Health Financial Systems IU HEALTH WEST HOSPITAL	In Lieu of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result	
payments made since the beginning of the cost reporting period being deemed overpayments (42)	
	EXPI RES 03-31-2022
	eriod: Worksheet S rom 01/01/2021 Parts I-III
AND SETTLEMENT SUMMARY	
	5/26/2022 3:15 pm
PART I - COST REPORT STATUS	
Provider 1. [X] Electronically prepared cost report	Date: 5/26/2022 Time: 3:15 pm
use only 2. [] Manually prepared cost report	
 O] If this is an amended report enter the number of times the provider res F] Medicare Utilization. Enter "F" for full or "L" for low. 	ubmitted this cost report
Contractor 5. [1] Cost Report Status 6. Date Received: 10. NPR	
use only (1) As Submitted 7. Contractor No. 11. Con	tractor's Vendor Code: 4
(2) Settled without Audit 8. [N]Initial Report for this Provider CCN12. [0 (2) Settled with Audit 9. [N]Final Report for this Provider CCN	JIT LINE 5, COLUMN LIS 4: ENTER
	number of times reopened = $0-9$.
(4) Reopened (5) Amended	
(3) Allended	
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)	
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUL	
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES	
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWIS	SE ILLEGAL, CRIMINAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)	
I HEREBY CERTIFY that I have read the above certification statement and that I have e	xamined the accompanying
electronically filed or manually submitted cost report and submitted cost report and	
Statement of Revenue and Expenses prepared by IU HEALTH WEST HOSPITAL (15-0158) for	
beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief	
are true, correct, complete and prepared from the books and records of the provider i	
applicable instructions, except as noted. I further certify that I am familiar with t regarding the provision of health care services, and that the services identified in	
provided in compliance with such laws and regulations.	this cost report were
provided in compilation with such raws and regulations.	

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
	1		2	SI GNATURE STATEMENT	
1	Cara	a Breidster	Ŷ	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	HI T	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	C	326, 183	6, 306	0	0	1.00
2.00 Subprovider - IPF	C	0	0		0	2.00
3.00 Subprovider - IRF	C	0	0		0	3.00
5.00 Swing Bed - SNF	C	0	0		0	5.00
6.00 Swing Bed - NF	C				0	6.00
200. 00 Total	C	326, 183	6, 306	0	0	200.00

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

		DENTIFICATION DATA	Provi de	er CCN:		eriod: rom 01/01/	/2021	Workshe Part I	et S-2	2
						o 12/31/	/2021	Date/Ti		
	1.00	2.00		3.00			4.00	5/26/20)22 3:1	l5 pm
_	Hospital and Hospital Health Care Co			5.00	I		1.00			
00	Street: 1111 N. RONALD REAGAN PARKWAY									1.
00	City: AVON	State: IN			3-7085 County			nt Curt	om (D	2.
		Component Name	CCN Number	CBSA Numbei		Date Certified		ent Syst , 0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componen		450450	0 (000		10/01/0001	N			
0 0	Hospital Subprovider - IPF	IU HEALTH WEST HOSPITAL	150158	26900) 1	12/01/2004	N	P	P	3.
00	Subprovider - IRF									5.
0	Subprovider - (Other)									6.
0	Swing Beds - SNF									7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF Hospital-Based NF									9.
00	Hospital -Based OLTC									111.
00	Hospital-Based HHA									12.
00	Separately Certified ASC									13.
	Hospital -Based Hospice									14.
00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC									16.
00	Hospital -Based (CMHC) I									17.
00	Renal Dialysis									18.
00	Other					_				19.
						From: 1.00				-
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20.
00	Type of Control (see instructions)					2				21.
				_	1.00	2.00		3. 0	0	-
	Inpatient PPS Information			I	1.00	2.00		5.0		
00	5 1 5				Y	N				22.
	di sproporti onate share hospi tal adju									
	§412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo	r yes or "N" for no.								
01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un	compensated care paymen	ts for this	s	Y	Y				22.
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02	Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph 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 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 Does this hospital contain at least counted in accordance with 42 CFR 41	compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to "for no for the portion er October 1. (see instr requires final uncompen- port settlement? (see in "for no, for the portion er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 44 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 44 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes of g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 44	ts for thi: for no fi October 1 n of the co ructions) insated card istruction: on of the "Y" for ; on or afted m urban to stical area ructions) 29 beds (a: 3, "Y" for in urban to stical area "N" for no istical area "N" for no stical area "N" for no	or ost e s) yes er eas o r s r as no r s	N	N				22.
