	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Cara	a Breidster	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	Signatory Printed Name	Cara Breidster			2
3	Signatory Title	CFO			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	35, 525	31, 005	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	35, 525	31, 005	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 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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX		Provi de	000		Period: From 01/01/	2021	Part I	eet S-2	
						o 12/31/	2021	Date/Ti 5/26/20		
	1.00	2.00		3.00		4	. 00			-
00	Hospital and Hospital Health Care Co Street: 11700 NORTH MERIDIAN ST	PO Box:								1.0
00	City: CARMEL	State: IN	Zip Code	e: 4603	32-4656 County	: HAMILTON				2.
		Component Name	CCN	CBS				nt Syst		
			Number	Numb	er Type	Certi fi ed	<u>Т,</u> V	0, or		-
		1.00	2.00	3.0	0 4.00	5.00	6.00	XVIII 7.00	XIX 8.00	-
	Hospital and Hospital-Based Componen	t Identification:								
00	Hospi tal	IU HEALTH NORTH	150161	2690	0 1	12/20/2005	Ν	P	P	3.
00	Subprovider - IPF	HOSPI TAL								4.
00	Subprovi der – IRF									5.
00	Subprovider - (Other)									6.
00 00	Swing Beds - SNF Swing Beds - NF									7. 8.
00	Hospital-Based SNF									9.
. 00	Hospital-Based NF									10.
. 00										11. 12.
	Hospital-Based HHA Separately Certified ASC									12.
	Hospi tal -Based Hospi ce									14.
	Hospital-Based Health Clinic - RHC									15.
. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16. 17.
	Renal Dialysis									18.
. 00	Other									19.
						From: 1.00				-
. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/20)21	12/31/		20.
	Type of Control (see instructions)					2				21.
				-	1.00	2.00		3. (20	-
	Inpatient PPS Information				1.00	2.00		5.0	50	
. 00					Y	N				22.
	disproportionate share hospital adju §412.106? In column 1, enter "Y" fo			8						
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo									
. 01					Y	Y				22.
	cost reporting period? Enter in colu the portion of the cost reporting pe									
	Enter in column 2, "Y" for yes or "N	51								
	reporting period occurring on or aft									
2. 02	Is this a newly merged hospital that payments to be determined at cost re				N	N				22.
	Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob	er 1. Enter in column	2, "Y" for	yes						
	or "N" for no, for the portion of th October 1.	e cost reporting peric	od on or aft	er						
2. 03	Did this hospital receive a geograph	ic reclassification fr	om urban to		N	N		N		22.
	rural as a result of the OMB standar	ds for delineating sta	ntistical ar	eas						
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			er.						
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41 yes or "N" for no.	∠. iub)? Enter in Colum	шэ, Y° TC	л						
. 04	Did this hospital receive a geograph				Ν	N		N		22.
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for			·						
	reporting period occurring on or aft	er October 1. (see ins	structions)							
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41 yes or "N" for no.	∠. ius)? Enter in Colt	annti 3, `Y``Ť	UL.						
00	Which method is used to determine Me	dicaid days on lines 2	24 and/or 25	5		3 N				23.
5.00										1
5. 00	below? In column 1, enter 1 if date									
. 00	below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the	of identifying the day	/s in this c							

	tems IU HEA L HEALTH CARE COMPLEX IDENTIFICATION D	LTH NORTH H ATA	Provider CC	N: 15-0161	Pe	eri od:	In Lie			t S-2	
					Fr	rom 01/0 0 12/3	1/2021 1/2021	Part Date	∣ ∕Tim		pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Me Me	ut-of State di cai d i gi bl e npai d	Medica HMO da		Oth Medio day	cai d	
		1.00	2.00	3.00		4.00	5.00	0	6. (00	
in-state Medic Medicaid eligi out-of-state M 4, Medicaid HM column 5, and 25.00 If this provid Medicaid paid Medicaid eligi out-of-state M Medicaid eligi	ler is an IPPS hospital, enter the aid paid days in column 1, in-state ble unpaid days in column 2, ledicaid paid days in column 3, ledicaid eligible unpaid days in columr 0 paid and eligible but unpaid days in other Medicaid days in column 6. ler is an IRF, enter the in-state days in column 1, the in-state ble unpaid days in column 2, ledicaid days in column 4, Medicaid ble unpaid days in column 4, Medicaid sligible but unpaid days in column 5.	0	1, 398			0	5	, 872		23	24. 00 25. 00
	angibre but unpart days in cordinit 5.					Urban/R	ural S	Date	of (Geogr	
	ndered energies along if entire (act w			al and an af	4 1 4	1. (00	1	2.00		24.00
cost reporting 27.00 Enter your sta	ndard geographic classification (not w period. Enter "1" for urban or "2" fo ndard geographic classification (not w od. Enter in column 1, "1" for urban c	or rural. age) status	at the en	d of the co			1				26.00 27.00
enter the effe 5.00 If this is a s	cctive date of the geographic reclassif iole community hospital (SCH), enter th cost reporting period.	ication in	column 2.		n		C	D			35.00
						Begi nr		-	ndi ng	-	
6.00 Enter applicab	le beginning and ending dates of SCH s	tatus. Subs	script line	36 for num	nber	1. (0		2.00		36.00
of periods in 7.00 If this is a M is in effect i	excess of one and enter subsequent dat ledicare dependent hospital (MDH), ente n the cost reporting period.	es. er the numbe	er of perio	ds MDH stat			C	D			37.00
	al a former MDH that is eligible for t h FY 2016 OPPS final rule? Enter "Y" f										37.01
,		2									
8.00 If line 37 is	1, enter the beginning and ending date , subscript this line for the number c nt dates.	s of MDH st	atus. If I	ine 37 is							38.00
8.00 If line 37 is greater than 1	, subscript this line for the number of	s of MDH st	atus. If I	ine 37 is		<u> </u>			Y/N 2.00		38.00
 8.00 If line 37 is greater than 1 enter subseque 9.00 Does this faci hospitals in a 1 "Y" for yes accordance wit or "N" for no. 	, subscript this line for the number of ent dates. lity qualify for the inpatient hospita iccordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet h 42 CFR 412.101(b)(2)(i), (ii), or (i (see instructions)	s of MDH st of periods i il payment a), (ii), or the mileage ii)? Enter	atus. If I n excess o adjustment (iii)? En e requireme in column	for low vol for low vol ter in colu nts in 2 "Y" for y	ımn /es		00				
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 3.00 If line 37 is greater than 1 enter subseque 9.00 Does this faci hospitals in a 1 "Y" for yes accordance wit or "N" for no. 0.00 Is this hospit "N" for no in no in column 2 	, subscript this line for the number c ent dates. lity qualify for the inpatient hospita accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet h 42 CFR 412.101(b)(2)(i), (ii), or (i (see instructions) al subject to the HAC program reduction column 1, for discharges prior to Octo the the the the the the the the the the	es of MDH st of periods i), (ii), or the mileage ii)? Enter on adjustmer ober 1. Ente . (see inst	atus. If I n excess o adjustment - (iii)? En e requireme in column ht? Enter " er "Y" for cructions)	for low vol for low vol ter in colu nts in 2 "Y" for y Y" for yes yes or "N"	umn ves or for	1. (N	D0	XVI 0 2.(2.00 N N	XI X 3. 00	39.00
 3.00 If line 37 is greater than 1 enter subseque 9.00 Does this faci hospitals in a 1 "Y" for yes accordance wit or "N" for no. 0.00 Is this hospit "N" for no in column 2 5.00 Does this faci with 42 CFR Se 5.00 Is this facili 	, subscript this line for the number c int dates. lity qualify for the inpatient hospital accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet h 42 CFR 412.101(b)(2)(i), (ii), or (i (see instructions) ral subject to the HAC program reduction column 1, for discharges prior to Octo , for discharges on or after October 1 inty qualify and receive Capital payme toction §412.320? (see instructions) ty eligible for additional payment exc	es of MDH st of periods i i payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter . (see inst ent for disp ception for	adjustment (iii)? En e requireme in column at? Enter " er "Y" for cructions) proportiona extraordin	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" te share in ary circums	or for a aco	1.(N N cordance	D0	XVI	2.00 N N	XI X	39.00 40.00 45.00
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 3. 00 If line 37 is greater than 1 enter subseque 2. 00 Does this faci hospitals in a 1 "Y" for yes accordance wit or "N" for no. 5. 00 Does this faci with 42 CFR Se 6. 00 Is this facili pursuant to 42 Pt. III. 7. 00 Is the facilit Teaching Hospi 	<pre>, subscript this line for the number c nt dates. lity qualify for the inpatient hospita accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet h 42 CFR 412.101(b)(2)(i), (ii), or (i (see instructions) al subject to the HAC program reductic column 1, for discharges prior to Octo t, for discharges on or after October 1 wyment System (PPS)-Capital lity qualify and receive Capital payme ection §412.320? (see instructions) ty eligible for additional payment exc CFR §412.348(f)? If yes, complete Wks hospital under 42 CFR §412.300(b) PPS y electing full federal capital payment</pre>	es of MDH st of periods i if payment a), (ii), or the mileage ii)? Enter on adjustmer ber 1. Enter on adjustmer ber 1. Enter . (see inst capiton for t. L, Pt. I capital? E tt? Enter "	atus. If I n excess o adjustment (iii)? En e requireme in column at? Enter " er "Y" for cructions) proportiona extraordin II and Wks Enter "Y for Y" for yes	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for	Imn yes or for n acconstance l ^ n acconstance l ^ n c.	1.(N N cordance ces through pr no.	DO 1.00 2. N N N N N	XVI 0 2.(Y	2.00 N N	XI X 3. 00 N N	39.00 40.00 45.00 46.00 47.00 48.00
 3. 00 If line 37 is greater than 1 enter subseque 2. 00 Does this faci hospitals in a 1 "Y" for yes accordance wit or "N" for no. 3. 00 Is this hospit to no. 3. 00 Is this hospit to no. 4. 100 Is this facilit pursuant to 42 Pt. III. 5. 00 Is this facilit to this a new 10. 11 to this a new 11. 11. 5. 00 Is this a new 11. 11 to this a new 12. 11 to this a new 13. 11 to this a new 14. 11 to this a new 15. 11	<pre>, subscript this line for the number c nt dates. lity qualify for the inpatient hospital accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet h 42 CFR 412.101(b)(2)(i), (ii), or (i (see instructions) al subject to the HAC program reductic column 1, for discharges prior to Octo t, for discharges on or after October 1 wyment System (PPS)-Capital lity qualify and receive Capital payment ection §412.320? (see instructions) ty eligible for additional payment exc CFR §412.348(f)? If yes, complete Wks hospital under 42 CFR §412.300(b) PPS y electing full federal capital payment tals ital involved in training residents in column 1. For column 2, if the respons n training residents in approved GME p you are impacted by CR 11642 (or appli)</pre>	es of MDH st of periods i il payment a), (ii), or the mileage ii)? Enter on adjustmer bber 1. Enter on adjustmer bber 1. Enter case inst ent for disp ception for st. L, Pt. I capital? Enter " approved (ce to column roograms in cable CRs)	atus. If I n excess o adjustment (iii)? En e requireme in column nt? Enter " er "Y" for cructions) oroportiona extraordin II and Wks Enter "Y fo Y" for yes SME program 1 is "Y", the prior	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen	umn ves or for n acc l - stand l - no. (" fo s hos nul ti	1.(N cordance ces through or no. or yes c spital mate	00 V 1.0 N N N N N N N N N N	XVI 0 2.0 Y N N	2.00 N N	XI X 3. 00 N N	39.00 40.00 45.00 46.00 47.00 48.00
 B. 00 If line 37 is greater than 1 enter subseque 9. 00 Does this faci hospitals in a 1 "Y" for yes accordance wit or "N" for no. 0. 00 Is this hospit to r"N" for no. 0. 00 Is this hospit "N" for no in no in column 2 5. 00 Does this faci ipursuant to 42 Pt. 111. 7. 00 Is this a new 8. 00 Is the facilit Teaching Hospi 6. 00 Is this a new 1s the facilit Teaching Hospi 6. 00 Is this a new 1s the facilit guar, and are Enter "Y" for no in was involved i year, and are Enter "Y" for 7. 00 If line 56 is GME programs tis "Y" did res for yes or "N" 	<pre>, subscript this line for the number c nt dates. lity qualify for the inpatient hospital accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet h 42 CFR 412.101(b)(2)(i), (ii), or (i (see instructions) al subject to the HAC program reductic column 1, for discharges prior to Octo t, for discharges on or after October 1 hyment System (PPS)-Capital lity qualify and receive Capital payment ection §412.320? (see instructions) ty eligible for additional payment exc CFR §412.348(f)? If yes, complete Wks hospital under 42 CFR §412.300(b) PPS y electing full federal capital payment tals ital involved in training residents in column 1. For column 2, if the respons n training residents in approved GME p you are impacted by CR 11642 (or appli yes; otherwise, enter "N" for no in co yes, is this the first cost reporting rained at this facility? Enter "Y" for idents start training in the first mor for no in column 2. If column 2 is "</pre>	es of MDH st of periods i il payment a), (ii), or the mileage ii)? Enter on adjustmer ober 1. Enter on adjustmer ober 1. Enter to column capital? Enter in approved (0 is to column programs in cable CRs) olumn 2. period duri or yes or "N th of this Y", complet	atus. If I n excess o adjustment (iii)? En e requireme in column nt? Enter " er "Y" for cructions) cructions) cructions oroportiona extraordin II and Wks Enter "Y fo 'Y" for yes GME program n 1 is "Y", the prior MA direct ng which r " for no i cost repor	ine 37 is f one and for low vol ter in colu nts in 2 "Y" for yes yes or "N" Y" for yes yes or "N" te share in ary circums t. L-1, Pt. r yes or "N or "N" for s? Enter "Y or if this year or pen GME payment esidents in n column 1. ting period	umn ves or for 1 acc 1 accc 1 accc 1 accc 1 accc 1 accc 1 accc 1 acc	1.(N Cordance ces through or no. or yes c spital mate duction? oroved column Enter "Y	200 V 1.00 N N N N N N N N 1	XVI 0 2.0 Y N N	2.00 N N	XI X 3. 00 N N	39.00 40.00 45.00 46.00 47.00 48.00 56.00
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Health Financial Systems IU HEAL	TH NORT	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/26/2022 2:5	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME		Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 				0.00	0.00	61.00
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.10
61.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
 61.20 Of the FTEs in Line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser						
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting p	eriod for which	0.00	62.00
62.01 Énter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi aram. (s	see instructio		to your hospital	0.00	62.01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, completing	ettings	during this o			N	63.00

SPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION D	ATA Provider CO		<u>In Lieu</u> eriod: rom 01/01/2021	Worksheet S-2 Part I	
				T		Date/Time Pre 5/26/2022 2:5	
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTES	FTEs in	1/ (col . 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
				1.00	2.00	3.00	1
	Section 5504 of the ACA Base Yea	r FTE Residents in M	lonprovider Settings				
. 00	period that begins on or after J Enter in column 1, if line 63 is			0.00	0.00	0. 000000	64 00
. 00	in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio			0.000000	, 04.0
		Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
		5	5	FTEs	FTEsin	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
				Si te			
		1.00	2.00	3.00	4.00	5.00	
	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 in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	10			Unweighted FTEs in Hospital 2.00 For cost report	Ratio (col. 1/ (col. 1 + col. 2)) 3.00 ing periods	
5. 00	Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. mry care resident 3 the ratio of	0.00	0.00	0. 000000	66.0
		Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col.	
				FTEs	FTEsin	3/ (col. 3 +	
				Nonprovi der	Hospi tal	col. 4))	
		1 00	2.00	Si te	4.00	F 00	-
. 00	Enter in column 1, the program	1.00	2.00	3.00	4.00 0.00	5.00 0.000000	67 0
	name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						

Heal th	Financial Systems IU HEALTH NORTH HOSPITAL	In Lie	u of Form (CMS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0161 Performance Performance Provider CCN: 15-0161 Performance Perf	eriod: rom 01/01/2021 o 12/31/2021	Worksheet Part I Date/Time 5/26/2022	Prepared:
		1.0	0 2.00 3	
70.00	<u>Inpatient Psychiatric Facility PPS</u> Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub	provi der? N		70.00
71.00	Enter "Y" for yes or "N" for no. 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
76.00	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 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 ,		0 76.00
			1.00	
90.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N	80.00
	Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter	N N	80.00
86.00	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		N	85. 00 86. 00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87.00
		V 1.00	XI X 2.00	
	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
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Ν	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
96.00	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 00 N	95.00 96.00
97.00	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 column 1 for title V, and in column 2 for title XIX.	0. 00 N	0. 00 Y	97.00 98.00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? 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	N	N	98.03
98.04	for title V, and in column 2 for title XIX. 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	N	98.04
	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 for outpatient services? (see instructions)			106.00
107. 00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R 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	N		107.00
	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 NORTH	H HOSPI TAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: com 01/01/2021 o 12/31/2021	Worksheet S- Part I Date/Time Pr 5/26/2022 2:	- repared:
			V 1.00	XI X	_
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	1.00 N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2. 00	Speech 3.00	4.00	_
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
110 00 Did this baseled antisische is the Dural Community Harrite	L Demenstreet:	an and other	104	1.00 N	110.00
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 Wor applicable.	Y" for yes or	"N" for no. I	f yes,	N	110.00
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad for tele-health services.	ost reporting Dumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? s "Y", enter ne	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 "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub.15-1, chapter 22, §2208.1.	3, or E only) 93" percent (includes				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insur	ance? Enter	N			117.00
"Y" for yes or "N" for no. 118.00 Is the malpractice insurance a claims-made or occurrence pol if the policy is claim-made. Enter 2 if the policy is occurr		1			118.00
		Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 339,046	2.00	3.00	0118.01
		007,010			
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein.			1.00 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 qu Hold Harmless provision in ACA \$3121 and applicable amendmen	ו column 1, "א alifies for t	(" for yes or the 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 impla patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y	5.05	122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo	or 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, en in column 1 and termination date, if applicable, in column 2		fication date			126.00
127.00 If this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2		fication date			127.00
128.00 If this is a Medicare certified liver transplant center, ent	er the certif	fication date			128.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		cation date in			129.00

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE		H NORTH HOSPITAL A Provider Co	CN: 15-0161	From O			2 epared:
					1.00	2.00	-
0.00 If this is a Medicare certified pa			ti fi cati or	۱			130. 0
date in column 1 and termination of 1.00 of this is a Medicare certified in			erti fi cati	on			131.0
date in column 1 and termination of	date, if applicable,	in column 2.					
2.00 If this is a Medicare certified is in column 1 and termination date,	•		ication da	ite			132.0
3.00 Removed and reserved							133.0
4.00 If this is an organ procurement or and termination date, if applicabl	5	iter the OPO number	in column	1			134.0
All Providers						1	
0.00 Are there any related organization chapter 10? Enter "Y" for yes or '					Y	15H059	140.0
are claimed, enter in column 2 the		umber. (see instruc					
<u> </u>	in organization ente	2.00 ar on lines 141 thro	uah 143 th	ne name ar	3.00	of the home	_
office and enter the home office	contractor name and o	contractor number.	ugii 143 ti			s of the nome	
1.00Name: IU HEALTH, INC 2.00Street:340 W. 10TH STREET	Contractor's Na PO Box:	me: WPS	Contra	actor's Nu	mber: 0810)1	141.0 142.0
3.00City: INDIANAPOLIS	State:	IN	Zip Co	ode:	4620)2	142.0
						1.00	_
4.00 Are provider based physicians' cos	sts included in Works	heet A?				1.00 Y	144.0
					1 00	0.00	_
5.00 If costs for renal services are cl	aimed on Wkst. A. Li	ne 74, are the cost	s for		1.00	2.00	145.0
inpatient services only? Enter "Y	" for yes or "N" for	no in column 1. If	column 1 i				
no, does the dialysis facility ind period? Enter "Y" for yes or "N"		ation for this cost	reporting)			
6.00 Has the cost allocation methodolog	gy changed from the p				Ν		146.0
Enter "Y" for yes or "N" for no in		Pub. 15-2, chapter	40, §4020)	lf			
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o		Pub. 15-2, chapter	40, §4020)	lf			
yes, enter the approval date (mm/o	dd/yyyy) in column 2.	•		lf		1.00	_
yes, enter the approval date (mm/o 7.00Was there a change in the statisti	dd/yyyy) in column 2. ical basis? Enter "Y"	for yes or "N" for	no.			N	147. C
yes, enter the approval date (mm/o	dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "	for yes or "N" for Y" for yes or "N" f Nod? Enter "Y" for y	no. Tor no. Tes or "N"	for no.		N N N	147. 0 148. 0 149. 0
yes, enter the approval date (mm/o 7.00Was there a change in the statisti 8.00Was there a change in the order of	dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "	for yes or "N" for Y" for yes or "N" f nod? Enter "Y" for y Part A	no. or no. es or "N" Part I	for no. 3 T	itle V	N N Title XIX	148.0
yes, enter the approval date (mm/o 7.00Was there a change in the statisti 8.00Was there a change in the order of	dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter " ied cost finding meth	for yes or "N" for Y" for yes or "N" f Nod? Enter "Y" for y Part A 1.00	no. Tor no. Tes or "N" Part I 2.00	for no. B T	3.00	N N Title XIX 4.00	148.0
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Health Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre	
				5/26/2022 2:5	5 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg	inning date and ending da	te for the reporting			170.00
period respectively (mm/dd/yyyy)		· · · · ·			
			1.00	2.00	
171.00 If line 167 is "Y", does this provid	er have any days for indi	viduals enrolled in	Y	782	171.00
section 1876 Medicare cost plans rep	orted on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column	1. If column 1 is yes, e	nter the number of section	on		
1876 Medicare days in column 2. (see	instructions)				

OSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Date/Time Pr	epared
				Y/N	5/26/2022 2: Date	55 pm
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ent			
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the			N		1.0
	reporting period? If yes, enter the date of the change in	column 2. (see				
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare	Drogram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.	mn 3, "V" for				
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
. 00	Column 1: Were the financial statements prepared by a Cer- Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av- column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4. (
. 00	Are the cost report total expenses and total revenues diffe	erent from	N			5.0
	those on the filed financial statements? If yes, submit re-					_
				Y/N	Legal Oper.	
				1.00	2.00	_
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provide	er N		6.0
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th	ne N		7. (8. (
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9. (
0. 00	Was an approved Intern and Resident GME program initiated	or renewed in	the current	N		10.0
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than	l & D in an An	provod	Ν		11. (
1.00	Teaching Program on Worksheet A? If yes, see instructions.		proved	IN		''.
					Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			cost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement				N	14.0
. 00	Did total beds available change from the prior cost report	<u> </u>	<u>yes, see ins</u> t A	structions.	n N	15.
		Y/N	Date	Y/N	Date	-
		1.00	2.00	3.00	4.00	
	PS&R Data					
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		Ν		16.
. 00	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.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19.

0SPI	Financial Systems IU HEALTH NOR TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	: 15-0161	Peri od:	u of Form CM Worksheet S	
				From 01/01/2021 To 12/31/2021	Date/Time P	
	· · · · · · · · · · · · · · · · · · ·	Descri p	tion	Y/N	5/26/2022 2 Y/N	2:55 pm
		0		1.00	3.00	
D. 00	If line 16 or 17 is yes, were adjustments made to PS&R	Ŭ		N	N	20.
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
I. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		Ν		21.
					1.00	_
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS HO	SPI TALS)		1.00	
	Capital Related Cost					
2.00					N	22.
. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.			0	N	23.
. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during t	his cost r	<pre>reporting period?</pre>	Y	24.
. 00	Have there been new capitalized leases entered into during instructions.	g the cost report	ing period	1? If yes, see	Ν	25
. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	lfyes, see	Ν	26		
. 00	Has the provider's capitalization policy changed during th copy.	ne cost reporting	period?	fyes, submit	Ν	27
. 00	333	entered into duri	ng the cos	st reporting	N	28
. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		t Service	Reserve Fund)	Ν	29
. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		ebt? lf y€	es, see	N	30
. 00	instructions. Has debt been recalled before scheduled maturity without i instructions.	ssuance of new d	ebt?lfy€	es, see	Ν	31
	Purchased Services					
. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		through c	contractual	N	32
. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	oplied pertaining	to compet	titive bidding? If	Γ N	33
00	Provider-Based Physicians Are services furnished at the provider facility under an a	rrangement with	providor k	asod physicians?	N	34
. 00	If yes, see instructions.	arrangement with	provider-L	based physicians?	IN IN	34
. 00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		s with the	Provi der-based	Ν	35
				Y/N 1.00	Date 2.00	_
0.0	Home Office Costs					
	Were home office costs claimed on the cost report?	managed by the l		-? Υ Υ		36
. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the h	OME OTTICE	97 Y		37
00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			of N		38
. 00				es, Y		39
. 00	If line 36 is yes, did the provider render services to the instructions.	e home office? I	f yes, see	e N		40
		1.00)	2.	00	-
	Cost Report Preparer Contact Information					
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41
. 00		1				
	respectively. Enter the employer/company name of the cost report preparer.	I NDI ANA UNI VERSI	TY HEALTH			42

Health Financial Systems IU HEALTH	NORTH HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0161	Peri od:	Worksheet S-2	
		From 01/01/2021 To 12/31/2021		pared:
			5/26/2022 2:5	
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	DIRECTOR OF GOVERNMENT			41.00
held by the cost report preparer in columns 1, 2, and 3	, PROGRAMS			
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	t			43.00
report preparer in columns 1 and 2, respectively.				

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Date/Time P	rep	
						5/26/2022 2		5 pm
						0/P Visits		
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Trips Title V	_	
	component	Li ne Number	NO. OI DEUS	Avai I abl e	CAIT HOULS	in the v		
		1.00	2.00	3.00	4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	126	45, 99	0. 00		0	1. (
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)							
. 00	HMO and other (see instructions)							2.
. 00	HMO I PF Subprovi der							2. 3.
. 00	HMO IRF Subprovider							4.
00	Hospital Adults & Peds. Swing Bed SNF						0	5.
00	Hospital Adults & Peds. Swing Bed NF						0	6.
00	Total Adults and Peds. (exclude observation		126	45, 99	0.00		0	7.
	beds) (see instructions)							
00	INTENSIVE CARE UNIT							8.
00	CORONARY CARE UNIT							9.
. 00	BURN INTENSIVE CARE UNIT							10
. 00	SURGI CAL I NTENSI VE CARE UNI T	34.00	0		0 0.00		0	11
. 01	PEDIATRIC INTENSIVE CARE UNIT	34.01	0		0 0.00		0	11
. 02	PREMATURE INTENSIVE CARE UNIT	34.02	23	8, 39	95 0.00		0	11
. 00	OTHER SPECIAL CARE (SPECIFY)	40.00						12
. 00	NURSERY	43.00	149	E4 20	0.00		0	13 14
. 00	Total (see instructions) CAH visits		149	54, 38	35 0.00		0	14
. 00	SUBPROVIDER - IPF							16
. 00	SUBPROVIDER - IRF							17
. 00	SUBPROVIDER							18
. 00	SKILLED NURSING FACILITY							19
. 00	NURSING FACILITY							20
. 00	OTHER LONG TERM CARE							21
. 00	HOME HEALTH AGENCY							22
. 00	AMBULATORY SURGICAL CENTER (D. P.)							23
. 00	HOSPI CE							24
. 10	HOSPICE (non-distinct part)	30.00						24
. 00	CMHC - CMHC							25
. 00	RURAL HEALTH CLINIC							26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00					0	26
. 00	Total (sum of lines 14-26)		149					27
00	Observation Bed Days						0	28
. 00	Ambulance Trips							29
. 00	Employee discount days (see instruction)							30
. 00	Employee discount days - IRF							31
. 00	Labor & delivery days (see instructions)		12	4, 38	30			32
. 01	Total ancillary labor & delivery room							32
	outpatient days (see instructions)							
3.00	LTCH non-covered days							33.
3. 01	LTCH site neutral days and discharges							33

	nancial Systems AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Worksheet S-3 Part I Date/Time Pre 5/26/2022 2:5	epared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
8 e Hos	spital Adults & Peds. (columns 5, 6, 7 and exclude Swing Bed, Observation Bed and spice days)(see instructions for col. 2 r the portion of LDP room available beds)	8, 423	752	28, 25			1.00
2.00 HM0 3.00 HM0	0 and other (see instructions) 0 IPF Subprovider	4, 889 0	6, 447 0				2.00 3.00
5.00 Hos	0 IRF Subprovider spital Adults & Peds. Swing Bed SNF	0 0	0 0		0		4.00
7.00 Tot bec	spital Adults & Peds. Swing Bed NF tal Adults and Peds. (exclude observation ds) (see instructions)	8, 423	0 752	28, 25	0 2		6.00 7.00
9. 00 COF 10. 00 BUF	TENSIVE CARE UNIT RONARY CARE UNIT RN INTENSIVE CARE UNIT						8.00 9.00 10.00
11. 01 PEI 11. 02 PRI	RGICAL INTENSIVE CARE UNIT DIATRIC INTENSIVE CARE UNIT EMATURE INTENSIVE CARE UNIT HER SPECIAL CARE (SPECIFY)	0 0 0	0 0 133		0 0 9		11.00 11.01 11.02 12.00
13.00 NUF	RSERY		956	4, 25			13.00
15.00 CAH 16.00 SUE 17.00 SUE	tal (see instructions) H visits BPROVIDER - IPF BPROVIDER - IRF BPROVIDER	8, 423 0	1, 841 0	36, 76	6 0.00 0	924.14	14.00 15.00 16.00 17.00 18.00
20.00 NUF 21.00 OTF 22.00 HOM	ILLED NURSING FACILITY RSING FACILITY HER LONG TERM CARE ME HEALTH AGENCY						19.00 20.00 21.00 22.00 23.00
24.00 H03 24.10 H03 25.00 CMH	BULATORY SURGICAL CENTER (D.P.) SPICE SPICE (non-distinct part) HC - CMHC RAL HEALTH CLINIC			20	9		23.00 24.00 24.10 25.00 26.00
26. 25 FEI 27. 00 To	DERALLY QUALIFIED HEALTH CENTER tal (sum of lines 14-26) servation Bed Days	0	0 0	2, 79	0 0.00 0.00		26.2
29.00 Amb 30.00 Emp	bulance Trips ployee discount days (see instruction) ployee discount days - IRF	O			0		29.00 30.00 31.00
32.00 Lat 32.01 To	bor & delivery days (see instructions) tal ancillary labor & delivery room tpatient days (see instructions)	O	23	1, 99			32.00 32.0
33. 00 LT(CH non-covered days CH site neutral days and discharges	0					33.00 33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 5/26/2022 2:5	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 11.01 11.02 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 24.00 25.00 24.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.0	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 HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT BURN INTENSI VE CARE UNIT SURGI CAL INTENSI VE CARE UNIT PEDI ATRIC INTENSI VE CARE UNIT PREMATURE INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER - IRF 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 instructions) Total ancillary labor & delivery room	0.00	0	1, 7(01 116 19 1, 164 0 0	10, 081	1.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.01 11.02 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 24.00 24.10 25.00 24.00 24.00 24.00 24.10 25.00 24.00 24.00 24.00 24.00 24.00 25.00 24.00 24.00 24.00 25.00 24.00 26.25 27.00 28.00 28.00 29.00 20.20 21.00 22.00 22.00 23.00 24.00 24.00 25.00 24.00 26.00 27.00 27.00 28.00 29.00 20.00 21.00 22.00 22.00 23.00 24.00 25.00 24.00 25.00 26.00 27.00 27.00 28.00 29.00 20.00 21.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 27.00 28.00 29.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 21.00 22.00 23.00 24.00 24.00 26.00 26.00 27.00 27.00 24.00 26.00 27.00 28.00 29.00 29.00 20
33. 00 33. 01	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		33.00 33.01

SPIL	AL WAGE INDEX INFORMATION			Provider C		eriod: rom 01/01/2021 p 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/26/2022 2:5	epar
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							1
0	Total salaries (see	200.00	69, 672, 570	-294, 599	69, 377, 971	1, 912, 105. 35	36. 28	1
0	instructions)		0		0	0.00	0.00	
0	Non-physician anesthetist Part A		0	0	0	0.00	0.00	
0	Non-physician anesthetist Part		0	0	0	0.00	0.00	
0	B Physician-Part A -		0	0	0	0.00	0.00	
0	Admini strati ve		0	0	0	0.00	0.00	1
1	Physicians - Part A - Teaching		0	-	0	0.00		
0	Physician and Non Physician-Part B		130, 287	0	130, 287	1, 237. 89	105. 25	5 5
00	Non-physician-Part B for		0	0	0	0.00	0.00	ϵ
	hospital-based RHC and FQHC							
0	services Interns & residents (in an	21.00	0	0	0	0.00	0.00	, -
.0	approved program)	21.00	0	0	0	0.00	0.00	1
)1	Contracted interns and		0	0	0	0.00	0.00	
	residents (in an approved programs)							
00	Home office and/or related		0	0	0	0.00	0.00) 8
00	organization personnel	44.00	0		0	0.00	0.00	
00	SNF Excluded area salaries (see	44.00	0 786, 251	288, 836	0 1, 075, 087	0. 00 32, 905. 26		
	instructions)				.,	,		
	OTHER WAGES & RELATED COSTS Contract Labor: Direct Patient		0	0	0	0.00	0.00	1 1 -
00	Care		0	0	0	0.00	0.00	ή'
00	Contract Labor: Top Level		0	0	0	0.00	0.00	12
	management and other							
	management and administrative services							
00	Contract Labor: Physician-Part		2, 306, 294	0	2, 306, 294	15, 375. 29	150.00	1:
00	A - Administrative Home office and/or related		0	0	0	0.00	0.00	1.
00	organization salaries and		0	0	0	0.00	0.00	″ '
	wage-related costs							
01 02	Home office salaries Related organization salaries		30, 516, 971 0	0	30, 516, 971 0	527, 975. 00 0. 00		
	Home office: Physician Part A		0	-	0	0.00		
	- Administrative							
00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
01	Home office Physicians Part A		0	0	0	0.00	0.00	10
	- Teaching							
02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16
	WAGE-RELATED COSTS			1				1
00	Wage-related costs (core) (see		19, 640, 100	0	19, 640, 100			17
00	instructions) Wage-related costs (other)							18
	(see instructions)							
00 00	Excluded areas Non-physician anesthetist Part		330, 860	0	330, 860			19
00	A		0		0			2
00	Non-physician anesthetist Part		0	0	0			2'
00	B Physician Part A -		0		0			22
	Administrative		0		0			
	Physician Part A - Teaching		0	0	0			22
	Physician Part B Wage-related costs (RHC/FQHC)		19, 716 0		19, 716 0			23
	Interns & residents (in an		0	0	0			25
50	approved program)		7 007 /00		7 007 400			
50	Home office wage-related (core)		7, 397, 498	0	7, 397, 498			25
51	Related organization		0	о	0			25
	wage-related (core) Home office: Physician Part A		-		-			25
52			0		0			

	Financial Systems		IU HEALTH NOR				u of Form CMS-2	2552-10
HOSPI T	HOSPITAL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/26/2022 2:5	pared:
		Wkst. A Line	Amount	Recl assi fi cat		Paid Hours	Average	
		Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from Wkst. A-6)	3)	col. 4	col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARI							
26.00	Employee Benefits Department	4.00						
27.00	Administrative & General	5.00	3, 330, 995					
28.00	Administrative & General under		323, 273	0	323, 27	3 3, 618. 95	89.33	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00						
30.00	Operation of Plant	7.00	1, 011, 744					
31.00	Laundry & Linen Service	8.00	0	0		0.00		
32.00	Housekeepi ng	9.00	1, 470, 273	-9, 159	1, 461, 11			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	648, 864	6, 059	654, 92	3 36, 140. 79	18. 12	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	1, 008, 127	-11, 242	996, 88	5 53, 216. 15	18. 73	36.00
37.00	Maintenance of Personnel	12.00	0	0		0.00	0.00	37.00
38.00	Nursing Administration	13.00	5, 494, 199	-10, 572	5, 483, 62	7 44, 204. 38	124.05	38.00
39.00	Central Services and Supply	14.00	243	0	24	3 7.83	31.03	39.00
40.00	Pharmacy	15.00	3, 386, 570	1, 926	3, 388, 49	6 79, 553. 44	42.59	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	400		40			41.00
42.00	Soci al Servi ce	17.00	1, 217, 911	13, 577	1, 231, 48	8 28, 446. 65	43.29	42.00
43 00	Other General Service	18.00						43.00

Heal th	Financial Systems		IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part III Date/Time Pre 5/26/2022 2:5	pared:
		Worksheet A	Amount	Recl assi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY			_			
1.00	Net salaries (see		69, 865, 556	-294, 599	69, 570, 95	7 1, 914, 486. 41	36.34	1.00
	instructions)							
2.00	Excluded area salaries (see		786, 251	288, 836	1, 075, 08	7 32, 905. 26	32.67	2.00
	instructions)							
3.00	Subtotal salaries (line 1		69, 079, 305	-583, 435	68, 495, 87	0 1, 881, 581. 15	36.40	3.00
	minus line 2)							
4.00	Subtotal other wages & related		32, 823, 265	0	32, 823, 26	5 543, 350. 29	60.41	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		27, 037, 598	0	27, 037, 59	8 0.00	39.47	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		128, 940, 168	-583, 435	128, 356, 73	3 2, 424, 931. 44	52.93	6.00
7.00	Total overhead cost (see		19, 849, 055	14, 856	19, 863, 91	1 517, 290. 86	38.40	7.00
	instructions)							
				•				•

Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS		Provi der	CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV Date/Time Pre 5/26/2022 2:5	pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					2, 580, 332	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrik	oution				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see	instructions)				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	structions)				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla					0	6.00
7.00	Employee Managed Care Program Administration	n Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					0	8.00
8.01	Health Insurance (Self Funded without a Thir					0	
8.02	Health Insurance (Self Funded with a Third F	Party Administrato	or)			11, 438, 414	8.02
8.03	Health Insurance (Purchased)					0	8.03
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					0	10.00
11.00	Life Insurance (If employee is owner or bene					0	
12.00	Accident Insurance (If employee is owner or	benefi ci ary)				0	12.00
13.00	Disability Insurance (If employee is owner of					299, 021	13.00
14.00	Long-Term Care Insurance (If employee is owr	ner or beneficiary	y)			0	14.00
15.00	'Workers' Compensation Insurance					546, 762	15.00
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	aordinary a	accrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)						
	TAXES						
	FICA-Employers Portion Only					5, 126, 148	
18.00	Medicare Taxes - Employers Portion Only					0	
19.00	Unemployment Insurance					0	
20.00	State or Federal Unemployment Taxes					0	20.00
	OTHER						
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost F	Reported or	n lines 1 thro	ugh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	Tuition Reimbursement					0	
24.00	Total Wage Related cost (Sum of lines 1 -23))				19, 990, 677	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Heal th Financi	al Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI TAL CONTR	RACT LABOR AND BENEFIT COST		Provider CCN: 15-0161	Period:	Worksheet S-3	
				From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	narod
				10 12/31/2021	5/26/2022 2:5	
Сс	ost Center Description			Contract	Benefit Cost	
				Labor		
				1.00	2.00	
	- Contract Labor and Benefit Cost					
	I and Hospital-Based Component Identi				10 000 (77	
	acility's contract labor and benefit	cost		0	19, 990, 677	1.00
2.00 Hospita				0	19, 990, 677	2.00
	rider - IPF					3.00
	vider - IRF					4.00
	vider - (Other)			0	0	5.00
	Beds - SNF			0	0	6.00
	Beds - NF			0	0	7.00
	I -Based SNF					8.00
	I -Based NF					9.00
	I -Based OLTC					10.00
	I -Based HHA					11.00
	ely Certified ASC					12.00
	I -Based Hospi ce					13.00
	l-Based Health Clinic RHC					14.00
	nl-Based Health Clinic FQHC					15.00
	I-Based-CMHC					16.00
)i al ysi s					17.00
18.00 Other				0	0	18.00

Heal th	Financial Systems IU HEALTH NORTH H	OSPI TAL		In Lie	eu of Form CMS-2	2552-10	
		Provider CC	CN: 15-0161	Peri od:	Worksheet S-1		
				From 01/01/2021			
				To 12/31/2021			
					5/26/2022 2:5	5 pm	
					1.00		
	Uncompensated and indigent care cost computation				1100		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by li	ne 202 colum	n 8)	0. 205838	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				17, 681, 941	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			ai d?		4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments fi	om Medicai	d		0	5.00	
6.00	Medicaid charges				145, 741, 401 29, 999, 118		
	7.00 Medicaid cost (line 1 times line 6)						
8.00	Difference between net revenue and costs for Medicaid program	(line 7 mir	nus sum of li	nes 2 and 5; if	12, 317, 177	8.00	
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions for </pre>	n oach lin	20)				
9.00	Net revenue from stand-al one CHIP				0	9.00	
10.00					0		
11.00	5				0	11.00	
12.00		(line 11 mi	nus line 9 [.]	if < zero then	0		
.2.00	enter zero)	(2010 11011		12.00	
	Other state or local government indigent care program (see inst	ructions f	or each line)			
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00	
14.00	Charges for patients covered under state or local indigent care	e program ((Not included	in lines 6 or	0	14.00	
	10)						
15.00	State or local indigent care program cost (line 1 times line 14				0		
16.00		digent care	e program (li	ne 15 minus line	a 0	16.00	
	13; if < zero then enter zero)	D				-	
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and stat	e/local indi	gent care progra	ams (see		
17.00	Private grants, donations, or endowment income restricted to fu	Indi na char	rity care		0	17.00	
	Government grants, appropriations or transfers for support of H				0		
	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines			
	8, 12 and 16)	5	1 5		, - ,		
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col . 2)		
	Uncompared Comp (and instructions for each line)		1.00	2.00	3.00		
20.00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	si Li ty	10, 227, 34	0 2, 197, 440	12, 424, 780	20.00	
20.00	(see instructions)	JIIILY	10, 227, 32	2, 197, 440	12, 424, 700	20.00	
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	2, 105, 17	2, 197, 440	4, 302, 615	21.00	
	instructions)		, ,				
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00	
	charity care						
23.00	Cost of charity care (line 21 minus line 22)		2, 105, 17	2, 197, 440	4, 302, 615	23.00	
					1.00		
24.00	Deep the ensure of Line 20 column 2, include charges for notice			aff atau limit	1.00	24.00	
24.00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay rimit	N	24.00	
25 00	If line 24 is yes, enter the charges for patient days beyond th		t care progra	m's length of	0	25.00	
25.00	stay limit	le murgent		ii 3 Tengtii 0	0	23.00	
26.00	Total bad debt expense for the entire hospital complex (see ins	structions))		7, 676, 797	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex	,			172,001		
27.01	Medicare allowable bad debts for the entire hospital complex (s	•			264, 616		
28.00							
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see	instructions)	1, 618, 324		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				5, 920, 939	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			18, 238, 116	31.00	

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IU HEALTH NORTH				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE U	F EXPENSES	Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet A Date/Time Pre	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	5/26/2022 2:5 Reclassified Trial Balance (col. 3 +- col. 4)	<u>5 pm</u>
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0 0 0 0	0 0 0 0	0 770, 068 10, 125, 659	10, 118, 044 0 770, 068 10, 125, 659	1.00 1.01 1.02 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATIENT TELEPHONES 5. 02 00550 DATA PROCESSING	1, 406 0 0	484, 742 0 77, 438	486, 148 0 77, 438	12, 384, 210 0 0	12, 870, 358 0 77, 438	4.00 5.01 5.02
5. 03 00560 PURCHASING RECEIVING AND STORES 5. 04 00570 ADMITTING 5. 05 00590 OTHER ADMINISTRATIVE & GENERAL	325, 259 3, 005, 736	402, 255 53, 546, 373	0 727, 514 56, 552, 109	0 -127, 907 -9, 765, 782	0 599, 607 46, 786, 327	5.03 5.04 5.05
6. 00 00600 MAINTENANCE & REPAIRS	1, 724, 543	5, 769, 655	7, 494, 198		6, 720, 655	6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVICE	1, 011, 744 0	762, 761 198, 825	1, 774, 505 198, 825	-320, 980 0	1, 453, 525 198, 825	7.00 8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	1, 470, 273 648, 864	4, 736, 936 794, 347	6, 207, 209 1, 443, 211	-439, 224 -169, 136	5, 767, 985 1, 274, 075	9.00 10.00
11. 00 01100 CAFETERI A	1,008,127	1, 125, 182	2, 133, 309	-371,612	1, 274, 075	11.00
13.00 01300 NURSING ADMINISTRATION	5, 494, 199	2, 815, 912	8, 310, 111	-1, 777, 493	6, 532, 618	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	243 3, 386, 570	31, 270 41, 665, 077	31, 513 45, 051, 647		8, 591, 667 4, 326, 988	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	3, 380, 570	41, 003, 077	43, 031, 047	-40, 724, 037 -8	4, 320, 988	16.00
17.00 01700 SOCIAL SERVICE	1, 217, 911	507, 052	1, 724, 963	-232, 057	1, 492, 906	17.00
18. 00 01850 PATIENT TRANSPORTATION	230, 507	71, 566	302, 073	-53, 510	248, 563	18.00
30. 00 03000 ADULTS & PEDIATRICS	16, 611, 144	16, 632, 420	33, 243, 564	-4, 883, 863	28, 359, 701	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	О	0	0	0	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0	1 094 244	0	0 454 711	0	34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	2, 684, 037 0	1, 984, 266 0	4, 668, 303 0	-654, 711 1, 151, 687	4, 013, 592 1, 151, 687	34.02 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	5, 668, 474 2, 517, 820	29, 497, 741 1, 126, 222	35, 166, 215 3, 644, 042	-23, 331, 042 -743, 187	11, 835, 173 2, 900, 855	50.00 51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 800, 760	4, 308, 033	8, 108, 793		6, 205, 403	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 335, 728	5, 361, 061	9, 696, 789	-4, 770, 155	4, 926, 634	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	3,085,858	5, 117, 259	8, 203, 117	-2, 938, 259	5, 264, 858	55.00
56.00 05600 RADI 0I SOTOPE 60.00 06000 LABORATORY	243, 721 852, 960	237, 437 9, 535, 180	481, 158 10, 388, 140	-189, 890 -211, 088	291, 268 10, 177, 052	56.00 60.00
65. 00 06500 RESPIRATORY THERAPY	2, 381, 481	942, 683	3, 324, 164	-781, 291	2, 542, 873	65.00
66.00 06600 PHYSI CAL THERAPY	1, 761, 363	542, 357	2, 303, 720	-340, 787	1, 962, 933	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	504, 757 330, 949	113, 662 133, 696	618, 419 464, 645	-80, 939 -107, 401	537, 480 357, 244	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	415, 173	589, 691	1, 004, 864		736, 185	
70.00 07000 ELECTROENCEPHALOGRAPHY	158, 678	433, 317	591, 995	-75, 671	516, 324	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	4, 095, 119 10, 928, 885	4, 095, 119 10, 928, 885	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	41, 950, 018	41, 950, 018	
75.00 07500 ASC (NON-DISTINCT PART)	Ō	Ō	0	0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 105, 639	3, 968, 414	5, 074, 053	-2, 965, 554	2, 108, 499	75.01
91.00 09100 EMERGENCY	2,901,995	4,042,509	6, 944, 504	-999, 981	5, 944, 523	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	68, 886, 319	197, 555, 359	266, 441, 678	82, 045	266, 523, 723	118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0			192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	86, 075 81, 860	768, 509 44, 496	854, 584 126, 356	-225, 678 95, 526	628, 906 221, 882	
192. 02 19202 CHI LIDI RTH EDUCATION 192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	01, 800	44, 490	120, 350	95, 528 0		192.02
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	14, 737	61, 263	76,000	-58, 810	17, 190	192.04
192. 05 19205 PHYSI CI AN PRACTI CE	603, 579	666, 435	1, 270, 014	-314, 378	955, 636	
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL	0	0	0	70, 286 274, 378	70, 286 274, 378	
192. 08 19208 SAXONY HOSPI TAL	o	o	0	76, 631	76, 631	192.08
200.00 TOTAL (SUM OF LINES 118 through 199)	69, 672, 570	199, 096, 062	268, 768, 632	0	268, 768, 632	200.00

Health Financial Systems	IU HEALTH NORT	TH HOSPI TAL		In Lieu	J of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BAL	ANCE OF EXPENSES	Provider CC	CN: 15-0161	Period:	Worksheet A
				From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/26/2022 2:55 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For			

		(See A-8)	For		
			Allocation	-	
		6.00	7.00		
1 00	GENERAL SERVICE COST CENTERS	075 000	0 140 004		1 1 00
1.00 1.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST	975, 820- 11, 600, 592	9, 142, 224 11, 600, 592		1.00
1.01	00102 MOB LEASED SPACE	11,000,372	770, 068		1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	1, 233, 906	11, 359, 565		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	284, 133	13, 154, 491		4.00
5.01	00540 NONPATI ENT TELEPHONES	201,100	0		5.01
5.02	00550 DATA PROCESSI NG	10, 089, 671	10, 167, 109		5.02
5.03	00560 PURCHASING RECEIVING AND STORES	1, 659, 043	1, 659, 043		5.03
5.04	00570 ADMI TTI NG	2, 162, 495	2, 762, 102		5.04
5.05	00590 OTHER ADMINISTRATIVE & GENERAL	-18, 249, 416	28, 536, 911		5.05
6.00	00600 MAINTENANCE & REPAIRS	-730, 196	5, 990, 459		6.00
7.00	00700 OPERATION OF PLANT	-14, 215	1, 439, 310		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	198, 825		8.00
9.00	00900 HOUSEKEEPI NG	0	5, 767, 985		9.00
10.00	01000 DI ETARY	0	1, 274, 075		10.00
11.00		-204, 101	1, 557, 596		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	-398, 044	6, 134, 574		13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY	0	8, 591, 667		14.00
16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	-36, 112 0	4, 290, 876 412		15.00 16.00
17.00	01700 SOCIAL SERVICE	0	1, 492, 906		17.00
18.00	01850 PATI ENT TRANSPORTATI ON	-15, 399	233, 164		18.00
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	10,077	200, 101		10.00
30.00	03000 ADULTS & PEDIATRICS	-5, 598, 761	22, 760, 940		30.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		34.00
34.01	03401 PEDIATRIC INTENSIVE CARE UNIT	0	0		34.01
34.02	03402 PREMATURE INTENSIVE CARE UNIT	-683, 833	3, 329, 759		34.02
43.00	04300 NURSERY	0	1, 151, 687		43.00
	ANCILLARY SERVICE COST CENTERS			1	
50.00	05000 OPERATING ROOM	-729, 239			50.00
51.00	05100 RECOVERY ROOM	-551	2,900,304		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-348, 737	5, 856, 666		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 449	4, 928, 083		54.00
55.00	05500 RADI OLOGY - THERAPEUTI C	-443, 846	4, 821, 012		55.00
56.00 60.00	05600 RADI OI SOTOPE 06000 LABORATORY	0	291, 268		56.00 60.00
65.00	06500 RESPIRATORY THERAPY	0	10, 177, 052 2, 542, 873		65.00
66.00	06600 PHYSI CAL THERAPY	11, 334	1, 974, 267		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	537, 480		67.00
68.00	06800 SPEECH PATHOLOGY	-40, 810	316, 434		68.00
69.00	06900 ELECTROCARDI OLOGY	-223, 708	512, 477		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	-2, 174	514, 150		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4,095,119		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	10, 928, 885		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	41, 950, 018		73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75.00
75.01	07501 CARDI AC CATHERI ZATI ON LABORATORY	-130, 400	1, 978, 099		75.01
	OUTPATIENT SERVICE COST CENTERS				
	09100 EMERGENCY	-869, 028	5,075,495		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
110.00	SPECIAL PURPOSE COST CENTERS	2 (51 7/7	2/2 071 05/		110.00
118.00		-2, 651, 767	263, 871, 956		118.00
102.00	NONREI MBURSABLE COST CENTERS	0	0		102.00
	19200 PHISICIANS PRIVATE OFFICES	0	628, 906		192.00 192.01
	19202 CHI LDBI RTH EDUCATI ON	0	221, 882		192.01
	19203 PHYSI CI ANS' PRI VATE OFFI CES	0	221,002		192.02
	19204 PHYSI CLANS' PRI VATE OFFICES	0	17, 190		192.03
	19205 PHYSI CI AN PRACTI CE	0	955, 636		192.04
	19206 TI PTON HOSPI TAL	0	70, 286		192.06
	19207 WEST HOSPI TAL	0 0	274, 378		192.07
	19208 SAXONY HOSPI TAL	0	76, 631		192.08
200.00		-2, 651, 767	266, 116, 865		200.00
		'			-

	Financial Systems		IU HEALTH NOR			eu of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provider CCN: 15-C	0161 Period: From 01/01/202 To 12/31/202	Worksheet A-6 1 1 Date/Time Prepared: 5/26/2022 2:55 pm
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00 A - LEASES	3.00	4.00	5.00		
1.00	NEW CAP REL COSTS-BLDG &	1.00		2, 098, 593		1.00
0.00	FI XT	1.00		770 0/0		0.00
2.00 3.00	MOB LEASED SPACE NEW CAP REL COSTS-MVBLE	1.02 2.00		770, 068 80, 337		2.00 3.00
	EQUI P			00,007		0.00
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	0 2,948,998		8.00
	B - DEPRECIATION		ų	2, 940, 990		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	8, 019, 451		1.00
2.00	FIXT NEW CAP REL COSTS-MVBLE	2.00	0	10, 045, 322		2.00
2.00	EQUI P	2.00	Ŭ	10, 040, 322		2.00
3.00		0.00	0	0		3.00
4.00 5.00		0.00 0.00	0	0		4.00 5.00
6.00		0.00	О	0		6.00
7.00 8.00		0.00 0.00	0	0		7.00
8.00 9.00		0.00	0	0		9.00
10.00		0.00	О	0		10.00
11. 00 12. 00		0.00 0.00	0	0		11.00 12.00
12.00		0.00	0	0		13.00
14.00		0.00	О	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 20.00		0.00 0.00	0	0 0		19.00 20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00 24.00		0.00 0.00	0	0		23.00 24.00
25.00		0.00	О	0		25.00
26.00 27.00		0.00 0.00	0	0		26.00 27.00
27.00		0.00		0		27.00
	0		0	18,064,773		
1.00	C - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	12, 269, 284		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	0	0		4.00 5.00
6.00		0.00	0	0		6.00
7.00 8.00		0.00 0.00	0 0	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 0		15.00 16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19. 00 20. 00		0.00 0.00	0 0	0		19.00 20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00 24.00		0.00 0.00	0 0	0 0		23.00 24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00 28.00		0.00 0.00	0	0		27.00 28.00
29.00		0.00	0	0		29.00

	Financial Systems		IU HEALTH NOR		In Lieu of Form C	
RECLAS	SI FI CATI ONS			Provider CCN: 15-0161	Period: Worksheet From 01/01/2021 To 12/31/2021 Date/Time	
		Increases			5/26/2022	
	Cost Center	Line #	Sal ary	Other		
30.00	2.00	3.00	4.00	5.00		30.00
31.00		0.00	0	0		31.00
32.00		0.00	0	0		32.00
33.00 34.00		0.00 0.00	0	0		33.00 34.00
	0		0	12, 269, 284		
1.00	E - LABOR AND DELIVERY ADULTS & PEDIATRICS	30.00	336, 927	150, 640		1.00
2.00	NURSERY	43.00	27, 015	12, 078		2.00
			363, 942	162, 718		
1.00	F - MARKETING CHILDBIRTH EDUCATION	192.02	0	99, 692		1.00
2.00		0.00	0	0		2.00
3.00 4.00		0.00 0.00	0	0		3.00 4.00
4.00	<u> </u>	0.00		99, 692		4.00
1 00	G - NURSERY	42.00	024 471	177 000		1.00
1.00	NURSERY	43.00	<u> </u>	<u>177, 923</u> 177, 923		1.00
	H - FMLA					
1.00	OTHER ADMINISTRATIVE & GENERAL	5.05	0	30, 769		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	1, 219		2.00
3.00	HOUSEKEEPI NG CAFETERI A	9.00	0	11, 101		3.00
4.00 5.00	NURSING ADMINISTRATION	11.00 13.00	0	1, 408 13, 233		4.00 5.00
6.00	PHARMACY	15.00	0	7, 935		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	80, 317		7.00
8.00 9.00	OPERATING ROOM RECOVERY ROOM	50.00 51.00	0	24, 528 18, 893		8.00 9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	0	32, 481		10.00
11.00		54.00	0	21, 167		11.00 12.00
12.00 13.00	RADI OLOGY – THERAPEUTI C LABORATORY	55.00 60.00	0	14, 688 1, 031		13.00
14.00	RESPI RATORY THERAPY	65.00	0	8, 585		14.00
15.00	PHYSICAL THERAPY	66.00	0	11,674		15.00
16.00 17.00	OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	67.00 68.00	0	3, 745 648		16.00 17.00
18.00	CARDI AC CATHERI ZATI ON	75.01	0	5, 078		18.00
19.00	LABORATORY EMERGENCY	91.00	0	1, 031		19.00
20.00	PHYSICIAN_PRACTICE	1 <u>92.</u> 05	0	<u> </u>		20.00
	0 I – ACCRUED PTO		0	294, 599		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	123, 258	0		1.00
2.00	ADMI TTI NG	5.04	549	0		2.00
3.00	OTHER ADMINISTRATIVE & GENERAL	5.05	122, 379	0		3.00
4.00	OPERATION OF PLANT	7.00	3, 668	О		4.00
5.00	HOUSEKEEPI NG	9.00	1, 942	0		5.00
6.00 7.00	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	6, 059 24, 536	0		6.00 7.00
8.00	PHARMACY	15.00	9, 861	0		8.00
9.00 10.00	SOCIAL SERVICE PREMATURE INTENSIVE CARE	17.00 34.02	13, 577 1, 902	0		9.00 10.00
10.00	UNI T	54. 02	1, 702			10.00
11.00	RADI OLOGY - THERAPEUTI C	55.00	14, 441	0		11.00
12.00 13.00	PHYSI CAL THERAPY SPEECH PATHOLOGY	66.00 68.00	29, 063 1, 837	0		12.00 13.00
14.00	ELECTROCARDI OLOGY	69.00	1, 792	Ō		14.00
15.00		70.00	1, 749	0		15.00
16.00	PHYSICIAN_PRACTICE	192.05	<u>7, 072</u> 363, 685	<u>0</u>		16.00
	J – BILLABLE SUPPLIES					
1.00 2.00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO	14.00 71.00		464, 662 4, 095, 119		1.00 2.00
	PATIENTS	/1.00		4,020,117		2.00
3.00		0.00	0	0		3.00
4.00 5.00		0.00 0.00	0	0 0		4.00 5.00
6.00		0.00	0	0		6.00
7.00 8.00		0.00 0.00	0	0 0		7.00 8.00
8.00 9.00		0.00	0	0		9.00

Health Financial Systems RECLASSIFICATIONS

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

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

RECLAS	SI FI CATI ONS			Provider (CCN: 15-0161	Period: From 01/01/2021	Worksheet A-	6
						To 12/31/2021	Date/Time Pr	
		Increases					5/26/2022 2:	<u>55 pm</u>
	Cost Center	Line #	Sal ary	Other				
10.00	2.00	3.00	4.00	5.00				10.00
10. 00 11. 00		0. 00 0. 00	0	0 0				10.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00 18.00		0.00 0.00	0	0				17.00 18.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22.00		0.00	0	0				22.00
23.00 24.00		0. 00 0. 00	0	0				23.00 24.00
24.00		0.00		0				25.00
	o — — — — — — — — — — — — — — — — — — —		0	4, 559, 781				
	K - NON-BILLABLE SUPPLIES		-		1			
1.00 2.00	CENTRAL SERVICES & SUPPLY ADMITTING	14.00 5.04	0	8, 101, 046 418				1.00
3.00	OTHER ADMINISTRATIVE &	5.04	0	84, 707				3.00
01.00	GENERAL	0100	Ŭ	01,707				0.00
4.00	OPERATION OF PLANT	7.00	0	292				4.00
5.00	HOUSEKEEPING	9.00	0	64, 712				5.00
6.00 7.00	DI ETARY CAFETERI A	10. 00 11. 00	0	70 340				6.00 7.00
8.00	SOCIAL SERVICE	17.00	0	82				8.00
9.00	RADI OI SOTOPE	56.00	0	16, 690				9.00
10.00	ELECTROCARDI OLOGY	69.00	0	1, 647				10.00
11.00	OTHER NON-REIMBURSABLE	192.01	0	51 1				11.00
12.00 13.00	CHI LDBI RTH EDUCATI ON	192. 02 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		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18. 00 19. 00		0.00 0.00	0	0				18.00 19.00
20.00		0.00	0	0				20.00
21.00	L	0.00		0				21.00
	O L – BI LLABLE DRUGS		0	8, 270, 056)			
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	41, 950, 018	3			1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00 5.00		0. 00 0. 00	0	0 0				4.00 5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0. 00 0. 00	0	0				10.00
11. 00 12. 00		0.00	0 0	0				11.00 12.00
13.00		0.00	0	0				13.00
14.00		0.00	О	0)			14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17.00 18.00		0.00 0.00	0	0 0				17.00 18.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22.00		0.00	0	0				22.00
23.00	b — — — — — — —	0.00	<u>0</u>	00 41,950,018				23.00
	M - NON-BILLABLE DRUGS							1
1.00	PHARMACY	15.00		704, 720				1.00
2.00 3.00		0. 00 0. 00	0	0 0				2.00 3.00
3.00 4.00		0.00	0	0				4.00
5.00		0.00	О	0)			5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00

Provider CCN: 15-0161

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2021

					From 01/01/2021 To 12/31/2021 Date/Time Pr	repared:
		Increases			5/26/2022 2:	55 pm
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
	0 — — — — — —			704, 720		
	N - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENT	72.00	0	10, 928, 885		1.00
2.00	PHARMACY	15.00	0	21, 250		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	286		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
	<u> </u>			10, 950, 421		
	0 - NORTH TO TIPTON ISR ALLO	CATION				1
1.00	TI PTON HOSPI TAL	192.06	53, 611	16, 675		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
	0 — — — — — — — — — — — — — — — — — — —		53, 611	16, 675		
	P - NORTH TO WEST ISR ALLOCA					
1.00	WEST HOSPITAL	192.07	182, 524	91, 854		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		182, 524	91, 854		
	Q - NORTH TO SAXONY ISR ALLO					
1.00	SAXONY HOSPI TAL	192.08	50, 911	25, 720		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
	0		50, 911	25, 720		_
	R – PHYSICIAN	т т				4
1.00	ADULTS & PEDIATRICS	30.00	0	59, 223		1.00
2.00	NURSING ADMINISTRATION	13.00	0	<u>6, 2</u> 66		2.00
	TOTALS		0	65, 489		
500.00	Grand Total: Increases		1, 949, 344	100, 652, 721		500.00

LASSI	FICATIONS			Provi der	CCN: 15-0161	Period: From 01/01/2021	Worksheet A-6
						To 12/31/2021	Date/Time Prepare 5/26/2022 2:55 pm
		Decreases	Cal	0.11			
	Cost Center 6.00	Line #	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	·	
A	A - LEASES	7.00	0.00	7.00	10.00		
	OTHER ADMINISTRATIVE &	5.05		2, 480, 963	3 1	0	1.
	GENERAL MAINTENANCE & REPAIRS	6.00		177,04	7 1	0	2.
	NURSI NG ADMI NI STRATI ON	13.00		8, 849		0	3.
	ADULTS & PEDIATRICS	30.00		57, 239	9	o	4.
	OPERATING ROOM	50.00		21, 89	-	0	5.
	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54.00 65.00		55, 730 1, 203		0	6.
	PHYSICIAN PRACTICE	192.05		146,060		0	8.
0			0	2, 948, 998			
	3 - DEPRECIATION	4.00	0	1 200		9	1
	EMPLOYEE BENEFITS DEPARTMENT	4.00 5.04	0	1, 299 17, 260		9	1.
	THER ADMINISTRATIVE &	5.05	0	6, 607, 56	-	o	3.
	GENERAL						
	MAINTENANCE & REPAIRS	6.00	0	230, 290		0	4.
	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	0	6, 614 1, 77		0	5.
	DI ETARY	10.00	0	5, 698		0	7.
	CAFETERIA	11.00	0	39, 540	-	0	8.
	NURSING ADMINISTRATION	13.00 15.00	0	1, 253, 31 ⁻ 94, 056		0	9.
	ADULTS & PEDIATRICS	30.00	0	247, 345	-	0	11.
	PREMATURE INTENSIVE CARE	34. 02	0	97, 690		0	12.
	JNI T				_		
	DPERATING ROOM RECOVERY ROOM	50.00 51.00	0	2, 578, 443 36, 652		0	13.
	DELIVERY ROOM & LABOR ROOM	51.00	0	36, 65. 176, 50		0	14.
	RADI OLOGY-DI AGNOSTI C	54.00	Ö	3, 011, 920		0	16.
	RADI OLOGY - THERAPEUTI C	55.00	0	2, 164, 049		o	17.
	RADI OI SOTOPE RESPI RATORY THERAPY	56.00 65.00	0	20, 14	-	0	18.
	PHYSICAL THERAPY	66. 00	0	94, 309 15, 020		0	20.
	SPEECH PATHOLOGY	68.00	0	6, 590	-	0	20.
	ELECTROCARDI OLOGY	69.00	О	139, 414	4	o	22.
		70.00	0	46, 32	-	0	23.
	CARDI AC CATHERI ZATI ON LABORATORY	75.01	0	751, 293	3	0	24.
	EMERGENCY	91.00	О	127, 409	9	0	25.
	OTHER NON-REIMBURSABLE	192.01	0	210, 664		0	26.
	PHYSICIANS' PRIVATE OFFICES	192.04	0	48, 34		0	27.
00 P	PHYSICIAN_PRACTICE	1 <u>92.05</u>	— — — 0	3 <u>5, 2</u> 3 18, 064, 77		<u>o</u>	28.
C	C - EMPLOYEE BENEFITS				-		
		5.04	0	111, 608		0	1.
	OTHER ADMINISTRATIVE & GENERAL	5.05	0	518, 913	3	0	2.
	MAINTENANCE & REPAIRS	6.00	о	264, 399	9	0	3.
	PERATION OF PLANT	7.00	0	235, 704		0	4.
	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	504, 054 169, 560		0	5.
	CAFETERIA	11.00	0	322, 57		0	7.
	NURSING ADMINISTRATION	13.00	0	511, 743	3	0	8.
	CENTRAL SERVICES & SUPPLY	14.00	0	40	-	0	9.
		15.00	0	493, 279		0	10.
	MEDICAL RECORDS & LIBRARY	16.00 17.00	0	236, 332		0	11.
	PATIENT TRANSPORTATION	18.00	0	49, 059	9	0	13.
	ADULTS & PEDIATRICS	30.00	0	2, 930, 71		0	14.
	PREMATURE INTENSIVE CARE	34.02	0	451, 729	9	0	15.
	JNI T DPERATI NG ROOM	50.00	0	1, 093, 865	5	0	16.
	RECOVERY ROOM	51.00	0	445, 782		0	17.
	DELIVERY ROOM & LABOR ROOM	52.00	0	688, 810		0	18.
	RADI OLOGY – DI AGNOSTI C	54.00	0	675, 100		0	19.
	RADI OLOGY – THERAPEUTI C RADI OI SOTOPE	55.00 56.00	0	572, 499 45, 691		0	20.
	ABORATORY	60.00	0	179, 96		0	22.
	RESPIRATORY THERAPY	65.00	0	366, 618		0	23.
	PHYSI CAL THERAPY	66.00	0	328, 665	-	0	24.
	OCCUPATIONAL THERAPY	67.00	0	68, 450	-	0	25.
00 S	SPEECH PATHOLOGY	68.00 69.00	0	66, 232		0	26. 27.

Heal th	Financial Systems		IU HEALTH NOR	TH_HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (Period:	Worksheet A-	-6
						From 01/01/2021 To 12/31/2021	Date/Time Pr	renared
						10 12/31/2021	5/26/2022 2:	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
28.00	ELECTROENCEPHALOGRAPHY	70.00	0	27, 230				28.00
29.00	CARDI AC CATHERI ZATI ON	75.01	0	190, 649	C			29.00
20.00	LABORATORY	01.00	0	4/0 700				20.00
30.00	EMERGENCY	91.00	0	462, 789				30.00
31.00	OTHER NON-REIMBURSABLE	192.01	0	15, 053				31.00
32.00	CHILDBIRTH EDUCATION	192.02	0	3, 965				32.00
33.00	PHYSICIANS' PRIVATE OFFICES	192.04	0	4, 343				33.00
34.00	PHYSICIAN_PRACTICE	<u> </u>	0	13 <u>7, 722</u>		1		34.00
			U	12, 269, 284				_
1.00	E - LABOR AND DELIVERY DELIVERY ROOM & LABOR ROOM	52.00	363, 942	162, 718	C			1.00
2.00	DELIVERT ROOM & LABOR ROOM	0.00	303, 942	102, 710				2.00
2.00	<u> </u>		363, 942	162, 718				2.00
	F - MARKETING		303, 742	102,710				-
1.00	OTHER ADMINISTRATIVE &	5.05		98, 749	C			1.00
1.00	GENERAL	5.05		70, 747				1.00
2.00	NURSI NG ADMI NI STRATI ON	13.00		211	C			2.00
3.00	ADULTS & PEDIATRICS	30.00		286	-	-		3.00
4.00	RADI OLOGY - THERAPEUTI C	55.00		446				4.00
				99,692				
	G - NURSERY			,,,,,,,,	1			1
1.00	ADULTS & PEDIATRICS	30.00	934, 671	177, 923	0)		1.00
	0		934, 671	177, 923		1		
	H – FMLA					_		
1.00	OTHER ADMINISTRATIVE &	5.05	30, 769	0	C	D		1.00
	GENERAL							
2.00	MAINTENANCE & REPAIRS	6.00	1, 219	0	C			2.00
3.00	HOUSEKEEPING	9.00	11, 101	0	C			3.00
4.00	CAFETERIA	11.00	1, 408	0	0			4.00
5.00	NURSI NG ADMI NI STRATI ON	13.00	13, 233	0	-			5.00
6.00	PHARMACY	15.00	7, 935	0	C			6.00
7.00	ADULTS & PEDIATRICS	30.00	80, 317	0	0			7.00
8.00	OPERATING ROOM	50.00	24, 528	0	C			8.00
9.00	RECOVERY ROOM	51.00	18, 893	0	C	-		9.00
10.00	DELIVERY ROOM & LABOR ROOM	52.00	32, 481	0	C			10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	21, 167	0	C			11.00
12.00	RADI OLOGY - THERAPEUTI C	55.00	14, 688	0	0			12.00
13.00	LABORATORY	60.00	1,031	0	0			13.00
14.00	RESPI RATORY THERAPY	65.00	8, 585	0	-			14.00
15.00	PHYSICAL THERAPY	66.00	11,674	0	0			15.00
16.00	OCCUPATIONAL THERAPY	67.00	3, 745	0	0			16.00
17.00	SPEECH PATHOLOGY	68.00	648	0	0			17.00
18.00	CARDI AC CATHERI ZATI ON	75.01	5, 078	0	C			18.00
10 00	LABORATORY EMERGENCY	01 00	1 021	0	C			10.00
		91.00	1,031	-	-	-		19.00
20.00	PHYSICIAN_PRACTICE	1 <u>92.</u> 05	<u>5, 068</u> 294, 599	0		1		20.00
	I - ACCRUED PTO	<u> </u>	274, 377	0				-
1.00	MAINTENANCE & REPAIRS	6.00	10, 985	0	0	ו		1.00
2.00	CAFETERIA	11.00	9,834	0				2.00
3.00	PATI ENT TRANSPORTATI ON	18.00	4, 451	0				3.00
4.00	ADULTS & PEDIATRICS	30.00	93, 417	0				4.00
5.00	OPERATI NG ROOM	50.00	23, 168	0				5.00
6.00	RECOVERY ROOM	51.00	28, 944	0				6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	52, 825	0				7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	28, 051	0	0			8.00
9.00	RADI OI SOTOPE	56.00	2, 482	0	0			9.00
10.00	LABORATORY	60.00	23, 369	0	0			10.00
11.00	RESPI RATORY THERAPY	65.00	46, 436	0	0			11.00
12.00	OCCUPATIONAL THERAPY	67.00	6, 242	0	0			12.00
13.00	CARDI AC CATHERI ZATI ON	75.01	965	0	0			13.00
	LABORATORY			-				
14.00	EMERGENCY	91.00	32, 302	0	C			14.00
15.00	OTHER NON-REIMBURSABLE	192.01	12	0	C)		15.00
16.00	CHILDBIRTH EDUCATION	192. 02	202	0	0			16.00
	TOTALS		363, 685	o				
	J – BILLABLE SUPPLIES				1			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		61	(1.00
2.00	ADMI TTI NG	5.04		6				2.00
3.00	OTHER ADMINISTRATIVE &	5.05		7	C)		3.00
	GENERAL							
4.00	OPERATION OF PLANT	7.00		5				4.00
5.00	HOUSEKEEPING	9.00		52				5.00
6.00	DI ETARY	10.00		1	(0		6.00

