60400         ELECTROCARDI OLOGY         0         0         0         37, 190, 256         0.000000         0         0         0.002000         0         0         0         0.000000         0         0.000000         0         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.00	63.00
67.00         06700         0CCUPATIONAL THERAPY         0         0         2, 382, 117         0.00000         68.00         68.00         SPEECH PATHOLOGY         0         0         0         1, 855, 309         0.000000         69.00         0.6900         ELECTROCARDIOLOGY         0         0         0         37, 190, 256         0.000000         0           70.00         07000         ELECTROCARDIOLOGY         0         0         0         37, 190, 256         0.000000         0         0         0         37, 190, 256         0.000000         0         0         0         0         0         0         0         0         0         0         0.000000         0	65.00
68.00         06800         SPEECH PATHOLOGY         0         1,855,309         0.00000         69.00         69.00         69.00         69.00         ELECTROCARDI OLOGY         0         0         0         37,190,256         0.000000         69.00         69.00         69.00         634,731         0.000000         634,731         0.000000         634,731         0.000000         634,731         0.000000         634,731         0.000000         634,731         0.000000         634,731         0.000000         634,731         0.000000         62,158,060         0.000000         62,158,060         0.000000         62,158,060         0.000000         72.00         IMPL         DEV.         CHARGED TO PATI ENTS         0         0         120,181,006         0.000000         0.000000         73.00         07300         DRUSS CHARGED TO PATI ENTS         0         350,338         350,338         254,748,167         0.01375         74.00         0         0         0         0         0.000000         75.00         75.00         ASC (NON-DI STI NCT PART)         0         0         0         0.000000         0         0.000000         75.00         0.350,352,7,665         0.000000         0         0.000000         75.00         0.000000         0         0         0	66.00
69.00         06900         ELECTROCARDI OLOGY         0         0         37, 190, 256         0.000000           70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         634, 731         0.000000           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         62, 158, 060         0.000000           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS         0         0         120, 181, 006         0.000000           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         350, 338         350, 338         254, 748, 167         0.001375           74.00         O7400         RENAL DI ALYSI S         0         0         0         2, 524, 008         0.000000           75.00         07500         ASC (NON-DI STI NCT PART)         0         0         0         0.000000           75.01         ASC (NON-DI STI NCT PART)         0         0         0         0.000000           75.01         ASC (NON-DI STI NCT PART)         0         0         0         0.000000           76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0.000000           76.01         039	67.00
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         634,731         0.00000           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         62,158,060         0.00000           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         120,181,006         0.000000           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         0         0         120,181,006         0.000000           74.00         07400         RENAL DI ALYSI S         0         0         0         2,524,008         0.000000           75.01         07500         ASC (NON-DI STI NCT PART)         0         0         0         0.000000           75.01         07501         ASC (NON-DI STI NCT PART)         0         0         0         0.000000           76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0.000000         0.000000           76.01         03951         OUTPATI ENT WOUND CARE CENTER         0         0         0         0.000000           76.97         CARDI AC REHABI LI TATI ON         0         0         0         0.000000	68.00
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         62, 158, 060         0.00000           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         120, 181, 006         0.000000           73.00         07300         DRUGS CHARGED TO PATI ENTS         0         350, 338         350, 338         254, 748, 167         0.001375           74.00         07400         RENAL DI ALYSI S         0         0         0         2, 524, 008         0.000000           75.01         07501         ASC (NON-DI STI NCT PART)         0         0         0         0.000000           76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0.000000         0.000000           75.01         03951         OUTPATI ENT WOUND CARE CENTER         0         0         0         0.000000           76.01         03951         CARDI AC REHABI LI TATI ON         0         0         0         0.000000	69.00
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0         0         120, 181, 006         0.00000         0           73.00         07300         DRUGS CHARGED TO PATIENTS         0         350, 338         350, 338         254, 748, 167         0.001375           74.00         07400         RENAL DI ALYSI S         0         0         0         2, 524, 008         0.000000           75.00         07501         ASC (NON-DI STINCT PART)         0         0         0         0.000000           75.01         07501         ASC (NON-DI STINCT PART)         0         0         0         0.000000           76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0         0.000000           76.01         03951         OUTPATI ENT WOUND CARE CENTER         0         0         0         0.000000           76.97         CARDI AC REHABILITATION         0         0         0         0.000000	70.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0         350, 338         350, 338         254, 749, 167         0.001375           74.00         07400         RENAL DI ALYSIS         0         0         0         2, 524, 008         0.000000           75.01         07501         ASC (NON-DI STINCT PART)         0         0         0         133, 527, 665         0.000000           76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0         0.000000           76.01         03951         OUTPATIENT WOUND CARE CENTER         0         0         0         0.000000           76.07         07607         CARDI AC REHABILITATION         0         0         0         0.000000	71.00
74.00         07400         RENAL DI ALYSI S         0         0         2, 524, 008         0.00000           75.00         07500         ASC (NON-DI STINCT PART)         0         0         0         0         0.00000           75.01         07501         ASC (NON-DI STINCT PART)         0         0         0         133, 527, 665         0.000000           76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0         0.000000           76.01         03951         OUTPATI ENT WOUND CARE CENTER         0         0         0         12, 518, 056         0.000000           76.97         07697         CARDI AC REHABI LI TATI ON         0         0         0         0         0.000000	
75.00         07500         ASC (NON-DISTINCT PART)         0         0         0         0.00000           75.01         07501         ASC (NON-DISTINCT PART)         0         0         0         133, 527, 665         0.000000           76.00         03950         CARDIAC CATHERIZATION         0         0         0         0         0.000000           76.01         03951         OUTPATIENT WOUND CARE CENTER         0         0         0         12, 518, 056         0.000000           76.97         07697         CARDIAC REHABILITATION         0         0         0         0.000000	
75. 01         07501         ASC (NON-DI STINCT PART)         0         0         133, 527, 665         0.00000           76. 00         03950         CARDI AC CATHERI ZATI ON         0         0         0         0.00000           76. 01         03951         OUTPATI ENT WOUND CARE CENTER         0         0         0         12, 518, 056         0.000000           76. 97         07697         CARDI AC REHABI LI TATI ON         0         0         0         0         0.000000	
76.00         03950         CARDI AC CATHERI ZATI ON         0         0         0         0.00000           76.01         03951         0UTPATI ENT WOUND CARE CENTER         0         0         0         12, 518, 056         0.000000           76.97         07697         CARDI AC REHABI LI TATI ON         0         0         0         0         0.000000	
76. 01         03951         0UTPATI ENT WOUND CARE CENTER         0         0         12, 518, 056         0.00000           76. 97         07697         CARDI AC REHABI LI TATI ON         0         0         0         0         0.000000	
76. 97 07697 CARDIAC REHABILITATION 0 0 0 0 0.000000	
OUTPATTENT SERVICE COST CENTERS	76.97
	90.00
90. 01 04950 SLEEP CLINIC 0 0 5, 632, 352 0. 000000	90.01
90. 02 09001 ANTI COAGULATI ON CLI NI C 0 0 0 584, 422 0. 000000	90.02
90. 03 09002 ARNETT CANCER CARE CENTER 0 0 0 30, 894, 116 0. 000000	
90. 04         09003         0UTPATI ENT INFUSION CENTER         0         0         791, 296         0.00000           91. 00         09100         EMERGENCY         0         0         0         205, 411, 777         0.000000	
92. 01         09201         0BSERVATI ON BEDS (DI STI NCT PART)         0         0         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.000000         0         0.0000000         0         0.0000000         0         0.0000000         0         0.0000000         0         0.0000000         0         0.0000000         0         0.0000000         0	
	200.00
	1200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS       Provider CCN: 15-0173       Period: From 01/01/2021 To 12/31/2021       Worksheet D Part IV Date/Time Pr 5/26/2022 3: 5/26/2022 3:         Title XIX       Hospital       PPS         Cost Center Description       Outpatient Ratio of Cost       Inpatient Program       Outpatient Program       Outpatient Program       Outpatient Program       Outpatient Program       Outpatient Program	
To     12/31/2021     Date/Time Pr       5/26/2022 3:     Title XIX     Hospital     PPS       Cost Center Description     Outpatient     Inpatient     Inpatient     Outpatient	
5/26/2022 3:       Title XIX     Hospital     PPS       Cost Center Description     Outpatient     Inpatient     Inpatient     Outpatient     Outpatient	
Cost Center Description Outpatient Inpatient Inpatient Outpatient Outpatient	
Ratio of Cost   Program   Program   Program   Program   Program	
to Charges Charges Pass-Through Charges Pass-Through Charges Pass-Through	
(col. 6 ÷ col. Costs (col. 8 Costs (col. 9 C	
7)         x col. 10)         x col. 12)           9.00         10.00         11.00         12.00         13.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00 05000 OPERATING ROOM 0. 000000 528, 452 0 0	50.00
51. 00 05100 RECOVERY ROOM 0. 000000 52, 836 0 0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0. 000000 268, 068 0 0	
53. 00   05300   ALESTHESI OLOGY 0.000000 31, 120 0 0	53.00
53. 01  05301  ASC ANESTHESI OLOGY 0. 000000 0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 000000 641, 736 0 0	
55.00 (05500) RADI OLOGY - THERAPEUTI C 0.000000 0 0	
56. 00 05600 RADI 0I SOTOPE 0. 000000 14, 929 0 0	
59. 00 (05900) CARDI AC CATHETERI ZATI ON 0.000000 206, 485 0 0	
60.00 06000 LABORATORY 0.00000 675,065 0 0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 41, 297 0 0	
65. 00 06500 RESPI RATORY THERAPY 0. 000000 580, 377 0 0	
66. 00 06600 PHYSI CAL THERAPY 0. 000000 42, 622 0 0	
67.00 06700 OCCUPATIONAL THERAPY 0.000000 31, 222 0 0	
68.00 06800 SPEECH PATHOLOGY 0.000000 40,483 0 0	
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 292, 369 0 0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 22, 331 0 0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 302,469 0 0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.000000 62,619 0 0	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 001375 1, 376, 574 1, 893 0	73.00
74. 00 07400 RENAL DIALYSIS 0. 000000 93, 728 0 0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 0	75.00
75. 01 07501 ASC (NON-DISTINCT PART) 0. 000000 0 0 0	75.01
76. 00 03950 CARDIAC CATHERIZATION 0. 000000 0 0 0	76.00
76. 01 03951 OUTPATI ENT WOUND CARE CENTER 0. 000000 0 0 0	76.01
76. 97 07697 CARDIAC REHABILITATION 0. 000000 0 0 0	76.97
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0. 000000 0 0 0	90.00
90. 01 04950 SLEEP CLINIC 0. 000000 0 0 0	90.01
90. 02 09001 ANTI COAGULATI ON CLI NI C 0. 000000 0 0 0	90. 02
90. 03 09002 ARNETT CANCER CARE CENTER 0. 000000 5, 418 0 0	
90. 04 09003 OUTPATIENT INFUSION CENTER 0. 000000 0 0 0	
91. 00 09100 EMERGENCY 0. 000000 899, 194 0 0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 27,950 0 0	
92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0. 000000 0 0 0	
93. 00 04951 OTHER OUTPATI ENT SERVI CES 0. 000000 0 0 0	
200.00         Total (lines 50 through 199)         6, 237, 344         1, 893         0	200.00