02 03 04	Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph 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 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 Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to "for no for the portio er October 1. (see inst requires final uncompen- port settlement? (see in "for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati- olumn 1, "Y" for yes or g period prior to Octobe no for the portion of the er October 1. (see inst 100 but not more than 44 2. 105)? Enter in column ic reclassification from delineations for stati- column 1, "Y" for yes of g period prior to Octobe no for the portion of the er October 1. (see inst 100 but not more than 44 2. 105)? Enter in column	ts for this october 1 nof the co- nuctions) insated caru- instructions on of the "Y" for 1 on or after nurban to stical arr "N" for m er 1. Enter in cost "Utions) 29 beds (a: arr, "N" for m er 1. Enter tical are "N" for m on urban to stical are "N" for m arr, "N"	or ost e s) yes er eas o r s r as no r s or	N N	N				22.
02 03 04	Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft ls this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Des this hospital receive a geograph 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 Des this hospital receive a geograph 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 Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to " for no for the portio" er October 1. (see inst requires final uncompen- port settlement? (see in " for no, for the portio er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati- olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 4" 2.105)? Enter in column ic reclassification from delineations for stati- column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 4" 2.105)? Enter in column dic reclassification from delineations for stati- column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 4" 2.105)? Enter in column dicaid days on lines 24	ts for this off no find october 1 no f the con- nuctions) insated caru- instructions on of the "Y" for 1 on or after nurban to stical area "N" for nur- ter 1. Enter inde cost "N" for in tical area "N" for	or ost e s) yes er eas o r s r as no r s or	N N	N				22.
04	Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital receive a geograph 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 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 Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	compensated care payment mn 1, "Y" for yes or "N" riod occurring prior to "for no for the portion er October 1. (see instr requires final uncompen- port settlement? (see in "for no, for the portion er 1. Enter in column 2, e cost reporting period ic reclassification from ds for delineating stati olumn 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 4" 2.105)? Enter in column ic reclassification from delineations for statist column 1, "Y" for yes on g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 4" 2.105)? Enter in column dic reclassification from delineations for statist column 1, "Y" for yes on g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 4" 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censo	ts for thi: for no fi october 1 no f the con- ructions) insated cara- instructions: on of the "Y" for y on or afti- nurban to stical are- "N" for nu- re 1. Enter he cost "Under 1. Enter he cost "N" for nu- er 1. Enter he cost "N" for nu- er 1. Enter he cost cuctions) 29 beds (a: 1. The he cost cuctions) 29 beds (a: 1. Structions) 29 beds (a: 1. Structions) 20 beds (a: 1. Structions) 20 beds (a: 1. Structions) 20 beds (a: 1. Structions) 21 beds (a: 22 beds (a: 23 cost) 23 beds (a: 25 cost) 24 beds (a: 25 cost) 25 cost) 26 cost) 27 cost) 28 cost) 29 beds (a: 27 cost) 28 cost) 29 beds (a: 28 cost) 29 beds (a: 29 cost) 20 cost) 2	or ost ess) yes er eas or s r as no r s or s or s	N N	N				22. 22. 22. 22. 22. 22.