Heal th	Financial Systems		IU HEALTH NO	RTH HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-0161	Period: From 01/01/2021	Worksheet A-	-6
						To 12/31/2021		
		Decreases					5/26/2022 2:	55 pm
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
7.00	6.00	7.00	8.00	9.00	10.00	0		7.00
7.00 8.00	CAFETERIA NURSING ADMINISTRATION	11. 00 13. 00		1 1, 254		0		7.00 8.00
9.00	PHARMACY	15.00		1, 043		0		9.00
10.00	ADULTS & PEDIATRICS	30.00		146, 045		0		10.00
11.00	PREMATURE INTENSIVE CARE	34.02		6, 628		0		11.00
12.00	OPERATING ROOM	50.00		3, 403, 884		o		12.00
13.00	RECOVERY ROOM	51.00		7, 698		0		13.00
14.00 15.00	DELIVERY ROOM & LABOR ROOM	52.00		125, 923		0		14.00
15.00 16.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY - THERAPEUTI C	54.00 55.00		18, 021 25, 124		0		15.00 16.00
17.00	LABORATORY	60.00		459		0		17.00
18.00	RESPI RATORY THERAPY	65.00		749		0		18.00
19.00 20.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00		1,004		0		19.00 20.00
20.00	ELECTROENCEPHALOGRAPHY	70.00		791		0		20.00
22.00	CARDI AC CATHERI ZATI ON	75.01		802, 045		0		22.00
	LABORATORY	01.00		10 700				00.00
23.00 24.00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91.00 192.04		18, 788 121		0		23.00 24.00
25.00	PHYSI CI AN PRACTI CE	192.05		22		0		25.00
	0		0	4, 559, 781		1		
1.00	K - NON-BILLABLE SUPPLIES EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,024		0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0			0		2.00
3.00	NURSING ADMINISTRATION	13.00	0			o		3.00
4.00	PHARMACY	15.00	0			0		4.00
5.00 6.00	ADULTS & PEDIATRICS PREMATURE INTENSIVE CARE	30. 00 34. 02	0	624, 888 79, 061		0		5.00 6.00
0.00	UNI T	54.02	0	77,001				0.00
7.00	OPERATING ROOM	50.00	0			0		7.00
8.00 9.00	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	51.00 52.00	0			0		8.00 9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0			0		10.00
11.00	RADI OLOGY - THERAPEUTI C	55.00	0			0		11.00
12.00		60.00	0	7, 282		0		12.00
13.00 14.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	256, 034 12, 017		0		13.00 14.00
15.00	OCCUPATI ONAL THERAPY	67.00	0	6, 241		0		15.00
16.00	SPEECH PATHOLOGY	68.00	0	.,		0		16.00
17.00 18.00	ELECTROENCEPHALOGRAPHY CARDI AC CATHERI ZATI ON	70. 00 75. 01	0	950 253, 236		0		17.00 18.00
16.00	LABORATORY	75.01	0	203, 230		0		18.00
19.00	EMERGENCY	91.00	0	198, 483		0		19.00
20.00	PHYSI CLANS' PRI VATE OFFI CES	192.04	0			0		20.00
21.00	PHYSICIAN_PRACTICE	1 <u>92.</u> 05	0			0		21.00
	L - BILLABLE DRUGS		0	0,210,000				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		5, 884		0		1.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5.05		6, 142		0		2.00
3.00	HOUSEKEEPING	9.00		1		o		3.00
4.00	NURSING ADMINISTRATION	13.00		190		0		4.00
5.00 6.00	CENTRAL SERVICES & SUPPLY PHARMACY	14.00 15.00		476 40, 821, 049		0		5.00 6.00
7.00	SOCIAL SERVICE	17.00		9, 384		0		7.00
8.00	ADULTS & PEDIATRICS	30. 00		87, 314		о		8.00
9.00	PREMATURE INTENSIVE CARE	34.02		1, 314		0		9.00
10.00	UNIT OPERATING ROOM	50.00		262, 811		0		10.00
11.00	RECOVERY ROOM	51.00		26, 687		0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00		22, 788		0		12.00
13.00 14.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY - THERAPEUTI C	54.00 55.00		411, 077 23, 167		0		13.00 14.00
14.00 15.00	RADI OLOGI - THERAPEOTIC	56.00		137, 923		0		15.00
16.00	RESPI RATORY THERAPY	65.00		15, 871		о		16.00
17.00	PHYSI CAL THERAPY	66.00		10		0		17.00
18.00 19.00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00		36, 538 1		0		18.00 19.00
20.00	CARDI AC CATHERI ZATI ON	75.01		50, 782		0		20.00
01 00	LABORATORY	o						
21.00 22.00	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91.00 192.04		28, 653 454		0		21.00 22.00
23.00	PHYSICIAN PRACTICE	192.04		1, 502		0		23.00
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	Worksheet	A-6
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RECLASSI FIGATIONS Provider ON: 15-0161 Provider ON: 15-0161 Provider On: 10/07/2021 Arc March 16-6 Loo Cost Center Line # Sei ary Other Acco State Line # Sei ary Other Acco State Line # Sei ary Other Acco State Desco State Acco State Desco State Acco State Desco State Acco State Desco State Des	Heal th	Financial Systems		IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS	-2552-10
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O O NORTH TO TIPTON ISR ALLOCATION I.00 0 - NORTH TO TIPTON ISR ALLOCATION 10,950,421 1 1.00 OTHER ADMINISTRATIVE & 5.05 17,647 10,313 0 2.00 OPERATION OF PLANT 7.00 7,273 3,639 0 3.00 2.00 OPERATION OF PLANT 7.00 7,273 3,639 0 3.00 4.00 NURSING ADMINISTRATION 13.00 21,875 0 0 4.00 9 - NORTH TO WEST ISR ALLOCATION 13.00 21,875 0 0 4.00 1.00 OTHER ADMINISTRATIVE & 5.05 81,688 47,735 0 1.00 2.00 P - NORTH TO WEST ISR ALLOCATION 1.00 2.00 3.00 2.00 3.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 62,837 25,106 0 0 3.00 0 - NORTH TO SAXONY ISR ALLOCATION 1.00 182,524 91,854 1.00 2.00 3.00 2.00 3.00	7.00		75.01	0	830, 309		0		7.00
0 - NORTH TO TI PTON I SR ALLOCATION 1 1 1 1 0 0 OTHER ADMINISTRATIVE & 5 5 0 1 0 0 1 0		LABORATORY			10.050.421	<u> </u>	-		
1.00 OTHER ADMI NI STRATI VE & 5.05 17,647 10,313 0 1.00 2.00 OPERATI ON OF PLANT 7.00 7,273 3,639 0 3.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 6,816 2,723 0 3.00 4.00 NURSI NG ADMI NI STRATI ON 13.00 21,875 0 0 0 0 0 53,611 16,675 0 0 4.00 0 0 13.00 21,875 0 0 0 1.00 OTHER ADMI NI STRATI VE & 53.611 16,675 0 4.00 0 0 0 13.00 21,875 0 0 4.00 1.00 OTHER ADMI NI STRATI VE & 5.05 81,688 47,735 0 1.00 2.00 OPERATI ON OF PLANT 7.00 37,999 19,013 0 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 62,837 25,106 0 0 3.00 0 - NORTH TO SAXONY I SR ALLOCATI ON - 1.00 2.00 1.00<				U	10, 950, 421				_
GENERAL 7.00 7.273 3.639 0 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 6.816 2.723 0 3.00 4.00 NURSI NG ADMI NI STRATI ON 13.00 21.875 0 0 4.00 0 0 53.611 16.675 0 0 4.00 P - NORTH TO WEST ISR ALLOCATION 5.05 81,688 47,735 0 1.00 CHER ADMI NI STRATI VE & 5.05 81,688 47,735 0 2.00 2.00 OPERATION OF PLANT 7.00 37,999 19,013 0 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 62,837 25,106 0 0 0 0 182,524 91,854 0 2.00 3.00 1.00 OTHER ADMI NI STRATI VE & 5.05 23,763 13,886 0 1.00 2.00 OPERATI ON OF PLANT 7.00 9,793 4,900 0 2.00 3.00 0 <t< td=""><td>1 00</td><td></td><td></td><td>17 647</td><td>10 313</td><td></td><td>0</td><td></td><td>1 00</td></t<>	1 00			17 647	10 313		0		1 00
2.00 OPERATI ON OF PLANT 7.00 7.273 3.639 0 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 6.816 2.723 0 3.00 4.00 NURSI NG ADMI NI STRATI ON 13.00 21.875 0 0 4.00 0 NURSI NG ADMI NI STRATI VE & 53.611 16.675 0 4.00 1.00 OTHER ADMI NI STRATI VE & 50.05 81,688 47,735 0 1.00 2.00 OPERATI ON OF PLANT 7.00 37,999 19,013 0 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 62,837 25,106 0 0 0 OPERATI ON OF PLANT 7.00 37,999 19,013 0 3.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 62,837 25,106 0 0 0 OPERATI ON OF PLANT 7.00 9,793 4,900 0 1.00 2.00 OPERATI ON OF PLANT 7.00 9,793 4,900 0 3.00 0 OPERATI ON OF PLANT 7.00 9,793 4,900<	1.00		5.05	17,047	10, 515		0		1.00
3.00 RADI OLOGY-DI AGNOSTI C 54.00 6,816 2,723 0 3.00 4.00 NURSI NG ADMI NI STRATI ON 13.00 21,875 0 0 0 0 0 53,611 16,675 0 0 0 4.00 0 0 0 53,611 16,675 0 0 4.00 1.00 0 0 0 5.05 81,688 47,735 0 1.00 2.00 OPERATION OF PLANT 7.00 37,999 19,013 0 2.00 3.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 62,837 25,106 0 0 3.00 0 0 0 182,524 91,854 0 3.00 3.00 0 0 0 182,524 91,854 0 2.00 3.00 2.00 OPERATION OF PLANT 7.00 9,793 4,900 0 2.00 3.00 2.00 OPERATION OF PLANT 7.00 9,793 4,900 0 3.00 2.00 3.00 0 <t< td=""><td>2 00</td><td></td><td>7 00</td><td>7 273</td><td>3 639</td><td></td><td>0</td><td></td><td>2 00</td></t<>	2 00		7 00	7 273	3 639		0		2 00
4.00 NURSI NG ADMI NI STRATI ON									
O					2, 720				
P - NORTH TO WEST ISR ALLOCATION 1.00 OTHER ADMINISTRATIVE & 5.05 81,688 47,735 0 1.00 2.00 OPERATION OF PLANT 7.00 37,999 19,013 0 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 62,837 25,106 0 3.00 0 0 182,524 91,854 0 3.00 3.00 0 0 182,524 91,854 0 3.00 3.00 0 0 182,524 91,854 0 3.00 3.00 1.00 OTHER ADMINISTRATIVE & 5.05 23,763 13,886 0 1.00 2.00 OPERATION OF PLANT 7.00 9,793 4,900 0 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 17,355 6,934 0 3.00 0 0 50,911 25,720 0 3.00 3.00 1.00 OTHER ADMINISTRATIVE & 5.05 0 65,489 0 3.00				+	16.675				
GENERAL 7.00 37,999 19,013 0 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 62,837 25,106 0 3.00 <		P - NORTH TO WEST ISR ALLOCA	TI ON						-
GENERAL 7.00 37,999 19,013 0 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 62,837 25,106 0 3.00 <	1.00			81, 688	47, 735		0		1.00
3. 00 RADI OLOGY-DI AGNOSTIC 54.00 62,837 25,106 0 0 0 182,524 91,854 0 <t< td=""><td></td><td>GENERAL</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>		GENERAL							
O 182,524 91,854 Q - NORTH TO SAXONY ISR ALLOCATION Q Q NO NO 1.00 OTHER ADMINISTRATIVE & 5.05 23,763 13,886 Q 1.00 2.00 OPERATION OF PLANT 7.00 9,793 4,900 Q 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 17,355 6,934 Q 3.00 Q O 50,911 25,720 0 3.00 3.00 3.00 1.00 R - PHYSI CI AN 1.00 OTHER ADMINISTRATIVE & 5.05 0 65,489 0 1.00 2.00 TOTALS 0 65,489 0 2.00 2.00	2.00	OPERATION OF PLANT		37, 999	19, 013		0		2.00
Q - NORTH TO SAXONY ISR ALLOCATION 1.00 0 THER ADMINISTRATIVE & 5.05 23,763 13,886 0 1.00 2.00 OPERATION OF PLANT 7.00 9,793 4,900 0 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 17,355 6,934 0 3.00 0 50,911 25,720 3.00	3.00	RADI OLOGY-DI AGNOSTI C	54.00	<u>62, 8</u> 37	2 <u>5, 1</u> 06		0		3.00
1. 00 OTHER ADMINISTRATIVE & 5. 05 23, 763 13, 886 0 1. 00 2. 00 OPERATION OF PLANT 7. 00 9, 793 4, 900 0 2. 00 3. 00 RADI OLOGY-DI AGNOSTIC 54. 00 17, 355 6, 934 0 3. 00 0 0 50, 911 25, 720 0 3. 00 3. 00 1. 00 OTHER ADMINISTRATIVE & 5. 05 0 65, 489 0 1. 00 2. 00 TOTALS 0 0 0 0 2. 00 2. 00		0		182, 524	91, 854				
GENERAL 2.00 OPERATION OF PLANT 7.00 9,793 4,900 0 2.00 3.00 3.00 RADI 0LOGY-DI AGNOSTIC 54.00 17,355 6,934 0 3.00 3.00 0 50,911 25,720 0 50,911 25,720 0 3.00 1.00 OTHER ADMINISTRATIVE & 5.05 0 65,489 0 1.00 2.00						1	-		_
2.00 OPERATI ON OF PLANT 7.00 9,793 4,900 0 2.00 3.00 RADI OLOGY-DI AGNOSTIC 54.00 55.5 6,934 0 3.00 0 50.911 55.720 0 3.00 3.00 1.00 OTHER ADMI NI STRATI VE & 5.05 0 65,489 0 1.00 2.00	1.00		5.05	23, 763	13, 886		0		1.00
3. 00 RADI OLOGY-DI AGNOSTIC 54.00 _17,355 6,934 0									
O - - 50, 911 25, 720 - <									
R - PHYSI CI AN 1.00 OTHER ADMI NI STRATI VE & 5.05 0 65, 489 0 1.00 2.00	3.00	KADI OLOGY-DI AGNOSTIC	<u>54.</u> 00				믹		3.00
1. 00 OTHER ADMINISTRATIVE & 5. 05 0 65, 489 0 1. 00 2. 00				50, 911	25, 720	l			-
2.00 GENERAL <u>TOTALS</u> <u>0.00</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u> <u>0</u>	1 00		E of		4E 400		0		1 00
2.00 <u>TOTALS 0.00</u> 0.00 2.00 2.00	1.00		5.05	0	65,489				1.00
TOTALS 0 65, 489 0	2 00		0.00	0	0		0		2 00
	2.00			— — — <u> </u>		<u> </u>	4		2.00
	500 00			2,243,943			-		500 00
	225.00		· ·	_, , ,	, 555, 122	I.	I		1

RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	:N: 15-0161	Peri From To	od: n 01/01/2021 12/31/2021	Worksheet A-7 Part I Date/Time Prep 5/26/2022 2:55	
				Acqui si ti on	IS			
		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	BALANCES						
. 00	Land	0	0		0	0	0	1.00
. 00	Land Improvements	12,041,302	0		0	0	0	2.00
. 00	Buildings and Fixtures	196, 283, 882	0		0	0	0	3.00
. 00	Building Improvements	12, 628, 405	403, 418		0	403, 418	0	4.0
. 00	Fixed Equipment	0	0		0	0	0	5.0
. 00	Movable Equipment	101, 287, 994	17, 505, 288		0	17, 505, 288	6, 022, 239	6.0
. 00	HIT designated Assets	0	0		0	0	0	7.0
. 00	Subtotal (sum of lines 1-7)	322, 241, 583	17, 908, 706		0	17, 908, 706	6, 022, 239	8.0
. 00	Reconciling Items	022,211,000	0		0	0	0,022,20,	9.0
0.00	Total (line 8 minus line 9)	322, 241, 583	17, 908, 706		0	17, 908, 706	6, 022, 239	10.0
0.00		Ending	Fully		0	, , , , , , , , , , , , , , , , , ,	0/022/20/	1010
		Balance	Depreciated					
		Baranoo	Assets					
		6,00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
. 00	Land	0	0					1.0
. 00	Land Improvements	12,041,302	11, 917, 611					2.0
. 00	Buildings and Fixtures	196, 283, 882	0					3.0
. 00	Building Improvements	13, 031, 823	1, 230, 991					4.0
. 00	Fixed Equipment	0	0					5.0
. 00	Movable Equipment	112, 771, 043	51, 400, 633					6.0
. 00	HIT designated Assets	0	0					7.0
. 00	Subtotal (sum of lines 1-7)	334, 128, 050	64, 549, 235					8.0
. 00	Reconciling Items	0	0					9.0
0.00	Total (line 8 minus line 9)	334, 128, 050	64, 549, 235					10.0

Health Financial Systems	IU HEALTH NORTH	H HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021		pared:
		S	SUMMARY OF CAP	ITAL		
Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMN	12, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT 1.01 NEW CAP REL COSTS-INTEREST	0	(0	0 0 0 0	0	1.00 1.01
1.02 MOB LEASED SPACE	0	(0	0 0	0	1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	(0	0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	(0	0 0	0	3.00
	SUMMARY OF	CAPI TAL				
Cost Center Description	Other	Total (1)				
	Capital-Relat (sum of cols.				
	ed Costs (see 9) through 14)				
	instructions)		_			
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMN	12, LINES 1	and 2			
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	(1.00
1. 01 NEW CAP REL COSTS-INTEREST 1. 02 MOB LEASED SPACE	0	(1.01 1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0					2.00
3.00 Total (sum of lines 1-2)	0	(2.00
3.00 + 10 call (Sull 01 + 1105 + 2)	U U	(3.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 2:55	bared:
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 -	Ratio (see instructions)	Insurance	
	1.00	2.00	col. 2) 3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	0.00	4.00	3.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	221, 357, 007	0	221, 357, 00	7 0. 662492	0	1.00
1.01 NEW CAP REL COSTS-INTEREST	0	0		0.00000		1.01
1.02 MOB LEASED SPACE	0	0		0 0.000000		1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	112, 771, 043					2.00
3.00 Total (sum of lines 1-2)	334, 128, 050					3.00
	ALLUCA	TION OF OTHER (JAPITAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5	•		
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	-				0.005.504	1 00
1.00 NEW CAP REL COSTS-BLDG & FIXT 1.01 NEW CAP REL COSTS-INTEREST	0	0		0 7, 106, 720		1.00 1.01
1. 01 NEW CAP REL COSTS-INTEREST 1. 02 MOB LEASED SPACE	0	0		0 11, 306, 535 0 0		1.01
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 11, 279, 228		2.00
3.00 Total (sum of lines 1-2)	0			0 29, 692, 483		2.00
	0	<u> </u>	JMMARY OF CAPI		2,005,909	3.00
		50		IAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1		0.140.004	1 00
1.00 NEW CAP REL COSTS-BLDG & FLXT	0	e e e e e e e e e e e e e e e e e e e		0 0	9, 142, 224	1.00
1.01 NEW CAP REL COSTS-INTEREST 1.02 MOB LEASED SPACE	294, 057	0		0 0		1. 01 1. 02
1.02 MOB LEASED SPACE 2.00 NEW CAP REL COSTS-MVBLE EQUIP	0				770, 068 11, 359, 565	1.02
3.00 Total (sum of lines 1-2)	294, 057	-			32, 872, 449	2.00 3.00
5.00 [10tal (Sull 01 11165 1-2)	274,037	0	Т	0	32,012,449	3.00

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

			TU HEALTH NUR			Workshoot A 9	
ADJUST	MENTS TO EXPENSES			F	Period: From 01/01/2021 Fo 12/31/2021		pared:
				Expense Classification on		5/26/2022 2: 5	5 pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	cost center bescription	(2)				Ref.	
1.00	Investment income - NEW CAP	1.00	2.00 0	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.00
	REL COSTS-BLDG & FIXT (chapter 2)			FIXT			
1.01	Ínvestment income – NEW CAP REL COSTS-INTEREST (chapter 2)	В	294, 057	NEW CAP REL COSTS-INTEREST	1. 01	11	1.01
1. 02	Investment income - MOB LEASED		0	MOB LEASED SPACE	1. 02	0	1. 02
2.00	SPACE (chapter 2) Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	О	2.00
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00		9.00
10.00	Provider-based physician adjustment	A-8-2	-9, 294, 945			0	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	33, 032, 969			0	12.00
13.00	Laundry and linen service	5	0		0.00		
14.00 15.00	Cafeteria-employees and guests Rental of quarters to employee		-204, 101	CAFETERI A	11. 00 0. 00		
16.00	and others Sale of medical and surgical		0		0.00	0	16.00
	supplies to other than patients						
17.00	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
19.00	abstracts Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		
21.00	interest, finance or penalty				0.00	Ŭ	21.00
22.00			0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
24.00	therapy costs in excess of	A-0-3		FILITICAL TILLAFT	80.00		24.00
25.00	limitation (chapter 14) Utilization review –		0	*** Cost Center Deleted ***	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26.00
26. 01	Depreciation - NEW CAP REL			NEW CAP REL COSTS-INTEREST	1.01	0	26. 01
26. 02	COSTS-INTEREST Depreciation - MOB LEASED		0	MOB LEASED SPACE	1. 02	0	26. 02
	SPACE					ı I	

	Financial Systems		IU HEALIH NOR			u of Form CMS-2	
ADJUST	MENTS TO EXPENSES				eriod: rom 01/01/2021	Worksheet A-8	
						Date/Time Pre	nared
					12/31/2021	5/26/2022 2:5	5 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					2		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)			-	Ref.	
		1.00	2.00	3.00	4.00	5.00	
27.00	Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-MVBLE	2.00	0	27.00
	COSTS-MVBLE EQUIP			EQUI P			
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	•
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
00177	instructions)		, i i i i i i i i i i i i i i i i i i i		001.00		
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
01100	pathology costs in excess of		, i i i i i i i i i i i i i i i i i i i		00.00		000
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
02.00	Depreciation and Interest		, i i i i i i i i i i i i i i i i i i i		0.00	0	02.00
33.00	MI SCELLANEOUS I NCOME	В	-8 937	DATA PROCESSING	5.02	0	33.00
33.01	MI SCELLANEOUS I NCOME	B		OTHER ADMINISTRATIVE &	5.05	0	•
55. 01	IN SCEELANEOUS THOOME		105,052	GENERAL	5.05	0	33.01
33. 02	MISCELLANEOUS INCOME	В	-503 865	MAINTENANCE & REPAIRS	6.00	0	33.02
33.03	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7.00	0	
33.04	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13.00	0	
33.05	MI SCELLANEOUS I NCOME	В		PHARMACY	15.00	0	•
33.06	MI SCELLANEOUS I NCOME	В		OPERATING ROOM	50.00	0	•
33.07	MI SCELLANEOUS I NCOME	B		SPEECH PATHOLOGY	68.00	0	•
33.07	IC LEASE INCOME	B		NEW CAP REL COSTS-BLDG &	1.00	10	•
55.00	TO LEASE TROOME	В	-03, 009	FIXT	1.00	10	33.00
33.09	INTERCOMPANY	В	24 221	ADMI TTI NG	5.04	0	33.09
33. 10	INTERCOMPANY	B		OTHER ADMINISTRATIVE &	5.05	0	
33.10	TNTERCOWPANT	D	-314, 707	GENERAL	5.05	0	33.10
33. 11	INTERCOMPANY	В	E4 100	MAINTENANCE & REPAIRS	6.00	0	33.11
33.12		B		PATIENT TRANSPORTATION		0	
					18. 00 13. 00		•
33.13		В		NURSING ADMINISTRATION		0	
33.14		В		OPERATING ROOM	50.00	0	
33. 15	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.15
22 1/		^	10 0/0 044		4 00	0	22.17
33.16	EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	•
33. 17	MEDICALD HOSPITAL ASSESSMENT	A		OTHER ADMINISTRATIVE &	5.05	0	33.17
22 10		^			20.00	~	22.10
	TELEPHONE EQUI PMENT	A		ADULTS & PEDIATRICS	30.00	0	
	UNWONTED SI TUATI ONS	A		ADULTS & PEDIATRICS	30.00	0	•
33.20	UNWONTED SI TUATI ONS	A		OPERATING ROOM	50.00	0	
33.21	CARMEL REHAB START-UP	A		PHYSICAL THERAPY	66.00	0	
33. 22	CANCER CENTER PLANNING	A		OTHER ADMINISTRATIVE &	5.05	0	33.22
	START-UP			GENERAL			
33. 23	CONTRI BUTI ON EXPENSE	A		OTHER ADMINISTRATIVE &	5.05	0	33.23
				GENERAL		-	
33.24	CONTRI BUTI ON EXPENSE	A		PHARMACY	15.00	0	
33.25	CONTRI BUTI ON EXPENSE	A		RADI OLOGY-DI AGNOSTI C	54.00	0	
33.26	CONTRI BUTI ON EXPENSE	A		PHYSI CAL THERAPY	66.00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-2, 651, 767				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

(2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANI ZATI ONS AND HO	ME Provider CCN: 15-0161	Period:	Worksheet A-8	4
OFFICE	COSTS				WULKSHEEL A-0	/ -
				From 01/01/2021		
				To 12/31/2021	Date/Time Pre 5/26/2022 2:5	
	Line No.	Cost Center	Expense Items	Amount of	Amount	<u>5 piii</u>
	LITTE NO.	COST Center	Expense i tems	Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST					
	OFFICE COSTS:	IENTS REQUIRED AS A RESULT OF	INANSAGITONS WITH RELATED	UNUANI ZATI UNU UN		
. 00		NEW CAP REL COSTS-BLDG & FIX	HOME OFFICE ALLOCATION	1, 013, 719	1, 926, 450	1.00
2.00			HOME OFFICE ALLOCATION	11, 306, 535	1, 920, 430	2.00
3.00		NEW CAP REL COSTS-INTEREST		1, 233, 906	0	3.00
					0	
3. 01		EMPLOYEE BENEFITS DEPARTMENT		12, 553, 477	0	3.0
3. 02			HOME OFFICE ALLOCATION	10, 098, 608	0	3.02
. 00		PURCHASING RECEIVING AND STO		1, 659, 043	0	4.0
l. 01			HOME OFFICE ALLOCATION	2, 196, 716	0	4.0
1. 02	5.05	OTHER ADMINISTRATIVE & GENER		23, 471, 057	28, 401, 499	4.0
1.03	0.00		HOME OFFICE ALLOCATION	0	0	4.0
l. 04	4.00	EMPLOYEE BENEFITS DEPARTMENT	I NTERCOMPANY	170, 023	170, 023	4.0
1.05	5.04	ADMI TTI NG	I NTERCOMPANY	107, 663	107, 663	4.0
1.06	5.05	OTHER ADMINISTRATIVE & GENER	I NTERCOMPANY	30, 875, 834	30, 875, 834	4.00
I. 07	6.00	MAINTENANCE & REPAIRS	INTERCOMPANY	0	172, 143	4.0
. 08			INTERCOMPANY	133, 900	133, 900	4.08
1.09			INTERCOMPANY	5, 658, 050	5, 658, 050	4.0
1. 10		PREMATURE INTENSIVE CARE UNI		701, 833	701, 833	4.10
I. 10			INTERCOMPANY	485, 127	485, 127	4.1
I. 12			INTERCOMPANY	1, 585, 817	1, 585, 817	4.1
i. 12 I. 13			INTERCOMPANY	138, 018	138, 018	4.1
i. 13 I. 14			INTERCOMPANY			4.1
				1, 264, 644	1, 264, 644	
1.15			I NTERCOMPANY	8, 621, 809	8, 621, 809	4.1
. 16			I NTERCOMPANY	8, 985	8, 985	4.1
. 17			I NTERCOMPANY	46	46	4.1
. 18			I NTERCOMPANY	223, 708	223, 708	4.1
. 19			I NTERCOMPANY	261, 525	261, 525	4.1
1.20		CARDIAC CATHERIZATION LABORA	I NTERCOMPANY	320, 743	320, 743	4.2
l. 21			I NTERCOMPANY	941, 496	941, 496	4.2
1. 22	192.01	OTHER NON-REIMBURSABLE	I NTERCOMPANY	9, 597	9, 597	4.2
1.23	192.02	CHILDBIRTH EDUCATION	I NTERCOMPANY	27, 400	27, 400	4.2
1.24	192.05	PHYSICIAN PRACTICE	INTERCOMPANY	49, 746	49, 746	4.2
5.00	TOTALS (sum of lines 1-4).			115, 119, 025	82, 086, 056	5.0
	Transfer column 6, line 5 to				02,000,000	0.0
	Worksheet A-8, column 2,					
	line 12.					

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

Related Organization(s) and/or Home Office								
Symbol (1) Name Percentage of Name Percentage of								
Ownership Ownership								
1.00 2.00 3.00 4.00 5.00								
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	В	0.00 I U HEALTH 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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

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

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

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

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

Health Financial Systems IU H	EALTH NORTH	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATION	IS AND HOME	Provider CCN: 15-0161		Worksheet A-8-1
OFFICE COSTS			From 01/01/2021 To 12/31/2021	Date/Time Prepared:

						10 12/31/2021	5/26/2022 2:5	5 pm
	Net	Wkst. A-7 Ref.				· · · · · · · · · · · · · · · · · · ·		- F
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCURF	RED AND ADJUSTMEN	'S REQUIRED AS A RESULT C	F TRANSACTIONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:							
1.00	-912, 731	9						1.00
2.00	11, 306, 535	9						2.00
3.00	1, 233, 906	9						3.00
3.01	12, 553, 477	0						3.01
3.02	10, 098, 608	0						3.02
4.00	1, 659, 043	0						4.00
4.01	2, 196, 716	0						4.01
4.02	-4, 930, 442	0						4.02
4.03	0	0						4.03
4.04	0	0						4.04
4.05	0	0						4.05
4.06	0	0						4.06
4.07	-172, 143	0						4.07
4.08	0	0						4.08
4.09	0	0						4.09
4.10	0	0						4.10
4.11	0	0						4.11
4.12	0	0						4.12
4.13	0	0						4.13
4.14	0	0						4.14
4.15	0	0						4.15
4.16	0	0						4.16
4.17	0	0						4.17
4.18	0	0						4.18
4.19	0	0						4.19
4.20	0	0						4.20
4.21	0	0						4.21
4.22	0	0						4.22
4.23	0	0						4.23
4.24	0	0						4.24
5.00	33, 032, 969							5.00

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

nas	not been posted to worksneet A,	corumns r and/or 2,	the amount	allowable should be	I noi cated i	n column 4 of	this part.	
	Related Organization(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.

	HEALTHCARE	6.00
7.00		7.00
7.00 8.00		8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

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

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

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

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

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

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

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

Heal th	Fi nanci a	I Systems	
PROVI D	FR BASED	PHYSI CLAN	AD JUSTMENT

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

			TU HEALTH NC					
PROVIDE	ER BASED PHYSIC	TAN ADJUSTMENT		Provi der (F	Period: From 01/01/2021 To 12/31/2021		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		OTHER ADMINISTRATIVE &	401, 435	401, 435	0	0	0	1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	5, 598, 065			0	0	
3.00	34.02	PREMATURE INTENSIVE CARE	683, 833	683, 833	0	0	0	3.00
						_	_	
4.00		OPERATING ROOM	539, 503			0	0	
5.00		DELIVERY ROOM & LABOR ROOM	1, 438, 599		1, 438, 599	237, 100		1
6.00 7.00		EMERGENCY RADI OLOGY - THERAPEUTI C	869,028		0	0	0	
8.00		ELECTROCARDI OLOGY	443, 846 223, 708		-	0	0	8.00
9.00		ELECTROENCEPHALOGRAPHY	2, 174		0	0	0	9.00
10.00		PHARMACY	1, 415		0	0	0	10.00
11.00		RECOVERY ROOM	551	551	0	0	0	
12.00		NURSING ADMINISTRATION	52, 250		0	0	0	12.00
13.00		CARDI AC CATHERI ZATI ON	130, 400		0	0	0	13.00
		LABORATORY			-	-	-	
200.00			10, 384, 807	8, 946, 208	1, 438, 599		9, 561	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
1 00	1.00		8.00	9.00	12.00	13.00	14.00	1.00
1.00		OTHER ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00		ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00		PREMATURE INTENSIVE CARE			0	0	0	1
0.00	01.02	UNI T			0	0	0	0.00
4.00	50.00	OPERATING ROOM	0	0	0	0	0	4.00
5.00		DELIVERY ROOM & LABOR ROOM	1, 089, 862	54, 493	0	0	0	5.00
6.00	91.00	EMERGENCY	0	0	0	0	0	6.00
7.00	55.00	RADI OLOGY – THERAPEUTI C	0	0	0	0	0	7.00
8.00	69.00	ELECTROCARDI OLOGY	0	0	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	9.00
10.00		PHARMACY	0	0	0	0	0	10.00
11.00		RECOVERY ROOM	0	0	0	0	0	11.00
12.00		NURSING ADMINISTRATION	0	0	0	0	0	12.00
13.00	/5.01	CARDIAC CATHERIZATION	0	0	0	0	0	13.00
200 00		LABORATORY	1, 089, 862	54, 493	0	0	0	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WKSU. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
		ruenti ri ei	Share of col.		Di Sul i Gilande			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OTHER ADMINISTRATIVE &	0	0	0	401, 435		1.00
		GENERAL						
2.00		ADULTS & PEDIATRICS	0		0	5, 598, 065		2.00
3.00	34.02	PREMATURE INTENSIVE CARE	0	0	0	683, 833		3.00
4 00	50.00	UNI T				500 500		1 00
4.00		OPERATING ROOM		1 000 0(2		539, 503		4.00
5.00		DELIVERY ROOM & LABOR ROOM	0	1, 089, 862	348, 737	348, 737		5.00
6.00 7.00		EMERGENCY RADI OLOGY - THERAPEUTI C		0		869, 028 443, 846		6.00 7.00
8.00		ELECTROCARDI OLOGY				223, 708		8.00
9.00		ELECTROEARDIOLOGT			0	2, 174		9.00
10.00		PHARMACY		0	0	1, 415		10.00
11.00		RECOVERY ROOM		0	0	551		11.00
12.00		NURSING ADMINISTRATION	0	0	0	52, 250		12.00
13.00		CARDIAC CATHERIZATION	0	0	0	130, 400		13.00
		LABORATORY						
200.00			0	1, 089, 862	348, 737	9, 294, 945		200.00
								•