MPUT	Financial Systems IU HEALTH ARNET ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0173	Period: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Prep 5/26/2022 3:42	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
20	INPATIENT DAYS			44 545	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			46, 565 46, 565	1
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	hed days)		41, 765	
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	nom davs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	ta tha Dragram (avaluding	, owing had and	15 272	9
50	newborn days) (see instructions)	to the Program (excruding	g swiftg-bed and	15, 372	
00	Swing-bed SNF type inpatient days applicable to title XVIII of		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 of		room days) after	0	11
~~	December 31 of the cost reporting period (if calendar year, e		,		1.10
. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	ix only (including privat	te room days)	0	12
. 00	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	year, enter 0 on this iir ram (excluding swing-bed	ie) davs)	0	14
00	Total nursery days (title V or XIX only)			0	15
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17
reporting period .00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost					
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service			0. 00 0. 00	
	reporting period	0			
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter December 31 of 1	ne cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction			74, 971, 686	
. 00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
	x line 20)		, p= == ( =		
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 74, 971, 686	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	· · ·		, , , , , , , , , , , , , , , , , , , ,	1 - '
. 00 . 00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	inus line 33)(soo instruk	stions)	0. 00 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	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	36
00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	74, 971, 686	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
~ ~	Adjusted general inpatient routine service cost per diem (see	-		1, 610. 04	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		24, 749, 535 0	39

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH ARNET	TT HOSPITAL Provider CC		eri od:	u of Form CMS- Worksheet D-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 3:4	
			Title	XVIII	Hospi tal	PPS	τ <u>2</u> μπ
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
2.00	NURSERY (title V & XIX only)	0	0	0.00	0	C	42.0
	Intensive Care Type Inpatient Hospital Units	44.455.440	0.547		1	0.115.100	1
3.00 4.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	11, 155, 668	3, 547	3, 145. 10	1, 000	3, 145, 100	43. C
4.00 5.00	BURN INTENSIVE CARE UNIT	0	о	0.00	0	C	
5.01	BURN INTENSIVE CARE UNIT	0	0	0.00			
6.00	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	NEONATAL INTENSIVE CARE UNIT Cost Center Description	6, 543, 612	2, 962	2, 209. 19	0	C	47.0
	cost center bescription					1.00	-
8.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			22, 962, 142	2 48. C
9.00	Total Program inpatient costs (sum of lines 4	1 through 48)(s	ee instruction	ıs)		50, 856, 777	49.0
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing a	orvicos (from	What D sum	of Parts L and	3, 540, 630	50 0
0.00		strent routine s	ervices (110m	WKSL. D, SUII		3, 540, 650	50.0
1. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fro	om Wkst. D, su	m of Parts II	1, 439, 089	9 51.0
2 00	and IV)					4 070 710	
2.00 3.00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		ated non-nhv	sician anesthe	tist and	4, 979, 719 45, 877, 058	
5.00	medical education costs (line 49 minus line 5		atea, non phy.			43, 077, 030	55.0
	TARGET AMOUNT AND LIMIT COMPUTATION						
4.00	Program di scharges					0.00	
5.00 5.00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 C	
7.00	Difference between adjusted inpatient operati	ng cost and tar	get amount (li	ne 56 minus l	ine 53)		
3. 00	Bonus payment (see instructions)	0			·	C	
9.00	Lesser of lines 53/54 or 55 from the cost rep	orting period e	nding 1996, u	odated and com	pounded by the	0.00	59.
D. 00	market basket Lesser of lines 53/54 or 55 from prior year of	ost report und	lated by the m	arket basket		0.00	60.
1.00	If line 53/54 is less than the lower of lines				he amount by	C	
	which operating costs (line 53) are less than		(lines 54 x d	50), or 1% of	the target		
2 00	amount (line 56), otherwise enter zero (see i	nstructions)					62.0
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST	(					
4.00	Medicare swing-bed SNF inpatient routine cost	s through Decem	ber 31 of the	cost reportin	g period (See	C	64.0
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decembe	or 31 of the c	ost reporting	neriod (See	C	65.0
5.00	instructions) (title XVIII only)			bat reporting			
6.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVIII	only). For	C	) 66. (
7 00	CAH (see instructions)	anota through	December 21 er	E the east rea	onting pariod	c	
7.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs thiough	December 31 0	the cost rep	or tring period	L L	) 67. (
8.00	Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repor	ting period	C	68.
0 00	(line 13 x line 20)			(0)			
9. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					C	) 69. (
D. 00	Skilled nursing facility/other nursing facili						70.
1. 00	Adjusted general inpatient routine service co	ost per diem (li					71. (
2.00	Program routine service cost (line 9 x line 7		(Lipo 14 ··· 1'	25)			72.
3.00 4.00	Medically necessary private room cost applica Total Program general inpatient routine servi			ie 35)			73.
4.00 5.00	Capital -related cost allocated to inpatient r	•		orksheet B, Pa	rt II, column		75.
	26, line 45)						
5.00	Per diem capital-related costs (line 75 ÷ lir						76.
7.00 3.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 78.
9.00	Aggregate charges to beneficiaries for excess		ovider records	5)			79.
0. 00	Total Program routine service costs for compa	arison to the co			s line 79)		80.
. 00	Inpatient routine service cost per diem limit						81.
. 00 . 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s	,					82. 83.
I. 00	Program inpatient ancillary services (see ins		·/				84.
5.00	Utilization review - physician compensation (		is)				85.
5.00	Total Program inpatient operating costs (sum		ough 85)				86.
7.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					4, 800	87.
	Adjusted general inpatient routine cost per o	liem (line 27 ÷	line 2)			1, 610. 04	1 88. (

Health Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021	Date/Time Pre 5/26/2022 3:4	pared: 2 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	9, 862, 369	74, 971, 686	0. 13154	3 7, 728, 192	1, 016, 628	90.00
91.00 Nursing Program cost	0	74, 971, 686	0.00000	7, 728, 192	0	91.00
92.00 Allied health cost	0	74, 971, 686	0.00000	7, 728, 192	0	92.00
93.00 All other Medical Education	0	74, 971, 686	0.00000	7, 728, 192	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0173	Period: From 01/01/2021	Worksheet D-1 Date/Time Pre	
		Title XIX	To 12/31/2021 Hospi tal	5/26/2022 3: 42 PPS	
	Cost Center Description		•	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed da	vs excluding newborn)		46, 565	1 1
00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d	-bed and newborn days)	rivate room dave	46, 565 0	2
	do not complete this line.	5. 5 5.	rvate room days,		
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r	<b>J</b> <i>i</i>	er 31 of the cost	41, 765 0	
00	reporting period Total swing-bed SNF type inpatient days (including private r	oom 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 ro	om days) through December	- 31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December 3	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (excluding	g swing-bed and	623	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII		room days)	0	10
00	through December 31 of the cost reporting period (see instru- Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or X through December 21 of the cost reporting period		e room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
	Medically necessary private room days applicable to the Prog			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 465 1, 338	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 d	of the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	f the cost	0.00	19
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ns)		74, 971, 686	21
00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	ber 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	r 31 of the cost reportin	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 74, 971, 686	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed ct	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)			0	29
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0 0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 m		ctions)	0.00	
00	Average per diem private room cost differential (line 34 x l			0.00	
00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		fferential (line	0 74, 971, 686	36
	27 minus line 36)			, , , , , , , , , , , , , , , , , , , ,	"
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (se	e instructions)		1, 610. 04	
3.00 9.00 ).00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Prog	-		1, 003, 055 0	39