	ALTH WEST H			_	In Lieu	u of For	rm CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC	CN: 15-0158	Period: From 01/07	1/2021	Worksh Part I	eet S-2	2
				To 12/3	1/2021		ime Pre 022 3:1	
	In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medica HMO da	id C)ther di cai d	
	paid days	eligible	Medi cai d	Medi cai d	nivio ua	2	days	
		unpai d days	paid days	el i gi bl e unpai d				
	1.00	2.00	3.00	4.00	5.00) (6.00	-
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state	1, 284	275	2	28	5,	612	25	24.00
Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in columr								
4, Medicaid HMO paid and eligible but unpaid days in								
column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state	0	0	0	0		0		25.00
Medicaid paid days in column 1, the in-state								20100
Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state	e							
Medicaid eligible unpaid days in column 4, Medicaid								
HMO paid and eligible but unpaid days in column 5.				Urban/Ru	ural S	Date of	f Geogr	
26.00 Enter your standard geographic classification (not w	vade) status	s at the be	ainnina of	1.0	0 1	2.	00	26.00
cost reporting period. Enter "1" for urban or "2" fo	or rural.		0 0					
27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban c	vage) status or "2" for i	s at the en rural. If a	d of the co pplicable,	st	1			27.00
enter the effective date of the geographic reclassif	Fication in	column 2.		_				25.00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	ne number of	r periods S	CH STATUS I	n	0			35.00
				Begi nn 1.0		Endi 2	i ng: 00	_
36.00 Enter applicable beginning and ending dates of SCH s		script line	36 for num		0	۷.	00	36.00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), enter	tes. er the numbe	er of perio	ds MDH stat	us	0			37.00
is in effect in the cost reporting period.					_			
37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37.01
instructions)	5							38.00
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of								38.00
enter subsequent dates.				Y/I	N	Y	/N	
				1.0	0	2.	00	
39.00 Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i						ſ	N	39.00
1 "Y" for yes or "N" for no. Does the facility meet	the mileage	e requireme	nts in					
accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)	II)? Enter	in column	2 "Y" for y	es				
40.00 Is this hospital subject to the HAC program reduction	2		2			1	N	40.00
"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1			yes or N	TOP		_		
					V 1.00	XVIII 2.00		-
Prospective Payment System (PPS)-Capital					1			
45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	ent for disp	proporti ona	te share in	accordance	N	Y	N	45.00
46.00 Is this facility eligible for additional payment exc					N	N	N	46.00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	ST. L, PT. I	III and WKS	t. L-I, Pt.	i through				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymer					N	N	N N	47.00
Teaching Hospi tal s	It? Litter	i ioi yes		110.				40.00
56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the respons					r N			56.00
was involved in training residents in approved GME p	programs in	the prior	year or pen	ultimate				
year, and are you are impacted by CR 11642 (or appli Enter "Y" for yes; otherwise, enter "N" for no in co		MA direct	GME payment	reduction?				
57.00 If line 56 is yes, is this the first cost reporting	period duri							57.00
GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor								
for yes or "N" for no in column 2. If column 2 is "	Y", complet	te Workshee						
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I 58.00 If line 56 is yes, did this facility elect cost reim			ans' servic	es as	N			58.00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete N	Wkst. D-5.			N			59.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye	s, comprete	J WASL D-2	, г. І.		IN	1	1	00.40

ealth Financial Systems IU HEA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		F HOSPITAL Provider CO	CN: 15-0158	Period:	u of Form CMS-2 Worksheet S-2	
			1	From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/26/2022 3:1	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
50.00 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 (adjustement? Enter "Y" for yes or "N" for no in col	85? (s umn 1. CR) NAHE	see lf column 1	N			60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 bit of your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) bit of Enter the average number of unweighted primary care 	N			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) 01.02 Enter the current year total unweighted primary care						61.02
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.03
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						01.03
 an 1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.04
51.05 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
51.06 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	gram Name	Program Code	Unweighted	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	(1.1.1)
11.10 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
51.20 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 Se						
22.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct)		d in this cost	reporting pe	riod for which	0.00	62.00
52.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi gram. (s	see instructio		o your hospital	0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovide 53.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this o			N	63.00

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLI		ALTH WEST HOSPITAL ATA Provider CO		eriod:	u of Form CMS-2 Worksheet S-2	
			Fr Tc	rom 01/01/2021 0 12/31/2021		
			Unweighted	Unweighted	5/26/2022 3:1 Ratio (col.	
			FTĔs Nonprovider	FTEs in Hospital	1/ (col. 1 + col. 2))	
			Site			-
Section 5504 of the ACA Base Year	ETE Residents in N	lonprovider Settings	1.00 This base year	2.00	3.00 reporting	
period that begins on or after Ju	ly 1, 2009 and befo	ore June 30, 2010.				