	nancial Systems CATION - GENERAL SERVICE COSTS	IU HEALTH NOR	TH HOSPITAL Provider C	CN: 15-0161 P	In Lie eriod:	u of Form CMS-: Worksheet B	2552-10
					rom 01/01/2021	Part I Date/Time Pre 5/26/2022 2:5	pared:
				CAPI TAL REI	_ATED COSTS	572072022 2.5	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW INTEREST	MOB LEASED SPACE	NEW MVBLE EQUI P	
		0	1.00	1.01	1. 02	2.00	
	NERAL SERVICE COST CENTERS	9, 142, 224	9, 142, 224	1			1.00
1.01 001 1.02 001	101 NEW CAP REL COSTS-INTEREST 102 MOB LEASED SPACE	11, 600, 592 770, 068	9, 142, 224 0 0	11, 600, 592	770, 068		1.01 1.02
4.00 004	200 NEW CAP REL COSTS-MVBLE EQUIP 400 EMPLOYEE BENEFITS DEPARTMENT 540 NONPATIENT TELEPHONES	11, 359, 565 13, 154, 491 0	24, 885 0		12, 026 0	11, 359, 565 1, 390 0	1
5.02 005 5.03 005	550 DATA PROCESSING 560 PURCHASING RECEIVING AND STORES	10, 167, 109 1, 659, 043	141, 997 0	0	7, 053 0	0 0	•
	570 ADMI TTI NG 590 OTHER ADMI NI STRATI VE & GENERAL	2, 762, 102 28, 536, 911	28, 623 282, 560		0 139, 903	152 146, 838	5.04 5.05
6.00 006	500 MAINTENANCE & REPAIRS	5, 990, 459	1, 333, 645	1, 692, 266	16, 989	132, 199	6.00
	700 OPERATION OF PLANT 300 LAUNDRY & LINEN SERVICE	1, 439, 310 198, 825	5, 349 0		1, 838 0	7, 080 0	
	HOUSEKEEPING	5, 767, 985	110, 541	-	4, 302	1, 896	
	DOO DI ETARY	1, 274, 075	46, 901		0	6, 099 42, 323	
	100 CAFETERIA 300 NURSING ADMINISTRATION	1, 557, 596 6, 134, 574	281, 232 142, 688		0	42, 323 1, 440, 071	
14.00 014	400 CENTRAL SERVICES & SUPPLY	8, 591, 667	300, 520	381, 331	0	0	14.00
	500 PHARMACY 500 MEDICAL RECORDS & LIBRARY	4, 290, 876 412	142, 972 0		0	100, 676 0	1
	700 SOCIAL SERVICE	1, 492, 906	177, 917		0	0	
	350 PATIENT TRANSPORTATION	233, 164	0	0	0	0	18.00
	PATIENT ROUTINE SERVICE COST CENTERS	22, 760, 940	1, 716, 506	2, 178, 082	0	240, 525	30.00
34.00 034	400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
	401 PEDIATRIC INTENSIVE CARE UNIT	0	0	-	0 5, 402	0	34.01 34.02
	402 PREMATURE INTENSIVE CARE UNIT 300 NURSERY	3, 329, 759 1, 151, 687	384, 741 156, 486		5, 402	66, 991 8, 839	•
	CILLARY SERVICE COST CENTERS	11 105 004	4 0/4 750	4 054 075		0 001 710	50.00
	DOO OPERATING ROOM 100 RECOVERY ROOM	11, 105, 934 2, 900, 304	1, 064, 759 163, 447		0	3, 301, 713 33, 132	
52.00 052	200 DELIVERY ROOM & LABOR ROOM	5, 856, 666	497,000	630, 644	0	163, 903	52.00
	400 RADI OLOGY-DI AGNOSTI C 500 RADI OLOGY – THERAPEUTI C	4, 928, 083	257, 356 860, 167		192, 850 0	3, 085, 313 1, 221, 588	
	500 RADIOLOGY - THERAPEOTIC	4, 821, 012 291, 268	18, 527		0	21, 563	
60.00 060	DOO LABORATORY	10, 177, 052	208, 081	264, 034	0	0	60.00
	500 RESPI RATORY THERAPY 500 PHYSI CAL THERAPY	2, 542, 873 1, 974, 267	32, 590 6, 181		0 68, 230	101, 147	65.00 66.00
	700 OCCUPATI ONAL THERAPY	537, 480	0, 181		08,230	0	
	BOO SPEECH PATHOLOGY	316, 434	0	-	0	1, 742	
	900 ELECTROCARDI OLOGY DOO ELECTROENCEPHALOGRAPHY	512, 477 514, 150	37, 337 12, 558		0	148, 205 49, 586	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 095, 119	0		0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENT	10, 928, 885	0	-	0	0	72.00
	300 DRUGS CHARGED TO PATIENTS 500 ASC (NON-DISTINCT PART)	41, 950, 018 0	0		0	0	
75.01 075	501 CARDI AC CATHERI ZATI ON LABORATORY	1, 978, 099	230, 735	292, 780	0	915, 565	
	IPATIENT SERVICE COST CENTERS	5,075,495	202, 360	256, 775	0	48, 725	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART) ECIAL PURPOSE COST CENTERS	3,073,473	202, 300	230, 773	0	40, 723	92.00
	SUBTOTALS (SUM OF LINES 1 through 117) IREIMBURSABLE COST CENTERS	263, 871, 956	8, 868, 661	1	448, 593		1
	200 PHYSICIANS' PRIVATE OFFICES 201 OTHER NON-REIMBURSABLE	0 628, 906	0 8, 449		0		192.00 192.01
192.02 192	202 CHILDBIRTH EDUCATION	221, 882	0	0	0	0	192.02
	203 PHYSICIANS' PRIVATE OFFICES 204 PHYSICIANS' PRIVATE OFFICES	0 17 190	241, 433		0		192. 03 192. 04
	204 PHYSICIANS PRIVATE OFFICES 205 PHYSICIAN PRACTICE	17, 190 955, 636	0 0		0 209, 530		192.04 192.05
192.06 192	206 TI PTON HOSPI TAL	70, 286	2, 285	2, 899	25, 923	0	192.06
	207 WEST HOSPI TAL 208 SAXONY HOSPI TAL	274, 378 76, 631	16, 844 4, 552		51, 120 34, 902		192. 07 192. 08
200.00	Cross Foot Adjustments	70,031	4, 552	5, 776	34, 902	0	200.00
201.00	Negative Cost Centers	0// 111	0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	266, 116, 865	9, 142, 224	11, 600, 592	770, 068	11, 359, 565	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part I Date/Time Pre	pared:
Cont Conton Deconintion			DATA		5/26/2022 2:5	5 pm
Cost Center Description	EMPLOYEE BENEFI TS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASI NG RECEI VI NG AND STORES	ADMI TTI NG	
	4.00	5.01	5.02	5.03	5.04	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-INTEREST						1.01
1.02 00102 MOB LEASED SPACE						1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	13, 224, 369					2.00 4.00
5. 01 00540 NONPATIENT TELEPHONES	13, 224, 309	0				5.01
5. 02 00550 DATA PROCESSI NG	0	0	10, 496, 340			5.02
5. 03 00560 PURCHASING RECEIVING AND STORES	0	0				5.03
5. 04 00570 ADMI TTI NG	62, 215	0	95, 950	2	2, 985, 363	5.04
5. 05 00590 OTHER ADMINI STRATI VE & GENERAL	567, 951	0			0	5.05
6.00 00600 MAI NTENANCE & REPAI RS	326, 981	0			0	6.00
7.00 00700 OPERATION OF PLANT	183, 384	0			0	7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	0			0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	279, 008 125, 061	0			0	9.00 10.00
11. 00 01100 CAFETERIA	190, 361	0			0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1,047,131	0		-	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	46	0			0	14.00
15.00 01500 PHARMACY	647, 054	0	444, 859		0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	76	0	0	0	0	16.00
17.00 01700 SOCI AL SERVI CE	235, 160	0			0	17.00
18.00 01850 PATIENT TRANSPORTATION	43, 167	0	73, 969	0	0	18.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	3, 024, 718	0	2, 315, 010	43, 991	300, 953	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	3, 024, 718	0			300, 933	34.00
34. 01 03401 PEDIATRI C INTENSI VE CARE UNI T	0	0		0	0	34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT	512, 896	0	364, 377	5, 567	51, 968	34.02
43. 00 04300 NURSERY	183, 640	0	0	0	16, 981	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1 072 221	0	1 020 444	424 510	E71 00E	50.00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	1, 073, 321 471, 658	0			571, 335 82, 503	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	639, 991	0			100, 395	
54.00 05400 RADI OLOGY-DI AGNOSTI C	801, 920	0			194, 359	
55. 00 05500 RADI OLOGY – THERAPEUTI C	589, 216	0			178, 284	
56. 00 05600 RADI OI SOTOPE	46, 066	0			23, 237	1
	158, 219	0			132, 193	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	444, 251 339, 663	0 0			34, 929 21, 409	1
67. 00 06700 OCCUPATI ONAL THERAPY	94, 479	0			7, 376	
68. 00 06800 SPEECH PATHOLOGY	63, 424	0			3, 897	1
69. 00 06900 ELECTROCARDI OLOGY	79, 622	0			36, 994	
70.00 07000 ELECTROENCEPHALOGRAPHY	30, 634	0	23, 958			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	279, 287	97, 008	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	-	745, 355	228, 101	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	572, 863	•
75. 00 07500 ASC (NON-DI STINCT PART) 75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0 209, 974	0		0 24, 792	0 76, 412	•
OUTPATIENT SERVICE COST CENTERS	207, 774	0	102,700	24,772	70,412	/3.01
91.00 09100 EMERGENCY	547, 788	0	419, 621	13, 707	245, 820	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS	40.040.075		10 010 000	4 (50 770	0.005.0(0	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	13, 019, 075	0	10, 312, 233	1, 658, 772	2, 985, 363	118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0	0	0	0	192.00
192.01 19201 OTHER NON-REI MBURSABLE	16, 434	0				192.01
192. 02 19202 CHI LDBI RTH EDUCATI ON	15, 593	0	14, 887	0		192. 02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.03
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	2, 814	0				192.04
192. 05 19205 PHYSI CLAN PRACTI CE	115, 640	0				192.05 192.06
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL	10, 237 34, 854	0	6, 048 23, 609			192.06
192. 08 19208 SAXONY HOSPITAL	9, 722	0	6, 397			192.07
200.00 Cross Foot Adjustments	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0			0	200.00
201.00 Negative Cost Centers	0	0		-		201.00
202.00 TOTAL (sum lines 118 through 201)	13, 224, 369	0	10, 496, 340	1, 659, 043	2, 985, 363	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2021 o 12/31/2021		pared:
Cost Center Description	Subtotal	OTHER ADMI NI STRATI V E & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LI NEN SERVI CE	<u>5 pm</u>
	5A. 04	5. 05	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS	Γ	Γ	1	Γ	1	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	30, 412, 787 9, 768, 125 1, 866, 933 198, 825 6, 782, 701 1, 713, 789 2, 725, 871 9, 193, 381 9, 297, 859 5, 812, 338	1, 260, 381 240, 890 25, 654 875, 172 221, 130 351, 719 1, 186, 222 1, 199, 703	11, 028, 506 8, 047 166, 305 166, 305 423, 103 2 214, 669 452, 122	2, 115, 870 0 31, 930 13, 547 81, 234 41, 215 86, 805	224, 479 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$
16.00 01600 MEDICAL RECORDS & LIBRARY	488			0	-	16.00
17.00 01700 SOCIAL SERVICE	2, 290, 845			51, 391		17.00
18. 00 01850 PATIENT TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	350, 300	45, 199	0	0	0	18.00
30.00 O3000 ADULTS & PEDI ATRICS 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 34.01 03401 PEDI ATRIC INTENSI VE CARE UNI T 34.02 03402 PREMATURE INTENSI VE CARE UNI T 32.02 03402 PREMATURE INTENSI VE CARE UNI T	32, 580, 725 0 5, 209, 900	0 0 672, 233	0 0 578, 829	0 0 111, 132	0 0 26, 004	30.00 34.00 34.01 34.02
43.00 04300 NURSERY	1, 716, 198	221, 441	235, 427	45, 201	25, 979	43.00
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM	19, 923, 100 4, 240, 476					50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	8, 360, 379					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	10, 408, 964 9, 297, 782					54.00 55.00
56. 00 05600 RADI OI SOTOPE	454, 525					56.00
60. 00 06000 LABORATORY	11, 335, 395			60, 104		60.00
65. 00 06500 RESPI RATORY THERAPY	3, 547, 651					65.00
66.00 06600 PHYSI CAL THERAPY	2, 678, 784					66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	707, 102 429, 438			0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	921, 215			10, 785		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	655, 250			3, 627	0	70.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	4, 471, 414	576, 947		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	11, 902, 341 42, 522, 881	1, 535, 759 5, 486, 618		0	0	72.00 73.00
75. 00 07500 DR0GS CHARGED TO PATTENTS 75. 00 07500 ASC (NON-DI STINCT PART)	42, 522, 661			0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	3, 891, 065		347, 132	66, 648		75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	6, 810, 291 0	878, 732	304, 444	58, 452	0	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	262, 479, 118					
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0 739, 126			-		192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	252, 362			2,440		192. 01 192. 02
192. 03 19203 PHYSI CI ANS' PRI VATE OFFI CES	548, 684			69, 738		192.02
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	30, 465	3, 931		0	0	192.04
192. 05 19205 PHYSI CI AN PRACTI CE	1, 389, 273			0		192.05
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL	117, 678 422, 179					192.06 192.07
192. 07/19207/WEST HOSPITAL 192. 08/19208/SAXONY HOSPITAL	422, 179 137, 980			4, 865 1, 315		192.07 192.08
200.00 Cross Foot Adjustments	0	//,004	0, 040	1, 515		200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 266, 116, 865	0 30, 412, 787		-	0	201.00

Health Financial Systems	IU HEALTH NORT	H HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0161 P	eriod: rom 01/01/2021	Worksheet B Part I	
			Ť		Date/Time Pre 5/26/2022 2:5	pared:
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
				ADMI NI STRATI O N	SERVICES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 NEW CAP REL COSTS-INTEREST						1.01
1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						1.02 2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG						5.01 5.02
5. 03 00560 PURCHASI NG RECEI VI NG AND STORES						5.03
5. 04 00570 ADMI TTI NG 5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL						5.04 5.05
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
9. 00 00900 HOUSEKEEPI NG	7, 856, 108					9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	51, 072 306, 237	2, 070, 100				10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	155, 375	0 0	3, 888, 164 112, 398			11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	327, 241	0	0	-	11, 363, 730	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	155, 684 0	0 0	202, 316 0	0	31, 300 0	15.00 16.00
17.00 01700 SOCIAL SERVICE	193, 737	0	72, 358		0	17.00
18. 00 01850 PATI ENT TRANSPORTATI ON I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	33, 640	0	0	18.00
30. 00 03000 ADULTS & PEDIATRICS	1, 869, 130	1, 913, 680	1, 052, 834		307, 108	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T	0	0	0	0	0	34.00 34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	418, 950	0	165, 714	875, 937	38, 862	34.02
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	170, 400	0	0	315, 222	0	43.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	1, 159, 431 177, 979	0 13, 575	468, 632 170, 474		2, 963, 609	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	541, 190	98, 192	205, 172		50, 194 144, 096	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	280, 238	0	269, 543		208, 342	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	936, 648 20, 174	0	240, 240 13, 805		54, 447 0	55.00 56.00
60. 00 06000 LABORATORY	226, 582	0	179, 783		3, 508	60.00 65.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	35, 488 6, 731	0 0	151, 327 113, 191		124, 015 6, 998	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	30, 625	0	2, 990	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0 40, 657	0	19, 729 26, 923		3, 910 32	
70. 00 07000 ELECTROENCEPHALOGRAPHY	13, 674	0	10, 896	0	580	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1, 949, 731 5, 203, 351	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART) 75.01 07501 CARDIAC CATHERIZATION LABORATORY	0 251, 250	0 41, 535	0 73, 997		0 173, 077	75.00 75.01
OUTPATIENT SERVICE COST CENTERS		2 110			05 (00	01.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	220, 353	3, 118	190, 838	705, 634	95, 688	91.00 92.00
SPECIAL PURPOSE COST CENTERS	7 550 221	2 070 100	2 004 425	10 000 470	11 241 020	110.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	7, 558, 221	2,070,100	3, 804, 435	10, 888, 479	11, 361, 838	118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	9, 200	0	10, 526 6, 770			192.01 192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	262, 900	0	0	4, 499	0	192.03
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES 192. 05 19205 PHYSI CLAN PRACTI CE	0	0 0	741 49, 296	321 9, 961		192.04 192.05
192. 06 19206 TI PTON HOSPI TAL	2,488	0	2, 750	0	0	192.06
192. 07 19207 WEST HOSPI TAL 192. 08 19208 SAXONY HOSPI TAL	18, 342 4, 957	0	10, 737 2, 909			192. 07 192. 08
200.00 Cross Foot Adjustments		Ŭ				200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 7, 856, 108	0 2, 070, 100	0 3, 888, 164	-	0 11, 363, 730	201.00 202.00
	,	, ,	2, 230, 101		,	

Health Financial Systems	IU HEALTH NORT	TH HOSPI TAL		In Lie	u 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 Pre 5/26/2022 2:5	
				OTHER GENERAL		
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	SERVI CE PATI ENT	Subtotal	
		RECORDS &	SERVI CE	TRANSPORTATI 0		
	15.00	LI BRARY 16. 00	17.00	N 18.00	24.00	
GENERAL SERVICE COST CENTERS				1		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST						1.00
1.02 00102 MOB LEASED SPACE						1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATIENT TELEPHONES						4.00 5.01
5. 02 00550 DATA PROCESSI NG						5.02
5. 03 00560 PURCHASI NG RECEIVING AND STORES 5. 04 00570 ADMITTING						5.03 5.04
5. 05 00590 OTHER ADMINI STRATI VE & GENERAL						5.04
6.00 00600 MAINTENANCE & REPAIRS						6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION						11.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	7, 207, 997	551				15.00
17. 00 01700 SOCIAL SERVICE	0	551	3, 172, 14	1		17.00
18.00 01850 PATIENT TRANSPORTATION	0	0		429, 139		18.00
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	22, 154	0	2, 437, 56	43, 231	52, 106, 039	30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	02,100,007	34.00
34. 01 03401 PEDIATRI C INTENSI VE CARE UNI T	0	0			0	
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	3, 412 0	0	367, 46 367, 11		8, 475, 901 3, 099, 425	
ANCILLARY SERVICE COST CENTERS		-				
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	11, 719 15, 712	0		0 82,070 0 11,851	30, 310, 693 6, 400, 635	
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 125	0		14, 421	12, 336, 456	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 616	0		27, 919	13, 160, 556	•
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	9, 684 56	0 0		25, 610 3, 338	14, 101, 939 583, 769	•
60. 00 06000 LABORATORY	2	0		18, 989	13, 859, 652	60.00
65. 00 06500 RESPIRATORY THERAPY	12	0		5,017	4, 379, 708	•
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0 0		0 3, 075 0 1, 060	3, 171, 613 833, 014	•
68.00 06800 SPEECH PATHOLOGY	0	0		560	509, 047	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		D 5, 314 D 1, 199	1, 179, 962 788, 666	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		13, 935	7, 012, 027	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		32, 766	18, 674, 217	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 75. 00 07500 ASC (NON-DI STI NCT PART)	7, 089, 243	0		0 82, 593 0 0	55, 181, 335 0	73.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	14, 580	0		10, 976	5, 630, 671	75.01
	22,222	a		0 05 014	0 335 003	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	22, 232	0		35, 311	9, 325, 093	91.00 92.00
SPECIAL PURPOSE COST CENTERS		1				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	7, 207, 547	551	3, 172, 14	1 429, 139	261, 120, 418	118.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 OTHER NON-REI MBURSABLE	0	0		0 0	869, 372	192.01
192. 02 19202 CHI LDBI RTH EDUCATI ON 192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0 450	0			291, 694 1, 320, 295	
192. 04 19204 PHYSI CLANS' PRI VATE OFFI CES	430	0				192.03
192. 05 19205 PHYSI CI AN PRACTI CE	0	0		0 0	1, 628, 301	
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL		0			142, 197 535, 938	•
192. 08 19208 SAXONY HOSPI TAL	0	0			171, 813	192.08
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 7, 207, 997	0 551	3, 172, 14	0 0 1 429, 139	0 266, 116, 865	201.00
		551	5, 172, 14		200, 110, 000	

Health Financial Systems	IU HEALTH NORT	TH HOSPI TAL	In Lieu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0161	Period: Worksheet B	
			From 01/01/2021 Part I To 12/31/2021 Date/Time Pre	
Cost Center Description	Intern &	Total	5/26/2022 2:5	<u>5 pm</u>
	Resi dents			
	Cost & Post			
	Stepdown Adjustments			
	25.00	26.00		
GENERAL SERVICE COST CENTERS	1 1			1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST				1.00 1.01
1. 02 00102 MOB LEASED SPACE				1.01
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 01 00540 NONPATI ENT TELEPHONES				5.01
5. 02 00550 DATA_PROCESSING 5. 03 00560 PURCHASING_RECEIVING_AND_STORES				5.02 5.03
5. 04 00570 ADMI TTI NG				5.04
5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL				5.05
6.00 00600 MAINTENANCE & REPAIRS				6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE				7.00 8.00
9. 00 00900 HOUSEKEEPING				9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
14. 00 01400 CENTRAL_SERVI CES & SUPPLY 15. 00 01500 PHARMACY				14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17.00 01700 SOCIAL SERVICE				17.00
18.00 01850 PATI ENT TRANSPORTATI ON				18.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	52, 106, 039		30.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	52, 100, 039		30.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	o		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	0	8, 475, 901		34.02
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	3, 099, 425		43.00
50. 00 05000 OPERATING ROOM	0	30, 310, 693		50.00
51.00 05100 RECOVERY ROOM	0	6, 400, 635		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 336, 456		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	0	13, 160, 556		54.00 55.00
56. 00 05500 RADI 0LOGT - THERAPEUTIC	0	14, 101, 939 583, 769		56.00
60. 00 06000 LABORATORY	0	13, 859, 652		60.00
65. 00 06500 RESPI RATORY THERAPY	0	4, 379, 708		65.00
66. 00 06600 PHYSI CAL THERAPY	0	3, 171, 613		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	833, 014 509, 047		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 179, 962		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	788, 666		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7,012,027		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	18, 674, 217		72.00 73.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	55, 181, 335 0		75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	5, 630, 671		75.01
OUTPATIENT SERVICE COST CENTERS		0.005.000		0.0.5.5
91.00 09100 EMERGENCY	0	9, 325, 093		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0			92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	261, 120, 418		118.00
NONREI MBURSABLE COST CENTERS				
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	0	869, 372 291, 694		192.01 192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFICES	0	1, 320, 295		192.02
192. 04 19204 PHYSI CI ANS' PRI VATE OFFI CES	0	36, 837		192.04
192. 05 19205 PHYSI CI AN PRACTI CE	0	1, 628, 301		192.05
192. 06 19206 TI PTON HOSPI TAL	0	142, 197		192.06
192. 07 19207 WEST HOSPI TAL 192. 08 19208 SAXONY HOSPI TAL	0	535, 938 171, 813		192. 07 192. 08
200.00 Cross Foot Adjustments	0	0		200.00
201.00 Negative Cost Centers	0	o		201.00
202.00 TOTAL (sum lines 118 through 201)	0	266, 116, 865		202.00

OCATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-0161 Pe	eriod: 	Worksheet B Part II	
					Date/Time Pre	
			CAPI TAL REL	ATED COSTS	5/26/2022 2:5	
Cost Center Description	Directly	NEW BLDG &	NEW INTEREST	MOB LEASED	NEW MVBLE	-
oust outer bescription	Assigned New Capital	FLXT	NEW THTEREST	SPACE	EQUI P	
	Related Costs	1.00	1 01	1.00	2.00	-
GENERAL SERVICE COST CENTERS	0	1.00	1.01	1.02	2.00	-
00 00100 NEW CAP REL COSTS-BLDG & FIXT						1
01 00101 NEW CAP REL COSTS-INTEREST						1
02 00102 MOB LEASED SPACE						1
00 00200 NEW CAP REL COSTS-MVBLE EQUIP 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	24, 885	31, 577	12, 026	1, 390	2
01 00540 NONPATIENT TELEPHONES	0	24, 885	31, 377	12, 020	1, 370	
00550 DATA PROCESSI NG	0	141, 997	180, 181	7, 053	0	
03 00560 PURCHASING RECEIVING AND STORES	0	0	0	0	0	
	0	28, 623	36, 319	0	152	
05 00590 OTHER ADMINISTRATIVE & GENERAL 00 00600 MAINTENANCE & REPAIRS	0	282, 560 1, 333, 645	358, 541 1, 692, 266	139, 903 16, 989	146, 838 132, 199	
00 00700 OPERATION OF PLANT	0	5, 349	6, 787	1, 838	7, 080	
00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8
00 00900 HOUSEKEEPI NG	0	110, 541	140, 265	4, 302	1, 896	
00 01000 DI ETARY	0	46, 901	59, 513	0	6, 099	
00 01100 CAFETERIA 00 01300 NURSING ADMINISTRATION	0	281, 232 142, 688	356, 856 181, 057	0	42, 323 1, 440, 071	
00 01400 CENTRAL SERVICES & SUPPLY	0	300, 520	381, 331	0	1, 440, 0, 1	
00 01500 PHARMACY	0	142, 972	181, 417	0	100, 676	15
00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	
00 01700 SOCIAL SERVICE	0	177, 917	225, 760	0	0	
00 01850 PATIENT TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	18
00 03000 ADULTS & PEDIATRICS	0	1, 716, 506	2, 178, 082	0	240, 525	30
00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	
01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	
02 03402 PREMATURE INTENSIVE CARE UNIT 00 04300 NURSERY	0	384, 741 156, 486	488, 199 198, 565	5, 402 0	66, 991 8, 839	
ANCI LLARY SERVI CE COST CENTERS	Y	130, 400	170, 303	V	0,037	`
00 05000 OPERATI NG ROOM	0	1, 064, 759	1, 351, 075	0	3, 301, 713	50
00 05100 RECOVERY ROOM	0	163, 447	207, 398	0	33, 132	
00 05200 DELIVERY ROOM & LABOR ROOM	0	497,000	630, 644	100.050	163, 903	
00 05400 RADI OLOGY-DI AGNOSTI C 00 05500 RADI OLOGY - THERAPEUTI C	0	257, 356 860, 167	326, 559 1, 091, 468	192, 850 0	3, 085, 313 1, 221, 588	
00 05600 RADI OI SOTOPE	0	18, 527	23, 509	0	21, 563	
00 06000 LABORATORY	0	208, 081	264, 034	0	0	
00 06500 RESPI RATORY THERAPY	0	32, 590	41, 354	0	101, 147	
00 06600 PHYSICAL THERAPY 00 06700 OCCUPATIONAL THERAPY	0	6, 181 0	7, 844	68, 230 0	11, 300	60
00 06800 SPEECH PATHOLOGY	0	0	0	0	1, 742	
00 06900 ELECTROCARDI OLOGY	0	37, 337	47, 377	0	148, 205	
00 07000 ELECTROENCEPHALOGRAPHY	0	12, 558	15, 935	0	49, 586	
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	
00 07200 I MPL. DEV. CHARGED TO PATI ENT 00 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0	
00 07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	230, 735	292, 780	0	915, 565	7!
OUTPATIENT SERVICE COST CENTERS			05 (775			
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	202, 360	256, 775	0	48, 725	91
SPECIAL PURPOSE COST CENTERS						72
3.00 SUBTOTALS (SUM OF LINES 1 through 117) 0	8, 868, 661	11, 253, 468	448, 593	11, 298, 561	118
NONREI MBURSABLE COST CENTERS		.1				
2. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0	0	0		192
2. 01 19201 OTHER NON-REIMBURSABLE 2. 02 19202 CHI LDBI RTH EDUCATI ON	0	8, 449	10, 720 0	0	51, 473 0	192
2. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0	241, 433	306, 355	0		192
2. 04 19204 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	Ö	8, 635	
2. 05 19205 PHYSI CI AN PRACTI CE	0	0	0	209, 530		192
2. 06 19206 TI PTON HOSPI TAL	0	2, 285	2,899	25, 923		192
2. 07 19207 WEST HOSPI TAL 2. 08 19208 SAXONY HOSPI TAL	0	16, 844 4, 552	21, 374 5, 776	51, 120 34, 902		192 192
0.00 Cross Foot Adjustments		4,002	5,770	54, 702	0	200
I.00 Negative Cost Centers		о	0	0	0	201
2.00 TOTAL (sum lines 118 through 201)	0	9, 142, 224	11, 600, 592	770, 068	11, 359, 565	loor

ALLECATION OF CARTAL RELATED COSTS Provider COL 15-0161 Perf of the 12/2/2022 Deckmeet B (2/2/2022 speed) Cost Center Description Subtotal LancyTE Deckments NOVMATIENT TELEMINES NOVMATIENT TELEMINES NOVMATIENT NULLEMINES NOVMATIENT NUL	Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Const Center Description Subtoreal Print Transmission Data Print Print Const Center Description Subtoreal Print Print Print </td <td></td> <td></td> <td></td> <td></td> <td>eri od:</td> <td>Worksheet B</td> <td></td>					eri od:	Worksheet B	
Cost Content Description Subicital PPLAYEE BRAFTS PARTATENT DEPLAYEE BRAFTS DATA PROCESSING PLPCAYES PLACESSING 1:00 DOUGN RAY CAP REL COST CENTERS 1:00 20 5,01 5,02 5,00 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 5,01 5,02 1,00 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 00000 RAY CAP REL COSTS CENTERS 1:00 1,00 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 00000 RAY CAP REL COSTS CENTERS 1:00 1,00 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 00000 RAY CAP REL COSTS CENTERS 1:00 1,00 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 000 0 0 0 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 0 0 0 0 0 0 1:00 DOUGN RAY CAP REL COSTS CENTERS 1:00 0 </td <td></td> <td></td> <td></td> <td></td> <td>b 12/31/2021</td> <td>Date/Time Pre</td> <td>pared:</td>					b 12/31/2021	Date/Time Pre	pared:
BEREFITS FLEPPONES PROCESSING RECEIVING AND 1.00 OTION US OF ALL COST-INTERS 24 4.00 5.01 5.02 5.03 1.00 OTION US OF APEL COST-INTERSIT 0 1.00 1.00 1.00 1.00 OTION US OF APEL COST-INTERSIT 0.0 1.00 1.00 2.00 OUTON US OF APEL COST-INTERSIT 0.0 0.0 2.00 0.000 Deriver Bayer Bayer TS DEPARTIEST 0.0 1.00 2.00 OUTON US OF APENDET ELEVENTERSIT 0.0 <td< td=""><td>Cost Center Description</td><td>Subtotal</td><td>EMPLOYEE</td><td>NONPATI ENT</td><td>DATA</td><td></td><td>5 pm</td></td<>	Cost Center Description	Subtotal	EMPLOYEE	NONPATI ENT	DATA		5 pm
GENERAL STRUCT CONTROL 2A 4.00 5.01 5.02 5.03 100 CODEN INTA CAP ENT CONTROL 1.00 1.00 CODEN INTA CAP ENT CONTROL 1.00 100 CODEN INTA CAP ENT CONTROL 1.00 CODEN INTA CAP ENT CONTROL 1.00 100 CODEN INTA CAP ENT CONTROL 1.00 1.00 1.00 100 CODEN INTA CAP ENT CONTROL 0.00 2.00 0.00 2.00 100 CODEN INTA CAP ENT CONTROL 0.00 0.00 2.00 0.0			BENEFI TS			RECEIVING AND	
EXEMPL SERVICE COST CONTENT Image: control Mark Ord PEL DOST-ATTREEST Image: control Mark Ord PEL DOS		24		5.01	5.02		
1.0101 LEW CAP REL: COSTS - MARREST 1.01 2.00 DOUCDO LEW CAP REL: COSTS - MARREST 60, 673 2.00 DOUCDO LEW CAP REL: COSTS - MARREST 60, 673 2.00 DOSSO LATA: FROMESTING 60, 673 3.01 DOSSO LATA: FROMESTING 329, 231 3.01 DOSSO LATA: FROMESTING 60, 673 3.01 DOSSO LATA: FROMESTING 60, 673 3.01 DOSSO LATA: FROMESTING 60, 673 3.01 DOSSO LATA: FROMESTING THE FROMESTING 60, 674 3.01 DOSSO LATA: FROMESTING 61, 600 3.01 DOSSO LATA: FROMESTING 61, 600 3.01 DOSSO LATA: FROMESTING 61, 60	GENERAL SERVICE COST CENTERS	211	1.00	0.01	0.02	0.00	
1.02 00102 MOB LEASED SPACE 1.02 1.02 0.0020 MOB CAP REL COSTS-MAULE EQUIP 4.00 1.02 0.00 4.00 0.000 MAR OVER CAP REL COSTS-MAULE EQUIP 4.00 1.02 0.00 4.00 0.000 MAR OVER STREED 2.92,231 0 0 0.00 5.00 0.000 MAR OVER STREED 2.92,231 0 0 0.00 5.00 0.000 MAR OVER STREED 2.92,231 0.010 0 5.00 0.0000 MAR OVER STREED IN CONSTRUCT IN A DOTORES 0.0 0 0.00 0 0.00 0							
2.00 00200 LEW CAP KEL COSTS-MVBLE EXUP 40,978 60,978 60,978 70							
5.01 00540 00MMAR PROCESSING 3.9 0 0 3.9 5.00 000500 00660 00660 00 0 0.9							
5. 02 00550 DATA PROCESSI NG 329, 231 0 0 329, 231 5. 02 6. 00 DOSTO APMITTING 6 65, 004 329 0 3, 010 5 04 6. 00 DOSTO APMITTING FILE 66, 004 329 0 3, 010 5 04 6. 00 DOSTO APMITTING FILE 66, 004 0		69, 878					
5.03 00560 00560 0 <t< td=""><td></td><td>0 329-231</td><td>-</td><td></td><td>329 231</td><td></td><td></td></t<>		0 329-231	-		329 231		
5. 05 000500 [OTHER ADM IN STRATI VE & EXERAL 927, 842 3,001 0 11, 922 5, 05 0.00 00600 [OPERATION OF PLANT 21, 054 969 0 0,000 0<			-	-		0	
6. 00 06600 [MAINTERNANCE & REPAIRES 3.175,099 1.728 0 8.449 0 6.00 0				-			
7. 00 00700 (OPERATION OF PLANT 21,054 969 0 7.000 0 7.000 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
8.00 000000 LAURDRY & LI NEN SERVICE 0 <							
10.00 01000 D1 CHETRAY 112, 513 661 0 6, 340 0 10.00 11.00 01000 CAFTERIA 680, 411 1, 060 0 9, 332 0 11.00 13.00 01300 NURSING ADM INISTRATION 1, 763, 816 5, 533 0 7, 752 0 13.00 14.00 D1400 PHAMAKCY 425, 665 3, 419 0 0 0 0 0 16.00 0						0	8.00
11.00 01100 CAFETERIA 660, 411 1.006 0 9, 332 0 11.00 13.00 01300 CENTRAL SERVICES & SUPPLY 661, 851 0 0 0 0 14.00 0 0 0 0 0 14.00 0 0 0 0 0 14.00 0							
13.00 01300 NURSI NG ADMI NI STRATION 1, 763, 816 5, 533 0 7, 752 0 13.00 14.00 01400 CHIRAL SERVICES & SUPPLY 461, 851 0 0 0 0 14.00 15.00 01500 PHARMACY 425, 065 3, 419 0 13.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
15:00 OTSOD PHARMACY 425,065 3,419 0 13,954 0 15:00 16:00 OTOD SCI LBRARY 0 0 0 0 0 0 16:00 17:00 OTTOD SCI LL SERVICE 443,677 1.243 0 4,990 0 17:00 18:00 OTSOD SCI LL SERVICE 0 222 0 2,320 0 18:00 19:00 OSAGO SCI LL SERVICE COST CENTERS 0 72,611 0 0 0 34:00 0 34:00 36:00 0 0 0 0 36:00 0 0 0 36:00							
16.00 01000 UEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 0 0 16.00 17.00 01705 001850 PATIENT TRANSPORTATION 0 0 228 0 2,320 0 18.00 18.00 01850 PATIENT TRUTINE COST CENTERS			-		-		
17.0.0 [01700] SOCIAL SERVICE 403.677 1,243 0 4.990 0 17.00 18.00 [1500] PATIENT RANSPORTATION 0 228 0 2.320 0 18.00 18.00 [1500] AULTS & PENJATRIC S 4,135.113 15.987 0 72.611 0 30.00 34.00 [3300] AULTS & PENJATRIC S 4,135.113 15.987 0 0 0 0 34.01 34.01 [3401] PENJATRIC TRENSIVE CARE UNI T 945.333 2,710 0 11.429 0 34.02 34.02 [3400] OUPSERTIVE COST CENTERS					13, 954		
18. 00 D1850 PATTENT TRANSPORTATION 0 228 0 2, 320 0 18. 00 10. 00 03000 ADULTS & PEDI ATRIC S 4, 135, 113 15, 987 0 72, 611 0 30. 00 34. 00 36. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 55. 00 56. 00 56. 00 56. 00			-		4, 990		
30.00 03000 ADULTS & PEDIATRIC SARE UNIT 4,135,113 15,987 0 72,611 0 30.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0	18.00 01850 PATIENT TRANSPORTATION			0	2, 320	0	18.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT 0		4 125 112	15 007	0	70 411	0	20.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0 0 34.01 34.02 034001 PREMATINE INTENSIVE CARE UNIT 945,333 2,710 0 11,429 0 34.00 360.00 00000 0 0 363,890 970 0 0 0 34.00 ARCILLARY SERVICE COST CENTERS 0 32,321 0 50.00 65.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
43.00 0 <td>34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT</td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>0</td> <td></td>	34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	0		-	0	
ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROM 5,717,547 5,671 0 32,321 0 50.00 51.00 D05000 OPERATING ROM 403,977 2,492 0 11,757 0 51.00 52.00 D5200 DELIVERY ROM & LABOR ROM 1,291,547 3,382 0 14,151 0 52.00 54.00 D5400 RADIOLOGY - INERAREUTI C 3,173,223 3,113 0 16,569 55.00 50.00 D6500 RADIOLOGY - INERAREUTI C 3,173,223 3,113 0 16,569 55.00 60.00 D6500 RADIOLOGY - INERARENY 472,115 836 0 12,400 60.00 60.00 D6500 CRESPIR RATORY THERAPY 175,091 2,347 0 16,437 66.00 60.00 D6600 SRESPIR RATORY THERAPY 93,555 1,795 0 7,807 6 60.00 70.00 D100 CAL THERAPY 93,555 1,797 162 0 75.00 70.00 70.00 71.00 68.00 68.00							
50.00 05000 05000 051.00 57.77, 547 5.671 0 32, 321 0 50.00 51.00 05000 REDVERY ROM 403, 977 2, 492 0 11, 757 0 51.00 52.00 05200 DELIVERY ROM & LABOR ROM 1, 291, 547 3, 382 0 14, 151 0 52.00 54.00 054000 RADIOLOCY-DI AGNOSTIC 3, 662, 078 4, 237 0 18, 590 0 55.00 55.00 055000 RADIOLOCY-DI AGNOSTIC 3, 632, 078 4, 237 0 18, 590 0 55.00 56.00 05600 RADIOLOCY - THERAPEUTIC 3, 173, 223 3, 113 0 16, 569 0 55.00 0.00 06000 LABORATORY 472, 115 836 0 12, 400 0 60.00 60.00 66.00 06600 PHYSICAL THERAPY 75, 107 79 780 7807 6 60.00 60.00 67.00 06700 OCCUPATI ONAL THERAPY 1, 742 335 0 1, 361 6 60.00 0 0 00000 0 0		363, 890	970	0	0	0	43.00
52.00 05200 DELLVERY ROOM & LABOR ROOM 1.291,547 3.382 0 14.151 0 52.00 54.00 05400 RADI LOGY ~DI AGNOSTI C 3.862,078 4.237 0 18.590 0 54.00 55.00 05500 RADI OLOGY - THERAPEUTI C 3.173,223 3,113 0 16.569 0 56.00 60.00 06000 LABORATORY 472,115 836 0 12.400 0 66.00 60.00 66000 HSIGAL THERAPY 175,091 2,347 0 10.437 65.00 60.00 66000 SPECIAL THERAPY 93,555 1.795 0 7.807 0 66.00 67.00 66700 OCCUPAT LONAL THERAPY 93,219 421 0 1.857 0 68.00 69.00 068000 SPECIAL MARCED TO PATI ENTS 0 0 0 0 71.00 70.00 73.00 73.00 73.00 73.00 73.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.		5, 717, 547	5, 671	0	32, 321	0	50.00
54.00 05400 RADIOLOGY-DIARNOSTIC 3.862.078 4.237 0 18.590 0 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 3.173.223 3.113 0 16.569 0 55.00 56.00 05600 RADIOLOGY-THERAPEUTIC 3.173.223 3.113 0 16.569 0 55.00 66.00 06000 RADRATORY 472.115 836 0 12.400 0 60.00 65.00 06500 RSPI RATORY THERAPY 175.091 2.347 0 10.437 0 65.00 66.00 06000 CUPATIONAL THERAPY 93.555 7.795 0 7.807 66.00 67.00 06700 00000 CUPATIONAL THERAPY 232.919 421 0 1.857 0 0 0 0 0 0 71.00 72.00 7000 0500 ASC (NON-DISTINCT PATIENTS 0 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00							
55:00 00 05500 RADIOLOGY - THERAPEUTIC 3, 173, 223 3, 113 0 16, 569 0 55.00 60:00 06000 LABORATORY 63, 559 243 0 952 56.00 60:00 06000 LABORATORY 472, 115 836 0 12, 400 60.00 65:00 06500 PHYSICAL THERAPY 175, 091 2, 347 0 10, 437 0 65.00 60:00 06600 PHYSICAL THERAPY 93, 555 1, 795 0 7, 807 0 66.00 60:00 06600 PHYSICAL THERAPY 0 499 0 2, 112 0 67.00 60:00 06600 PHYSICAL THERAPY 0 499 0 1, 351 0 68.00 60:00 06000 DECITROENCEPHALOGRAPHY 742 335 0 1, 351 0 69.00 <							
60.00 06000 LABORATORY 472, 115 836 0 12, 400 0 60.00 65.00 065000 RESPI RATORY THERAPY 175, 091 2, 347 0 10, 437 0 65.00 66.00 06600 PHEYSI CAL THERAPY 0 499 0 2, 112 0 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 499 0 2, 112 0 67.00 68.00 068000 PEECH PATHOLOCY 1, 742 335 0 1, 361 0 69.00 69.00 69000 ELECTROCARDI OLOGY 232, 919 421 0 1, 857 0 69.00 70.00 07000 ELECTROCARDI OLOGY 232, 919 421 0 0 0 0 70.00 70.00 70.00 0 0 0 0 0 70.00<							
65.00 06500 RESPI RATORY THERAPY 175,091 2,347 0 10,437 0 65.00 66.00 06600 06700 000 7,807 0 66.00 67.00 06700 000 000 7,807 0 66.00 67.00 06700 000 000 1,742 335 0 1,361 0 68.00 69.00 06900 ELECTROCARDIOLOGY 232,919 421 0 1,857 0 69.00 70.00 07000 ELCTROCARDIOLOGY 232,919 421 0 0 0 0 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 0 0 0 70.00 70.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 75.00 75.00 75.00 75.00 75.00 75.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
66.00 06000 PHYSI CAL THERAPY 93,555 1,795 0 7,807 0 66.00 67.00 06700 0CCUPATI INAL THERAPY 0 499 0 2,112 0 67.00 68.00 06800 SPEECH PATHOLOGY 1,742 335 0 1,361 0 68.00 069.00 06900 ELCTROCARDI OLOGY 232,919 421 0 1,857 0 69.00 70.00 OTOOD ELECTROCARDI OLOGY 232,919 421 0 1,857 0 69.00 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td>				-			
68.00 06800 SPEECH PATHOLOGY 1,742 335 0 1,361 0 68.00 69.00 06900 ELECTROCARDIOLOGY 232,919 421 0 1,857 0 69.00 70.00 7000 ELECTROCARDIOLOGY 232,919 421 0 1,857 0 69.00 71.00 ORODE ELECTROCARDIOLOGY 78.079 162 0 751 0 70.00 71.00 OTOOL LECTROCARDIALOGRAPHY 78.079 162 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 73.00 73.00 0 0 0 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.01 75.01 75.01 75.01 75.01 75.01 75.01 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.00 75.01 75.01 75.01 75.01 75.01				-			
69.00 06900 ELECTROCARDIOLOGY 232,919 421 0 1,857 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 78,079 162 0 751 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 75.01 07501 ASC (NON-DISTINCT PART) 0 0 0 0 75.01 07501 07501 CATHERIZATION LABORATORY 1,439,080 1,109 0 5,104 0 75.01 07501 09100 EMEGENCY 507,860 2,894 0 13,162 0 91.00 92.00 92.00 09200 DBESERVATION BEDS (NON-DISTINCT PART) 0 323,455 0 18.00 192.01 0 13,162 0 192.01 192.01 192.01 192.01 192.01 192.01<		0		-		0	
70.00 07000 ELECTROENCEPHALOGRAPHY 78,079 162 0 751 0 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
71.00 V7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 <td< td=""><td></td><td></td><td></td><td>0</td><td></td><td></td><td></td></td<>				0			
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0 75.00 75.00 75.00 0 75.01 0 0 0 0 0 0 0 0 0 0 0 75.00 75.00 75.00 0 75.00 0 0 0 0 75.00 0 75.00 0 75.00 0 0 0 0 75.00 0 75.00 0 75.00 0 0 0 0 0 75.00 75.00 75.00 75.00 0 <td>71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>1</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>71.00</td>	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1		0		0	71.00
75.00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 75.01 0 75.01 0		0	-	-	0		
75.01 O7501 CARDIAC CATHERIZATION LABORATORY 1,439,080 1,109 0 5,104 0 75.01 0UTPATIENT SERVICE COST CENTERS 91.00 99100 EMERGENCY 507,860 2,894 0 13,162 0 91.00 92.00 9200 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 91.00 92.00 9200 0BSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 92.00 9200 0BSERVATION BEDS (NON-DISTINCT PART) 0 323,455 0 118.00 91.00 92.00 92.00 9200 0DVENTION BEDS (NON-DISTINCT PART) 0 323,455 0 118.00 118.00 118.00 0 323,455 0 118.00 118.00 192.00 192.01 192.01 192.02 01 192.01 192.02 0 192.00 192.02 0 192.00 192.02 0 192.00 192.02 0 192.00 192.02 0 192.00 192.02 0 192.02 0 192.02 0 192.02 0 192.02 0 192.02 0 192.02 0 192.02 <td></td> <td>0</td> <td>•</td> <td>-</td> <td>0</td> <td></td> <td></td>		0	•	-	0		
91. 00 09100 EMERGENCY 507, 860 2, 894 0 13, 162 0 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 13, 162 0 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 869, 283 68, 794 0 323, 455 0 118. 00 NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192. 01 192.01 179201 OTHER NON-REI MBURSABLE 70, 642 87 0 726 0 192. 02 192.02 CHI LDBI RTH EDUCATI ON 0 82 0 467 0 192. 02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 548, 684 0 0 0 0 192. 02 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 8, 635 15 0 10 192. 02 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 8, 635 15		1, 439, 080	1, 109	-	5, 104		
92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 31,869,283 68,794 0 323,455 0 118.00 NONRE I MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 0 82 0 467 0192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFI CES 548,684 0 0 0 192.02 192.04 19204 PHYSI CI ANS' PRI VATE OFFI CES 8,635 15 0 51 0 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFI CES 8,635 15 0 51 0 192.04 192.05 19205 PHYSI CI AN S' PRI VATE OFFI CES 8,635 15 0 192.		507.0(0	0.004		40.470		01 00
SPECIAL PURPOSE COST CENTERS Image: Cost centers <thimage: centers<="" cost="" th=""> Image: Cost cente</thimage:>			2, 894	0	13, 162	0	
NONRET MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.02 19200 CHI LDBI RTH EDUCATI ON 0 82 0 726 0 192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFI CES 548,684 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFI CES 548,684 0 0 0 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFI CES 8,635 15 0 51 0 192.04 192.05 19205 PHYSI CI AN PRACTI CE 209,530 611 0 3,400 0 192.05 192.06 19206 TI PTON HOSPI TAL 31,107 54 0 190 0 192.06 192.07 19207 WEST HOSPI TAL 89,338 184 0 <	SPECIAL PURPOSE COST CENTERS						72.00
192.00 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.01 19201 OTHER NON-REI MBURSABLE 70, 642 87 0 726 0 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 0 82 0 467 0 192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 548, 684 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 548, 684 0 0 0 192.03 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 548, 684 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 8, 635 15 0 51 0 192.04 192.05 19205 PHYSI CI AN PRACTICE 209, 530 611 0 3, 400 0 192.06 192.06 19206 TI PTON HOSPI TAL 31, 107 54 0 192.07 192.07 192.07 192.07 192.07 192.07 192.07 192.07 192.07 192.07		31, 869, 283	68, 794	0	323, 455	0	118.00
192.01 0THER NON-REI MBURSABLE 70, 642 87 0 726 0 192.01 192.02 19202 CHI LDBI RTH EDUCATI ON 0 82 0 467 0 192.02 192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 548, 684 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 548, 684 0 0 0 192.04 192.05 19205 PHYSI CI ANS' PRI VATE OFFICES 8, 635 15 0 51 0 192.04 192.05 19206 TI PTON HOSPI TAL 209, 530 611 0 3, 400 0 192.05 192.06 19206 TI PTON HOSPI TAL 31, 107 54 0 190.07 192.07 192.07 WEST HOSPI TAL 89, 338 184 0 741 0 192.08 192.08 19208 SAXONY HOSPI TAL 45, 230 51 0 201 0 192.08 200.00 Cross Foot Adj ustments 0 0 0 0 200.00 201.00		0	0	0	0	0	192 00
192.03 19203 PHYSI CI ANS' PRI VATE OFFICES 548,684 0 0 0 192.03 192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 8,635 15 0 51 0 192.04 192.05 19205 PHYSI CI AN PRACTI CE 209,530 611 0 3,400 0 192.05 192.06 19206 TI PTON HOSPI TAL 31,107 54 0 190 192.06 192.07 19207 WEST HOSPI TAL 89,338 184 0 741 0 192.07 192.08 SAXONY HOSPI TAL 45,230 51 0 201 0 192.08 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00		70, 642		-	-		
192.04 19204 PHYSI CI ANS' PRI VATE OFFICES 8,635 15 0 51 0 192.04 192.05 19205 PHYSI CI AN PRACTICE 209,530 611 0 3,400 192.05 192.06 19206 TI PTON HOSPI TAL 31,107 54 0 190 0 192.06 192.07 19207 WEST HOSPI TAL 89,338 184 0 741 0 192.07 192.08 SAXONY HOSPI TAL 45,230 51 0 201 0 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 0		0		0			
192.05 PHYSI CI AN PRACTICE 209, 530 611 0 3, 400 192.05 192.06 19206 TI PTON HOSPI TAL 31, 107 54 0 190 192.06 192.07 19207 WEST HOSPI TAL 89, 338 184 0 741 0 192.07 192.08 19208 SAXONY HOSPI TAL 45, 230 51 0 201 0 192.08 200.00 Cross Foot Adj ustments 0 0 0 0 0 201.00			-	0	-		
192.06 19206 TI PTON HOSPI TAL 31, 107 54 0 190 192.06 192.07 19207 WEST HOSPI TAL 89, 338 184 0 741 0 192.07 192.08 19208 SAXONY HOSPI TAL 45, 230 51 0 201 0 192.08 200.00 Cross Foot Adjustments 0 0 0 0 201.00				0		0	192.05
192.08 SAXONY HOSPITAL 45,230 51 0 201 0 192.08 200.00 Cross Foot Adjustments 0 0 200.00 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	192. 06 19206 TI PTON HOSPI TAL	31, 107	54	0	190	0	192.06
200.00 Cross Foot Adjustments 0 200.00				0			
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td>51</td> <td>0</td> <td>201</td> <td></td> <td></td>			51	0	201		
202.00 TOTAL (sum lines 118 through 201) 32,872,449 69,878 0 329,231 0 202.00	201.00 Negative Cost Centers	0	0		0	0	201.00
	202.00 TOTAL (sum lines 118 through 201)	32, 872, 449	69, 878	0	329, 231	0	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 2:5	pared:
Cost Center Description	ADMI TTI NG	OTHER ADMI NI STRATI V E & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	<u> </u>
	5.04	5.05	6.00	7.00	8.00	
GENERAL SERVICE COST CENTERS		1	1	[]		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 00600 MEDI CAL RECORDS & LI BRARY	68, 433 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	942, 765 39, 073 7, 468 795 27, 131 6, 855 10, 903 36, 774 37, 191 23, 249	3, 224, 349 2, 353 0 48, 622 20, 630 123, 701 62, 762 132, 185	38, 844 0 586 249 1, 491 757	795 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$
17.00 01700 SOCIAL SERVICE	0			943	0	17.00
18. 00 01850 PATIENT TRANSPORTATION	0	1, 401	0	0	0	18.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 34.01 03401 PEDI ATRI C INTENSI VE CARE UNI T 34.02 03402 PREMATURE INTENSI VE CARE UNI T 34.02 04300 NURSERY 43.00 04300 NURSERY	6, 907 0 0 1, 193 390	0 0 20, 840	0 0 169, 229	0	611 0 0 92 92	30. 00 34. 00 34. 01 34. 02 43. 00
ANCI LLARY SERVI CE COST CENTERS	12 112	70,602	160 227	5 6/6	0	50.00
50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 112 1, 893 2, 304 4, 460	16, 962 33, 442 41, 636	71, 892 218, 607 113, 199	867 2, 636 1, 365	0 0 0 0	50.00 51.00 52.00 54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 60. 00 06000 LABORATORY	4, 092 533 3, 034	1, 818	8, 149		0 0 0	55.00 56.00 60.00
65. 00 06500 RESPI RATORY THERAPY	802				0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	491 169				0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	89			0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	849			198	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	192			67	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 226 5, 235			0	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	13, 067			0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 754	15, 564	101, 489	1, 224	0	75.01
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 641	27, 241	89,009	1, 073	0	91.00 92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	68, 433	928, 213	3, 104, 022	37, 394	795	118.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			-		192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	0			45		192. 01 192. 02
192. 02 19202 CHILDBERTH EDUCATION 192. 03 19203 PHYSI CLANS' PRI VATE OFFI CES	0	1, 009 2, 195		1, 280		192.02 192.03
192. 04 19204 PHYSI CI ANS' PRI VATE OFFI CES	0			0	0	192.04
192. 05 19205 PHYSI CLAN PRACTI CE	0	5, 557	0	0	0	192.05
192. 06 19206 TI PTON HOSPI TAL	0	471				192.06
192. 07 19207 WEST HOSPI TAL 192. 08 19208 SAXONY HOSPI TAL	0	1, 689 552				192. 07 192. 08
200.00 Cross Foot Adjustments	0	352	2,002	24		200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	68, 433	942, 765	3, 224, 349	38, 844	795	202.00