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	IU HEALTH ARNET	Provider CC		eri od:	u of Form CMS-: Worksheet D-1	
			F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		Title	e XIX	Hospi tal	PPS	- p
Cost Center Description	Total Inpatient Costlr	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
	1.00	2.00	<u>col. 2)</u> 3.00	4.00	<u>4)</u> 5. 00	
42.00 NURSERY (title V & XIX only)	2, 112, 504	2, 465	857.00		1, 146, 666	42.00
Intensive Care Type Inpatient Hospital Uni						
43. 00 INTENSIVE CARE UNIT	11, 155, 668	3, 547	3, 145. 10	723	2, 273, 907	
44. 00 CORONARY CARE UNIT		o	0.00	0	0	44.00
45. 00 BURN INTENSIVE CARE UNIT 45. 01 BURN INTENSIVE CARE UNIT	0	0	0.00 0.00		0	
46. 00 SURGICAL INTENSIVE CARE UNIT		0	0.00	Ŭ	0	46.00
47.00 NEONATAL INTENSIVE CARE UNIT	6, 543, 612	2, 962	2, 209. 19	265	585, 435	47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			1, 079, 574	48.00
49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS			าร)		6, 088, 637	
50.00 Pass through costs applicable to Program i	npatient routine se	ervices (from	Wkst. D, sum	of Parts I and	594, 236	50.00
51.00 Pass through costs applicable to Program i	npatient ancillary	services (fro	om Wkst. D, su	m of Parts II	69, 223	51.00
and IV) 52.00 Total Program excludable cost (sum of line	es 50 and 51)				663, 459	52.00
53.00 Total Program inpatient operating cost exemption costs (line 49 minus line)	cluding capital rela	ated, non-phys	sician anesthe	tist, and	5, 425, 178	•
TARGET AMOUNT AND LIMIT COMPUTATION           54.00         Program di scharges					0	54.00
55.00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)					0	
57.00 Difference between adjusted inpatient oper	rating cost and targ	get amount (li	ne 56 minus I	ine 53)	0	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost	reporting period of	ding 1004 u	adated and com	nounded by the	0	
59.00 Lesser of lines 53/54 or 55 from the cost market basket	reporting period e	iai ng 1996, up	buated and com	pounded by the	0.00	59.0
60.00 Lesser of lines 53/54 or 55 from prior year	ar cost report, upda	ated by the ma	arket basket		0.00	60.0
61.00 If line 53/54 is less than the lower of li					0	61.0
which operating costs (line 53) are less		(lines 54 x d	60), or 1% of	the target		
amount (line 56), otherwise enter zero (se 62.00 Relief payment (see instructions)					0	62.0
63.00 Allowable Inpatient cost plus incentive pa	ayment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine of instructions) (title XVIII only)	costs through Deceml	per 31 of the	cost reportin	g period (See	0	64.00
65.00 Medicare swing-bed SNF inpatient routine	costs after Decembe	- 31 of the co	ost reporting	period (See	0	65.00
<ul><li>instructions)(title XVIII only)</li><li>66.00 Total Medicare swing-bed SNF inpatient room</li></ul>	utine costs (line 64	1 plus line 65	5)(title XVIII	only). For	0	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient rou					0	67.00
(line 12 x line 19)	0			0.1		
68.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)				ting period	0	
69.00 Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					0	69.00
70.00 Skilled nursing facility/other nursing fac						70.00
71.00 Adjusted general inpatient routine service						71.00
72.00 Program routine service cost (line 9 x lin			25)			72.00
73.00Medically necessary private room cost appl74.00Total Program general inpatient routine set			ie 35)			73.00
75.00 Capital -related cost allocated to inpatient 26, line 45)			orksheet B, Pa	rt II, column		75.0
76.00 Per diem capital-related costs (line 75 ÷	line 2)					76.00
77.00 Program capital-related costs (line 9 x li						77.00
78.00 Inpatient routine service cost (line 74 mi 79.00 Aggregate charges to beneficiaries for exe		wider record	-)			78.0
80.00 Total Program routine service costs for co	• •			s line 79)		80.0
81.00 Inpatient routine service cost per diem li	•		, , , , , , , , , , , , , , , , , , ,	,		81.0
82.00 Inpatient routine service cost limitation	(line 9 x line 81)					82.0
83.00 Reasonable inpatient routine service costs		)				83.0
84.00 Program inpatient ancillary services (see 85.00 Utilization review - physician compensatio		2)				84. 0 85. 0
86.00 Total Program inpatient operating costs (						86.0
PART IV - COMPUTATION OF OBSERVATION BED F						1
87.00 Total observation bed days (see instruction					4, 800	
88.00 Adjusted general inpatient routine cost per 88.00 Observation bod cost (Line 87 x Line 88)		ıne 2)			1,610.04	
89.00 Observation bed cost (line 87 x line 88)	(ace instructions)				7, 728, 192	1 07. U

Health Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	pared: 2 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	9, 862, 369	74, 971, 686	0. 13154	3 7, 728, 192	1, 016, 628	90.00
91.00 Nursing Program cost	0	74, 971, 686	0.00000	7, 728, 192	0	91.00
92.00 Allied health cost	0	74, 971, 686	0.00000	7, 728, 192	0	92.00
93.00 All other Medical Education	0	74, 971, 686	0.00000	7, 728, 192	0	93.00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0173	Peri od:	Worksheet D-3	3
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Title	e XVIII	Hospi tal	PPS	72 pi
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	_
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
D. 00 03000 ADULTS & PEDI ATRI CS			54, 478, 775		30.
1. 00 03100 I NTENSI VE CARE UNI T			6, 681, 984		31.
3. 00 03300 BURN INTENSIVE CARE UNIT			0		33.
3. 01 03301 BURN INTENSIVE CARE UNIT			0		33.
5. 00 02060 NEONATAL INTENSIVE CARE UNIT			0		35.
3. 00 04300 NURSERY					43.
ANCI LLARY SERVI CE COST CENTERS		1			
. 00 05000 OPERATING ROOM		0. 1145			
. 00 05100 RECOVERY ROOM		0. 1829			
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2993		38, 814	
		0.9175		1, 079, 674	
. 01  05301 ASC_ANESTHESI 0L0GY . 00  05400  RADI 0L0GY-DI AGNOSTI C		0.0157		1 ( 40, 20(	
. 00 05400 RADI OLOGY-DI AGNOSTI C . 00 05500 RADI OLOGY-THERAPEUTI C		0. 1012		1, 648, 386	
00 05600 RADIOLOGI-THERAPEOTIC		0. 0586		51, 858	
00 05900 CARDI AC CATHETERI ZATI ON		0. 0667		651, 245	
. 00 06000 LABORATORY		0. 17802		1, 980, 679	
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2225		313, 640	
. 00 06500 RESPI RATORY THERAPY		0. 1910		1, 086, 679	
. 00 06600 PHYSI CAL THERAPY		0. 2719			
. 00 06700 OCCUPATI ONAL THERAPY		0. 3105		284, 211	
. 00 06800 SPEECH PATHOLOGY		0. 2851		219, 931	68
. 00 06900 ELECTROCARDI OLOGY		0. 06902	21 8, 364, 701	577, 340	69
07000 ELECTROENCEPHALOGRAPHY		0. 2045	45 218, 267	44, 645	5 70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2284	75 8, 002, 613	1, 828, 397	7 71
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1295		2, 435, 721	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2235			
00 07400 RENAL DIALYSIS		0. 4452			
. 00 07500 ASC (NON-DI STI NCT PART)		0.0000		0	
. 01 07501 ASC (NON-DI STI NCT PART)		0.0618			
. 00 03950 CARDI AC CATHERI ZATI ON		0.0000		0 700	
. 01 03951 OUTPATI ENT WOUND CARE CENTER . 97 07697 CARDI AC REHABI LI TATI ON		0. 0867			
OUTPATIENT SERVICE COST CENTERS		0.0000	0	0	1 /0
. 00 09000 CLINIC		0.0000	0 00	C	0 90
. 01 04950 SLEEP CLINIC		0. 15652			
02 09001 ANTI COAGULATI ON CLINIC		0. 2841			
03 09002 ARNETT CANCER CARE CENTER		0.0950			
. 04 09003 OUTPATIENT INFUSION CENTER		0. 2343		612	
00 09100 EMERGENCY		0. 0967		1, 828, 124	1 91
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 31672		58, 685	
. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000			
. 00 04951 OTHER OUTPATIENT SERVICES		0.0000		-	
0.00 Total (sum of lines 50 through 94 and 96 through 98)			150, 739, 332	22, 962, 142	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201
02.00 Net charges (line 200 minus line 201)			150, 739, 332		202