4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	er of unweighted no ations occurring in number of unweighte r hospital. Enter i	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. OC
	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider	FTEs in Hospital	3/ (col. 3 + col. 4))	
			Si te			
5.00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	45 00
<pre>b. bo Enter inf conumn i, inf the base 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)</pre>			Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
Section 5504 of the ACA Current Y	ear FTE Residents i	n Nonprovider Setting	1.00 nsEffective f	2.00 Or cost report	<u> </u>	
beginning on or after July 1, 201	0					
6.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	curring in all nonp nweighted non-prima I. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column			0.00	0.00	0. 000000	1 67.00

	Financial Systems IU HEALTH WEST HOSPITAL	In	<u>Lieu o</u>	of Form	CMS-2	2552-10
HOSPI T		eriod: rom 01/01/20 o 12/31/20	021 Pa 021 Da	orkshee art l ate/Tim	ne Pre	pared:
				26/202		5 pm
70.00	Inpatient Psychiatric Facility PPS			2.00	3.00	70.00
	ls this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub Enter "Y" for yes or "N" for no.		N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac	no. (see			0	71.00
	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	no.				
	(see instructions) Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75.00
	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in				0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on no. Column 2: Did this facility train residents in a new teaching program in accordance	with 42				
	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)					
				1.00	C	
<u>00 00</u>	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? En	ter	N		80.00
	TEFRA Provi ders					
86.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectio §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85.00 86.00
	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			Ν		87.00
		V 1.00		XI 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
	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.00
	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		Ν		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		Ν		94.00
	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	0. 00 N		0. 00 N	C	95.00 96.00
	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00		0. 00	n	97.00
	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	N 0.00		0. UC Y	J	97.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst.	N		Y		98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	N		Y		98.02
98. 03	for title V, and in column 2 for title XIX. 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		Ν		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	N		N		98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.					
	Does title V or XIX follow Medicare (title XVIII) 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	N		Y		98.06
	column 2 for title XIX. 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)	N				107.00
	Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)					

IDDEFITAL_AND_IDDEFITAL_IEALTH_CARE COMPLEX IDDITITIONTION DATA Provider CDL:15:050 Period Period <th></th> <th></th> <th>T HOSPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS</th> <th>5-2552-10</th>			T HOSPI TAL		In Lie	u of Form CMS	5-2552-10
100 2.00 0.00 B015: This a rural hospital qualifying for an exception to the CBM fee schedule? See 42.9 100.00 0.07 B015: This a rural hospital qualifies as a CMI or a cost provider, and the cBM fee schedule? See 42.9 100.00 0.07 B015: This hospital qualifies as a CMI or a cost provider, and the cBM fee schedule? See 42.0 3.00 4.00 0.08 B015: This hospital qualifies as a CMI or a cost provider, and the cBM fee schedule? See 42.0 N	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	A	Provider C	F	rom 01/01/2021 To 12/31/2021	Part I Date/Time Pr 5/26/2022 3:	repared:
108. 0015 this a rural nogit tai qualifying for an exception to the CRM Free schedule? See 42 N 108. 001 0.CR Section 512. 102.01 Deter ''', for yes of '''. For one contended in the schedule? See 42 N N 108. 0017 this hospital qualifying for an exception to the CRM Free schedule? See 42 N <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>_</td>							_
10.00 old if this hespital qualifies as a CAL or a cost provider, and the provider and provider and the provide			CRNA fee sch	edul e? See 42		2.00	108.00
100. 0014 This hospital qualifies as a CM or a cost provider, are N N N N N N N N N N 100. 0014 this hospital particlipate in the Rural Comunity Hospital Demonstration project (§110A) N N N N N N N N N N N 100. 0014 this hospital particlipate in the Rural Comunity Hospital Demonstration project (§110A) N N N N N N N 110. 001 this hospital particlipate in the Rural Comunity Hospital Demonstration for this cost reporting period? Future for this particlipate in the Future Comunity N N 110. 001 2.00 2.00 1.00 2.00 110. 00 2.00 110. 00 2.00 110. 00 110. 00 2.00 111. 00 110. 00 2.00 110. 00 2.00 110. 00 110. 00 110. 00 2.00 3.00 111. 00 111. 00 110. 00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>/</td></td<>							/
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Demonstration for the current cost reporting period? Enter "Y" for yes or "W" for no. If yes, supplicable. 111.001F this facility qualifies as a CML did it participate in the Frontier Community Med Hintogration Project (CMH) dominantation for this cost reporting period? Enter "Y" for yes or "W" for no in column 1. If the response to column 1 is Y, enter the integration Project (CMH) dominantation for this cost reporting period? Enter "P" for tele-health services. 10.00 2.00 3.00 111.00 Head this integration Project (CMH) dominantation for this cost reporting period? Enter "P" for yes or "W" for no in column 1. If the response to column 1 is Y, enter the integration project (CMH) dominantation period of the theory of the period per						1.00	-