Health Financial Systems	IU HEALTH NOR	TH_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 2:5	pared: 5 pm
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	
	9.00	10.00	11.00	13.00	14.00	
GENERAL SERVICE COST CENTERS	1 1					1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00570 ADMI TTI NG 5.05 00590 OTHER ADMI NI STRATI VE & GENERAL 6.00 00600 MAI NTENANCE & REPAI RS 7.00 00700 OPERATI ON OF PLANT 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE </td <td>349, 832 2, 274 13, 637 6, 919 14, 572 6, 933 0 8, 627</td> <td>149, 522 0 0 0 0 0 0 0 0</td> <td>840, 481 24, 296 0 43, 733 0 15, 641</td> <td>0 0 0</td> <td>867, 393 2, 389 0 0</td> <td>15. 00 16. 00 17. 00</td>	349, 832 2, 274 13, 637 6, 919 14, 572 6, 933 0 8, 627	149, 522 0 0 0 0 0 0 0 0	840, 481 24, 296 0 43, 733 0 15, 641	0 0 0	867, 393 2, 389 0 0	15. 00 16. 00 17. 00
18.00 01850 PATIENT TRANSPORTATION I NPATIENT ROUTINE SERVICE COST CENTERS	0	0	7,272	0	0	18.00
30. 00 03000 ADULTS & PEDIATRICS 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY	83, 232 0 0 18, 656 7, 588	138, 224 0 0 0 0 0	227, 587 0 35, 821 0	0 153, 332	23, 441 0 2, 966 0	30.00 34.00 34.01 34.02 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	51, 629	0	101, 301	213, 911	226, 209	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	7, 925 24, 099 12, 479 41, 709 898	981 7, 092 0 0 0	36, 850 44, 351 58, 265 51, 931 2, 984	154, 063 173, 975	3, 831 10, 999 15, 903 4, 156 0	51.00 52.00 54.00
60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	10, 090 1, 580 300 0 0	0 0 0 0	38, 863 32, 711 24, 468 6, 620 4, 265	0 1, 069 0 0	268 9, 466 534 228 298	66.00 67.00 68.00
69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73.00 07300 DRUGS CHARGED TO PATI ENTS 75.00 07500 ASC (NON-DI STI NCT PART)	1, 810 609 0 0 0	0 0 0 0 0 0	5, 820 2, 355 0 0 0 0	0	2 44 148, 821 397, 179 0 0	72.00 73.00
75.01 07501 CARDI AC CATHERI ZATI ON LABORATORY	11, 188	3, 000	15, 996	45, 223	13, 211	1
OUTPATI ENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	9, 812	225	41, 252	123, 521	7, 304	91.00 92.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	336, 566	149, 522	822, 382	1, 906, 022	867, 249	118.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.01 19201 OTHER NON-REIMBURSABLE 192.02 19202 CHILDBIRTH EDUCATION 192.03 19203 PHYSICIANS' PRIVATE OFFICES 192.04 19204 PHYSICIANS' PRIVATE OFFICES 192.05 19205 PHYSICIANS' PRIVATE OFFICES 192.06 19205 PHYSICIAN PRACTICE 192.07 19207 WEST HOSPITAL 192.08 19208 SAXONY HOSPITAL 200.00 Cross Foot Adjustments	0 410 0 11, 707 0 0 111 817 221	0 0 0 0 0 0 0 0 0 0	0 2, 275 1, 463 0 160 10, 656 595 2, 321 629	0 0 787 56 1, 744 0 0	0 0 105 39 0 0 0	192. 00 192. 01 192. 02 192. 03 192. 04 192. 05 192. 06 192. 07 192. 08 200. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 349, 832	0 149, 522	0 840, 481		0 867, 393	201. 00 202. 00

Heal th	Financial Systems	IU HEALTH NORT	H HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der (CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 2:5	epared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCI AL SERVI CE	OTHER GENERAL SERVICE PATIENT TRANSPORTATIO	Subtotal	
		15.00	LI BRARY 16.00	17.00	N 18.00	24.00	
	GENERAL SERVICE COST CENTERS		101.00			21100	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 18.\ 00\\ \end{array}$	00100 NEW CAP REL COSTS-BLDG & FIXT 00101 NEW CAP REL COSTS-INTEREST 00102 MOB LEASED SPACE 00200 NEW CAP REL COSTS-INTEREST 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATIENT TELEPHONES 00550 DATA PROCESSI NG 00560 PURCHASI NG RECEI VI NG AND STORES 00570 ADMI TTI NG 00590 OTHER ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01700 SOCI AL SERVI CE	582, 386 0 0	:	2 522, 5	543 0 11, 221		$\begin{array}{c} 1.00\\ 1.01\\ 1.02\\ 2.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 5.04\\ 5.05\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ \end{array}$
16.00	INPATIENT ROUTINE SERVICE COST CENTERS	-			l		18.00
30.00	03000 ADULTS & PEDIATRICS	1, 790		0 401, 5		6, 777, 220	30.00
34.00 34.01	03400 SURGI CAL I NTENSI VE CARE UNI T 03401 PEDI ATRI C I NTENSI VE CARE UNI T	0			0 0	0 0	34.00 34.01
34.02	03402 PREMATURE INTENSIVE CARE UNIT	276		60, 5			1
43.00	04300 NURSERY	0	(0 60,4	475 65	565, 175	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	0.47			0 0 105	(010 500	1 50 00
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	947 1, 269			0 2, 185 0 316		
52.00	05200 DELIVERY ROOM & LABOR ROOM	737			0 384	1, 827, 706	
54.00	05400 RADI OLOGY-DI AGNOSTI C	777			0 743		
55.00	05500 RADI OLOGY - THERAPEUTI C	782	(D	0 682	3, 855, 570	55.00
56.00	05600 RADI OI SOTOPE	5		D	0 89		1
60.00		0	(0	0 506		
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1			0 134 0 82	261, 268 143, 568	
67.00	06700 OCCUPATI ONAL THERAPY	0			0 28		
68.00	06800 SPEECH PATHOLOGY	О	(D	0 15		
	06900 ELECTROCARDI OLOGY	0		D	0 141	264, 125	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 32 0 371	90, 436	
71.00 72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0 872	169, 304 450, 895	
73.00	07300 DRUGS CHARGED TO PATIENTS	572, 792	(D	0 1, 994		
75.00		0		D	0 0	0	75.00
75.01	07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 178	(0	0 292	1, 655, 412	75.01
91.00	OUTPATIENT SERVICE COST CENTERS	1, 796	(0	0 940	831, 730	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,770	,		0 740	031,730	92.00
	SPECIAL PURPOSE COST CENTERS			1	I	I	
118.00		582, 350		2 522, 5	543 11, 221	31, 691, 962	118.00
102.00	NONREI MBURSABLE COST CENTERS	ol				0	100.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 OTHER NON-REI MBURSABLE	0			0 0 0 0		192.00 192.01
	19202 CHI LDBI RTH EDUCATI ON	Ő			0 0		192.02
	19203 PHYSI CLANS' PRI VATE OFFI CES	36	(D	0 0	670, 884	
	19204 PHYSI CLANS' PRI VATE OFFI CES	0		0	0 0		192.04
	19205 PHYSI CI AN PRACTI CE 19206 TI PTON HOSPI TAL	0	(0 0	231, 537	192.05 192.06
	19206 TEPTON HOSPITAL 19207 WEST HOSPITAL	0	(0 0	102, 588	
	19208 SAXONY HOSPI TAL	Ő			0 0		192.08
200.00	Cross Foot Adjustments					0	200.00
201.00	ů, s	0			0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	582, 386	-	2 522, 5	543 11, 221	32, 872, 449	202.00

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lieu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 15-0161	Period: Worksheet B From 01/01/2021 Part II	
			To 12/31/2021 Date/Time Pre 5/26/2022 2:5	
Cost Center Description	Intern & Residents Cost & Post	Total	5/20/2022 2.3	
	Stepdown			
	Adjustments 25.00	26.00		
GENERAL SERVICE COST CENTERS	<u>г</u>			1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST				1.00
1.02 00102 MOB LEASED SPACE				1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATI ENT TELEPHONES				4.00 5.01
5. 02 00550 DATA PROCESSI NG				5.02
5. 03 00560 PURCHASI NG RECEI VI NG AND STORES				5.03
5. 04 00570 ADMITTING				5.04
5. 05 00590 OTHER ADMINI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS				5.05 6.00
7. 00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9. 00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY 11. 00 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 01500 PHARMACY				15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE				16.00 17.00
18. 00 01850 PATIENT TRANSPORTATION				18.00
INPATIENT ROUTINE SERVICE COST CENTERS	I I.			
30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 777, 220		30.00
34.00 03400 SURGI CAL INTENSI VE CARE UNI T	0	0		34.00
34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 34. 02 03402 PREMATURE I NTENSI VE CARE UNI T	0	1, 424, 648		34.01 34.02
43. 00 04300 NURSERY	0	565, 175		43.00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	0	6, 918, 508 715, 075		50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 827, 706		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	4, 160, 225		54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	3, 855, 570		55.00
56. 00 05600 RADI OI SOTOPE 60. 00 06000 LABORATORY	0	79, 368 721, 530		56.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	261, 268		65.00
66. 00 06600 PHYSI CAL THERAPY	0	143, 568		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	12, 484		67.00
68. 00 06800 SPEECH PATHOLOGY	0	9,823		68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	264, 125 90, 436		69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	169, 304		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	450, 895		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 75.00 07500 ASC (NON-DISTINCT PART)	0	757, 892		73.00 75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	1, 655, 412		75.00
OUTPATIENT SERVICE COST CENTERS	· · ·			
91.00 09100 EMERGENCY	0	831, 730		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECIAL PURPOSE COST CENTERS	0			92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	31, 691, 962		118.00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
192. 01 19201 OTHER NON-REI MBURSABLE 192. 02 19202 CHI LDBI RTH EDUCATI ON	0	80, 858 3, 021		192.01 192.02
192. 03 19203 PHYSI CLANS' PRI VATE OFFICES	0	670, 884		192.02
192. 04 19204 PHYSI CI ANS' PRI VATE OFFI CES	0	9, 144		192.04
192. 05 19205 PHYSI CI AN PRACTI CE	0	231, 537		192.05
192. 06 19206 TI PTON HOSPI TAL 192. 07 19207 WEST HOSPI TAL	0	33, 545 102, 588		192.06 192.07
192. 08 19208 SAXONY HOSPITAL	o	48, 910		192.07
200.00 Cross Foot Adjustments	0	0		200.00
201.00 Negative Cost Centers	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	32, 872, 449		202.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH NOR	TH HOSPITAL		eriod:	u of Form CMS-2 Worksheet B-1	
			F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 2:5	
		CAPI TAL REI	LATED COSTS		0/20/2022 2.0	
Cost Center Description	NEW BLDG & FI XT (SQUARE FEET)	NEW INTEREST (SQUARE FEET)	MOB LEASED SPACE (MOB SQ FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	1.00	1.01	1.02	2.00	4.00	
GENERAL SERVICE COST CENTERS 1. 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1. 01 00101 NEW CAP REL COSTS-INTEREST 1. 02 00102 MOB LEASED SPACE 2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	516, 159 0 0 1, 405	516, 159 0 1, 405	69, 987	10, 612, 588 1, 299	69, 253, 307	1.00 1.01 1.02 2.00 4.00
5. 01 00540 NONPATI ENT TELEPHONES 5. 02 00550 DATA PROCESSI NG 5. 03 00560 PURCHASI NG RECEI VI NG AND STORES	0 8, 017 0	0 8, 017 0	0 641 0	0 0 0	0 0 0 0 0	
5. 04 00570 ADMI TTI NG 5. 05 00590 OTHER ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAI RS	1, 616 15, 953 75, 296	15, 953	12, 715	142 137, 182 123, 506	325, 808 2, 974, 248 1, 712, 339	5.05
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	302 0 6, 241	302 0 6, 241	167 0 391	6, 614 0 1, 771	960, 347 0 1, 461, 114	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	2, 648 15, 878 8, 056 16, 967	2, 648 15, 878 8, 056 16, 967	0	5, 698 39, 540 1, 345, 375 0	654, 923 996, 885 5, 483, 627 243	11.00 13.00
15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	8, 072 0 10, 045	8, 072 0	0	94, 056 0 0	3, 388, 496 400 1, 231, 488	15.00 16.00
18. 00 01850 PATIENT TRANSPORTATION INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	226, 056	18.00
30.00 03000 ADULTS & PEDIATRICS 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	96, 912 0 0	96, 912 0 0	0 0 0	224, 709 0 0	15, 839, 666 0 0	30.00 34.00 34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	21, 722 8, 835	21, 722 8, 835	491	62, 586 8, 258	2, 685, 939 961, 686	43.00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	60, 115 9, 228 28, 060 14, 530	9, 228	0	3, 084, 603 30, 953 153, 125 2, 882, 430	5, 620, 778 2, 469, 983 3, 351, 512 4, 199, 502	51.00 52.00
55. 00 05500 RADI 0L0GY - THERAPEUTI C 56. 00 05600 RADI 0L SOTOPE 60. 00 066000 LABORATORY	48, 564 1, 046 11, 748	48, 564 1, 046	0	2, 882, 430 1, 141, 259 20, 145 0	4, 199, 302 3, 085, 611 241, 239 828, 560	55.00 56.00
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY	1, 840 349 0	1, 840	0 6, 201	94, 496 10, 557 0	2, 326, 460 1, 778, 752 494, 770	65.00 66.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0 2, 108 709	0 2, 108 709		1, 627 138, 459 46, 325	332, 138 416, 965 160, 427	69.00 70.00
71.0007100MEDI CAL SUPPLI ES CHARGED TO PATI ENTS72.0007200IMPL. DEV. CHARGED TO PATI ENT73.0007300DRUGS CHARGED TO PATI ENTS75.0007500ASC (NON-DI STI NCT PART)				0 0 0	0 0 0	71.00 72.00 73.00 75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY 0UTPATIENT SERVICE COST CENTERS	13, 027	13, 027	0	855, 360	1, 099, 596	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	11, 425	11, 425	0	45, 521	2, 868, 662	91.00 92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	500, 714	500, 714	40, 770	10, 555, 596	68, 178, 220	118.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192.01 19201 OTHER NON-REI MBURSABLE 192.02 19202 CHI LDBI RTH EDUCATI ON	0 477 0	0 477 0	0	0 48, 088 0	86, 063 81, 658	192.02
192. 03 19203 PHYSI CI ANS' PRI VATE OFFI CES 192. 04 19204 PHYSI CI ANS' PRI VATE OFFI CES 192. 05 19205 PHYSI CI AN PRACTI CE 192. 06 19206 TI PTON HOSPI TAL	13, 631 0 0	13, 631 0 0 129	0 19, 043	837 8, 067 0	14, 737 605, 583	•
192.07 19207 WEST HOSPITAL 192.08 19208 SAXONY HOSPITAL 200.00 Cross Foot Adjustments	129 951 257	129 951 257	2, 356 4, 646 3, 172	0 0 0	182, 524	192. 08 200. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part L)	9, 142, 224	11, 600, 592	770, 068	11, 359, 565	13, 224, 369	201.00 202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	17. 712031	22. 474842	11. 003015	1. 070386	0. 190956	203.00

Heal th Fi	nancial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLC	CATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:5	
			CAPI TAL REI				
	Cost Center Description	NEW BLDG &	NEW INTEREST	MOB LEASED	NEW MVBLE	EMPLOYEE	
		FLXT	(SQUARE	SPACE	EQUI P	BENEFI TS	
		(SQUARE	FEET)	(MOB SQ FEET) (DOLLAR	DEPARTMENT	
		FEET)			VALUE)	(GROSS	
						SALARI ES)	
		1.00	1.01	1.02	2.00	4.00	
204.00	Cost to be allocated (per Wkst. B, Part II)					69, 878	204.00
205.00	Unit cost multiplier (Wkst. B, Part					0. 001009	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

	nancial Systems DCATION - STATISTICAL BASIS	IU HEALTH NOR	Provi der C	CN: 15-0161 Pe	eriod:	u of Form CMS-2 Worksheet B-1	
OUDT NEED					rom 01/01/2021	Date/Time Pre	
						5/26/2022 2:5	5 pm
	Cost Center Description	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND	ADMI TTI NG (GROSS	Reconciliatio n	
		(FTES)	(FTEs)	STORES	CHARGES)	11	
		. ,		(COSTED	ŕ		
		5. 01	5.02	REQUISITIONS) 5.03	5.04	5A. 05	
GE	NERAL SERVICE COST CENTERS	5.01	5.02	5.05	5.04	JA: 05	
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	101 NEW CAP REL COSTS-INTEREST 102 MOB LEASED SPACE						1.01 1.02
	200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	540 NONPATI ENT TELEPHONES	90, 250	00.050				5.01
	1550 DATA PROCESSING 1560 PURCHASING RECEIVING AND STORES	0	90, 250 0				5.02
	570 ADMITTING	825	825		1, 268, 571, 551		5.04
	590 OTHER ADMI NI STRATI VE & GENERAL	3, 268	3, 268		0	-30, 412, 787	5.05
	600 MAINTENANCE & REPAIRS	2, 316	2, 316		0	0	
	700 OPERATION OF PLANT 1800 LAUNDRY & LINEN SERVICE	1, 919 0	1, 919 0		0	0	7.00 8.00
	900 HOUSEKEEPI NG	4, 116	4, 116		0	0	9.00
	000 DI ETARY	1, 738	1, 738		0	0	10.00
		2, 558	2, 558		0	0	
	300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY	2, 125	2, 125		0	0	13.00 14.00
	500 PHARMACY	3, 825	3, 825		0	0	15.00
	600 MEDI CAL RECORDS & LI BRARY	0	0	Ŭ	0	0	
	700 SOCIAL SERVICE	1, 368	1, 368		0	0	17.00
	850 PATIENT TRANSPORTATION PATIENT ROUTINE SERVICE COST CENTERS	636	636	0	0	0	18.00
	000 ADULTS & PEDIATRICS	19, 905	19, 905	645,034	127, 902, 023	0	30.00
	400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
	401 PEDIATRIC INTENSIVE CARE UNIT	0	0	u u u u u u u u u u u u u u u u u u u	0	0	34.01
	402 PREMATURE INTENSIVE CARE UNIT 300 NURSERY	3, 133 0	3, 133 0		22, 085, 751 7, 216, 646	0	
	CI LLARY SERVI CE COST CENTERS	0	0		7,210,040	0	45.00
	000 OPERATING ROOM	8, 860	8, 860		242, 811, 210	0	
	100 RECOVERY ROOM	3, 223	3, 223		35, 062, 861	0	51.00
	200 DELIVERY ROOM & LABOR ROOM 400 RADIOLOGY-DIAGNOSTIC	3, 879 5, 096	3, 879 5, 096		42, 666, 929 82, 600, 299	0	52.00 54.00
	500 RADI OLOGY - THERAPEUTI C	4, 542	4, 542		75, 768, 763	0	55.00
	600 RADI OI SOTOPE	261	261		9, 875, 660	0	56. OC
	000 LABORATORY 500 RESPI RATORY THERAPY	3, 399 2, 861	3, 399 2, 861		56, 180, 778 14, 844, 457	0	60.00 65.00
	600 PHYSI CAL THERAPY	2, 801	2, 801		9, 098, 505	0	66.00
67.00 06	700 OCCUPATI ONAL THERAPY	579	579		3, 134, 893	0	67. OC
	800 SPEECH PATHOLOGY	373	373		1, 656, 211	0	
	900 ELECTROCARDI OLOGY 000 ELECTROENCEPHALOGRAPHY	509 206	509 206		15, 722, 086 3, 546, 845	0	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200	200	4, 095, 118	41, 227, 409	0	
	200 IMPL. DEV. CHARGED TO PATIENT	0	0	10, 928, 885	96, 940, 448	0	
	300 DRUGS CHARGED TO PATIENTS	0	0	0	243, 284, 585	0	
	500 ASC (NON-DI STI NCT PART) 501 CARDI AC CATHERI ZATI ON LABORATORY	0 1, 399	1, 399	363, 522	0 32, 474, 225	0	75.00 75.01
	TPATIENT SERVICE COST CENTERS	1,077	1,077	000, 022	02, 171, 220	0	/0.01
	100 EMERGENCY	3, 608	3, 608	200, 978	104, 470, 967	0	
	200 OBSERVATION BEDS (NON-DISTINCT PART) ECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	88, 667	88, 667	24, 322, 110	1, 268, 571, 551	-30, 412, 787	118.00
NO	NREIMBURSABLE COST CENTERS				,, , , , , , , , , , , , , , , , ,		
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192.00
	201 OTHER NON-REIMBURSABLE 202 CHI LDBI RTH EDUCATI ON	199 128	199 128		0		192.01 192.02
	203 PHYSI CLANS' PRI VATE OFFI CES	128	128		0		192.02
192.04 19	204 PHYSI CLANS' PRI VATE OFFI CES	14	14	2, 897	Ō	0	192.04
	205 PHYSI CI AN PRACTI CE	932	932		0		192.05
	206 TI PTON HOSPI TAL 207 WEST HOSPI TAL	52 203	52 203		0		192.06 192.07
	207 WEST HOSPITAL 208 SAXONY HOSPITAL	203 55	203		0		192.08
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)	0	10, 496, 340	1, 659, 043	2, 985, 363		202.00
203.00	Part) Unit cost multiplier (Wkst. B, Part)	0. 000000	116. 302936	0. 068200	0. 002353		203.00
204.00	Cost to be allocated (per Wkst. B,	0.000000	329, 231		68, 433		204.00
2011.00							

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
					5/26/2022 2:5	
Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	ADMI TTI NG	Reconciliatio	
	TELEPHONES	PROCESSI NG	RECEI VI NG ANI) (GROSS	n	
	(FTEs)	(FTEs)	STORES	CHARGES)		
			(COSTED			
			REQUI SI TI ONS)		
	5. 01	5.02	5.03	5.04	5A. 05	
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	3. 647989	0.00000	0 0. 000054		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 NOR	TH HOSPITAL Provider CO		<u>In Lie</u> eriod: rom 01/01/2021	u of Form CMS-2 Worksheet B-1	
			T		Date/Time Pre 5/26/2022 2:5	pared:
Cost Center Description	OTHER ADMI NI STRATI V E & GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATI ON OF PLANT (SOUARE FEET)	LAUNDRY & LI NEN SERVI CE (TOTAL PATI ENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	
	5.05	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-INTEREST 1.02 00102 MOB LEASED SPACE 2.00 00200 NEW CAP REL COSTS-INVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00540 NONPATIENT TELEPHONES Solos 5.03 00550 DATA PROCESSING Solos Solos Solos DATA PROCESSING 5.04 00570 ADMITTING STOS SOS 00560 PURCHASING RECEIVING AND STORES 5.05 00590 OTHER ADMINISTRATIVE & GENERAL 6.00 00600 MAINTENANCE & REPAIRS RO 7.00 00700	235, 704, 078 9, 768, 125 1, 866, 933 198, 825 6, 782, 701 1, 713, 789 2, 725, 871 9, 193, 381 9, 297, 859 5, 812, 338 488 2, 290, 845 350, 300	413, 872 302 0 6, 241 2, 648 15, 878 8, 056 16, 967 8, 072 0 10, 045 0	413, 570 0 6, 241 2, 648 15, 878 8, 056 16, 967 8, 072 0 10, 045 0	36, 766 0 0 0	407, 329 2, 648 15, 878 8, 056 16, 967 8, 072 0 10, 045 0	10.00 11.00 13.00 14.00 15.00 16.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS30. 0003000 ADULTS & PEDI ATRI CS34. 0003400 SURGI CAL INTENSI VE CARE UNI T34. 0103401 PEDI ATRI C INTENSI VE CARE UNI T34. 0203402 PREMATURE INTENSI VE CARE UNI T34. 0004300 NURSERY	32, 580, 725 0 0 5, 209, 900 1, 716, 198	96, 912 0 0 21, 722 8, 835	96, 912 0 0 21, 722 8, 835	28, 252 0 0 4, 259	96, 912 0 0 21, 722 8, 835	30.00 34.00 34.01 34.02
ANCI LLARY SERVICE COST CENTERS 50.00 OS000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY - THERAPEUTI C 56.00 05600 RADI OLOGY - THERAPEUTI C 56.00 06600 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 75.00 07300 DRUGS CHARGED TO PATI ENTS 75.00 07500 ASC (NON-DI STI NCT PART) 75.01 07501 LACDI AC CATHERI ZATI ON LABORATORY 0UTPATI ENT SERVICE COST CENTERS	19, 923, 100 4, 240, 476 8, 360, 379 10, 408, 964 9, 297, 782 454, 525 11, 335, 395 3, 547, 651 2, 678, 784 707, 102 429, 438 921, 215 655, 250 4, 471, 414 11, 902, 341 42, 522, 881 0 3, 891, 065	60, 115 9, 228 28, 060 14, 530 48, 564 1, 046 11, 748 1, 840 349 0 0 0 0 2, 108 709 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60, 115 9, 228 28, 060 14, 530 48, 564 1, 046 11, 748 1, 840 349 0 0 0 2, 108 709 0 0 0 0 13, 027		60, 115 9, 228 28, 060 14, 530 48, 564 1, 046 11, 748 1, 840 349 0 0 0 0 2, 108 709 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 55.\ 00\\ 66.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 71.\ 00\\ 71.\ 00\\ 73.\ 00\\ 75.\ 00\\ \end{array}$
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 810, 291	11, 425	11, 425	0	11, 425	91.00 92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	232, 066, 331	398, 427	398, 125	36, 766		118.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192.01 19201 OTHER NON-REI MBURSABLE 192.02 19202 CHI LDBI RTH EDUCATI ON 192.03 19203 PHYSI CI ANS' PRI VATE OFFI CES 192.04 19204 PHYSI CI ANS' PRI VATE OFFI CES 192.05 19205 PHYSI CI ANS' PRI VATE OFFI CES 192.06 19205 PHYSI CI AN PRACTI CE 19206 192.07 19207 WEST HOSPI TAL 192.08 192.08 19208 SAXONY HOSPI TAL 200.00 Cross Foot Adj ustments	0 739, 126 252, 362 548, 684 30, 465 1, 389, 273 117, 678 422, 179 137, 980	0 477 0 13, 631 0 0 129 951 257	0 477 0 13, 631 0 0 129 951 257	0 0 0 0 0 0 0	477 0 13, 631 0 0 129 951	192.04 192.05 192.06 192.07 192.08 200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	30, 412, 787	11, 028, 506	2, 115, 870	224, 479	7, 856, 108	201.00 202.00
203.00Part I)204.00Cost to be allocated (per Wkst. B, Part II)	0. 129030 942, 765	26. 647142 3, 224, 349	5. 116111 38, 844		19. 286886 349, 832	