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0173	Peri od:	Worksheet D-3	;
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Titl	e XIX	Hospi tal	PPS	- <u>z</u> pii
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	-
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
. 00 03000 ADULTS & PEDI ATRI CS			2, 790, 363		30
. 00 03100 I NTENSI VE CARE UNI T			413, 631		31
. 00 03300 BURN INTENSIVE CARE UNIT			0		33
. 01 03301 BURN INTENSIVE CARE UNIT			0		33
. 00 02060 NEONATAL INTENSIVE CARE UNIT			1, 586, 372		35
. 00 04300 NURSERY			214, 600		43
ANCI LLARY SERVI CE COST CENTERS		1		L	
00 05000 OPERATING ROOM		0. 1145			
00 05100 RECOVERY ROOM		0. 1829			
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2993			
00 05300 ANESTHESI OLOGY		0. 9175			
01 05301 ASC ANESTHESI OLOGY		0.0157		0	
00 05400 RADI OLOGY-DI AGNOSTI C 00 05500 RADI OLOGY-THERAPEUTI C		0.1012			
00 05500 RADI OLOGY-THERAPEUTI C 00 05600 RADI OI SOTOPE		0.0000		0 875	
00 05900 CARDI AC CATHETERI ZATI ON		0. 0586 0. 0667		13, 783	
00 06000 LABORATORY		0. 1780			
00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2225		9, 191	
00 06500 RESPIRATORY THERAPY		0. 1910		110, 905	
. 00 06600 PHYSI CAL THERAPY		0. 2719			
00 06700 OCCUPATI ONAL THERAPY		0. 3105			
00 06800 SPEECH PATHOLOGY		0. 2851			
. 00 06900 ELECTROCARDI OLOGY		0.0690			
00 07000 ELECTROENCEPHALOGRAPHY		0. 2045		4, 568	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2284			
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1295			
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2235		307, 750	73
. 00 07400 RENAL DI ALYSI S		0. 4452	42 93, 728	41, 732	74
. 00 07500 ASC (NON-DI STINCT PART)		0.0000	0 00	0	75
. 01 07501 ASC (NON-DI STINCT PART)		0. 0618	70 0	0	75
00 03950 CARDI AC CATHERI ZATI ON		0.0000	0 00	0	76
01 03951 OUTPATIENT WOUND CARE CENTER		0. 0867			
. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	0 00	0	76
		0.0000	0 00	0	
. 00 09000 CLINIC . 01 04950 SLEEP CLINIC		0. 0000 0. 1565		-	
. 02 09001 ANTI COAGULATI ON CLINIC		0. 1565		0	
03 09002 ARNETT CANCER CARE CENTER		0. 2841			
. 04 09003 OUTPATIENT INFUSION CENTER		0. 2343		0	
00 09100 EMERGENCY		0. 0967		-	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 3167			
01 09201 OBSERVATION BEDS (INCH-DISTINCT PART)		0.0000			
00 04951 OTHER OUTPATIENT SERVICES		0.0000			
0.00 Total (sum of lines 50 through 94 and 96 through 98)			6, 237, 344		
1.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201
2.00 Net charges (line 200 minus line 201)	(	1	6, 237, 344	1	202

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre			
		Title XVIII	Hospi tal	5/26/2022 3: 4: PPS	2 pm		
				1.00			
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS						
I.00 I.01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	0 23, 553, 584	1.00 1.0 <sup>-</sup>		
1.02	DRG amounts other than outlier payments for discharges occurr instructions)	ring on or after October	1 (see	8, 953, 205	1.02		
1.03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	for discharges occurring	prior to October	0	1.03		
1.04	DRG for federal specific operating payment for Model 4 BPCI f October 1 (see instructions)	for discharges occurring	on or after	0	1.04		
2.00 2.01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.00 2.0		
2.01	Outlier payment for discharges for Model 4 BPCI (see instruct	tions)		0			
2.03	Outlier payments for discharges occurring prior to October 1	-		1, 100, 484	2.0		
2.04	Outlier payments for discharges occurring on or after October	- 1 (see instructions)		409, 797			
3.00 4.00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	orting ported (see instru	(ctions)	19, 441, 853 178. 13			
4.00	Indirect Medical Education Adjustment	bitting period (see firsting		170.13	4.0		
5.00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)	st recent cost reporting	period ending on	0.00	5.00		
5.00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)	the criteria for an add-o	on to the cap for	0.00	6.00		
7.00 7.01	MMA Section 422 reduction amount to the IME cap as specified ACA $\S$ 5503 reduction amount to the IME cap as specified under		0.00 0.00				
3. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa	athic and osteonathic pro	ograms for	0.00	8.0		
. 00	affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	0.0		
3. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0.00	8.0		
3. 02	The amount of increase if the hospital was awarded FTE cap sl under § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8.0		
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)			0.00			
0.00	FTE count for allopathic and osteopathic programs in the curr	rent year from your recom	rds		10.0		
11.00 12.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11.0 12.0		
13.00	Total allowable FTE count for the prior year.			0.00			
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ear ended on or after Sep	otember 30, 1997,		14. C		
15.00	Sum of lines 12 through 14 divided by 3.				15.0		
16.00	Adjustment for residents in initial years of the program			14.31			
17.00 18.00	Adjustment for residents displaced by program or hospital clo Adjusted rolling average FTE count	Sure		0.00 14.31	17. C 18. C		
9.00	Current year resident to bed ratio (line 18 divided by line 4	1).		0. 080335			
0.00	Prior year resident to bed ratio (see instructions)			0.066741			
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0. 066741			
22.00	IME payment adjustment (see instructions)			1, 163, 450			
2. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42			695, 843	]		
3.00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$ .	ient cap slots under 42 (	JFR 412.105	0.00			
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the instructions)	lower of line 23 or line	e 24 (see	0. 00 0. 00	24. 0 25. 0		
6. 00	instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000	26.0		
7.00	IME payments adjustment factor. (see instructions)			0. 000000			
8.00	IME add-on adjustment amount (see instructions)			0			
8.01	IME add-on adjustment amount - Managed Care (see instructions	5)		0			
9. 00 9. 01							
0. 00	Percentage of SSI recipient patient days to Medicare Part A p	patient davs (see instruc	ctions)	4.66	30.0		
	Percentage of Medicaid patient days (see instructions)			23. 11	1		
51.00							
31.00 32.00	Sum of lines 30 and 31			27.77	32.0		

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0173	Peri od:	Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	nare
				5/26/2022 3:42	2 pm
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1.00	2.00	
5.00	Total uncompensated care amount (see instructions)		8 290 014 521	7, 192, 008, 710	35.
5. 01	Factor 3 (see instructions)		0. 000326093		35.
5.02	Hospital uncompensated care payment (If line 34 is zero, er	nter zero on this line) (se			
	instructions)				
5.03	Pro rata share of the hospital uncompensated care payment a		2, 021, 929		
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35		2, 550, 139		36.
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu			
0.00	Total Medicare discharges (see instructions)		0		40.
1.00	Total ESRD Medicare discharges (see instructions)		0		41.
1.01	Total ESRD Medicare covered and paid discharges (see instru		0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qua	allry for adjustment)	0.00		42
3.00 4.00	Total Medicare ESRD inpatient days (see instructions) Ratio of average length of stay to one week (line 43 divide	d by Lipo 41 divided by 7	0.00000		43
4.00	days)	ed by Time 41 divided by 7	0.000000		44
5.00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00		45
6.00	Total additional payment (line 45 times line 44 times line		0		46
7.00	Subtotal (see instructions)		38, 716, 428		47
8.00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)				
				Amount	
9.00	Total payment for inpatient operating costs (see instruction			1.00 39,412,271	49
2.00 D.00	Payment for inpatient program capital (from Wkst. L, Pt. I			3, 022, 337	50
1.00	Exception payment for inpatient program capital (Wkst. L, F			0,022,007	51
2.00	Direct graduate medical education payment (from Wkst. E-4,			528, 407	
3.00	Nursing and Allied Health Managed Care payment			21, 008	
4.00	Special add-on payments for new technologies			697, 911	54
4.01	Islet isolation add-on payment			0	54
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	e 69)		0	55
6.00	Cost of physicians' services in a teaching hospital (see ir			0	56
7.00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35).	0	57
8.00	Ancillary service other pass through costs from Wkst. D, Pt	I. IV, col. 11 line 200)		32, 668	
9.00	Total (sum of amounts on lines 49 through 58)			43, 714, 602	
D. 00	Primary payer payments			17,010	
1.00 2.00	Total amount payable for program beneficiaries (line 59 mir	lus line 60)		43, 697, 592 3, 361, 608	
2.00 3.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			3, 301, 608 90, 524	
4.00	Allowable bad debts (see instructions)			376, 905	
5.00	Adjusted reimbursable bad debts (see instructions)			244, 988	
6.00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		38, 990	
7.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			40, 490, 448	
B. 00	Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (s	ee instructions)	0	68
9.00	Outlier payments reconciliation (sum of lines 93, 95 and 96			0	
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
0. 50	Rural Community Hospital Demonstration Project (§410A Demor	nstration) adjustment (see	instructions)	0	70
D. 87	Demonstration payment adjustment amount before sequestration			0	70
D. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70
	Pioneer ACO demonstration payment adjustment amount (see ir				70
	HSP bonus payment HVBP adjustment amount (see instructions)			0	
0. 90				0	70
0. 90 0. 91	HSP bonus payment HRR adjustment amount (see instructions)				
0. 90 0. 91 0. 92	Bundled Model 1 discount amount (see instructions)			0	
0. 89 0. 90 0. 91 0. 92 0. 93 0. 93				0 -41, 351 -96, 821	