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112.00Did this hospital participate in the Peneyl varia Rural Heal th Model demonstration of any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital caesed participation in the demonstration. If applicable. N 112.00 Miscellaneous Cost Reporting Information 115.00 N N 0115.00 115.00 is this an all inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If colum 2 is "E", enter in column 3 either "Sy percent for short tern hospital or "90" percent for long term care (Includes on the definition in CN behots). To applicable 2.200. If" N 0115.00 116.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. N 116.00 116.00 117.00 on "N" for no. 1.00 2.00 3.00 118.00 118.01 List anounts of malpractice premiums and paid losses: 257,134 0 0118.01 119.00D NOT USE THIS 1.01 High and paid losses reported in a cost center other the dupties of the outpain the pain the	Health Integration Project (FCHIP) demonstration for t "Y" for yes or "N" for no in column 1. If the response integration prong of the FCHIP demo in which this CAH Enter all that apply: "A" for Ambulance services; "B"	his co to co is par	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.			111.00
112.00Did this hospital participate in the Peneyl varia Rural Heal th Model demonstration of any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital caesed participation in the demonstration. If applicable. N 112.00 Miscellaneous Cost Reporting Information 115.00 N N 0115.00 115.00 is this an all inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If colum 2 is "E", enter in column 3 either "Sy percent for short tern hospital or "90" percent for long term care (Includes on the definition in CN behots). To applicable 2.200. If" N 0115.00 116.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. N 116.00 116.00 117.00 on "N" for no. 1.00 2.00 3.00 118.00 118.01 List anounts of malpractice premiums and paid losses: 257,134 0 0118.01 119.00D NOT USE THIS 1.01 High and paid losses reported in a cost center other the dupties of the outpain the pain the				1.00	2.00	2 00	_
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in column 2. If column 2 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "C", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (Includes psychiatric, creabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.001 s this facility (legally-required to carry malpractice insurance? Enter "N" for no. "N" for no. "It he malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. 118.001 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. 118.00 z.00 3.00 118.01_List amounts of malpractice premiums and paid losses: 257,134 0 118.02 118.02 Are malpractice premiums and paid losses: 257,134 0 118.02 Are malpractice premiums and paid losses: 257,134 0 118.02 Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00D KOT USE THIS LINE 119.00 to KIS THIS LINE 110.00 is this a SCH or EACH that qualifies for the Outpatient Hold Hamless provision in ACA N N 111.00 is fails a claim andments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Hamless provision in ACA S121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 120.00D this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date (S) (m/dd/yyyy) below. 120.00 This is a Keller in number where these takes are included. Transplant Center Information the column 1 and termination date, if applicable, in column 2. 120.00 This is a Method the ore certification date in column 1 and termination date, if applicable, in column 2. 120.00 This is a Meth		yes or	r "N" for no	N			0115.00
"N" for no. Image: Second	in column 1. If column 1 is yes, enter the method used in column 2. If column 2 is "E", enter in column 3 eit for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals pro the definition in CMS Pub.15-1, chapter 22, §2208.1.	(A, E her "9 care (ovider	B, or E only) 93" percent (includes rs) based on				
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118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 1 118.00 If the policy is claim-made. Enter 2 if the policy is occurrence. Premiums Losses Insurance 118.01[List amounts of malpractice premiums and paid losses: 257,134 0 0118.01 118.01[List amounts of malpractice premiums and paid losses: 257,134 0 0118.01 118.02[Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. N 118.02 119.00[Dot USE THIS LINE Insurance 118.02 N 118.02 120.00[I this is a SCH or EACH that qualifies for the 0utpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. N N 119.00 121.00[I this facility incur and report costs for high cost implantable devices charged to Y 121.00 121.00 Y 5.04 122.00 122.00[I this facility operate a transplant center? Enter "Y" for yes and "N" for no. If wes, enter certification date(S) (md/dyyyy) below. 125.00 Y 5.04 122.00 122.00[I this is a Medicare certified widey transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. N <td< td=""><td>117.00 Is this facility legally-required to carry malpractice</td><td>i nsur</td><td>rance? Enter</td><td>N</td><td></td><td></td><td>117.00</td></td<>	117.00 Is this facility legally-required to carry malpractice	i nsur	rance? Enter	N			117.00
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alth Financial Systems ISPITAL AND HOSPITAL HEALTH CARE COMPLE		H WEST HOSPITAL A Provider CO	CN: 15-0158	Peri o		u of Form CMS Worksheet S	-2
				From	01/01/2021 12/31/2021	Part I	repared
					1.00	2.00	_
0.00 If this is a Medicare certified pa			ti fi cati or	1	1100	2.00	130. (
date in column 1 and termination (1.00 f this is a Medicare certified in			ertificati	on			131.0
date in column 1 and termination of	date, if applicable, i	n column 2.					