Health Fina	ancial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 2:5	
	Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		ADMI NI STRATI V	REPAI RS	PLANT	LINEN SERVICE	(SQUARE	
		E & GENERAL	(SQUARE	(SQUARE	(TOTAL	FEET)	
		(ACCUM.	FEET)	FEET)	PATI ENT DAYS)		
		COST)					
		5.05	6.00	7.00	8.00	9.00	
205.00	Unit cost multiplier (Wkst. B, Part	0. 004000	7. 790691	0. 093924	0. 021623	0. 858844	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

	ancial Systems ATION – STATISTICAL BASIS	IU HEALTH NORT	HOSPITAL Provider CO	CN: 15 0141 D	In Lie eriod:	u of Form CMS-: Worksheet B-1	
CUST ALLUC	ATTON - STATISTICAL DASIS		Provider C		rom 01/01/2021	Date/Time Pre	pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI O N (NURSI NG FTES)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI SI TI ONS)	5/26/2022 2: 5 PHARMACY (COSTED REQUI S.)	
CENE		10.00	11.00	13.00	14.00	15.00	
	ERAL SERVICE COST CENTERS						1.00
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	01 NEW CAP REL COSTS-INTEREST 02 MOB LEASED SPACE 03 NEW CAP REL COSTS-MVBLE EQUIP 04 MOPATI ENT TELEPHONES 05 DATA PROCESSI NG 05 PURCHASI NG RECEI VI NG AND STORES 06 PURCHASI NG RECEI VI NG AND STORES 07 ADMI TTI NG 08 OTHER ADMI NI STRATI VE & GENERAL 09 OTHER ADMI NI STRATI VE & GENERAL 00 ADMI TTI NG 00 OPERATI ON OF PLANT 01 AUNDRY & LI NEN SERVI CE 02 OPERATI NG 03 DI ETARY 04 CAFETERI A 05 ONURSI NG ADMI NI STRATI ON 06 CAFETERI A 07 NURSI NG ADMI NI STRATI ON 08 CENTRAL SERVI CES & SUPPLY 09 PHARMACY 00 MEDI CAL RECORDS & LI BRARY 03 SOCI AL SERVI CE 04 PATI ENT TRANSPORTATI ON	84, 329 0 0 0 0 0 0 0 0 0 0 0 0 0	73, 510 2, 125 0 3, 825 0 1, 368 636	33, 932 0 0 0 0 0 0	23, 867, 838 65, 741 0 0	42, 652, 741 0 0 0	$\begin{array}{c} 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 5.\ 05\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
	ATIENT ROUTINE SERVICE COST CENTERS	77, 957	19, 905	13, 771	645, 034	131, 096	30.00
34.00 0340	DO SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	34.00
	01 PEDIATRIC INTENSIVE CARE UNIT 02 PREMATURE INTENSIVE CARE UNIT	0	0 3, 133	-	-	0 20, 191	34.01
	DO NURSERY	0	3, 133		01, 024	20, 191	•
	LLARY SERVICE COST CENTERS			1			
	DO OPERATING ROOM	0	8,860				
	DO RECOVERY ROOM DO DELIVERY ROOM & LABOR ROOM	553 4,000	3, 223 3, 879			92, 974 53, 999	
	DO RADI OLOGY-DI AGNOSTI C	0	5, 096		437, 592	56, 901	54.00
	00 RADI OLOGY - THERAPEUTI C	0	4, 542			57, 305	1
	DO RADI OI SOTOPE DO LABORATORY	0	261 3, 399		-	333	56.00 60.00
	DO RESPIRATORY THERAPY	0	2, 861	0		71	65.00
66.00 0660	DO PHYSI CAL THERAPY	0	2, 140	19		0	66.00
	00 OCCUPATI ONAL THERAPY	0	579			0	67.00
	DO SPEECH PATHOLOGY DO ELECTROCARDI OLOGY	0	373 509		8, 212 68	0	68.00 69.00
	DO ELECTROENCEPHALOGRAPHY	0	206		1, 218	0	
	DO MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0		0	
	DO IMPL. DEV. CHARGED TO PATIENT DO DRUGS CHARGED TO PATIENTS	0	0	0		0 41, 950, 017	72.00
	00 ASC (NON-DI STI NCT PART)	Ő	0		-	0	75.00
	DI CARDI AC CATHERI ZATI ON LABORATORY	1, 692	1, 399	804	363, 522	86, 275	75.01
91.00 0910	PATIENT SERVICE COST CENTERS	127	3, 608	2, 196	200, 978	131, 557	91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART)	127	5,000	2,170	200, 770	131, 337	92.00
118.00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	84, 329	71, 927	33, 886	23, 863, 864	42, 650, 077	118.00
	REIMBURSABLE COST CENTERS	0	0	0	0	0	192.00
192.01 1920	01 OTHER NON-REI MBURSABLE	0	199	0	0	0	192.01
	22 CHI LDBI RTH EDUCATI ON	0	128		-		192.02
	03 PHYSI CLANS' PRI VATE OFFI CES 04 PHYSI CLANS' PRI VATE OFFI CES	0	0 14		0 2, 897		192.03 192.04
192.05 1920	D5 PHYSI CI AN PRACTI CE	0	932	31	1,077	0	192.05
	06 TI PTON HOSPI TAL	0	52		0		192.06
	07 WEST HOSPI TAL 08 SAXONY HOSPI TAL	0	203 55		0		192.07 192.08
200.00	Cross Foot Adjustments	0	55		0	0	200.00
	Negative Cost Centers						201.00
201.00		2 070 100	3, 888, 164	10, 903, 260	11, 363, 730	7, 207, 997	202.00
201.00 202.00	Cost to be allocated (per Wkst. B,	2, 070, 100	5,000,104	10, 903, 200	,,,	., 20.,	
202.00	Part I)						
		2, 070, 100 24. 547902 149, 522	52. 892994 840, 481	321. 326771	0. 476111		203.00

Health Fin	ancial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					rom 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:5	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS	(FTEs)	ADMI NI STRATI O	SERVICES &	(COSTED	
		SERVED)		N	SUPPLY	REQUIS.)	
				(NURSI NG	(COSTED		
				FTEs)	REQUISITIONS)		
		10.00	11.00	13.00	14.00	15.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	1. 773079	11. 433560	56. 248055	0. 036341	0. 013654	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

	inancial Systems LOCATION - STATISTICAL BASIS	IU HEALTH NOR		CN: 15-0161	In Lieu Period:	u of Form CMS-255 Worksheet B-1	52-10
CUST ALL	LUCATION - STATISTICAL BASIS		FIOVIDEIC		From 01/01/2021 To 12/31/2021	Date/Time Prepar	red
						5/26/2022 2:55 p	
				OTHER GENERAL SERVI CE	-		
	Cost Center Description	MEDI CAL	SOCI AL	PATI ENT			
		RECORDS & LI BRARY	SERVI CE (TOTAL	TRANSPORTATI C			
		(GROSS	PATIENT DAYS)	(GROSS			
		CHARGES) 16.00	17.00	CHARGES) 18.00	_		
G	ENERAL SERVICE COST CENTERS	18.00	17.00	10.00			
	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	0101 NEW CAP REL COSTS-INTEREST 0102 MOB LEASED SPACE						1.01 1.02
	0200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0540 NONPATI ENT TELEPHONES 0550 DATA PROCESSI NG						5.01 5.02
	0560 PURCHASING RECEIVING AND STORES						5.02
	0570 ADMI TTI NG						5.04
	0590 OTHER ADMINISTRATIVE & GENERAL 0600 MAINTENANCE & REPAIRS						5.05 6.00
	0700 OPERATION OF PLANT						7.00
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPI NG 1000 DI ETARY						9.00 0.00
	1100 CAFETERI A						1.00
	1300 NURSI NG ADMI NI STRATI ON						3.00
	1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY						4.00 5.00
	1600 MEDICAL RECORDS & LIBRARY	1, 268, 571, 551					6.00
17.00 0	1700 SOCIAL SERVICE	0	36, 766			17	7.00
	1850 PATIENT TRANSPORTATION NPATIENT ROUTINE SERVICE COST CENTERS	0	0	1, 268, 571, 55	1	18	8.00
	3000 ADULTS & PEDIATRICS	127, 902, 023	28, 252	127, 902, 02	3	30	80.00
34.00 0	3400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0		34.00
	3401 PEDIATRIC INTENSIVE CARE UNIT	0	0		0		34.01
1	3402 PREMATURE INTENSIVE CARE UNIT 4300 NURSERY	22, 085, 751 7, 216, 646					34.02 3.00
A	NCILLARY SERVICE COST CENTERS		1	1			
	5000 OPERATING ROOM 5100 RECOVERY ROOM	242, 811, 210 35, 062, 861					50.00 51.00
	5200 DELIVERY ROOM & LABOR ROOM	42, 666, 929					52.00
	5400 RADI OLOGY-DI AGNOSTI C	82, 600, 299					64.00
	5500 RADI OLOGY – THERAPEUTI C 5600 RADI OI SOTOPE	75, 768, 763 9, 875, 660					5.00 6.00
	6000 LABORATORY	56, 180, 778					0.00
	6500 RESPI RATORY THERAPY	14, 844, 457					5.00
	6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY	9, 098, 505 3, 134, 893		.,			6.00 7.00
	6800 SPEECH PATHOLOGY	1, 656, 211					57.00 8.00
	6900 ELECTROCARDI OLOGY	15, 722, 086	0	15, 722, 08	6		9.00
	7000 ELECTROENCEPHALOGRAPHY 7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 546, 845 41, 227, 409					'0.00 '1.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	96, 940, 448					2.00
	7300 DRUGS CHARGED TO PATIENTS	243, 284, 585		, ,			3.00
	7500 ASC (NON-DISTINCT PART) 7501 CARDIAC CATHERIZATION LABORATORY	0 32, 474, 225	0		0		'5.00 '5.01
	UTPATIENT SERVICE COST CENTERS	52,474,225	1 0	32,474,22	5	/2	5.01
91.00 0	9100 EMERGENCY	104, 470, 967	0	104, 470, 96	7		91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)					92	2.00
118.00	PECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 268, 571, 551	36, 766	1, 268, 571, 55	1	118	8.00
N	ONREIMBURSABLE COST CENTERS	[1	1			
	9200 PHYSI CLANS' PRI VATE OFFI CES 9201 OTHER NON-REI MBURSABLE	0		1	0		92.00 92.01
	9201 OTHER NON-REIMBURSABLE 9202 CHI LDBI RTH EDUCATI ON			1	0		2.01
192.031	9203 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	192	2.03
	9204 PHYSICIANS' PRIVATE OFFICES	0	0		0		2.04 2.05
	9205 PHYSICIAN PRACTICE 9206 TIPTON HOSPITAL				0		2.05 2.06
192.071	9207 WEST HOSPI TAL	0	0		0	192	2.07
	9208 SAXONY HOSPITAL	0	0	1	0		2.08
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers)0. 00)1. 00
	5		1	1 100 10			
202.00	Cost to be allocated (per Wkst. B,	551	3, 172, 141	429, 13	9	202	02.00
	Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I))2.00)3.00

Health Financial Systems	IU HEALTH NOF	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
				To 12/31/2021	Date/Time Pre 5/26/2022 2:5	
			OTHER GENERA	L		
Cost Center Description	MEDI CAL RECORDS &	SOCI AL SERVI CE	SERVICE PATIENT TRANSPORTATI	0		
	LI BRARY	(TOTAL	N			
	(GROSS CHARGES)	PATIENT DAYS)	(GROSS CHARGES)			
	16.00	17.00	18.00	_		
204.00 Cost to be allocated (per Wkst. B, Part II)	2	522, 543	11, 22	21		204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	14. 212669	0.00000)9		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 F	inancial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 2:5	epared: 5 pm
			Title	XVIII	Hospi tal	PPS	•
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
11	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03	3000 ADULTS & PEDI ATRI CS	52, 106, 039		52, 106, 03	9 0	52, 106, 039	30.00
34.00 03	3400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
	3401 PEDIATRIC INTENSIVE CARE UNIT	0			0 0	0	34.01
34.02 03	3402 PREMATURE INTENSIVE CARE UNIT	8, 475, 901		8, 475, 90	01 0	8, 475, 901	34.02
43.00 04	4300 NURSERY	3, 099, 425		3, 099, 42	.5 0	3, 099, 425	43.00
AN	NCILLARY SERVICE COST CENTERS		•				
50.00 05	5000 OPERATING ROOM	30, 310, 693		30, 310, 69	0	30, 310, 693	50.00
51.00 05	5100 RECOVERY ROOM	6, 400, 635		6, 400, 63	5 0	6, 400, 635	51.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	12, 336, 456		12, 336, 45	6 348, 737	12, 685, 193	52.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	13, 160, 556		13, 160, 55	6 0	13, 160, 556	54.00
55.00 05	5500 RADI OLOGY – THERAPEUTI C	14, 101, 939		14, 101, 93	9 0	14, 101, 939	55.00
56.00 05	5600 RADI OI SOTOPE	583, 769		583, 76	9 0	583, 769	56.00
60.00 06	6000 LABORATORY	13, 859, 652		13, 859, 65	0	13, 859, 652	60.00
65.00 06	6500 RESPI RATORY THERAPY	4, 379, 708	0	4, 379, 70	0 8	4, 379, 708	65.00
66.00 06	6600 PHYSI CAL THERAPY	3, 171, 613	0	3, 171, 61	3 0	3, 171, 613	66.00
67.00 06	6700 OCCUPATI ONAL THERAPY	833, 014	0	833, 01	4 0	833, 014	67.00
68.00 06	6800 SPEECH PATHOLOGY	509, 047	0	509, 04	7 0	509, 047	68.00
69.00 00	6900 ELECTROCARDI OLOGY	1, 179, 962		1, 179, 96	02 0	1, 179, 962	69.00
70.00 0	7000 ELECTROENCEPHALOGRAPHY	788, 666		788, 66	6 0	788, 666	70.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 012, 027		7, 012, 02	.7 0	7, 012, 027	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENT	18, 674, 217		18, 674, 21	7 0	18, 674, 217	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	55, 181, 335		55, 181, 33	5 0	55, 181, 335	73.00
75.00 0	7500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
	7501 CARDI AC CATHERI ZATI ON LABORATORY	5, 630, 671		5, 630, 67	'1 0	5, 630, 671	75.01
OL	UTPATIENT SERVICE COST CENTERS						
91.00 09	9100 EMERGENCY	9, 325, 093		9, 325, 09	03	9, 325, 093	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 692, 359		4, 692, 35		4, 692, 359	
200.00	Subtotal (see instructions)	265, 812, 777	0	265, 812, 77	7 348, 737	266, 161, 514	200.00
201.00	Less Observation Beds	4, 692, 359		4, 692, 35	9	4, 692, 359	201.00
202.00	Total (see instructions)	261, 120, 418	0	261, 120, 41	8 348, 737	261, 469, 155	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 2:5	
	-	Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	I npati ent	
					Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	T					
30. 00 03000 ADULTS & PEDI ATRI CS	109, 420, 507		109, 420, 50			30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT	0			0		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	22, 085, 751		22, 085, 7			34.02
43.00 04300 NURSERY	7, 216, 646		7, 216, 6	16		43.00
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	60, 438, 937	182, 372, 273			0.00000	
51.00 05100 RECOVERY ROOM	4, 310, 646	30, 752, 215			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	34, 952, 078	7, 714, 851			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 451, 224	69, 149, 075			0.00000	
55. 00 05500 RADI OLOGY – THERAPEUTI C	711, 887	75, 056, 876			0.00000	
56. 00 05600 RADI OI SOTOPE	892, 368	8, 983, 292			0. 000000	
60. 00 06000 LABORATORY	25, 750, 243	30, 430, 535			0. 000000	
65. 00 06500 RESPI RATORY THERAPY	10, 514, 746	4, 329, 711			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	4, 305, 695	4, 792, 810			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	1, 892, 790	1, 242, 103			0. 000000	
68.00 06800 SPEECH PATHOLOGY	663, 963	992, 248			0. 000000	
69.00 06900 ELECTROCARDI OLOGY	5, 551, 429	10, 170, 657			0. 000000	
70.00 07000 ELECTROENCEPHALOGRAPHY	1, 409, 071	2, 137, 774			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 556, 698	27, 670, 711			0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	33, 936, 087	63,004,361			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	48, 706, 434	194, 578, 151	243, 284, 58		0.00000	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0.000000	0.00000	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	13, 471, 072	19,003,153	32, 474, 22	0. 173389	0.00000	75.01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	26, 434, 051	78, 036, 916	104, 470, 90			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	251, 493	18, 230, 023			0. 000000	
200.00 Subtotal (see instructions)	439, 923, 816	828, 647, 735	1, 268, 571, 5	51		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	439, 923, 816	828, 647, 735	1, 268, 571, 5	51		202.00

Health Financial Systems	IU HEALTH NORT	H HOSPI TAL	In Lieu of Form CMS-25		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 2:55 pm	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30.00	
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00	
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT				34.01	
34. 02 03402 PREMATURE INTENSIVE CARE UNIT				34.02	
43. 00 04300 NURSERY				43.00	
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 124832			50.00	
51.00 05100 RECOVERY ROOM	0. 182547			51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 297307			52.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 159328			54.00	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 186118			55.00	
56. 00 05600 RADI 0I SOTOPE	0. 059112			56.00	
60. 00 06000 LABORATORY	0. 246697			60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 295040			65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 348586			66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0. 265723			67.00	
68.00 06800 SPEECH PATHOLOGY	0. 307356			68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 075051			69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 222357			70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 170082			71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 192636			72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 226818			73.00	
75.00 07500 ASC (NON-DI STI NCT PART)	0. 000000			75.00	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 173389			75.01	
OUTPATIENT SERVICE COST CENTERS	0.170007			70.01	
91. 00 09100 EMERGENCY	0. 089260			91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 253895			92.00	
200.00 Subtotal (see instructions)	0.200070			200.00	
201.00 Less Observation Beds				200.00	
202.00 Total (see instructions)				201.00	
	1			202.00	

Health F	inancial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 2:5	pared: 5 pm
			Titl	e XIX	Hospi tal	PPS	•
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
11	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00 0	3000 ADULTS & PEDIATRICS	52, 106, 039		52, 106, 03	9 0	52, 106, 039	30.00
34.00 0	3400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34.00
34.01 0	3401 PEDIATRIC INTENSIVE CARE UNIT	0			0 0	0	34.01
34.02 0	3402 PREMATURE INTENSIVE CARE UNIT	8, 475, 901		8, 475, 90	01 0	8, 475, 901	34.02
43.00 0	4300 NURSERY	3, 099, 425		3, 099, 42	.5 0	3, 099, 425	43.00
IA	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	30, 310, 693		30, 310, 69	03 0	30, 310, 693	
51.00 0	5100 RECOVERY ROOM	6, 400, 635		6, 400, 63	5 0	6, 400, 635	51.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	12, 336, 456		12, 336, 45	6 348, 737	12, 685, 193	52.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	13, 160, 556		13, 160, 55		13, 160, 556	54.00
55.00 0	5500 RADI OLOGY – THERAPEUTI C	14, 101, 939		14, 101, 93	9 0	14, 101, 939	55.00
56.00 0	5600 RADI OI SOTOPE	583, 769		583, 76	09 0	583, 769	56.00
60.00 0	6000 LABORATORY	13, 859, 652		13, 859, 65	62 0	13, 859, 652	60.00
65.00 0	6500 RESPI RATORY THERAPY	4, 379, 708	0	4, 379, 70	0 8	4, 379, 708	65.00
66.00 0	6600 PHYSI CAL THERAPY	3, 171, 613	0	3, 171, 61	3 0	3, 171, 613	66.00
67.00 0	6700 OCCUPATI ONAL THERAPY	833, 014	0	833, 01	4 0	833, 014	67.00
	6800 SPEECH PATHOLOGY	509, 047	0	509, 04	7 0	509, 047	68.00
69.00 0	6900 ELECTROCARDI OLOGY	1, 179, 962		1, 179, 96	02 0	1, 179, 962	69.00
70.00 0	7000 ELECTROENCEPHALOGRAPHY	788, 666		788, 66	0 0	788, 666	70.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 012, 027		7,012,02	.7 0	7, 012, 027	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENT	18, 674, 217		18, 674, 21	7 0	18, 674, 217	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	55, 181, 335		55, 181, 33	5 0	55, 181, 335	73.00
75.00 0	7500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
	7501 CARDIAC CATHERIZATION LABORATORY	5, 630, 671		5, 630, 67	'1 0	5, 630, 671	75.01
OL	UTPATIENT SERVICE COST CENTERS						
91.00 0	9100 EMERGENCY	9, 325, 093		9, 325, 09	03	9, 325, 093	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 692, 359		4, 692, 35		4, 692, 359	
200.00	Subtotal (see instructions)	265, 812, 777	0	265, 812, 77	7 348, 737	266, 161, 514	200.00
201.00	Less Observation Beds	4, 692, 359		4, 692, 35	9	4, 692, 359	201.00
202.00	Total (see instructions)	261, 120, 418	0	261, 120, 41	8 348, 737	261, 469, 155	202.00

Health Financial Systems	IU HEALTH NORT	TH HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 2:5	
		Titl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100 100 507		100 100 5	-		
30. 00 03000 ADULTS & PEDIATRICS	109, 420, 507		109, 420, 50			30.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0			0		34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0			0		34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT	22, 085, 751		22, 085, 75			34.02
43.00 04300 NURSERY	7, 216, 646		7, 216, 64	16		43.00
ANCI LLARY SERVI CE COST CENTERS	(0, (0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0	400 070 070	0.40.014.0			
50. 00 05000 OPERATING ROOM	60, 438, 937	182, 372, 273				
51.00 05100 RECOVERY ROOM	4, 310, 646	30, 752, 215			0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	34, 952, 078	7, 714, 851				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 451, 224	69, 149, 075				
55. 00 05500 RADI OLOGY - THERAPEUTI C	711, 887	75, 056, 876				
56. 00 05600 RADI OI SOTOPE	892, 368	8, 983, 292				
60. 00 06000 LABORATORY	25, 750, 243	30, 430, 535			0.00000	
65. 00 06500 RESPI RATORY THERAPY	10, 514, 746	4, 329, 711				
66. 00 06600 PHYSI CAL THERAPY	4, 305, 695	4, 792, 810				
67. 00 06700 OCCUPATI ONAL THERAPY	1, 892, 790	1, 242, 103				
68.00 06800 SPEECH PATHOLOGY	663, 963	992, 248				
69. 00 06900 ELECTROCARDI OLOGY	5, 551, 429	10, 170, 657			0.00000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 409, 071	2, 137, 774			0.00000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	13, 556, 698	27, 670, 711				
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	33, 936, 087	63,004,361				
73. 00 07300 DRUGS CHARGED TO PATIENTS	48, 706, 434	194, 578, 151				
75.00 07500 ASC (NON-DI STI NCT PART)	0	0		0 0.00000		
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	13, 471, 072	19, 003, 153	32, 474, 22	0. 173389	0.00000	75.01
OUTPATIENT SERVICE COST CENTERS	0 / 10 / 05 d	70.00/.01/	101 170 0	7 0 0000 (0		
91.00 09100 EMERGENCY	26, 434, 051	78, 036, 916				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	251, 493	18, 230, 023			0. 000000	
200.00 Subtotal (see instructions)	439, 923, 816	828, 647, 735	1, 268, 571, 5	DT I		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	439, 923, 816	828, 647, 735	1, 268, 571, 5	1		202.00

Health Financial Systems	IU HEALTH NORTH	H HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 2:55 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT				34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT				34.02
43.00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 124832			50.00
51.00 05100 RECOVERY ROOM	0. 182547			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 297307			52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 159328			54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 186118			55.00
56. 00 05600 RADI OI SOTOPE	0. 059112			56.00
60. 00 06000 LABORATORY	0. 246697			60.00
65. 00 06500 RESPIRATORY THERAPY	0. 295040			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 348586			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 265723			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 307356			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 075051			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 222357			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 170082			70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 192636			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 226818			72.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 220818			75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 173389			75.01
OUTPATIENT SERVICE COST CENTERS	0. 173369			/5.01
91. 00 09100 EMERGENCY	0. 089260			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 253895			92.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part II Date/Time Pre 5/26/2022 2:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operati ng	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
	Part I, col.	Part II col.	Capital Cost	t	Reducti on	
	26)	26)	(col. 1 -		Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	30, 310, 693	6, 918, 508	23, 392, 18	35 0	0	50.00
51.00 05100 RECOVERY ROOM	6, 400, 635	715, 075	5, 685, 56	50 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 336, 456	1, 827, 706	10, 508, 75	50 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 160, 556	4, 160, 225	9,000,33	31 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	14, 101, 939	3, 855, 570	10, 246, 36	59 0	0	55.00
56. 00 05600 RADI OI SOTOPE	583, 769	79, 368	504, 40	01 0	0	56.00
60.00 06000 LABORATORY	13, 859, 652	721, 530	13, 138, 12	22 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	4, 379, 708	261, 268	4, 118, 44	40 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	3, 171, 613	143, 568	3, 028, 04	45 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	833, 014	12, 484	820, 53	30 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	509, 047	9, 823	499, 22	24 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	1, 179, 962	264, 125	915, 83	37 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	788, 666	90, 436	698, 23	30 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,012,027	169, 304	6, 842, 72	23 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	18, 674, 217				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	55, 181, 335				0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	5, 630, 671	1, 655, 412	3, 975, 25	59 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	9, 325, 093	831, 730	8, 493, 36	53 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 692, 359					92.00
200.00 Subtotal (sum of lines 50 thru 199)	202, 131, 412					200.00
201.00 Less Observation Beds	4, 692, 359					201.00
202.00 Total (line 200 minus line 201)	197, 439, 053	22, 924, 919			0	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS	-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RA REDUCTIONS FOR MEDICAID ONLY	TIOS NET OF	Provider C		Period: From 01/01/2021 To 12/31/2021	5/26/2022 2:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to			
	Operati ng	Part I,	Charge Ratio	D I		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	30, 310, 693	242, 811, 210	0. 12483	32		50.00
51.00 05100 RECOVERY ROOM	6, 400, 635	35, 062, 861	0. 18254	17		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 336, 456	42, 666, 929	0. 28913	34		52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	13, 160, 556	82, 600, 299	0. 15932	28		54.00
55.00 05500 RADI OLOGY - THERAPEUTI C	14, 101, 939	75, 768, 763	0. 1861 [.]	18		55.00
56. 00 05600 RADI OI SOTOPE	583, 769	9, 875, 660	0. 0591 ⁻	12		56.00
60. 00 06000 LABORATORY	13, 859, 652	56, 180, 778	0. 2466	97		60.00
65. 00 06500 RESPI RATORY THERAPY	4, 379, 708	14, 844, 457	0. 29504	40		65.00
66.00 06600 PHYSI CAL THERAPY	3, 171, 613	9, 098, 505	0. 34858	36		66.00
67.00 06700 OCCUPATI ONAL THERAPY	833, 014			23		67.00
68.00 06800 SPEECH PATHOLOGY	509, 047					68,00
69.00 06900 ELECTROCARDI OLOGY	1, 179, 962					69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	788, 666					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7,012,027					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	18, 674, 217					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	55, 181, 335					73.00
75.00 07500 ASC (NON-DI STINCT PART)	0					75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	5, 630, 671	-				75.01
OUTPATIENT SERVICE COST CENTERS	0,000,071	02, 171, 220	0. 17000	57		- /0.01
91. 00 09100 EMERGENCY	9, 325, 093	104, 470, 967	0. 08920	50		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 692, 359					92.00
200.00 Subtotal (sum of lines 50 thru 199)		1, 129, 848, 647		/5		200.00
201.00 Less Observation Beds	4, 692, 359					200.00
202.00 Total (line 200 minus line 201)		1, 129, 848, 647				201.00
	171,437,033	1, 127, 040, 047	l	I.		202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	_ COSTS	Provider C	1	Period: From 01/01/2021 Fo 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 2:5	pared: 5 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst.	Swing Bed Adjustment	Reduced Capital Related Cost	Total Patient Days	Per Diem (col. 3 / col. 4)	
	B, Part II, col. 26)		(col. 1 - col. 2)		,	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-1	-	1			
30. 00 ADULTS & PEDIATRICS 34. 00 SURGICAL INTENSIVE CARE UNIT	6, 777, 220 0	0	6, 777, 220	0 31, 048 0 0	218.28 0.00	34.00
34. 01 PEDIATRIC INTENSIVE CARE UNIT 34. 02 PREMATURE INTENSIVE CARE UNIT 43. 00 NURSERY	1, 424, 648 565, 175		1, 424, 648		0.00 334.50 132.83	34.02
200.00 Total (lines 30 through 199)	8, 767, 043		8, 767, 043			200.00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	-1					
30.00 ADULTS & PEDIATRICS 34.00 SURGICAL INTENSIVE CARE UNIT 34.01 PEDIATRIC INTENSIVE CARE UNIT 34.02 PREMATURE INTENSIVE CARE UNIT 43.00 NURSERY 200.00 Total (Lines 30 through 199)	8, 423 0 0 0 0 0 8, 423	0 0 0 0				30.00 34.00 34.01 34.02 43.00 200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1			- F		
50.00 05000 OPERATING ROOM	6, 918, 508				518, 867	
51.00 05100 RECOVERY ROOM	715, 075	35, 062, 861	0. 02039	4 1, 566, 635	31, 950	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 827, 706	42, 666, 929				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 160, 225	82, 600, 299			260, 660	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	3, 855, 570	75, 768, 763	0. 05088	6 576, 746	29, 348	55.00
56. 00 05600 RADI 0I SOTOPE	79, 368	9, 875, 660	0.00803	400, 415	3, 218	56.00
60. 00 06000 LABORATORY	721, 530	56, 180, 778			88, 826	60.00
65. 00 06500 RESPI RATORY THERAPY	261, 268	14, 844, 457	0. 01760	0 1, 801, 785	31, 711	65.00
66. 00 06600 PHYSI CAL THERAPY	143, 568	9, 098, 505	0. 01577	9 1, 437, 515	22, 683	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 484	3, 134, 893	0.00398	2 733, 272	2, 920	67.00
68.00 06800 SPEECH PATHOLOGY	9, 823	1, 656, 211	0.00593	1 297, 060	1, 762	68.00
69. 00 06900 ELECTROCARDI OLOGY	264, 125	15, 722, 086	0. 01680	0 2, 250, 842	37, 814	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	90, 436	3, 546, 845	0. 02549	214, 345	5, 465	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	169, 304	41, 227, 409	0. 00410	3, 873, 502	15, 908	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	450, 895	96, 940, 448	0. 00465	9, 819, 397	45, 670	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	757, 892	243, 284, 585	0. 00311	5 13, 205, 163	41, 134	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	1, 655, 412	32, 474, 225	0. 05097	6 5, 206, 229	265, 393	75.01
OUTPATIENT SERVICE COST CENTERS			•			1
91.00 09100 EMERGENCY	831, 730	104, 470, 967	0.00796	1 10, 321, 242	82, 167	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	610, 316	18, 481, 516	0. 03302	.3 66, 306	2, 190	92.00
200.00 Total (lines 50 through 199)	23, 535, 235	1, 129, 848, 647		82, 194, 916	1, 492, 934	200.00

Heal th Financial Systems IU HEALTH NORTH HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0161 Period: From 01/01/2021 Worksheet Date TI II Date/TI me Prepared: 5/26/2022 2: 55 pm Image: Service Cost Center Description Nursing Program Program Program Program Program Adjustments Allied Heal th Cost Allied Heal th Cost All Other Medical Education 30:00 0
Cost Center Description Nursing Program Post-Stepdown Adjustments Nursing Program Adjustments Allied Health Post-Stepdown Adjustments Allied Health Cost Allied Health Cost Allied Health Medical Education 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 34.00 34.00 03400 RVACIAL INTENSIVE CARE UNIT 0 0 0 0 0 34.00 34.00 0400 NURSERY 0
Program Post-Stepdown Adjustments Program Adjustments Post-Stepdown Adjustments Cost Medical Education Cost 30.00 03000 ADULTS & PEDIATRICS 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 30.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 34.01 34.01 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 34.01 34.02 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 0 34.01 34.02 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 0 34.02 200.00 Total (Lines 30 through 199) 0 0 0 0 0 0 0 0 0 200.00 Cost Center Description Swing-Bed Adjustment Adjustment Total Costs (sum of cols. Total Patient Days Program Days Program Days 0 0 0 0 0 0
Post-Stepdown Adj ustments Adj ustments Educati on Cost 30.00 03000 ADULTS & PEDI ATRICS 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDI ATRICS 0 0 0 0 30.00 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 0 0 0 0 34.00 34.01 03401 PEDI ATRI C INTENSI VE CARE UNI T 0 0 0 0 34.00 34.02 03402 PREMATURE INTENSI VE CARE UNI T 0 0 0 0 34.01 34.02 03402 PREMATURE INTENSI VE CARE UNI T 0 0 0 0 34.01 34.02 03400 NURSERY 0 0 0 0 0 0 200.00 0
Adj ustments Cost 1A 1.00 2A 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0 0 34.00 34.01 03401 PEDIATRIC INTENSI VE CARE UNIT 0 0 0 0 34.01 34.02 03402 PREMATURE INTENSI VE CARE UNIT 0 0 0 0 34.02 34.00 03400 NURSERY 0 <
INPATI ENT_ROUTI NE_SERVICE_COST_CENTERS 30. 00 03000(ADULTS & PEDI ATRI CS 0 0 0 0 0 0 0 0 0 0 0 0 0 30. 00 30. 00 30. 00 30. 00 0 0 0 0 0 0 0 0 0 0 0 30. 00 30. 00 30. 00 30. 00 30. 00 0 0 0 0 0 0 0 0 0 30. 00 34. 00 34. 00 0 0 0 0 0 0 0 0 0 0 0 0 34. 01 34. 01 34. 01 34. 02 0 0 0 0 0 0 0 0 0 0 0 0 34. 01 34. 01 34. 00 34. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0 0 34.00 34.01 03401 PEDIATRI C INTENSI VE CARE UNIT 0 0 0 0 0 34.00 34.01 03401 PEDIATRI C INTENSI VE CARE UNIT 0 0 0 0 0 34.01 34.02 03402 PREMATURE INTENSI VE CARE UNIT 0 0 0 0 0 34.02 203.00 04300 NURSERY 0
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30. 00 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 34. 00 34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0 0 0 34. 00 34. 02 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 0 34. 01 34. 02 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 0 34. 02 43. 00 04300 NURSERY 0 0 0 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 0 200. 00 0 0 200. 00 0 0 0 200. 00 0 0 0 0 0 0 0 0 0 0 0 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
34.00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 0 34.00 34.01 03401 PEDI ATRI C INTENSI VE CARE UNIT 0 0 0 0 34.01 34.02 03402 PREMATURE INTENSI VE CARE UNIT 0 0 0 0 0 34.02 43.00 04300 NURSERY 0
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0 0 34.01 34. 02 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 0 34.02 43. 00 04300 NURSERY 0
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 0 0 0 0 0 34.02 43. 00 04300 NURSERY 0<
43.00 04300 NURSERY 0
43.00 04300 NURSERY 0
Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of col s. 1 through 3, instructions) Total Patient Days Per Diem (col . 5 ÷ col . 6) Inpatient Program Days 30.00 03000 ADULTS & PEDIATRICS 0 0.00 6.00 7.00 8.00 34.00 03400 SURGICAL INTENSI VE CARE UNIT 0 0 0.00 0.00 0.00 34.00
Cost Center Description Swing-Bed Adjustment Amount (see instructions) Total Costs (sum of col s. 1 through 3, instructions) Total Patient Days Per Diem (col . 5 ÷ col . 6) Inpatient Program Days 30.00 03000 03000 ADULTS & PEDIATRICS 0 0 0.00 8.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0.00 0.00 8,423 30.00 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0.00 0 34.01
Amount (see i nstructions) 1 through 3, mi nus col. 4) col. 6) INPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 0 0 34. 00 03400 SURGI CAL INTENSI VE CARE UNIT 0 0 0 34. 01 03401
instructions minus col. 4) 4.00 5.00 6.00 7.00 8.00 0.00 03000 ADULTS & PEDIATRICS 0 31,048 0.00 8,423 30.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0.00 0 34.00 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0.00 0 34.01
instructions minus col. 4) 4.00 5.00 6.00 7.00 8.00 0.00 03000 ADULTS & PEDIATRICS 0 31,048 0.00 8,423 30.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0.00 0 34.00 34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0.00 0 34.01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 0 0 31, 048 0. 00 8, 423 30. 00 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 0 0. 00 0 34. 00 34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 0 0 0. 00 0 34. 01
30. 00 03000 ADULTS & PEDIATRICS 0 0 31, 048 0. 00 8, 423 30. 00 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 0 0.00 0 34. 00 34. 01 03401 PEDIATRIC I NTENSI VE CARE UNI T 0 0 0 0.00 0 34. 01
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 0 0.00 0 34. 00 34. 01 03401 PEDI ATRI C I NTENSI VE CARE UNI T 0 0 0.00 0 34. 01
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 0 0.00 0 34. 01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 0 4, 259 0. 00 0 34. 02
43. 00 04300 NURSERY 0 0 43. 00 0 43. 00
200.00 Total (lines 30 through 199) 0 39,562 8,423 200.00
Cost Center Description Inpatient
Program
Pass-Through
Cost (col. 7
x col. 8)
9.00
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 0 34. 00
34.01 03401 PEDIATRIC INTENSIVE CARE UNIT 0 34.01
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 0 34.02
43.00 04300 NURSERY 0 43.00
200.00 Total (lines 30 through 199) 0 200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0 0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0 0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		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 0I SOTOPE	0	0		0 0	0 0	56.00
60.00 06000 LABORATORY	0	0		0 0	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0 0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0 0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0 0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0 0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0 0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0	0		0 0	o o	75.01
OUTPATIENT SERVICE COST CENTERS	· · · ·			· ·		1
91.00 09100 EMERGENCY	0	0		0 0	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0 0	200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2021 To 12/31/2021	5/26/2022 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0	0		0 242, 811, 210	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 35, 062, 861	0.00000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 42, 666, 929	0.00000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 82, 600, 299	0.00000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 75, 768, 763	0.00000	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 9, 875, 660	0.00000	56.00
60.00 06000 LABORATORY	0	0		0 56, 180, 778	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 14, 844, 457	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 9, 098, 505	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 134, 893	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	1	0 1, 656, 211	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1	0 15, 722, 086	0. 000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 3, 546, 845	0. 000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1	0 41, 227, 409	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1	0 96, 940, 448	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1	0 243, 284, 585	0. 000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	1	0 0	0. 000000	75.00
75.01 07501 CARDIAC CATHERIZATION LABORATORY	0	0	1	0 32, 474, 225	0. 000000	75.01
OUTPATIENT SERVICE COST CENTERS				·		1
91.00 09100 EMERGENCY	0	0		0 104, 470, 967	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 18, 481, 516	0.00000	92.00
200.00 Total (lines 50 through 199)	0	0		0 1, 129, 848, 647		200.00