LCULATION OF REIMBURSEMENT SETTLEMENT	Provider CO	CN: 15-0173	Period:	Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre 5/26/2022 3:4	
	Title	XVIII	Hospi tal	PPS	ριιι
			(уууу)	Amount	
			0	1.00	
96 Low volume adjustment for federal fiscal year (yyyy) (Enter in	ı column O		0	0	70.
the corresponding federal year for the period prior to 10/1)			0	0	70
. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or aft			0	0	70.
. 98 Low Volume Payment-3				0	70.
99 HAC adjustment amount (see instructions)				0	70.
.00 Amount due provider (line 67 minus lines 68 plus/minus lines 6	9 & 70)			40, 352, 276	
.01 Sequestration adjustment (see instructions)				0	71.
.02 Demonstration payment adjustment amount after sequestration				0	
. 03 Sequestration adjustment-PARHM pass-throughs					71.
.00 Interim payments				38, 735, 725	
.01 Interim payments-PARHM				0	72.
.00  Tentative settlement (for contractor use only) .01  Tentative settlement-PARHM (for contractor use only)				0	73.
.00 Balance due provider/program (line 71 minus lines 71.01, 71.02	72 and			1, 616, 551	
73)	, , <u>, , , ,</u> , , , , , , , , , , , , ,			1,010,001	' ''
.01 Balance due provider/program-PARHM (see instructions)					74.
.00 Protested amounts (nonallowable cost report items) in accordan	ice with			875, 327	75.
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) 00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum c	£ 2.02			0	90.
0 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum c plus 2.04 (see instructions)	1 2.03			0	90.
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.
.00 Operating outlier reconciliation adjustment amount (see instru	ictions)			0	
.00 Capital outlier reconciliation adjustment amount (see instruct				0	93.
.00 The rate used to calculate the time value of money (see instru	ictions)			0.00	
.00 Time value of money for operating expenses (see instructions)				0	95.
.00 Time value of money for capital related expenses (see instruct	ions)		Prior to 10/1	$\frac{0}{00/4}$	96.
			1.00	2.00	
HSP Bonus Payment Amount					
0.00 HSP bonus amount (see instructions)			0	0	100.
HVBP Adjustment for HSP Bonus Payment					1
1.00 HVBP adjustment factor (see instructions)	•		0. 000000000000000000000000000000000000	0.000000000	101.
2.00 HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	•)		0	0	102.
3.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103
4.00 HRR adjustment amount for HSP bonus payment (see instructions)			0.0000		104.
			-		
Rural Community Hospital Demonstration Project (§410A Demonstr		stment			200.
Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 Is this the first year of the current 5-year demonstration per	ation) Adju				
Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	ation) Adju				
Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 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	ation) Adju iod under t				0.01
Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 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 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	ation) Adju iod under t				201.
Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 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 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions)	ation) Adju iod under t				202.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       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       Cost Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)	ation) Adju iod under t : 49)	he 21st	nt 5-vear demonst	ration	
Rural Community Hospital Demonstration Project (§410A Demonstr 0.00 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 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 2.00 Medicare discharges (see instructions)	ation) Adju iod under t : 49)	he 21st	nt 5-year demonst	ration	202.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       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       1.00         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount	ation) Adju iod under t : 49)	he 21st	nt 5-year demonst		202. 203. 204.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       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       Cost Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)	ation) Adju iod under t : 49)	he 21st	nt 5-year demonst		202. 203. 204. 205.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         6.00       Medicare inpatient routine cost cap (line 202 times line 205)	ation) Adju iod under t : 49)	he 21st	nt 5-year demonst		202. 203. 204.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         6.00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement	ation) Adju iod under t : 49) first year	he 21st	nt 5-year demonst		202. 203. 204. 205. 206.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         6.00       Medicare inpatient routine cost cap (line 202 times line 204)         6.00       Program reimbursement under the §410A Demonstration (see instructions)	ation) Adju iod under t : 49) first year -uctions)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       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       Cost Reimbursement         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         6.00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement         7.00       Program reimbursement under the §410A Demonstration (see instr         8.00       Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ation) Adju iod under t : 49) first year -uctions)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207. 208.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         6.00       Medicare inpatient routine cost cap (line 202 times line 204)         6.00       Program reimbursement under the §410A Demonstration (see instructions)	ation) Adju iod under t : 49) first year -uctions)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207. 208. 209.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       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         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjusted target amount (line 203 times line 204)         6.00       Medicare inpatient routine cost cap (line 202 times line 205)         Adjustment to Medicare Part A Inpatient Reimbursement         7.00       Program reimbursement under the §410A Demonstration (see instructions)         8.00       Medicare Part A inpatient service costs (from Wkst. E, Pt. A,         9.00       Adjustment to Medicare IPPS payments (see instructions)	ation) Adju iod under t : 49) first year -uctions)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207. 208. 209. 210.
Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00 Medicare discharges (see instructions)         3.00 Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00 Medicare target amount         5.00 Case-mix adjustment routine cost cap (line 202 times line 204)         6.00 Medicare inpatient routine cost cap (line 202 times line 204)         6.00 Medicare Part A Inpatient Reimbursement         7.00         Program reimbursement under the §410A Demonstration (see instructions)         0.00 Reserved for future use         0.00 Reserved for future use         0.00 Total adjustment to Medicare IPPS payments (see instructions)         0.00 Reserved for FPS versus Cost Reimbursement	ation) Adju iod under t 49) first year uctions) line 59)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207. 208. 209. 210. 211.
Rural Community Hospital Demonstration Project (§410A Demonstr         0.00       Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         1.00       Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00       Medicare discharges (see instructions)         3.00       Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00       Medicare target amount         5.00       Case-mix adjustment routine cost cap (line 203 times line 204)         6.00       Medicare target amount         7.00       Program reimbursement under the §410A Demonstration (see instructions)         7.00       Program reimbursement under the §410A Demonstration (see instructions)         0.00       Reserved for future use         1.00       Total adjustment to Medicare IPPS payments (see instructions)         0.00       Total adjustment to Medicare Part A IPPS payments (from line 2	ation) Adju iod under t 49) first year uctions) line 59)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212.
Rural Community Hospital Demonstration Project (§410A Demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.         Cost Reimbursement         1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line         2.00 Medicare discharges (see instructions)         3.00 Case-mix adjustment factor (see instructions)         Computation of Demonstration Target Amount Limitation (N/A in period)         4.00 Medicare target amount         5.00 Case-mix adjustment routine cost cap (line 202 times line 204)         6.00 Medicare inpatient routine cost cap (line 202 times line 204)         6.00 Medicare Part A Inpatient Reimbursement         7.00         Program reimbursement under the §410A Demonstration (see instructions)         0.00 Reserved for future use         0.00 Reserved for future use         0.00 Total adjustment to Medicare IPPS payments (see instructions)         0.00 Reserved for FPS versus Cost Reimbursement	ation) Adju iod under t e 49) first year ructions) line 59)	he 21st	nt 5-year demonst		202. 203. 204. 205. 206. 207. 208. 209. 210. 211.

	Financial Systems			Provider C		Period:	Worksheet E	. <i>.</i>
						From 01/01/2021 To 12/31/2021	Part A Exhibi	par
				Title	XVIII	Hospi tal	5/26/2022 3: 42 PPS	2р
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
)	DRG amounts other than outlier	0	1.00	2.00	3.00	4.00	5.00	1
I	payments DRG amounts other than outlier		23, 553, 584	0		-	23, 553, 584	
	payments for discharges occurring prior to October 1	4 60	0.050.005			0.050.005	0.050.005	
2	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	8, 953, 205	0		8, 953, 205	8, 953, 205	1
3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	(	D	0	1
1	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1. 04	0	0		0	0	
)	October 1 Outlier payments for discharges (see instructions)	2.00						2
I	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	(	0 0	0	
2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	1, 100, 484	0	1, 100, 484	4	1, 100, 484	2
3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	409, 797	0		409, 797	409, 797	
)	Operating outlier	2. 01	0	0		0 0	0	:
)	reconciliation Managed care simulated payments	3.00	19, 441, 853	0	13, 852, 115	5 5, 589, 738	19, 441, 853	
	Indirect Medical Education Adju				1			
)	Amount from Worksheet E, Part A, line 21 (see instructions) IME payment adjustment (see	21.00 22.00	0. 066741 1, 163, 450	0. 066741			1, 163, 450	
I	instructions)	22.00	695, 843	0			695, 843	
	managed care (see instructions)			-		200,002	0,0,010	
)	Indirect Medical Education Adju	ustment for the 27.00	e Add-on for Se 0.000000			0. 000000		
)	(see instructions) IME adjustment (see	27.00	0.000000	0.000000		D 0.000000 D 0	0	
I	instructions) IME payment adjustment add on for managed care (see	28.01	0	0	(	o o	0	8
)	instructions) Total IME payment (sum of	29.00	1, 163, 450	0	843, 006	6 320, 444	1, 163, 450	
I	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29.01	695, 843	0	495, 781	1 200, 062	695, 843	q
	8.01) Disproportionate Share Adjustme	ent			I			
00	Allowable disproportionate share percentage (see	33.00	0. 1213	0. 1213	0. 1213	3 0. 1213		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	985, 769	0	714, 263	3 271, 506	985, 769	11
01	Uncompensated care payments Additional payment for high per		2, 550, 139 D benefi ci ary	di scharges	· · ·			
00	Total ESRD additional payment (see instructions)	46.00	0	0				12
00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	38, 716, 428 0	0 0	28, 233, 266	5 10, 483, 162 0 0	38, 716, 428 0	13
00	Total payment for inpatient operating costs (see	49.00	39, 412, 271	0	28, 729, 047	7 10, 683, 224	39, 412, 271	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	3, 022, 337	0	2, 201, 16	1 821, 176	3, 022, 337	16