2.00 If this is a Medicare certified is in column 1 and termination date,			ication da	ite			132.
3.00 Removed and reserved							133. (
4.00 If this is an organ procurement of and termination date, if applicable All Providers			134.				
0.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	"N" for no in column 1	1. If yes, and home umber. (see instruc	office co		Y	15H059	140.
<u> </u>	in organization, enter	2.00 r on lines 141 thro	ugh 143 tl	ne name a	3.00 and address	of the home	
office and enter the home office	contractor name and co	ontractor number.					
1.00 Name: INDIANA UNIVERSITY HEALTH, 2.00 Street: 340 WEST 10TH ST	PO Box:	ne: WPS	Contra	actor's M	Number: 0810)1	141.0
3.00City: INDIANAPOLIS	State:	I N	Zip Co	ode:	4620)2	143. (
						1.00	-
4.00 Are provider based physicians' co	sts included in Worksh	neet A?				Y	144. (
					1.00	2.00	-
5.00 f costs for renal services are cl inpatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for r clude Medicare utiliza	no in column 1. If	column 1 i		Y		145.
	gy changed from the pr n column 1. (See CMS F			If	N		146.
6.00Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2.	Pub. 15-2, chapter	40, §4020)	lf	N	1.00	146.
 OOHas the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o 7.00Was there a change in the statistic 	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y"	Pub. 15-2, chapter for yes or "N" for	40, §4020) no.	If	N	N	147.
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Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		Period:	Worksheet S-2	
				Part I	
			To 12/31/2021	Date/Time Pre	
				5/26/2022 3:1	5 pm
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	inning date and ending da	ate for the reporting			170.00
			1.00	2.00	1
171.00 If line 167 is "Y", does this provide	er have any days for indi	viduals enrolled in	Y	2,072	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	enter the number of sectio	n		
1876 Medicare days in column 2. (see	instructions)				

IUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part II Date/Time Pr 5/26/2022 3:	reparec
				Y/N	Date	_
				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 NU P	esponses. En	ter all dates in	the	_
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in o	column 2. (see			N/ /I	_
			Y/N 1.00	 2.00	<u>V/I</u> 3. 00	
. 00	Has the provider terminated participation in the Medicare F	Program? If	N 1.00	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home of	ng management offices, drug	Y			3. (
	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)	of the board				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" 1 or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	For Compiled,	Y	A	02/25/2022	4.0
6. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.0
			1	Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, i	s the provid	er N		6.0
7.00 8.00	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 t	N he N		7.0 8.0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	n N		9.0
0.00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of another particular line and instructions		the current	N		10. (
1.00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N	N/ /b1	11.
					Y/N 1.00	_
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12.0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see i	nstructions.	N	14.
	Did total beds available change from the prior cost reportion	<u><u>v</u> 1</u>			N	15.
		Y/N	t A Date	Y/N	t B Date	_
		1.00	2.00	3.00	4.00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.0
7.00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	Y	04/01/2022	Y	04/01/2022	17.
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	·			5 ., 5 I <i>I LOLL</i>	
8. 00	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		N		18.