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVI CE OTHER PASS	Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 2:5	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	18, 210, 322		0 29, 981, 840	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 566, 635		0 5, 673, 808	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	122, 500		0 47, 121	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 175, 310		0 11, 569, 021	0	54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	0. 000000	576, 746		0 20, 114, 198	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	400, 415		0 3, 000, 028	0	56.00
60. 00 06000 LABORATORY	0. 000000	6, 916, 330		0 3, 566, 631	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 801, 785		0 1,000,250	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 437, 515		0 71, 766	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	733, 272		0 64, 730	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	297, 060		0 7,351	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	2, 250, 842		0 2, 473, 334	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	214, 345		0 162, 462	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 873, 502		0 6, 102, 370	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	9, 819, 397		0 16, 982, 921	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	13, 205, 163		0 66, 146, 789	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 000000	5, 206, 229		0 5, 868, 916	0	75.01
OUTPATIENT SERVICE COST CENTERS	· ·					1
91.00 09100 EMERGENCY	0. 000000	10, 321, 242		0 9, 183, 881	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	66, 306		0 1, 567, 261	0	92.00
200.00 Total (lines 50 through 199)		82, 194, 916		0 183, 584, 678	0	200.00
					•	

Health Fina	ncial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2021	Worksheet D Part V	
					To 12/31/2021		pared:
						5/26/2022 2:5	5 pm
			l litle	XVIII	Hospi tal	PPS	
	Cost Conton Description	Cost to	PPS	Charges Cost	Cost	Costs PPS Services	
	Cost Center Description	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not	(See That.)	
		Worksheet C.	inst.)	Subject To	Subject To		
		Part I, col.	11131.)	Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI I	LLARY SERVICE COST CENTERS		•	•			
50.00 05000	O OPERATING ROOM	0. 124832	29, 981, 840		0 0	3, 742, 693	50.00
51.00 05100	O RECOVERY ROOM	0. 182547	5, 673, 808		0 0	1, 035, 737	51.00
52.00 05200	O DELIVERY ROOM & LABOR ROOM	0. 289134	47, 121		0 0	13, 624	52.00
54.00 05400	0 RADI OLOGY-DI AGNOSTI C	0. 159328	11, 569, 021		0 0	1, 843, 269	54.00
55.00 05500	0 RADIOLOGY - THERAPEUTIC	0. 186118	20, 114, 198		0 0	3, 743, 614	55.00
56.00 05600	0 RADI OI SOTOPE	0. 059112	3, 000, 028		0 0	177, 338	56.00
	0 LABORATORY	0. 246697	3, 566, 631		0 0	879, 877	60.00
	0 RESPI RATORY THERAPY	0. 295040			0 0	295, 114	
	O PHYSI CAL THERAPY	0. 348586	71, 766		0 0	25, 017	66.00
	O OCCUPATIONAL THERAPY	0. 265723			0 0	17, 200	
	OSPEECH PATHOLOGY	0. 307356			0 0	2, 259	
	0 ELECTROCARDI OLOGY	0. 075051			0 0	185, 626	
	0 ELECTROENCEPHALOGRAPHY	0. 222357			0 0	36, 125	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 170082			0 0	1, 037, 903	
	O I MPL. DEV. CHARGED TO PATIENT	0. 192636			0 0	3, 271, 522	
	O DRUGS CHARGED TO PATIENTS	0. 226818		2, 56			
	O ASC (NON-DISTINCT PART)	0. 000000			0 0	0	
	1 CARDI AC CATHERI ZATI ON LABORATORY	0. 173389	5, 868, 916		0 0	1, 017, 605	75.01
	ATLENT SERVICE COST CENTERS	0.0000/0	0 100 001			040 750	01.00
	D EMERGENCY	0.089260			0 0		
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 253895			0 0	397, 920	
200.00	Subtotal (see instructions)		183, 584, 678	2, 56			
201.00	Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00	Net Charges (line 200 - line 201)		183, 584, 678	2, 56	26, 809	33, 545, 478	202 00
202.00	Iner ondiges (ITTIE 200 - ITTIE 201)	I	103, 304, 070	2,50	20, 009	33, 343, 476	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0161 Period :: From 01/01/2021 Worksheet D From 01/01/2021 Cost Center Description Cost S Cost Cost Cost Cost Cost Cost Cost Cost	Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS	-2552-10
Cost Center Description Cost St Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Cost Reimbursed Subject To Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 0 0 Subject To Ded. & Coins. (see inst.) 0 0 0 50.00 05000 (PERATING ROM 0 0 50.00 51.00 05000 (PERATING ROM 0 0 0 52.00 05200 (PEVP ROM & LABOR ROM 0 0 50.00 52.00 05500 (RADI OLOGY - THERAPEUTI C 0 0 55.00 56.00 05600 (RADI OLOGY - THERAPEUTI C 0 0 55.00 56.00 05600 (RADI OLOGY - THERAPEUTI C 0 0 0 66.00 06600 (PHYSI CAL THERAPY 0 0 0 0 66.00 06600 (SPEEL PATHORY THERAPY 0 0 0 0 0 68.00 06600 (SPEEL PATHORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST			From 01/01/2021 To 12/31/2021	Part V Date/Time Pr 5/26/2022 2:	epared: 55 pm
Cost Center Description Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) Sources Not Ded. & Coins. (see inst.) ANCILLARY SERVICE COST CENTERS 0 </td <td></td> <td></td> <td>Title</td> <td>XVIII</td> <td>Hospi tal</td> <td>PPS</td> <td></td>			Title	XVIII	Hospi tal	PPS	
Reimbursed Services Reimbursed Services Reimbursed Services Services Notice MCILLARY SERVICE COST CENTERS 0		Cos	sts				
ANCI LLARY SERVICE COST CENTERS Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.) 50.00 05000 OPERATING ROOM 0 0 51.00 05100 COVERN ROOM 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 50.00 05500 RADI OLOGY-DI AGNOSTI C 0 0 50.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 50.00 05500 RADI OLOGY - THERAPEUTI C 0 0 0 60.00 ABORATORY 0 0 0 6.0 60.00 ABORATORY 0 0 0 6.0 6.0 60.00 0 0 0 0 0 6.0 6.0 6.0 6.0 6.0 6.0 6.0 6.0 6.0 6.0 6.0 6.0 6.0	Cost Center Description						
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67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.0 68.00 06800 SPEECH PATHOLOGY 0 0 68.0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 71.0 72.00 072001 IMPL. DEV. CHARGED TO PATI ENT 0 0 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 581 6,081 73.0 75.01 07500 ASC (NON-DI STI NCT PART) 0 0 75.0 07501 CARDI AC CATHERI ZATI ON LABORATORY 0 0 75.0 07501 CARDI AC CATHERI ZATI ON LABORATORY 0 0 91.0 91.00 09100 EMERGENCY 0 0 91.0 92.00 09SERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.0 200.00 Subtotal (see instructions) 581 6,081 200.0 201.00		0	0				
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201.00 Less PBP Clinic Lab. Services-Program 0 201.0		-	•				
		581	0, 081				
		0					201.00
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202.00 Net Charges (line 200 - line 201) 581 6,081 202.0	202.00 [Net charges (The 200 - The 201)	581	0, 081	I			1202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2021 Fo 12/31/2021	Worksheet D Part I Date/Time Pre 5/26/2022 2:5	pared: 5 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 777, 220	0	6, 777, 220	31, 048	218. 28	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	0			0 0	0.00	34.01
34.02 PREMATURE INTENSIVE CARE UNIT	1, 424, 648		1, 424, 648	3 4, 259	334.50	34.02
43.00 NURSERY	565, 175		565, 175	5 4, 255	132.83	43.00
200.00 Total (lines 30 through 199)	8, 767, 043		8, 767, 043	3 39, 562		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	752	164, 147				30.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
34.01 PEDIATRIC INTENSIVE CARE UNIT	0	0				34.01
34.02 PREMATURE INTENSIVE CARE UNIT	133					34.02
43.00 NURSERY	956		•			43.00
200.00 Total (lines 30 through 199)	1, 841	335, 621				200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 2:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	6, 918, 508	242, 811, 210	0. 02849	3 355, 385	10, 126	50.00
51.00 05100 RECOVERY ROOM	715, 075	35, 062, 861	0. 02039	4 22, 274	454	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 827, 706				4, 050	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 160, 225					54.00
55. 00 05500 RADI OLOGY – THERAPEUTI C	3, 855, 570	75, 768, 763	0. 05088	6 34, 560	1, 759	55.00
56. 00 05600 RADI 0I SOTOPE	79, 368	9, 875, 660	0. 00803	7 3, 990	32	56.00
60. 00 06000 LABORATORY	721, 530	56, 180, 778	0. 01284	3 475, 080	6, 101	60.00
65. 00 06500 RESPI RATORY THERAPY	261, 268	14, 844, 457	0. 01760	0 839, 894	14, 782	65.00
66. 00 06600 PHYSI CAL THERAPY	143, 568	9, 098, 505	0. 01577	9 52, 642	831	66.00
67.00 06700 OCCUPATI ONAL THERAPY	12, 484	3, 134, 893	0. 00398	2 28, 916	115	67.00
68.00 06800 SPEECH PATHOLOGY	9, 823	1, 656, 211	0. 00593	1 8, 974	53	68.00
69. 00 06900 ELECTROCARDI OLOGY	264, 125	15, 722, 086	0. 01680	0 70, 690	1, 188	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	90, 436	3, 546, 845	0. 02549	8 15, 817	403	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	169, 304	41, 227, 409	0.00410	7 324, 736	1, 334	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	450, 895	96, 940, 448	0. 00465	1 140, 822	655	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	757, 892	243, 284, 585	0. 00311	5 1, 125, 072	3, 505	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000	0 0	0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	1, 655, 412	32, 474, 225	0. 05097	6 72, 059	3, 673	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	831, 730	104, 470, 967	0.00796	1 331, 597	2,640	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	610, 316	18, 481, 516	0. 03302	3 1, 820	60	92.00
200.00 Total (lines 50 through 199)	23, 535, 235	1, 129, 848, 647		4, 195, 180	61, 648	200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	Worksheet D Part III Date/Time Pre 5/26/2022 2:5	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		n Allied Health	All Other	
	Program	Program	Post-Stepdow	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0)	0 0	0	30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0	0		0 0	0	34.01
34. 02 03402 PREMATURE I NTENSI VE CARE UNI T	0			0 0	0	34.02
43. 00 04300 NURSERY					0	43.00
200.00 Total (lines 30 through 199)	0			0 0	-	200.00
Cost Center Description	Swing-Bed	Total Costs	, Total Patien	t Per Diem	Inpatient	200.00
cost center bescription	Adj ustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	Days	•	Program Days	
				col. 6)		
	4,00	minus col. 4) 5.00	(00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	5.00	6.00	7.00	8.00	-
30. 00 03000 ADULTS & PEDIATRICS	0	0	31, 04	8 0.00	752	30,00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0		51,04	0.00		34.00
34. 01 03400 PEDIATRIC INTENSIVE CARE UNIT				0.00		34.00
			4.05			
34. 02 03402 PREMATURE INTENSIVE CARE UNIT		0	4, 25			•
43.00 04300 NURSERY		0	4, 25			
200.00 Total (lines 30 through 199)		0	39, 56	2	1, 841	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1	1				
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
34.00 03400 SURGI CAL I NTENSI VE CARE UNI T	0					34.00
34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT	0					34.01
34.02 03402 PREMATURE INTENSIVE CARE UNIT	0					34.02
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Li	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS	S Provider CO	CN: 15-0161	Period: From 01/01/202 To 12/31/202		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	Program	Program	Post-Stepdown	1	
	Cost	Post-Stepdown	-	Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0 0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0 0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0 0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 (0 0	54.00
55. 00 05500 RADI OLOGY - THERAPEUT I C	0	0		0 (0 0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 (0 0	56.00
60.00 06000 LABORATORY	0	0		0 (0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 (0 0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 (0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 (0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	o l	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	o l	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	o l	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	o l	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 (0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0 0	75.00
75. 01 07501 CARDIAC CATHERIZATION LABORATORY	0	0		0 0	0 0	75.01
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0		0 (0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0 0	200.00
		· · · · · · · · · · · · · · · · · · ·	•	1		•

Health Financial Systems	IU HEALTH NOR	TH HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	VICE OTHER PAS			Period: From 01/01/2021 To 12/31/2021	5/26/2022 2:5	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0 242, 811, 210	0.00000	50.00
51.00 05100 RECOVERY ROOM	0	0		0 35, 062, 861	0.00000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 42, 666, 929	0.00000	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 82, 600, 299	0.000000	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0	0		0 75, 768, 763	0.000000	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0 9, 875, 660	0.000000	56.00
60. 00 06000 LABORATORY	0	0		0 56, 180, 778	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 14, 844, 457	0.000000	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 9, 098, 505	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 134, 893	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 656, 211	0.000000	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 15, 722, 086	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 3, 546, 845	0.000000	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 41, 227, 409	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 96, 940, 448	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 243, 284, 585	0.000000	73.00
75.00 07500 ASC (NON-DI STINCT PART)	0	0		0 0	0.000000	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0	0		0 32, 474, 225	0.000000	75.01
OUTPATIENT SERVICE COST CENTERS				· · · · ·		
91.00 09100 EMERGENCY	0	0		0 104, 470, 967	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 18, 481, 516		92.00
200.00 Total (lines 50 through 199)	0	0		0 1, 129, 848, 647		200.00

Health Financial Systems	IU HEALTH NORTH	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 2:5	pared: 5 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	-	Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	355, 385		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	22, 274		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	94, 542		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	196, 310		0 0	0	54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	34, 560		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	3, 990		0 0	0	56.00
60. 00 06000 LABORATORY	0. 000000	475, 080		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	839, 894		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	52, 642		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	28, 916		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	8,974		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	70, 690		0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	15, 817		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 000000	324, 736		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0.000000	140, 822		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	1, 125, 072		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0,000000	72, 059		0 0	0	75.01
OUTPATI ENT SERVI CE COST CENTERS		,		-1 -		
91. 00 09100 EMERGENCY	0.000000	331, 597		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 820		0 0	0	92.00
200.00 Total (lines 50 through 199)	0.00000	4, 195, 180		0 0	-	200.00
	1 I		1		-	

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 2:5	
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 124832		.,,.		0	
51.00 05100 RECOVERY ROOM	0. 182547		204, 6		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 289134		34, 21	13 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 159328		472, 92		0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 186118		430, 94		0	
56. 00 05600 RADI 0I SOTOPE	0. 059112		26, 00		0	
60. 00 06000 LABORATORY	0. 246697		250, 00		0	
65. 00 06500 RESPI RATORY THERAPY	0. 295040		35, 20		0	
66. 00 06600 PHYSI CAL THERAPY	0. 348586	0	74, 85	56 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 265723	0	36, 80	55 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 307356	0	28, 29	92 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 075051	0	36, 58	39 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 222357	0	54, 94	43 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 170082	0	138, 51	19 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 192636	0	429, 89	94 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 226818	0	1, 267, 32	28 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	0. 173389	0	126, 95	56 0	0	75.01
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 089260	0	1, 012, 0	57 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 253895	0	302, 35	59 0	0	92.00
200.00 Subtotal (see instructions)		0	6, 066, 40	58 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	6, 066, 40	58 0	0	202.00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pro 5/26/2022 2:	epared: 55 pm
		Title	e XIX	Hospi tal	PPS	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	407 707					
50. 00 05000 OPERATING ROOM	137, 787					50.00
51.00 05100 RECOVERY ROOM	37, 363					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 892					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	75, 350					54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	80, 206					55.00
56. 00 05600 RADI OI SOTOPE	1, 541					56.00
	61, 676					60.00
65. 00 06500 RESPI RATORY THERAPY	10, 387					65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	26, 094					66.00 67.00
	9, 796					
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	8, 696					68.00 69.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 746					70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	12, 217 23, 560					70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	82, 813	-				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	287, 453					73.00
75.00 07500 ASC (NON-DI STINCT PART)	207, 453					75.00
75. 01 07500 ASC (NON-DISTINCT PART) 75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY	22, 013					75.00
OUTPATIENT SERVICE COST CENTERS	22,013	0				15.01
91. 00 09100 EMERGENCY	90, 336	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	76, 767					92.00
200.00 Subtotal (see instructions)	1, 056, 693					200.00
201.00 Less PBP Clinic Lab. Services-Program	1,030,093					200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	1, 056, 693	О				202.00
	., 000, 070					1-02.00

	Financial Systems IU HEALTH NORTH ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0161	Period: From 01/01/2021	u of Form CMS-2 Worksheet D-1	
			To 12/31/2021	Date/Time Pre 5/26/2022 2:5	
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s. excluding newborn)		31, 048	1 1
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da	bed and newborn days)	rivate room days,	31, 048 0	2
00 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	28, 252 0	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	3, 3		0	
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo			0	
00	reporting period Total swing-bed NF type inpatient days (including private roo	5.		0	6
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	8, 423	9
. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e	nly (including private	room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12
	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this li	ne)	0	
00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es through December 31	of the cost	0.00	17
	Medicare rate for swing-bed SNF services applicable to servic reporting period			0.00	
	Medicaid rate for swing-bed NF services applicable to service reporting period	0		0.00	
	Medicaid rate for swing-bed NF services applicable to service reporting period		the cost	0.00	
	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)		ting period (line	52, 106, 039 0	
00	Swing-bed cost applicable to SNF type services after December x line 18) $$	31 of the cost reporti	ng period (line 6	0	
	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)		0 1 1	0	24
	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		0 52, 106, 039	
	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed c	harges)	0	
00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TINE 28)		0.000000	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 / 70 01	1
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 678. 24 14, 135, 816	
	Medically necessary private room cost applicable to the Progr			14, 155, 810	
. 00					

IPUTATION OF INPATIENT OPERATING COST	Provi de	er CCN: 15-0161	Peri od:	Worksheet D-1	2552 I
			From 01/01/2021 To 12/31/2021	Date/Time Pre	epare
				5/26/2022 2:5	55 pm
Cost Center Description Tot		itle XVIII Average Per	Hospital Program Days	PPS Program Cost	
	tient Inpatier			(col. 3 x	
Co		÷ col . 2)	4.00	<u>col. 4)</u>	
00 NURSERY (title V & XIX only)	00 2.00	<u> </u>	4.00	5.00	42.
Intensive Care Type Inpatient Hospital Units			0		
00 INTENSIVE CARE UNIT					43.
00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT					44.
00 SURGICAL INTENSIVE CARE UNIT	0	0 0.0	0 0	0	
01 PEDIATRIC INTENSIVE CARE UNIT	0	0 0.0		0	
	475, 901 4	, 259 1, 990. ⁻	12 0	0	
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description					47.
Cost Center Description				1.00	
00 Program inpatient ancillary service cost (Wkst. D-3				14, 179, 257	48.
00 Total Program inpatient costs (sum of lines 41 through and the second	ugh 48)(see instru	uctions)		28, 315, 073	49.
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program inpatient	routine services	(from Wkst D su	m of Parts I and	1, 838, 572	50.
	Four the services			1,030,372	
00 Pass through costs applicable to Program inpatient a	ancillary service	s (from Wkst. D,	sum of Parts II	1, 492, 934	51.
and IV) 00 Total Program excludable cost (sum of lines 50 and 5	51)			3, 331, 506	52
00 Total Program inpatient operating cost excluding ca		n-physician anest	hetist, and	24, 983, 567	
medical education costs (line 49 minus line 52)					
TARGET AMOUNT AND LIMIT COMPUTATION 00 Program discharges				0	54
00 Program di scharges 00 Target amount per di scharge				0.00	
00 Target amount (line 54 x line 55)				0.00	
00 Difference between adjusted inpatient operating cos	t and target amoun	nt (line 56 minus	line 53)	0	
00 Bonus payment (see instructions)	newind and and an 10			0	
00 Lesser of lines 53/54 or 55 from the cost reporting market basket	period ending 19	96, updated and c	ompounded by the	0.00	59
00 Lesser of lines 53/54 or 55 from prior year cost re	port, updated by	the market basket		0.00	60
00 If line 53/54 is less than the lower of lines 55, 5				0	61
which operating costs (line 53) are less than expect	•	54 x 60), or 1% o	f the target		
amount (line 56), otherwise enter zero (see instruc 00 Relief payment (see instructions)	tions)			0	62
00 Allowable Inpatient cost plus incentive payment (see	e instructions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST		<u>C 11</u>	· · · · · · · · · · · · · · · · · · ·		
00 Medicare swing-bed SNF inpatient routine costs throu instructions)(title XVIII only)	ugn December 31 o	r the cost report	ing period (see	0	64
00 Medicare swing-bed SNF inpatient routine costs after	r December 31 of	the cost reportin	g period (See	0	65
instructions)(title XVIII only)					
00 Total Medicare swing-bed SNF inpatient routine cost: CAH (see instructions)	s (line 64 plus li	ine 65)(title XVI	II only). For	0	66
00 Title V or XIX swing-bed NF inpatient routine costs	through December	31 of the cost r	eporting period	0	67
(line 12 x line 19)	0				
00 Title V or XIX swing-bed NF inpatient routine costs	after December 3	1 of the cost rep	orting period	0	68
(line 13 x line 20) 00 Total title V or XIX swing-bed NF inpatient routine	costs (line 67 +	line 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER NURSING F		· · · · · · · · · · · · · · · · · · ·			1
00 Skilled nursing facility/other nursing facility/ICF.)		70
00 Adjusted general inpatient routine service cost per 00 Program routine service cost (line 9 x line 71)	aiem (line 70 ÷	iine 2)			71
00 Medically necessary private room cost applicable to	Program (line 14	x line 35)			73
00 Total Program general inpatient routine service cos	ts (line 72 + line	e 73)			74
00 Capital-related cost allocated to inpatient routine	service costs (f	rom Worksheet B,	Part II, column		75
26, line 45) 00 Per diem capital-related costs (line 75 ÷ line 2)					76
00 Program capital -related costs (line 9 x line 76)					77
00 Inpatient routine service cost (line 74 minus line					78
00 Aggregate charges to beneficiaries for excess costs 00 Total Program routine service costs for comparison		· · · · · · · · · · · · · · · · · · ·	nus Lino 70)		79 80
00 Total Program routine service costs for comparison 00 Inpatient routine service cost per diem limitation			1103 I I IC /7)		80
00 Inpatient routine service cost limitation (line 9 x	line 81)				82
00 Reasonable inpatient routine service costs (see ins					83
00 Program inpatient ancillary services (see instruction					84
00 Utilization review - physician compensation (see in: 00 Total Program inpatient operating costs (sum of line					85
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUG					
00 Total observation bed days (see instructions)				2, 796	
()) Indirected general impatient routing each new diam ()	ine 27 ÷ line 2)			1, 678. 24	88.
00 Adjusted general inpatient routine cost per diem (1 00 Observation bed cost (line 87 x line 88) (see instru	,			4, 692, 359	00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 777, 220	52, 106, 039	0. 13006	6 4, 692, 359	610, 316	90.00
91.00 Nursing Program cost	0	52, 106, 039	0.00000	0 4, 692, 359	0	91.00
92.00 Allied health cost	0	52, 106, 039	0.00000	0 4, 692, 359	0	92.00
93.00 All other Medical Education	0	52, 106, 039	0.00000	0 4, 692, 359	0	93.00

	F	eriod: rom 01/01/2021 o 12/31/2021	u of Form CMS-2 Worksheet D-1 Date/Time Prep 5/26/2022 2:55	pared
	Title XIX	Hospi tal	PPS	
	Cost Center Description		1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS			
00	Inpatient days (including private room days and swing-bed days, excluding newborn)		31, 048	1.0
00	Inpatient days (including private room days, excluding swing-bed and newborn days)		31, 048	2.0
00	Private room days (excluding swing-bed and observation bed days). If you have only private room days (excluding swing-bed and observation bed days).	vate room days,	0	3.0
00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)		28, 252	4.0
00	Total swing-bed SNF type inpatient days (including private room days) through December	31 of the cost		5.0
00	reporting period			
00	Total swing-bed SNF type inpatient days (including private room days) after December 3' reporting period (if calendar year, enter 0 on this line)	I OF THE COST	0	6.0
00	Total swing-bed NF type inpatient days (including private room days) through December 3	31 of the cost	0	7.(
	reporting period			_
00	Total swing-bed NF type inpatient days (including private room days) after December 31 reporting period (if calendar year, enter 0 on this line)	of the cost	0	8.
00	Total inpatient days including private room days applicable to the Program (excluding s	swing-bed and	752	9.
	newborn days) (see instructions)			
0. 00) Swing-bed SNF type inpatient days applicable to title XVIII only (including private roo through December 31 of the cost reporting period (see instructions)	om days)	0	10.
1.00		om days) after	0	11.
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
2.00) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private through December 31 of the cost reporting period	room days)	0	12.
3. 00) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private	room days)	0	13.
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line))		
) Medically necessary private room days applicable to the Program (excluding swing-bed day) Total nursery days (title V or XIX only)	ays)	0 4, 255	14. 15
	Nursery days (title V or XIX only)		4, 255 956	
	SWING BED ADJUSTMENT			
7.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of	the cost	0.00	17.
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of th	ne cost	0.00	18.
	reporting period		0.00	
9.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of t reporting period	the cost	0.00	19.
0. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the	e cost	0.00	20.
	reporting period		50 10/ 000	01
2.00	5 1 ,	na period (line	52, 106, 039 0	21. 22.
	5 x line 17)	ig period (init	Ű	22.
3.00	5 11 51	period (line 6	0	23.
. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting	a period (line	0	24.
	7 x line 19)		Ĵ	
5.00		period (line 8	0	25.
5.00	x line 20)) Total swing-bed cost (see instructions)		0	26.
7.00	5		52, 106, 039	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	>	0	20
00 . 00		rges)	0	28. 29.
			0	30.
	5		0. 000000	
. 00			0.00	32.
. 00 . 00	5 1 1 5 (ions)	0.00 0.00	33. 34.
			0.00	35.
. 00	Private room cost differential adjustment (line 3 x line 35)		0	36.
. 00) General inpatient routine service cost net of swing-bed cost and private room cost difi	ferential (line	52, 106, 039	37.
5.00 5.00 7.00	27 minus line 24)			
. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
. 00	27 minus Line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
5.00 7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)		1, 678. 24	
5.00 7.00	PART II - HOSPITAL AND SUBPROVIDERS ONLYPROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTSAdjusted general inpatient routine service cost per diem (see instructions)Program general inpatient routine service cost (line 9 x line 38)		1, 678. 24 1, 262, 036 0	

MPUTATION OF INPATIENT OPERATING COST		TH HOSPITAL Provider C		Period:	u of Form CMS- Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	epare
					5/26/2022 2:5	
Cost Center Description	Total	Iitl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost	
cost center bescription	Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only)	3, 099, 425	4, 255	728.4	2 956	696, 370	42
Intensive Care Type Inpatient Hospital Un 00 INTENSIVE CARE UNIT						43
00 CORONARY CARE UNIT						44
00 BURN INTENSIVE CARE UNIT						45
00 SURGICAL INTENSIVE CARE UNIT	0	0	0.0	0 0	0	46
01 PEDIATRIC INTENSIVE CARE UNIT	0	0			0	
02 PREMATURE INTENSIVE CARE UNIT	8, 475, 901	4, 259	1, 990. 1	2 133	264, 686	
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
					1.00	+
00 Program inpatient ancillary service cost					897, 200	48
00 Total Program inpatient costs (sum of lir	nes 41 through 48)((see instructi	ons)		3, 120, 292	49
PASS THROUGH COST ADJUSTMENTS	·		- What Daw	f. Dausta Iu.	225 (21	
00 Pass through costs applicable to Program	inpatrent routine	Services (110	III WKSL. D, SUI	I OF Parts F and	335, 621	50
00 Pass through costs applicable to Program	inpatient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	61, 648	51
and IV)		5				
00 Total Program excludable cost (sum of lir					397, 269	
.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li	5 1	elated, non-ph	ysıcıan anesti	netist, and	2, 723, 023	53
TARGET AMOUNT AND LIMIT COMPUTATION	THE 52)					
00 Program di scharges					0	54
00 Target amount per discharge					0.00	55
00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient ope	erating cost and ta	arget amount (line 56 minus	line 53)	0	
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost	t roporting poriod	onding 1006	undated and c	ampounded by the	0.00	
market basket	t reporting period	enuring 1990,		Silpounded by the	0.00	' ³⁷
.00 Lesser of lines 53/54 or 55 from prior ye	ear cost report, up	dated by the	market basket		0.00	60
.00 If line 53/54 is less than the lower of I					0	61
which operating costs (line 53) are less		ts (lines 54 x	60), or 1% o ⁻	f the target		
amount (line 56), otherwise enter zero (s .00 Relief payment (see instructions)	see instructions)				0	62
00 Allowable Inpatient cost plus incentive p	pavment (see instru	uctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
00 Medicare swing-bed SNF inpatient routine	costs through Dece	ember 31 of th	e cost reporti	ng period (See	0	64
instructions)(title XVIII only)						
.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after Decem	per 31 of the	cost reporting	g period (See	0	65
00 Total Medicare swing-bed SNF inpatient ro	outine costs (line	64 plus line	65)(title XVI	lonly) For	0	66
CAH (see instructions)					0	
00 Title V or XIX swing-bed NF inpatient rou	utine costs through	n December 31	of the cost re	eporting period	0	67
(line 12 x line 19)					0	
.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	utine costs after l	December 31 of	the cost rep	orting period	0	68
.00 Total title V or XIX swing-bed NF inpatie	ent routine costs (line 67 + lin	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHE		•	· · ·			
00 Skilled nursing facility/other nursing fa)		70
00 Adjusted general inpatient routine servic		ine 70 ÷ line	2)			71
00 Program routine service cost (line 9 x li 00 Medically necessary private room cost app	· ·	(lipo 14 v l	ino 25)			72
 Medically necessary private room cost app Total Program general inpatient routine s 	0					73
00 Capital -related cost allocated to inpatie	•		•	Part II, column		75
26, line 45)						
00 Per diem capital-related costs (line 75 =						76
00 Program capital-related costs (line 9 x l00 Inpatient routine service cost (line 74 m	,					77
00 Aggregate charges to beneficiaries for ex		provi den inecon	ds)			79
00 Total Program routine service costs for o			· ·	nus line 79)		80
00 Inpatient routine service cost per diem I	imitation			·		81
00 Inpatient routine service cost limitation	•	· .				82
00 Reasonable inpatient routine service cost		ns)				83
00 Program inpatient ancillary services (see 00 Utilization review - physician compensati		ane)				84
00 Utilization review - physician compensati 00 Total Program inpatient operating costs (85
PART IV - COMPUTATION OF OBSERVATION BED						1
00 Total observation bed days (see instructi	ons)				2, 796	
00 Adjusted general inpatient routine cost p					1, 678. 24	
00 Observation bed cost (line 87 x line 88)					4, 692, 359	1 00

Health Financial Systems	IU HEALTH NOR	TH HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2021	Worksheet D-1	
				To 12/31/2021		
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	6, 777, 220	52, 106, 039	0. 13006	6 4, 692, 359	610, 316	90.00
91.00 Nursing Program cost	0	52, 106, 039	0.00000	0 4, 692, 359	0	91.00
92.00 Allied health cost	0	52, 106, 039	0.00000	0 4, 692, 359	0	92.00
93.00 All other Medical Education	0	52, 106, 039	0.00000	0 4, 692, 359	0	93.00

Health Financial Systems	IU HEALTH NORTH HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0161	Peri od:	Worksheet D-3	3
			From 01/01/2021 To 12/31/2021	Date/Time Pre	parod
			10 12/31/2021	5/26/2022 2:5	
	Tit	le XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			20 (20 212		20.00
30. 00 03000 ADULTS & PEDI ATRI CS 34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			29, 639, 312		30.00 34.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 34. 01 03401 PEDIATRIC INTENSIVE CARE UNIT			0		34.00
			0		34.01
34. 02 03402 PREMATURE I NTENSI VE CARE UNI T 43. 00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 1248	32 18, 210, 322	2, 273, 231	50.00
51. 00 05100 RECOVERY ROOM		0. 1825			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 2973			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1593			
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 1861			
56. 00 05600 RADI 0I SOTOPE		0.0591			
60. 00 06000 LABORATORY		0.2466			
65. 00 06500 RESPI RATORY THERAPY		0. 2950			
66. 00 06600 PHYSI CAL THERAPY		0. 3485			66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 2657			67.00
68.00 06800 SPEECH PATHOLOGY		0. 3073	56 297, 060	91, 303	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0750	51 2, 250, 842	168, 928	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 2223	57 214, 345	47, 661	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1700		658, 813	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 1926			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2268		2, 995, 169	
75.00 07500 ASC (NON-DISTINCT PART)		0.0000		j s	
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY		0. 1733	5, 206, 229	902, 703	75.01
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0. 0892			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2538			92.00
200.00 Total (sum of lines 50 through 94 and			82, 194, 916		
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges (line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)			82, 194, 916		202.00

Health Financial Systems	IU HEALTH NORTH HOSPITAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0161	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
			10 12/31/2021	5/26/2022 2:5	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
UNDATIONT DOUTINE CEDVICE COST CENTEDS		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	2 204 004		20.00
30. 00 03000 ADULTS & PEDIATRICS 34. 00 03400 SURGICAL INTENSIVE CARE UNIT			2, 304, 804		30.00
			0		34.00
34. 01 03401 PEDIATRI CI NTENSI VE CARE UNI T			1 224 241		34.01 34.02
34. 02 03402 PREMATURE INTENSIVE CARE UNIT 43. 00 04300 NURSERY			1, 224, 241		34.02 43.00
ANCI LLARY SERVICE COST CENTERS			143, 838		43.00
50. 00 05000 OPERATI NG ROOM		0. 12483	32 355, 385	44, 363	50.00
51. 00 05100 RECOVERY ROOM		0. 1240			
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 29730			•
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 15932			•
55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 18/3			•
56. 00 05600 RADI OI SOTOPE		0. 0591			
60. 00 06000 LABORATORY		0. 2466			
65. 00 06500 RESPIRATORY THERAPY		0. 29504			•
66. 00 06600 PHYSI CAL THERAPY		0. 34858			
67.00 06700 OCCUPATI ONAL THERAPY		0.26572			
68.00 06800 SPEECH PATHOLOGY		0. 3073			
69.00 06900 ELECTROCARDI OLOGY		0.0750	70, 690	5, 305	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0. 2223	57 15, 817	3, 517	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 17008	32 324, 736	55, 232	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 19263	36 140, 822	27, 127	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2268	1, 125, 072	255, 187	73.00
75.00 07500 ASC (NON-DISTINCT PART)		0.0000	0 0	0	75.00
75. 01 07501 CARDI AC CATHERI ZATI ON LABORATORY		0. 17338	39 72,059	12, 494	75.01
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY		0.08920			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 25389			
200.00 Total (sum of lines 50 through 94 and 9			4, 195, 180	897, 200	
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			4, 195, 180		202.00