Heal th	Financial Systems		IU HEALTH ARNE	ETT_HOSPITAL		In Lie	eu of Form CMS-2	2552-10
LOW VC	LUME CALCULATION EXHIBIT 4			Provider CO		Period: From 01/01/2021 To 12/31/2021		pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	697, 911	0	541, 34	1 156, 570	697, 911	
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced	68.00	0	0		0 0	0	17.02
	devices for applicable MS-DRGs		_	_		_		
18.00	Capital outlier reconciliation adjustment amount (see	93.00	0	0		0 0	0	18.00
19.00	instructions) SUBTOTAL			0	31, 471, 54	9 11, 660, 970	43, 132, 519	19.00
		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	1.00 1.01	2, 479, 860 0		1, 806, 73	673, 123 0 0		
21.00	Capital DRG outlier payments	2.00	323, 753	0	235, 07	0 88, 683	323, 753	21.00
21.00	Model 4 BPCI Capital DRG outlier payments	2.00	0		233, 07	0 0	0	21.00
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0304	0. 0304	0. 030	0. 0304		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	75, 388	0	54, 92	20, 463	75, 388	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0578	0. 0578	0. 057	. 0578		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	143, 336	0	104, 42	.9 38, 907	143, 336	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3, 022, 337	0	2, 201, 16	821, 176	3, 022, 337	26.00
		line	(Amounts to E, Part A)					
	1	0	1.00	2.00	3.00	4.00	5.00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 00000	0 0. 000000 0	0	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

SPI T	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IU HEALTH ARN TION EXHIBIT 5			Peri od:	u of Form CMS-2 Worksheet E	
					From 01/01/2021 To 12/31/2021	Part A Exhibi Date/Time Prep	pare
			Ti the	XVIII	Hocni tol	5/26/2022 3: 42 PPS	2 pm
		Wkst. E, Pt.	Amt. from	Period to	Hospital Period on	Total (cols. 2	
		A, line	Wkst. E, Pt. A)	10/01	after 10/01	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	23, 553, 584	23, 553, 58	34	23, 553, 584	1. 1.
02	discharges occurring prior to October 1 DRG amounts other than outlier payments for	1.02	8, 953, 205		8, 953, 205		1.
02	discharges occurring on or after October 1 DRG for Federal specific operating payment	1.03	0, 700, 200		0	0, 700, 200	1.
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	for Model 4 BPCI occurring prior to October	1.05			0	0	
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1
00	Outlier payments for discharges (see instructions)	2.00					2
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	1, 100, 484	1, 100, 48	34	1, 100, 484	2
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	409, 797		409, 797	409, 797	2
00 00	Operating outlier reconciliation Managed care simulated payments	2.01 3.00	0 19, 441, 853	13, 852, 11	0 0 5 5, 589, 738	0 19, 441, 853	3 4
	Indirect Medical Education Adjustment						
0	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 066741	0. 06674	0. 066741		5
)0 )1	IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22.00 22.01	1, 163, 450 695, 843			1, 163, 450 695, 843	6
	instructions)						
	Indirect Medical Education Adjustment for the						-
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000			7
10 1	IME adjustment (see instructions) IME payment adjustment add on for managed	28.00 28.01	0		0 0 0 0	0	8
0	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00	1, 163, 450	843, 00	320, 444	1, 163, 450	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	695, 843	495, 78	200, 062	695, 843	9
	Disproportionate Share Adjustment						
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1213	0. 121	3 0. 1213		10
00	Disproportionate share adjustment (see instructions)	34.00	985, 769	714, 26	271, 506	985, 769	11
01	Uncompensated care payments Additional payment for high percentage of ESF	36.00 D beneficiary	2, 550, 139 di scharges	2, 021, 92	528, 210	2, 550, 139	11
00	Total ESRD additional payment (see instructions)	46. 00	0		0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH	47.00 48.00	38, 716, 428 0	28, 233, 26	06 10, 483, 162 0 0	38, 716, 428 0	13 14
	and MDH, small rural hospitals only.) (see instructions)						
00	Total payment for inpatient operating costs (see instructions)	49.00	39, 412, 271				
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable) Special, add on payments for new technologies	50.00	3, 022, 337				
00 01 02	Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for	54.00 68.00	697, 911	541, 34	1 156, 570 0 0	697, 911 0	17
02 00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	93.00				0	
	amount (see instructions)	73.00		a= .	0		
00	SUBTOTAL			31, 471, 54	11, 660, 970	43, 132, 519	19

Heal th	Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CO	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021		epared:
				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	2, 479, 860	1, 806, 7	37 673, 123	2, 479, 860	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	323, 753	235, 0	70 88, 683	323, 753	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. 0304	0. 03	0. 0304		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	75, 388	54, 9	25 20, 463	75, 388	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0578	0. 05	78 0. 0578		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	143, 336	104, 4	29 38, 907	143, 336	25.00
26.00	Total prospective capital payments (see instructions)	12.00	3, 022, 337	2, 201, 1	61 821, 176	3, 022, 337	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70. 96	0		0	0	
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	
30.00	HVBP payment adjustment (see instructions)	70. 93	-41, 351	-41, 3	51 0	-41, 351	
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	-96, 821	-79, 5	13 -17, 308	-96, 821	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	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CUL	Financial Systems         IU HEALTH ARNETT HOSE           ATION OF REIMBURSEMENT SETTLEMENT         Pro	vider CCN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2022 3: 4: PPS	2 pm
			10301 tui	113	
				1.00	
0	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			8, 909	1.00
0	Medical and other services reimbursed under OPPS (see instructions)	3)		32, 437, 757	
0	OPPS payments	·)		30, 935, 763	
00	Outlier payment (see instructions)			441, 692	
)1	Outlier reconciliation amount (see instructions)	<b>`</b>		0	
00	Enter the hospital specific payment to cost ratio (see instruction Line 2 times line 5	IS)		0. 000 0	
0	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
00	Transitional corridor payment (see instructions)			0	8.0
00	Ancillary service other pass through costs from Wkst. D, Pt. IV, c	col. 13, line 200		82, 878	
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 8, 909	
00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 909	11.0
	Reasonable charges				
	Ancillary service charges			61, 421	12.0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6	9)		0	
00	Total reasonable charges (sum of lines 12 and 13)			61, 421	14.0
00	Customary charges Aggregate amount actually collected from patients liable for payme	ent for services on	a charge basis	0	15.0
	Amounts that would have been realized from patients liable for pay			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		0		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.00000	
00 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if	Flipo 19 ovcoods li	no 11) (coo	61, 421 52, 512	
00	instructions)	TTHE TO EXCEEUS TT	ne II) (see	52, 512	19.0
00	Excess of reasonable cost over customary charges (complete only if	∃line 11 exceeds li	ne 18) (see	0	20.0
	instructions)				
00	Lesser of cost or charges (see instructions)			8, 909	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructi	ons)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	010)		31, 460, 333	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instructions)			6, 150	
00 00	Deductibles and Coinsurance amounts relating to amount on line 24 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			5, 308, 879 26, 154, 213	
00	instructions)	the sum of times 22		20, 154, 215	27.0
00	Direct graduate medical education payments (from Wkst. E-4, line 5	50)		338, 035	28.0
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			26, 492, 248	
	Primary payer payments Subtotal (line 30 minus line 31)			6, 001 26, 486, 247	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			20/ 100/ 21/	02.0
00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.0
	Allowable bad debts (see instructions)			580, 503	
00 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		377, 327 329, 532	
	Subtotal (see instructions)	013)		26, 863, 574	
	MSP-LCC reconciliation amount from PS&R			-9	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)				39.5
97 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replaced c	louicos (soo instruk	tions)	0	
90 99	RECOVERY OF ACCELERATED DEPRECIATION		.(10115)	0	1
00	Subtotal (see instructions)			26, 863, 583	
01	Sequestration adjustment (see instructions)			0	
	Demonstration payment adjustment amount after sequestration			0	
	Sequestration adjustment-PARHM pass-throughs			24 721 000	40.0
	Interim payments Interim payments-PARHM			26, 731, 088	41.0
	Tentative settlement (for contractors use only)			0	
01	Tentative settlement-PARHM (for contractor use only)				42.0
	Balance due provider/program (see instructions)			132, 495	
01	Balance due provider/program-PARHM (see instructions)	with CMS Dub 15 0	chaptor 1	10 770	43.0
00	Protested amounts (nonallowable cost report items) in accordance w §115.2	/ILN CM5 PUD. 15-2,	chapter I,	18, 773	44.C
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	90.0
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0. 00 0	92. C 93. C
	Time Value of Money (see instructions)				