9 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

 20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments: 21.00 Was the cost report prepared only using the provider's N records? If yes, see instructions. 20.00 Have assets been relifed for Medicare purposes? If yes, see instructions. 20.00 Have assets been relifed for Medicare purposes? If yes, see instructions. 20.00 Have assets been relifed for Medicare purposes? If yes, see instructions. 21.00 Have assets been relifed for Medicare purposes? If yes, see instruction Have changes occurred in the Medicare depreciation expense due to reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into If yes, see instructions. 25.00 Have there been new capitalized leases entered into during the cost instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost instructions. 27.00 Has the provider's capitalization policy changed during the cost ropy. 28.00 Were new loans, mortgage agreements or letters of credit entered i period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond fut treated as a funded depreciation account? If yes, see instructions. 30.00 Has debt been replaced prior to its scheduled maturity wi instructions. 31.00 Has debt been recalled before scheduled maturity without issuance instructions. 32.00 Have changes or new agreements occurred in patient care services farrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pe no, see instructions. 34.00 Are services furnished at the provider facility under an arrangements 	0 2.00 DRENS HOSPITALS) Ctions appraisals made during this cost re t reporting period? Treporting period? In eporting period? In the during the cost	eporting period? ? If yes, see If yes, see f yes, submit t reporting	Worksheet S Part II Date/Time P 5/26/2022 3 Y/N 3.00 N Date 4.00 Date 4.00 N N N N N N N N N N N N N	repared:				
Report data for Other? Describe the other adjustments: Y/ 21.00 Was the cost report prepared only using the provider's Necords? If yes, see instructions. N 21.00 Was the cost report prepared only using the provider's Necords? If yes, see instructions. N 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions. N 22.00 Have changes occurred in the Medicare depreciation expense due to reporting period? If yes, see instructions. N 23.00 Have there been new capitalized leases entered into during the cost instructions. N 24.00 Were new leases and/or amendments to existing leases entered into during the cost instructions. N 25.00 Have there been new capitalized leases entered into during the cost instructions. N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost instructions. N 27.00 Has the provider's capitalization policy changed during the cost instructions. N 29.00 Did the provider have a funded depreciation account and/or bond fut treated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with a suppliers of services? If yes, see instructions. 31.00 Has debt peer recalled before	0 Date 0 2.00 DRENS HOSPITALS) Ctions appraisals made dur during this cost re t reporting period? If reporting period? If the during the cost	1.00 N Y/N 3.00 N ring the cost eporting period? ? If yes, see If yes, see f yes, submit t reporting	3.00 N Date 4.00 1.00 N N N N N N N N	21.00 22.00 23.00 24.00 25.00 26.00 27.00				
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Provider-Based Physicians34.00Are services furnished at the provider facility under an arrangeme	rtaining to competi	tive bidding? If	Ν	33.00				
	nt with provider-ba	ased physi ci ans?	Y	34.00				
35.00 If line 34 is yes, were there new agreements or amended existing a		provi der-based	Ν	35.00				
physicians during the cost reporting period? If yes, see instructi	ons.	Y/N	Date					
		1.00	2.00					
Home Office Costs								
36.00 Were home office costs claimed on the cost report?		Y		36.00				
37.00 If line 36 is yes, has a home office cost statement been prepared If yes, see instructions.	by the home office	? Y		37.00				
38.00 If line 36 is yes, was the fiscal year end of the home office dif the provider? If yes, enter in column 2 the fiscal year end of the		f N		38.00				
39.00 If line 36 is yes, did the provider render services to other chain see instructions.		s, Y		39.00				
40.00 If line 36 is yes, did the provider render services to the home of instructions.	fice? If yes, see	Ν		40.00				
	1.00	2.0	00	_				
Cost Report Preparer Contact Information								
41.00 Enter the first name, last name and the title/position RHONDA held by the cost report preparer in columns 1, 2, and 3,	held by the cost report preparer in columns 1, 2, and 3,							
				42.00				
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	UNI VERSI TY HEALTH		I. ORG					

Health Financial Systems IU HEALTH V	VEST HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0158	Period:	Worksheet S-2	
		From 01/01/2021 To 12/31/2021		pared.
		10 12/01/2021	5/26/2022 3:1	
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	DIRECTOR - GOVERNMENT			41.00
held by the cost report preparer in columns 1, 2, and 3,	PROGRAMS			
respectively.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cost				43.00
report preparer in columns 1 and 2, respectively.				