ALCUL	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	H HOSPITAL Provider CCN: 15-0161	Period: From 01/01/2021	u of Form CMS-2 Worksheet E Part A	
			To 12/31/2021	Date/Time Pre 5/26/2022 2:5	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occur	rring prior to October 1	(see	0 11, 687, 897	
. 02	instructions) DRG amounts other than outlier payments for discharges occur instructions)	ring on or after October	1 (see	4, 251, 549	1.0
. 03	DRG for federal specific operating payment for Model 4 BPCI 1 (see instructions)	for discharges occurring	prior to October	0	1.0
. 04	DRG for federal specific operating payment for Model 4 BPCI October 1 (see instructions)	for discharges occurring	on or after	0	
. 00 . 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2.0
. 02	Outlier payment for discharges for Model 4 BPCI (see instruc	ctions)		0	2.0
. 03	Outlier payments for discharges occurring prior to October 1			664, 220	
. 04 . 00	Outlier payments for discharges occurring on or after Octobe Managed Care Simulated Payments	er 1 (see instructions)		296, 021 0	
. 00	Bed days available divided by number of days in the cost rep	porting period (see instr	uctions)	152.77	4.0
	Indirect Medical Education Adjustment				
. 00	FTE count for allopathic and osteopathic programs for the mc or before 12/31/1996. (see instructions)	ost recent cost reporting	perioa enaing on	0.00	5.0
. 00	FTE count for allopathic and osteopathic programs that meet new programs in accordance with 42 CFR 413.79(e)				6.0
. 00 . 01	MMA Section 422 reduction amount to the IME cap as specified ACA § 5503 reduction amount to the IME cap as specified under			0.00 0.00	
. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allop			0.00	8.
	affiliated programs in accordance with 42 CFR 413.75(b), 413 1998), and 67 FR 50069 (August 1, 2002).				
. 01	The amount of increase if the hospital was awarded FTE cap s report straddles July 1, 2011, see instructions.	slots under § 5503 of the	ACA. If the cost	0.00	8.
. 02	The amount of increase if the hospital was awarded FTE cap s under § 5506 of ACA. (see instructions)	slots from a closed teach	ing hospital	0.00	8.
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus li instructions)			0.00	
0. 00 1. 00	FTE count for allopathic and osteopathic programs in the cur FTE count for residents in dental and podiatric programs.	rrent year from your reco	ords	0.00 0.00	
2.00	Current year allowable FTE (see instructions)			0.00	
3.00 4.00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that y	vear ended on or after Se	ptember 30, 1997,	0.00 0.00	
5.00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00	15.
6.00	Adjustment for residents in initial years of the program			0.00	
7.00	Adjustment for residents displaced by program or hospital cl	osure		0.00	17.
B. 00	Adjusted rolling average FTE count			0.00	
	Current year resident to bed ratio (line 18 divided by line	4).		0.000000	
D. 00 1. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
2.00	IME payment adjustment (see instructions)			0.000000	
2.01	IME payment adjustment - Managed Care (see instructions)			0	
3.00	Indirect Medical Education Adjustment for the Add-on for § 4 Number of additional allopathic and osteopathic IME FTE resi		CFR 412.105	0.00	23.
1 00	(f)(1)(iv)(C).			0.00	24
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	e lower of line 23 or lin	e 24 (see	0.00 0.00	
5.00	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	26.
7.00	IME payments adjustment factor. (see instructions)			0.000000	
8.00	IME add-on adjustment amount (see instructions)			0	28.
8.01 9.00	IME add-on adjustment amount - Managed Care (see instruction Total IME payment (sum of lines 22 and 28)	15)		0	
9.00 9.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.	01)		0	
0 0-	Disproportionate Share Adjustment				
0.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (see instru	icti ons)	2.08	
1.00	Percentage of Medicaid patient days (see instructions) Sum of lines 30 and 31			21.44	
2.00				23.52	
3.00	Allowable disproportionate share percentage (see instruction	15.)	1	8.62	33.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Date/Time Pre	enare
				5/26/2022 2:5	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	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)		0.000131680		
5. 02	Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line) (s	see 1, 091, 625	809, 921	35.
	instructions)				
5. 03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	816, 475	204, 145	35.
. 00	Total uncompensated care (sum of columns 1 and 2 on line		1, 020, 620		36
	Additional payment for high percentage of ESRD beneficiar	y discharges (lines 40 thro			
0. 00	Total Medicare discharges (see instructions)		0		40
. 00	Total ESRD Medicare discharges (see instructions)		0		41
. 01	Total ESRD Medicare covered and paid discharges (see inst		0		41
. 00	Divide line 41 by line 40 (if less than 10%, you do not q	uality for adjustment)	0.00		42
. 00	Total Medicare ESRD inpatient days (see instructions)		0		43
. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by	7 0. 000000		44
. 00	days) Average weekly cost for dialysis treatments (see instruct	i ons)	0.00		45
. 00	Total additional payment (line 45 times line 44 times lin		0.00		40
. 00	Subtotal (see instructions)	le 41.01)	18, 263, 802		40
. 00	Hospital specific payments (to be completed by SCH and MD	H small rural bospitals	10, 203, 002		48
. 00	only. (see instructions)				'`
				Amount	
				1.00	
. 00	Total payment for inpatient operating costs (see instruct			18, 263, 802	
. 00	Payment for inpatient program capital (from Wkst. L, Pt.			1, 530, 680	
. 00	Exception payment for inpatient program capital (Wkst. L,			0	51
. 00	Direct graduate medical education payment (from Wkst. E-4	, Tine 49 see Instructions).	0	
3.00 4.00	Nursing and Allied Health Managed Care payment			-	
. 00	Special add-on payments for new technologies Islet isolation add-on payment			260, 840 0	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	55
. 00	Cost of physicians' services in a teaching hospital (see			0	56
. 00	Routine service other pass through costs (from Wkst. D, P		through 35)	0	57
3.00	Ancillary service other pass through costs from Wkst. D,		through boy.	0	58
0.00	Total (sum of amounts on lines 49 through 58)			20, 055, 322	
. 00	Primary payer payments			0	60
. 00	Total amount payable for program beneficiaries (line 59 m	inus line 60)		20, 055, 322	
2.00	Deductibles billed to program beneficiaries	,		1, 860, 520	62
. 00	Coinsurance billed to program beneficiaries			125, 769	63
. 00	Allowable bad debts (see instructions)			64, 815	64
. 00	Adjusted reimbursable bad debts (see instructions)			42, 130	65
b. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		7, 598	66
. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			18, 111, 163	
. 00	Credits received from manufacturers for replaced devices				
	Outlier payments reconciliation (sum of lines 93, 95 and	96). (For SCH see instruction	ons)	0	1 .
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Rural Community Hospital Demonstration Project (§410A Dem	, ,	e instructions)	0	
. 87	Demonstration payment adjustment amount before sequestrat			0	
. 88	SCH or MDH volume decrease adjustment (contractor use onl			0	
	Pioneer ACO demonstration payment adjustment amount (see				70
	HSP bonus payment HVBP adjustment amount (see instruction HSP bonus payment HRR adjustment amount (see instructions			0	
. 90		·/		0	
). 90). 91				n	
). 90). 91). 92	Bundled Model 1 discount amount (see instructions)			02 315	
 89 90 91 92 93 94 				0 92, 315 -1, 285	70

	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0161	Peri od:	u of Form CMS-2 Worksheet E	
				From 01/01/2021 To 12/31/2021	Part A Date/Time Pre 5/26/2022 2:5	pare
		Title	XVIII	Hospi tal	PPS	jo pili
			FFY	(уууу)	Amount	
				0	1.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70.
0. 97	the corresponding federal year for the period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter i			0	0	70.
	the corresponding federal year for the period ending on or af	ter 10/1)			0	70
). 98). 99	Low Volume Payment-3 HAC adjustment amount (see instructions)				0	
. 00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			18, 202, 193	
1.01	Sequestration adjustment (see instructions)				0	
1. 02	Demonstration payment adjustment amount after sequestration				0	71.
1. 03	Sequestration adjustment-PARHM pass-throughs					71.
2.00	Interim payments				18, 166, 668	
2.01	Interim payments-PARHM				0	72.
3.00 3.01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)				0	73.
4.00	Balance due provider/program (line 71 minus lines 71.01, 71.0	12 72 and			35, 525	
1. 00	(73)	<i>z, 12,</i> and			00, 020	' '.
4.01	Balance due provider/program-PARHM (see instructions)					74.
5.00	Protested amounts (nonallowable cost report items) in accorda	nce with			281, 986	75.
	CMS Pub. 15-2, chapter 1, §115.2					
0. 00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96) Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2.02			0	90.
J. UU	plus 2.04 (see instructions)	01 2.03			0	90.
. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.
2.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	
3.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93.
4.00	The rate used to calculate the time value of money (see instr	,			0.00	
5.00	Time value of money for operating expenses (see instructions)				0	
6.00	Time value of money for capital related expenses (see instruc	tions)		Prior to 10/1	$\frac{0}{0}$	96.
				1.00	2.00	
	HSP Bonus Payment Amount					
00.00	HSP bonus amount (see instructions)			0	0	100.
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 000000000	0. 000000000	
J2. UU	HVBP adjustment amount for HSP bonus payment (see instruction HRR Adjustment for HSP Bonus Payment	IS)		0	0	102.
	HRR adjustment factor (see instructions)					
03 00				0 0000		103
	3	;)		0.0000	0. 0000 0	
	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst		ustment			
04.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe	ration) Adju			0	104.
04.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no.	ration) Adju			0	104.
04.00 00.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	ration) Adju riod under			0	104. 200.
04.00 00.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ration) Adju riod under			0	104. 200. 201.
04.00 00.00 01.00 02.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions)	ration) Adju riod under			0	104. 200. 201. 202.
04.00 00.00 01.00 02.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin	ration) Adju eriod under ne 49)	the 21st		0	104. 200.
04.00 00.00 01.00 02.00 03.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period)	ration) Adju eriod under ne 49)	the 21st		0 trati on	104. 200. 201. 202. 203.
04.00 00.00 01.00 02.00 03.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adju eriod under ne 49)	the 21st		0 trati on	104. 200. 201. 202. 203. 204.
)4. 00)0. 00)1. 00)2. 00)3. 00)3. 00)4. 00)5. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ration) Adju eriod under ne 49) i first year	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205.
)4. 00)0. 00)1. 00)2. 00)3. 00)3. 00)4. 00)5. 00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, lin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adju eriod under ne 49) i first year	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205.
 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adju riod under ne 49) i first year	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206.
 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst	ration) Adju eriod under ne 49) first year	the 21st		0 tration	104. 200. 201. 202. 203. 204. 205. 206. 207.
04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adju eriod under ne 49) first year	the 21st		0 tration	 104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	ration) Adju eriod under ne 49) first year	the 21st		0 tration	 104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
 04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions)	ration) Adje priod under ne 49) first year ructions) line 59)	the 21st		0 tration	104. 200. 201. 202.
04.00 00.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 10.00 11.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adju riod under ne 49) first year ructions) line 59)	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.
04.00 00.00 01.00 02.00 03.00 04.00 05.00 06.00 07.00 08.00 09.00 11.00 11.00	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare Part A IPPS payments (from line	ration) Adju riod under ne 49) first year ructions) line 59)	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211. 211.
 54. 00 50. 00 51. 00 52. 00 52. 00 53. 00 55. 00 55. 00 56. 00 56. 00 57. 00 58. 00 59. 00 10. 00 11. 00 11. 00 12. 00 13. 00 	HRR adjustment amount for HSP bonus payment (see instructions Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, Iin Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see inst Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	ration) Adju eriod under ne 49) first year ructions) line 59) 211)	of the curre		0 tration	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 211.

W VC	Financial Systems		IU HEALTH NOR	Provi der C	F	Period: From 01/01/2021 Fo 12/31/2021	u of Form CMS-2 Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 2:5	t 4 parec
		W/S E, Part A line	Amounts (from E, Part A)	Title Pre/Post Entitlement	XVIII Period Prior to 10/01	Hospital Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier	1.00	0	0	(0 0	0	1. (
01	payments DRG amounts other than outlier payments for discharges	1.01	11, 687, 897	0	11, 687, 897	7	11, 687, 897	1.(
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1.02	4, 251, 549	0		4, 251, 549	4, 251, 549	1.
03	1 DRG for Federal specific operating payment for Model 4 BPCl occurring prior to	1.03	0	0	(0	1.
04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00						2.
01	Outlier payments for discharges for Model 4 BPCI	2.02	0	-			-	
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	664, 220	0	664, 220	J	664, 220	2.
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	296, 021	0		296, 021	296, 021	2.
00	Operating outlier reconciliation	2. 01	0	0	(0 0	0	3.
00	Managed care simulated payments	3.00	0	0	(0 0	0	4.
00	Indirect Medical Education Adju Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.
00	IME payment adjustment (see instructions)	22.00	0	-			-	
01	IME payment adjustment for managed care (see instructions)	22.01	0	0	(0 0	0	6.
	Indirect Medical Education Adju	ustment for the	e Add-on for Se	ection 422 of [.]	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000			0. 000000		7
)0	IME adjustment (see instructions)	28.00	0	0			0	
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	-				
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed	29. 00 29. 01	0	0			0	
,	care (sum of lines 6.01 and 8.01)	27.01						
	Disproportionate Share Adjustme		0.550	0.55				
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0862	0. 0862	0. 0862	0. 0862		10.
00	Disproportionate share adjustment (see instructions)	34.00	343, 495			91, 621	343, 495	11.
	Uncompensated care payments Additional payment for high per		1, 020, 620 RD beneficiary	di scharges	· ·			
00 00 00	Total ESRD additional payment (see instructions) Subtotal (see instructions) Hospital specific payments	46.00 47.00 48.00	0 18, 263, 802 0	0 0 0				
00	(completed by SCH and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient	49.00	18, 263, 802	0	13, 420, 466	6 4, 843, 336	18, 263, 802	15
	operating costs (see instructions)							

	Financial Systems LUME CALCULATION EXHIBIT 4			Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet E Part A Exhibi Date/Time Pre 5/26/2022 2:5	pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prio to 10/01	r Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3,00	4,00	5.00	
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 530, 680	0	1, 110, 8	92 419, 788		16.00
17.00	Special add-on payments for new technologies	54.00	260, 840	0	229, 04	49 31, 791	260, 840	
17.01	Net organ aquisition cost							17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)		0	0		0 0	0	18.00
10 00	SUBTOTAL			0	14, 760, 40	5, 294, 915	20, 055, 322	10 00
19.00		W/S L, line	(Amounts from L)	0	14, 700, 4	5, 274, 715	20, 033, 322	17.00
		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, 221, 644 0	0 0		10 322, 634 0 0	1, 221, 644 0	
21.00	Capital DRG outlier payments	2.00	249, 420	0	168, 0	11 81, 409	249, 420	21.00
21.00	Model 4 BPCI Capital DRG outlier payments	2.00	0	0		0 0	0	
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0000	0. 0000				22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0		23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0488	0. 0488	0. 048	38 0. 0488		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	59, 616	0	43, 8	71 15, 745	59, 616	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 530, 680	0	1, 110, 89	92 419, 788	1, 530, 680	26.00
		W/S E, Part A	(Amounts to					
		line	E, Part A)					
		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. 0000	0.000000	0	27.00 28.00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

)SPI T	Financial Systems TAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	<u>IU HEALTH NOR</u> TION EXHIBIT 5	6 Provider CC		Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:5	t 5 pared:
				XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
00 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	11, 687, 897	11, 687, 89	7	11, 687, 897	1. 00 1. 01
02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	4, 251, 549		4, 251, 549	4, 251, 549	1.02
03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1.03	0		0	0	1. 03
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
00	Outlier payments for discharges (see instructions)	2.00					2.00
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.01
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	664, 220	664, 22	0	664, 220	2.02
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	296, 021		296, 021	296, 021	2.03
00 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0 0 0	0 0	3.00 4.00
00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0. 00000	0.00000		5.00
00 01	(see instructions) IME payment adjustment (see instructions) IME payment adjustment for managed care (see	22. 00 22. 01	0		0 0 0 0	0 0	6. 00 6. 01
	instructions)	Add on for C	antion 100 of t	bo MMA			
00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see instructions)	27.00	0. 000000		0 0. 000000		7.OC
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0 0 0	0 0	8.00 8.01
00 01	care (see instructions) Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29. 00 29. 01	0		0 0 0 0	0 0	9.00 9.01
	Lines 6.01 and 8.01)						
0. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0862	0. 086	2 0. 0862		10.00
I. 00	(see instructions) Disproportionate share adjustment (see	34.00	343, 495	251, 87	91, 621	343, 495	11.00
I.01	instructions) Uncompensated care payments Additional payment for high percentage of ESM	36.00	1, 020, 620	816, 47	5 204, 145	1, 020, 620	11. 01
2.00	Total ESRD additional payment (see instructions)	46. 00	0 of scharges		0 0	0	12.00
3.00 4.00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47.00 48.00	18, 263, 802 0	13, 420, 46	6 4, 843, 336 0 0	18, 263, 802 0	
5.00	instructions) Total payment for inpatient operating costs	49.00	18, 263, 802	13, 420, 46	6 4, 843, 336	18, 263, 802	15.00
. 00	(see instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 530, 680	1, 110, 89	419, 788	1, 530, 680	16.00
7.00 7.01	Special add-on payments for new technologies Net organ acquisition cost	54.00	260, 840	229, 04	.9 31, 791	260, 840	17.00 17.01
7.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
3. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0	0	
	SUBTOTAL			14, 760, 40	5, 294, 915	20, 055, 322	10 0

Health Financial Systems	IU HEALTH NOR			In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:5	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3.00	4.00	
20.00 Capital DRG other than outlier	1.00	1, 221, 644	899, 01	10 322, 634	1, 221, 644	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20.01
21.00 Capital DRG outlier payments	2.00	249, 420	168, 0 ⁻	11 81, 409	249, 420	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0. 0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0488	0. 048	0. 0488		24.00
25.00 Disproportionate share adjustment (see instructions)	11.00	59, 616	43, 8	71 15, 745	59, 616	25.00
26.00 Total prospective capital payments (see instructions)	12.00	1, 530, 680	1, 110, 89	92 419, 788	1, 530, 680	26.00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3.00	4.00	
27.00						27.00
28.00 Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	92, 315	92, 3 [.]	15 0	92, 315	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30.01
31.00 HRR adjustment (see instructions)	70. 94	-1, 285		0 -1, 285	-1, 285	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
					(Amt. to Wkst. E, Pt.	
		1.00	0.00	2.00	A)	
22.00 UMC Deduction Drogram adjustment (0	1.00	2.00	3.00	4.00	32.00
32.00 HAC Reduction Program adjustment (see instructions)				0 0		
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100.00

	Financial Systems IU HEALTH NORTH ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0161	Peri od:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2021 To 12/31/2021	Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2022 2:5 PPS	5 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				1
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		6, 662 33, 545, 478	
3.00	OPPS payments			26, 618, 836	3.00
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			172, 258 0	
5.00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
6.00	Line 2 times line 5			0	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 6, 662	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0,002	11.00
12 00	Reasonable charges			20.340	10.00
12.00 13.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, 1	line 69)		29, 369 0	
14.00	Total reasonable charges (sum of lines 12 and 13)			29, 369	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	navment for services or	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for			0	
17 00	had such payment been made in accordance with 42 CFR §413.13	(e)		0. 000000	17.00
17.00 18.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			29, 369	
19.00	Excess of customary charges over reasonable cost (complete or	nly if line 18 exceeds l	ine 11) (see	22, 707	
20.00	instructions) Excess of reasonable cost over customary charges (complete or	nlvifline 11 exceeds l	ine 18) (see	0	20.00
	instructions)		(
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			6, 662	
23.00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			26, 791, 094	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	ns)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	ne 24 (for CAH, see inst		4, 492, 606	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2	2 and 23] (see	22, 305, 150	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	
30.00 31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			22, 305, 150 6, 104	
32.00	Subtotal (line 30 minus line 31)			22, 299, 046	
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	I CES)		0	33.00
34.00	Allowable bad debts (see instructions)			199, 801	
35.00	Adjusted reimbursable bad debts (see instructions)	tructiona)		129, 871	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see ins Subtotal (see instructions)	tructions)		136, 799 22, 428, 917	
38.00	MSP-LCC reconciliation amount from PS&R			-161	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.00 39.50
39.97	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for repla	aced devices (see instru	ctions)	26, 954	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 22, 429, 078	
40.01	Sequestration adjustment (see instructions)			0	40.01
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
40.03	Interim payments			22, 398, 073	1
41.01	Interim payments-PARHM				41.01
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00
43.00	Balance due provider/program (see instructions)			31, 005	43.00
43.01 44.00	Balance due provider/program-PARHM (see instructions)	ance with CMS Dub 15 0	chanter 1	E 140	43.01
44.UU	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with UMS PUD. 15-2,		5, 169	44.00
00.05	TO BE COMPLETED BY CONTRACTOR			-	00.05
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
74.00	Total (Sam of Titles / and /S)			0	1 / 7.00

	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021		pared:
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		18, 166, 6	68 0	22, 398, 073 0	1.00 2.00 3.00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3.02				0	0	3.02
3.03 3.04				0	0	3.03 3.04
3.04				0	0	3.04
0.00	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52 3.53				0	0	3.52 3.53
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		18, 166, 6	68	22, 398, 073	4.00
	TO BE COMPLETED BY CONTRACTOR				1	
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5. 01	Program to Provider TENTATIVE TO PROVIDER		[0	0	5.01
5.01				0	0	5.02
5.03				0	0	5.03
	Provider to Program		[
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		35, 5	25	31, 005 0	6.01 6.02
6.02 7.00	Total Medicare program liability (see instructions)		18, 202, 1	0	22, 429, 078	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 15-0161	Period: From 01/01/2021	Worksheet E-1 Part II	
				To 12/31/2021		
			Title XVIII	Hospi tal	PPS	
					1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	RD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTIO					
1.00	Total hospital discharges as defined in AARA					1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, su		8 through 12, and plus t	for cost		2.00
	reporting periods beginning on or after 10/					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, co					3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col reporting periods beginning on or after 10/		1, and 8 through 12, and	d plus for cost		4.00
5.00	Total hospital charges from Wkst C, Pt. I,					5.00
6.00	Total hospital charity care charges from Wks		ine 20			6.00
7.00	CAH only - The reasonable cost incurred for line 168			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 instru					9.00
	Calculation of the HIT incentive payment af		(see instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS 8					10.00
30.00	Initial/interim HIT payment adjustment (see					30.00
	Other Adjustment (specify)					31.00
	Balance due provider (line 8 (or line 10) m	inus line 30 and l	ine 31) (see instruction	ns)		32.00
			, (, I		

ALANC	Financial Systems IU HEALTH NOR E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provi der C		riod: om 01/01/2021	u of Form CMS-2 Worksheet G	
nl y)			Tc		Date/Time Pre 5/26/2022 2:5	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
. 00	Cash on hand in banks	395, 675, 403	0	0	0	1.00
. 00	Temporary investments	0	0	0	0	2.00
. 00	Notes receivable	0	0	0	0	3.00
. 00	Accounts receivable	66, 974, 397	0	0	0	4.00
. 00 . 00	Other receivable Allowances for uncollectible notes and accounts receivable	-14, 349, 097	0	0	0	5.00
. 00	Inventory	6, 050, 068	0	0	0	7.00
. 00	Prepai d expenses	816, 187	0	0	0	8.00
. 00	Other current assets	383, 253		0	0	9.0
0.00	Due from other funds	0	0	0	0	10.0
1.00	Total current assets (sum of lines 1-10) FIXED ASSETS	455, 550, 211	0	0	0	11.0
2.00	Land	0	0	0	0	12.0
	Land improvements	12, 041, 302		0	0	13.0
	Accumulated depreciation	-11, 957, 918		0	0	14.00
5.00	Bui I di ngs	208, 575, 164	0	0	0	15.0
	Accumulated depreciation	-68, 955, 768		0	0	16.0
	Leasehold improvements	740, 541	0	0	0	17.0
	Accumulated depreciation	-594, 905	0	0	0	18.0
	Fixed equipment Accumulated depreciation	0	0	0	0	19.0 20.0
	Automobiles and trucks	183, 263		0	0	20.0
	Accumulated depreciation	-145, 358		0	0	22.0
	Major movable equipment	112, 587, 780		0	0	23.0
	Accumulated depreciation	-77, 107, 559	0	0	0	24.0
	Minor equipment depreciable	0	0	0	0	25.0
	Accumulated depreciation	0	0	0	0	26.0
	HIT designated Assets Accumulated depreciation	0	0	0	0	27.0 28.0
	Mi nor equi pment-nondepreci abl e	0	0	0	0	20.0
	Total fixed assets (sum of lines 12-29)	175, 366, 542	0	0	0	30.0
	OTHER ASSETS		· · · · ·		-	
	Investments	0	0	0	0	31.0
	Deposits on Leases	0	0	0	0	32.0
	Due from owners/officers		0	0	0	33.0
	Other assets Total other assets (sum of lines 31-34)	7, 980, 477 7, 980, 477		0	0	34.0 35.0
	Total assets (sum of lines 11, 30, and 35)	638, 897, 230		0	0	
0.00	CURRENT LI ABI LI TI ES	000/07/200				
7.00	Accounts payable	19, 315, 409	0	0	0	37.0
	Salaries, wages, and fees payable	3, 651, 170	0	0	0	38.0
	Payroll taxes payable	0	0	0	0	
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income Accelerated payments	6, 181, 119	0	0	0	41.0 42.0
	Due to other funds	0, 101, 119	0	0	0	
	Other current liabilities	2, 718, 972		0	0	
	Total current liabilities (sum of lines 37 thru 44)	31, 866, 670		0	0	
	LONG TERM LIABILITIES					
	Mortgage payable	0	0	0	0	
	Notes payable	0	0	0	0	47.0
	Unsecured Loans	1 010 540	0	0	0	48.0 49.0
	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	1, 812, 563 1, 812, 563		0	0	49.0 50.0
	Total liabilities (sum of lines 45 and 50)	33, 679, 233		0	0	51.0
	CAPITAL ACCOUNTS		-	-1		1
2.00	General fund balance	605, 217, 997				52.0
	Specific purpose fund		0			53. C
	Donor created - endowment fund balance - restricted			0		54.0
	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.C
	Plant fund balance - reserve for plant improvement,				0	57.0 58.0
2.00	replacement, and expansion				0	
0 00	Total fund balances (sum of lines 52 thru 58)	605, 217, 997		0	0	59.0
9.00		638, 897, 230				

Heal th	Financial Systems	IU HEALTH NORT	H HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider C	CN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet G-7 Date/Time Pre 5/26/2022 2:5	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	491, 725, 383 113, 492, 621 605, 218, 004 605, 218, 004 605, 218, 004				5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_		
1.00		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING	0 0	0 0 0 0 0 0 0 0 0		0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18. 00 19. 00	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		18.00 19.00

STATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCM	N: 15-0161		/01/2021 2/31/2021	Worksheet G-2 Parts I & II Date/Time Pre 5/26/2022 2:5	epared:
	Cost Center Description		I npati ent	Outp	oati ent	Total	
	·		1.00	4	2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		116, 637, 1	53		116, 637, 153	1.00
2.00	SUBPROVIDER – IPF						2.00
3.00	SUBPROVIDER – IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF			0		0	5.00
5.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
3.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		116, 637, 1	53		116, 637, 153	10.00
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.00
12.00	CORONARY CARE UNIT						12.0
13.00	BURN INTENSIVE CARE UNIT						13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T			0		0	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT			0		0	14.0
14.02	PREMATURE INTENSIVE CARE UNIT		22, 085, 7	51		22, 085, 751	14.02
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	22, 085, 7	51		22, 085, 751	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		138, 722, 90	04		138, 722, 904	17.00
18.00	Ancillary services		274, 515, 30	58 732	2, 380, 795	1,006,896,163	18.00
19.00	Outpatient services		26, 685, 54	14 96	6, 266, 939	122, 952, 483	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.0
24.00	CMHC						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	NONALLOWABLE REVENUE				, 524, 933		
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	439, 923, 81	16 830), 172, 667	1, 270, 096, 483	28.00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)				3, 768, 632		29.00
30.00	ADD (SPECIFY)			0			30.00
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)				0		36.0
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00	Total deductions (sum of lines 07, 11)			0	~		41.00
12.00	Total deductions (sum of lines 37-41)				0		42.0
13.00	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	transfer		268	3, 768, 632		43.00

16.00 Revenue from sale of medical and surgical supplies to other than patients 0 16.00 17.00 Revenue from sale of drugs to other than patients 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 18.00 19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 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 INCOME 4, 317, 530 24.00 24.50 COVI D-19 PHE Funding 1, 141, 309 24.50 25.00 Total other income (sum of lines 6-24) 5, 458, 839 25.00 26.00 Total other expenses (SPECI FY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	Heal th	Financial Systems	IU HEALTH NORTH	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
To 12/31/201 Date/Time Prepared: Date/Time Prepared: 22/22/222 2:55 pm 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1, 270, 096, 483 1, 00 2.00 Less contractual allowances and discunts on patients' accounts 893, 294, 069 2.00 3.00 Net patient revenues (from Wkst. G-2, Part II, line 43) 3.06, 033, 284 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 268, 766, 632 4.00 0.01 Income from service to patients (line 3 minus line 4) 0.08, 033, 785 6.00 0.01 Income from investments 0 6.00 0 0.00 Pervenues from telephone and other miscel laneous communication services 0 9.00 0.00 Purchase discounts 0 10.00 10.00	STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0161		Worksheet G-3	
Image: 100 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1, 270, 096, 483 1. 00 1.00 Less contractual allowances and discounts on patients' accounts 893, 294, 069 2. 00 3.00 Net patient revenues (line 1 minus line 2) 376, 802, 414 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 268, 768, 632 4.00 5.00 Net income from investments 0 6.00 Contributions, donations, bequests, etc 0 6.00 0.01 Income from investments 0 6.00 7.00 0 8.00 9.00 8.00 9.00 8.00 9.00 8.00 9.00 8.00 9.00 8.00 9.00 10.00						Date/Time Pre	pared:
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 1,270,096,483 1.00 2.00 Less contractual allowances and discounts on patients' accounts 893,294,069 2.00 3.00 Net patient revenues (line 1 minus line 2) 376,802,414 3.00 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 268,768,632 4.00 0.01 Less total operating expenses (from Wkst. G-2, Part II, line 43) 108,033,782 5.00 0.01 The income from service to patients (line 3 minus line 4) 108,033,782 6.00 0.01 Income from investments 0 7.00 8.00 Revenues from television and radio service 0 7.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 0 11.00 11.00 10.00 Revenue from real of the miscell aneous communication services 0 12.00 10.00 Revenue from sale of the physes and guests 0 11.00 10.00 Revenue from rental of living quarters 0 15.00 10.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td>5/26/2022 2:5</td> <td>5 pm</td>						5/26/2022 2:5	5 pm
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19.00 Tuition (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 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, 317, 530 24.00 24.50 COVID-19 PHE Funding 1, 141, 309 24.50 25.00 Total other income (sum of lines 6-24) 5, 458, 839 25.00 26.00 Total (line 5 plus line 25) 113, 492, 621 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00				·		0	17.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 20.00 21.00 Rental of vending machines 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 MI SCELLANEOUS I NCOME 4, 317, 530 24.00 24.50 COVID-19 PHE Funding 1, 141, 309 24.50 25.00 Total other income (sum of lines 6-24) 5, 458, 839 25.00 26.00 Total (line 5 plus line 25) 113, 492, 621 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	18.00	Revenue from sale of medical records and	abstracts			0	18.00
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 4,317,530 24.00 24.50 COVID-19 PHE Funding 1,141,309 24.50 25.00 Total other income (sum of lines 6-24) 5,458,839 25.00 26.00 Total (line 5 plus line 25) 113,492,621 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	19.00	Tuition (fees, sale of textbooks, uniform	s, etc.)			0	19.00
22.00 Rental of hospital space 0 22.00 23.00 Governmental appropriations 0 23.00 24.00 MI SCELLANEOUS INCOME 4,317,530 24.00 24.50 COVID-19 PHE Funding 1,141,309 24.50 25.00 Total other income (sum of lines 6-24) 5,458,839 25.00 26.00 Total other expenses (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	20.00	Revenue from gifts, flowers, coffee shops	, and canteen			0	20.00
23.00 Governmental appropriations 0 23.00 24.00 MISCELLANEOUS INCOME 4,317,530 24.00 24.50 COVID-19 PHE Funding 1,141,309 24.50 25.00 Total other income (sum of lines 6-24) 5,458,839 25.00 26.00 Total (line 5 plus line 25) 113,492,621 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	21.00	Rental of vending machines				0	21.00
24.00 MI SCELLANEOUS I NCOME 4, 317, 530 24.00 24.50 COVI D-19 PHE Funding 1, 141, 309 24.50 25.00 Total other income (sum of lines 6-24) 5, 458, 839 25.00 26.00 Total (line 5 plus line 25) 113, 492, 621 26.00 27.00 OTHER EXPENSES (SPECI FY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	22.00	Rental of hospital space				0	22.00
24. 50 COVID-19 PHE Funding 1, 141, 309 24. 50 25. 00 Total other income (sum of lines 6-24) 5, 458, 839 25. 00 26. 00 Total (line 5 plus line 25) 113, 492, 621 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	23.00	Governmental appropriations				0	23.00
25.00 Total other income (sum of lines 6-24) 5,458,839 25.00 26.00 Total (line 5 plus line 25) 113,492,621 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	24.00	MI SCELLANEOUS I NCOME				4, 317, 530	24.00
26.00 Total (line 5 plus line 25) 113, 492, 621 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	24.50	COVI D-19 PHE Fundi ng				1, 141, 309	24.50
27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						5, 458, 839	25.00
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00						113, 492, 621	26.00
						-	27.00
20.00 [Net income (or loss) for the period (line 26 minus line 28) $112.402.621$ [20.00]						-	
27. 00 [net mooning (0) 1033/101 the period (111e 20 lining 111e 20) [113, 492, 021] 29. 00	29.00	Net income (or loss) for the period (line	26 minus line 28)			113, 492, 621	29.00

ALCULATION OF CAPITAL PAYMENT	Provi der CCN: 15-0161	Period: From 01/01/2021 To 12/31/2021	Worksheet L Parts I-III Date/Time Pre 5/26/2022 2:5	pare
	Title XVIII	Hospi tal	PPS	5 piii
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
00 Capital DRG other than outlier			1, 221, 644	
01 Model 4 BPCI Capital DRG other than outlier			0	1.
00 Capital DRG outlier payments			249, 420	
01 Model 4 BPCI Capital DRG outlier payments			0	2.
00 Total inpatient days divided by number of days in t	he cost reporting period (see ins	tructions)	94.53	
00 Number of interns & residents (see instructions)			0.00	
00 Indirect medical education percentage (see instruct			0.00	5.
00 Indirect medical education adjustment (multiply lin 1.01) (see instructions)	5		0	6.
00 Percentage of SSI recipient patient days to Medicar 30) (see instructions)		E, part A line	2.08	7.
00 Percentage of Medicaid patient days to total days (see instructions)		21.44	
00 Sum of lines 7 and 8			23. 52	
0.00 Allowable disproportionate share percentage (see in			4.88	
. 00 Disproportionate share adjustment (see instructions	·		59, 616	
. 00 Total prospective capital payments (see instruction	IS)		1, 530, 680	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST			1.00	
00 Program inpatient routine capital cost (see instruc	tions)		0	1 1.
00 Program inpatient ancillary capital cost (see instr			0	2.
00 Total inpatient program capital cost (line 1 plus l			0	3.
00 Capital cost payment factor (see instructions)			0	4.
00 Total inpatient program capital cost (line 3 x line	e 4)		0	5.
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	1
00 Program inpatient capital costs for extraordinary c			0	
00 Net program inpatient capital costs (line 1 minus l	ine 2)		0	-
00 Applicable exception percentage (see instructions)			0.00	4
00 Capital cost for comparison to payments (line 3 x l	<i>,</i>		0	-
00 Percentage adjustment for extraordinary circumstanc			0.00	
00 Adjustment to capital minimum payment level for ext	raordinary circumstances (line 2	x line 6)	0	7
00 Capital minimum payment level (line 5 plus line 7)			0	-
00 Current year capital payments (from Part I, line 12			0	
.00 Current year comparison of capital minimum payment .00 Carryover of accumulated capital minimum payment le			0	
Workshoot Part Lipo 14)	canital navments (Line 10 plus Li	no 11)	0	12.
Worksheet L, Part III, line 14)	Capital Davinghits (TITIG TO DIUS IT		0	
00 Net comparison of capital minimum payment level to			0	
2.00 Net comparison of capital minimum payment level to 2.00 Current year exception payment (if line 12 is posit	ive, enter the amount on this lin		0	11/
 .00 Net comparison of capital minimum payment level to .00 Current year exception payment (if line 12 is posit .00 Carryover of accumulated capital minimum payment le 	ive, enter the amount on this linevel over capital payment for the		0	14
 2.00 Net comparison of capital minimum payment level to 3.00 Current year exception payment (if line 12 is posit 4.00 Carryover of accumulated capital minimum payment le (if line 12 is negative, enter the amount on this l 	ive, enter the amount on this linevel over capital payment for the ine)		-	
 Net comparison of capital minimum payment level to Ourrent year exception payment (if line 12 is posit Ourryover of accumulated capital minimum payment le 	ive, enter the amount on this linevel over capital payment for the ine) ine) it (see instructions)		0	15