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0173	Period: From 01/01/2021 To 12/31/2021	Worksheet E-1 Part I Date/Time Prep 5/26/2022 3:42	pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 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 amount based on subsequent revision of the interim rate		38, 536, 6	25 0	26, 731, 088 0	1. 2. 3.
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01 02 03 04 05	ADJUSTMENTS TO PROVIDER	11/10/2021	199, 1 <sup>.</sup>	00 0 0 0	0 0 0 0	3. 3. 3. 3. 3.
	Provider to Program					
50 51 52 53 54	ADJUSTMENTS TO PROGRAM			0 0 0 0	0 0 0 0	3. 3. 3. 3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		199, 1	00	0	3
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) TO BE COMPLETED BY CONTRACTOR		38, 735, 7	25	26, 731, 088	4
0	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) Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		1, 616, 5	51	132, 495	6
)2 )0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		40, 352, 2	76	0 26, 863, 583	6
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0	)	1.00	2.00	

Heal th	Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-:	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0173	Peri od:	Worksheet E-1		
				From 01/01/2021	Part II		
				To 12/31/2021	Date/Time Pre 5/26/2022 3:4		
			Title XVIII	Hospi tal	PPS	2 pm	
					1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	ND COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTIC	ON AND CALCULATION					
1.00	Total hospital discharges as defined in AARA	A §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00	
2.00	00 Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost						
	reporting periods beginning on or after 10/0						
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col					3.00	
4.00	Total inpatient days (Wkst. S-3, Pt. I, col.		l, and 8 through 12, and	plus for cost		4.00	
	reporting periods beginning on or after 10/0						
5.00	Total hospital charges from Wkst C, Pt. I, c	col. 8 line 200				5.00	
6.00	Total hospital charity care charges from Wks	st. S-10, col. 3 li	ne 20			6.00	
7.00	CAH only - The reasonable cost incurred for line 168	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (se	ee instructions)				8.00	
9.00	Sequestration adjustment amount (see instruct					9.00	
10.00	Calculation of the HIT incentive payment aft		(see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &	CAH				1	
30.00	Initial/interim HIT payment adjustment (see	instructions)				30.00	
31.00	Other Adjustment (specify)	,				31.00	
	2.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 3						

I RECT	Financial         Systems         IU         HEALTH         ARNETT           GRADUATE         MEDICAL         EDUCATION         (GME)         & ESRD         OUTPATIENT         DIRECT	Provider CO	CN: 15-0173	Peri od:	u of Form CMS-2 Worksheet E-4	
EDI CA	L EDUCATION COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	pared
		Titlo	XVIII		5/26/2022 3: 4 PPS	
		IIIIe	AVIII	Hospi tal	PP3	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
. 00	Unweighted resident FTE count for allopathic and osteopathic	programs for	cost reporti	ng periods	0.00	1.
00	ending on or before December 31, 1996. Unweighted FTE resident cap add-on for new programs per 42 CF	R 413 79(e)(	1) (see instr	uctions)	0.00	2.
00	Amount of reduction to Direct GME cap under section 422 of MM.		1) (300 111311		0.00	
01						3.
00	instructions for cost reporting periods straddling 7/1/2011) Adjustment (plus or minus) to the FTE cap for allopathic and GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f)		programs due	to a Medicare	0.00	4.
01	ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0.00	4.
02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see inst	ructions for	cost reporting	0.00	4.
00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 pl 4.02 plus applicable subscripts		·		0.00	
00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0.00	
00	Enter the lesser of line 5 or line 6		Primary Care	e Other	0.00 Total	7.
			1.00	2.00	3.00	
00	Weighted FTE count for physicians in an allopathic and osteop program for the current year.	athi c	0.0	0.00	0.00	8
00	If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo 6.		0.0	0.00	0.00	9
00	o. Weighted dental and podiatric resident FTE count for the curr	ent year		0.00		10
. 01	Unweighted dental and podiatric resident FTE count for the cu	rrent year		0.00		10
. 00 . 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportini instructions)	g year (see	0. ( 0. (			11 12
. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	0.0	0.00		13.
. 00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0.0			14
00	Adjustment for residents in initial years of new programs		14.3			15
01	Unweighted adjustment for residents in initial years of new p Adjustment for residents displaced by program or hospital clo		0. ( 0. (			15 16
00	Unweighted adjustment for residents displaced by program or hospital cro Unweighted adjustment for residents displaced by program or h closure		0.0			16
. 00	Adjusted rolling average FTE count		14.3	0. 00		17
. 00	Per resident amount		112, 603. 6			18
00	Approved amount for resident costs		1, 611, 35	0 8	1, 611, 358	19
					1.00	
00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident	cap slots rec	eived under 42	0.00	20
00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			0.00	21
00	Allowable additional direct GME FTE Resident Count (see instr	uctions)			0.00	22
00	Enter the locality adjustment national average per resident a	mount (see i	nstructions)		0.00	
	Multiply line 22 time line 23				0	
00	Total direct GME amount (sum of lines 19 and 24)		Inpatient Par	t Managed Care	<u>1, 611, 358</u> Total	25
			A 1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2.00	3.00	
. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I 3.02, column 2)	X, line	16, 38	33 10, 517		26.
. 00	Total Inpatient Days (see instructions)		49, 23			27
. 00 . 00	Ratio of inpatient days to total inpatient days Program direct GME amount		0. 33277 536, 22		880, 452	28. 29.
. 00	Percent reduction for MA DGME		550, 22	4.07	000, 402	29.
0.00	Reduction for direct GME payments for Medicare Advantage			14, 010	14, 010	
	Net Program direct GME amount		1		866, 442	1 21

Heal th	Financial Systems IU HEAL	_TH ARNETT	HOSPI TAL	In Lie	u of Form CMS-2	2552-10			
DI RECT	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT D	DI RECT	Provider CCN: 15-0173	Peri od:	Worksheet E-4				
MEDI CA	L EDUCATION COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod:			
				10 12/31/2021	5/26/2022 3: 42				
			Title XVIII	Hospi tal	PPS				
					1.00				
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL								
22.00	EDUCATION COSTS)	d 22 lines 74	0	32.00					
32.00	00 Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)								
33.00	Renal dialysis and home dialysis total charges (Wkst	74 and 94)	2, 524, 008	33.00					
34.00	Ratio of direct medical education costs to total cha	rges (line	e 32 ÷ line 33)		0.00000	34.00			
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00					
36.00	Medicare outpatient ESRD direct medical education co		0	36.00					
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TI	TLE XVIII	ONLY						
	Part A Reasonable Cost								
37.00	Reasonable cost (see instructions)				50, 856, 777				
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1,				0	38.00			
39.00	Cost of physicians' services in a teaching hospital	(see instr	ructions)		0	39.00			
40.00	Primary payer payments (see instructions)				17, 010				
41.00	Total Part A reasonable cost (sum of lines 37 throug	jh 39 minus	s line 40)		50, 839, 767	41.00			
40.00	Part B Reasonable Cost				00 500 544	10.00			
42.00	Reasonable cost (see instructions)				32, 529, 544				
43.00 44.00	Primary payer payments (see instructions) Total Part B reasonable cost (line 42 minus line 43)				6, 001 32, 523, 543	43.00 44.00			
44.00 45.00	Total reasonable cost (sum of lines 41 and 44)				32, 523, 543 83, 363, 310				
45.00	Ratio of Part A reasonable cost to total reasonable	cost (ling	11 . Lipo 45)		0. 609858				
48.00	Ratio of Part B reasonable cost to total reasonable		,		0. 390142	48.00			
47.00	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART				0. 390142	47.00			
48.00		A AND I AP			866, 442	48.00			
49.00									
	19.00Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)528,40750.00Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)338,035								

	SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider CCN: 15-0173		Period: From 01/01/2021 To 12/31/2021		
		General Fund	Specific Purpose Func		Plant Fund	
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	143, 300, 610		0 0	0	1 1
00	Temporary investments	0		0 0	0	2
1 00	Notes receivable	0		0 0	0	3
	Accounts receivable	52, 693, 236		0 0	0	
	Other receivable	5, 423, 332		0 0	0	
	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
	Inventory	10, 886, 608		0 0	0	
	Prepaid expenses Other current assets	1, 470, 785		0 0	0	8
	Due from other funds			0 0	0	10
	Total current assets (sum of lines 1-10)	213, 774, 571		0 0	0	
	I XED ASSETS	210/11/0/1				1
	Land	2, 221, 221		0 0	0	1 12
. 00   I	Land improvements	590, 336		0 0	0	13
	Accumulated depreciation	-46, 791		0 0	0	14
	Buildings	183, 560, 470		0 0	0	15
	Accumulated depreciation	-62, 087, 601		0 0	0	16
	Leasehold improvements	0		0 0	0	17
1	Accumulated depreciation Fixed equipment			0 0	0	18
	Accumul ated depreciation			0 0	0	20
	Automobiles and trucks	138, 715		0 0	0	21
	Accumulated depreciation	-120, 708		0 0	0	22
	Major movable equipment	80, 286, 622		0 0	0	23
. 00 /	Accumulated depreciation	-58, 335, 664		0 0	0	24
. 00	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	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0	0	
	Total fixed assets (sum of lines 12-29) THER ASSETS	146, 206, 600	I	0 0	0	30
	Investments	4, 377, 499		0 0	0	31
	Deposits on leases	0		0 0	0	32
	Due from owners/officers	0		0 0	0	33
. 00 0	Other assets	697, 324		0 0	0	34
5.00	Total other assets (sum of lines 31-34)	5, 074, 823		0 0	0	35
	Total assets (sum of lines 11, 30, and 35)	365, 055, 994		0 0	0	36
	CURRENT LIABILITIES		1			
	Accounts payable	42, 860, 898		0 0	0	37
	Salaries, wages, and fees payable	4, 173, 484		0 0	0	
	Payroll taxes payable Notes and loans payable (short term)	0			0	
	Deferred income			0 0	0	
	Accelerated payments	0		0	Ŭ	42
	Due to other funds	2, 873, 510		0 0	0	
	Other current liabilities	39, 429		0 0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	49, 947, 321		0 0	0	45
	LONG TERM LIABILITIES					
	Mortgage payable	0		0 0	0	
	Notes payable	0		0 0	0	47
	Unsecured Loans	00/ 102		0 0	0	
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	996, 183 996, 183		0 0	0	
	Total liabilities (sum of lines 45 and 50)	50, 943, 504		0 0	0	
-	CAPITAL ACCOUNTS	30, 743, 304	I	0 0	0	
	General fund balance	314, 112, 490				52
	Specific purpose fund			0		53
. 00 [	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	31/ 112 /00		0 0	0	59
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	314, 112, 490 365, 055, 994		0 0	0	
	TOTAL FRANCES AND FUND DATABODES (SUII OF FEINES OF AND	000,000,794		0	0	1 01

Heal th	Financial Systems	IU HEALTH ARNET	TT HOSPITAL			In Lie	u of Form CMS-	2552-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0173		riod: om 01/01/2021 12/31/2021	Worksheet G-7 Date/Time Pre 5/26/2022 3:4	epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Func	
		1.00	2.00	3,00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY TRANSACTIONS Total deductions (sum of lines 12-17) Fund balance at end of period per balance	50 50 52, 668, 163 0 0 0 0 0 0 0 0 0	235, 746, 691 131, 033, 955 366, 780, 646 5366, 780, 651 52, 668, 163 314, 112, 488		0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_			
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	000000000000000000000000000000000000000	0.00	0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) INTERCOMPANY TRANSACTIONS Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0			0 0 0 0			7.00         10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00

	I Financial Systems I U HEALTH ARNETT HOSPIT		CN: 15-0173	Peri od:	eu of Form CMS-2552 Worksheet G-2	
STATE	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider C	UN. 15-0175	From 01/01/2021	Parts I & II	
				To 12/31/2021	Date/Time Pre 5/26/2022 3:4	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services		1	-	1	-
1.00	Hospi tal		152, 385, 6	44	152, 385, 644	1.0
2.00	SUBPROVIDER - IPF					2.0
3.00 4.00	SUBPROVIDER - IRF					3.0
4.00 5.00	SUBPROVIDER Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	7.0
8.00	NURSING FACILITY					8.0
9.00	OTHER LONG TERM CARE					9.0
10.00	Total general inpatient care services (sum of lines 1-9)		152, 385, 6	44	152, 385, 644	
	Intensive Care Type Inpatient Hospital Services			· · ·		
11.00	INTENSIVE CARE UNIT		26, 230, 5	61	26, 230, 561	11.0
12.00	CORONARY CARE UNIT					12.0
13.00	BURN INTENSIVE CARE UNIT			0	0	13.0
13.01	BURN INTENSIVE CARE UNIT			0	0	13.0
14.00	SURGICAL INTENSIVE CARE UNIT					14.0
15.00	NEONATAL INTENSIVE CARE UNIT		15, 141, 1		15, 141, 188	•
16.00	Total intensive care type inpatient hospital services (sum of	lines	41, 371, 7	49	41, 371, 749	16.0
	11-15)		400 757 0		100 757 000	17.0
17.00	Total inpatient routine care services (sum of lines 10 and 16	)	193, 757, 3		193, 757, 393	
18.00	Ancillary services		414, 192, 3		1, 153, 329, 897	
19.00 20.00	Outpatient services RURAL HEALTH CLINIC		51, 078, 7			
20.00	FEDERALLY QUALIFIED HEALTH CENTER					
22.00	HOME HEALTH AGENCY			0	0	22.0
23.00	AMBULANCE SERVICES					23.0
24.00	CMHC					24.0
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.0
26.00	HOSPICE					26.0
27.00	OTHER (PHYSICIAN/NON-REIMB.)		3	80 101, 071	101, 451	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	659, 028, 9	24 955, 874, 154	1, 614, 903, 078	28.0
	G-3, line 1)					
	PART II - OPERATING EXPENSES		1		-	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			298, 201, 038		29.0
30.00	ADD (SPECI FY)			0		30.0
31.00				0		31.0
32.00				0		32.0
33.00				0		33.0
34.00				0		34.0
35.00				0		35.0
36.00	Total additions (sum of lines 30-35)			C		36.0
37.00	DEDUCT (SPECI FY)			0		37.0
38.00 39.00				0		38.0
40.00				0		39.0 40.0
40.00				0		40.0
41.00	Total deductions (sum of lines 37-41)			0		41.0
42.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfor		298, 201, 038		42.0
-J. UU	to Wkst. G-3, line 4)		1	270, 201, 030	1	1 43.0

Heal th	Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0173	Peri od:	Worksheet G-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	hared
				10 12/31/2021	5/26/2022 3: 42	
	1				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part				1, 614, 903, 078	1.00
2.00	Less contractual allowances and discounts on	patients' account	S		1, 216, 791, 198	2.00
3.00	Net patient revenues (line 1 minus line 2)		•		398, 111, 880	3.00
4.00	Less total operating expenses (from Wkst. G-		3)		298, 201, 038	
5.00	Net income from service to patients (line 3	minus line 4)			99, 910, 842	5.00
( 00	OTHER I NCOME					( 00
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00 9.00	Revenues from telephone and other miscellane Revenue from television and radio service	ous communication	Ser vi ces		0	8.00 9.00
9.00 10.00	Purchase di scounts				0	9.00 10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
12.00	Revenue from Laundry and Linen service				0	12.00
14.00	Revenue from meals sold to employees and que	sts			0	14.00
15.00	Revenue from rental of living quarters	515			0	15.00
16.00	Revenue from sale of medical and surgical su	nnlies to other th	an natients		0	16.00
17.00	Revenue from sale of drugs to other than pat				0	17.00
18.00	Revenue from sale of medical records and abs				Ő	18.00
	Tuition (fees, sale of textbooks, uniforms,				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, a	,			0	20.00
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				0	22.00
23.00	Governmental appropriations				0	23.00
24.00	MI SCELLANEOUS I NCOME				4, 120, 280	24.00
24.50	COVI D-19 PHE Fundi ng				27, 002, 833	24.50
25.00	Total other income (sum of lines 6-24)				31, 123, 113	25.00
26.00	Total (line 5 plus line 25)				131, 033, 955	26.00
27.00	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and sub				0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)			131, 033, 955	29.00

CALCULATION OF CAPITAL PAYMENT			From 01/01/2021 To 12/31/2021	Parts I-III Date/Time Pre 5/26/2022 3:4	
		Title XVIII	Hospi tal	PPS	z pili
		· ·			
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				-
	CAPITAL FEDERAL AMOUNT			L	-
	Capital DRG other than outlier			2, 479, 860	
	Model 4 BPCI Capital DRG other than outlier			0	1
	Capital DRG outlier payments			323, 753	
	Model 4 BPCI Capital DRG outlier payments			0	
	Total inpatient days divided by number of days in the cost r	eporting period (see inst	ructions)	134.88	
	Number of interns & residents (see instructions)			14.31	
	Indirect medical education percentage (see instructions)	a cum of Linco 1 and 1 01	columno 1 and	3.04	
	Indirect medical education adjustment (multiply line 5 by the 1.01) (see instructions)	e sum of lines I and I. UI	, corumns r and	75, 388	6.
	Percentage of SSI recipient patient days to Medicare Part A	nationt dave (Workshoot E	part Alipo	4.66	7.
. 00	30) (see instructions)	patrent days (worksheet L		4.00	/ .
. 00					
					8.
					10.
	Disproportionate share adjustment (see instructions)			143, 336	
	Total prospective capital payments (see instructions)			3, 022, 337	12.
				1.00	
	PART II – PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions)			0	1
	Program inpatient ancillary capital cost (see instructions)			0	
	Capital cost payment factor (see instructions)			0	
. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	Program inpatient capital costs (see instructions)			0	1 1.
	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	2.
	Net program inpatient capital costs (line 1 minus line 2)	. , ,		0	3.
. 00	Applicable exception percentage (see instructions)			0.00	4.
. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.
.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6.
. 00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 ×	(line 6)	0	7.
	Capital minimum payment level (line 5 plus line 7)			0	
	Current year capital payments (from Part I, line 12, as appl			0	
	Current year comparison of capital minimum payment level to			0	
	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11.
	Net comparison of capital minimum payment level to capital p			0	1
	Current year exception payment (if line 12 is positive, ente			0	
4.00	Carryover of accumulated capital minimum payment level over	capital payment for the f	ollowing period	0	14.
	(if line 12 is negative, enter the amount on this line)				1
					1
5.00	Current year allowable operating and capital payment (see in: Current year operating and capital costs (see instructions)	structions)		0	