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/26/2022 3:1	pared:
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai I abl e	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider	30.00	131	47, 9			1.00 2.00 3.00 4.00
4.00 5.00 6.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		131	47, 9	40 0.00	0 0 0	4.00 5.00 6.00 7.00
8.00 9.00 10.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	31.00	14	5, 1			8.0 9.0 10.0
11.00 12.00 13.00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT NURSERY	35.00 43.00	11	4, 0	15 0.00	0	11.0 12.0 13.0
14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	30. 00	156	57, 0	65 0.00	0 0	14. 0 15. 0 16. 0 17. 0 18. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 1
25.00 26.00 26.25	CMHC – CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	25.0 26.0 26.2
27.00 28.00 29.00 30.00 31.00 32.00 32.01	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - LRF Labor & delivery days (see instructions) Total ancillary Labor & delivery room outpatient days (see instructions)		156 0		0	0	27.0 28.0 29.0 30.0 31.0 32.0 32.0
3. 00 3. 01	LTCH non-covered days LTCH si te neutral days and discharges						33. (33. (

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	<u> 5/26/2022_3:1</u> Equi val ents	<u>5 pm</u>
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	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)		520	35, 22		10.00	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	12, 267 0	5, 089 0				2.00 3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	11, 869	520	35, 22	-		6.00 7.00
3.00 9.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	1, 201	552	4, 19	4		8.00 9.00
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT		100	04	7		11.0
12.00 13.00	NEONATAL INTENSIVE CARE UNIT NURSERY	0	122 918	86 1, 74			12.0
13.00	Total (see instructions)	13,070	2, 112	42, 03		908, 80	
15.00	CAH visits	13, 070	2, 112		0.00	700.00	14.0
6.00	SUBPROVIDER - IPF	Ű	Ű				16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00 4.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						23.0
4.00	HOSPICE (non-distinct part)			37	2		24.0
5.00	CMHC - CMHC			57	2		24.
6.00	RURAL HEALTH CLINIC						26.0
6.25	FEDERALLY QUALIFIED HEALTH CENTER	О	0		0.00	0.00	
7.00	Total (sum of lines 14-26)				0.00	908.80	27.0
8.00	Observation Bed Days		41	2, 33	2		28.0
9.00	Ambul ance Trips	0					29.0
0.00	Employee discount days (see instruction)				0		30.0
1.00	Employee discount days - IRF		25		0		31.0
2. 00 2. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	25	50	0		32.0 32.0
3.00	LTCH non-covered days	О					33. (
	LTCH site neutral days and discharges	0					33.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre 5/26/2022 3:1	pared:
	Full Time		Di s	charges		
	Equi val ents					
Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1 00 Hospital Adults & Peds (columns 5 6 7 and	11.00	12.00				1.00
 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO and other (see instructions) HMO and other (see instructions) HMO IPF Subprovider HMO HO IRF Subprovider HMO HO IRF Subprovider HO HOSpital Adults & Peds. Swing Bed SNF O Hospital Adults & Peds. Swing Bed NF O Total Adults and Peds. (exclude observation beds) (see instructions) O INTENSIVE CARE UNIT O CORONARY CARE UNIT O SURGICAL INTENSIVE CARE UNIT O NURSERY O Total (see instructions) O SUBPROVIDER - IPF O SUBPROVIDER - IPF O SUBPROVIDER - IRF O AMURSING FACILITY O ONESING FACILITY O ONESING FACILITY O OTHER LONG TERM CARE O AMBULATORY SURGICAL CENTER (D. P.) AMO HOSPICE I HOSPICE (non-distinct part) 	0.00	0	1, 8:	33 1, 152 0 0	8, 627 8, 627	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 16. 00 17. 00 18. 00 9. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10
25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26)	0. 00 0. 00					25.00 26.00 26.25 27.00
 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary Labor & delivery room outpationt days (see instructions) 						28.00 29.00 30.00 31.00 32.00 32.01
outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges				0 0		33. 00 33. 01

SPI T.	AL WAGE INDEX INFORMATION			Provider CC	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/26/2022 3:1	par
		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)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
00	Total salaries (see	200.00	72, 398, 820	-252, 020	72, 146, 800	1, 790, 415. 76	40. 30	•
0	instructions) Non-physician anesthetist Part		0	o	0	0.00	0.00	
	A							
0	Non-physician anesthetist Part B		0	0	0	0.00	0.00	
0	Physician-Part A -		26, 650	0	26, 650	177.67	150.00	
)1	Administrative Physicians – Part A – Teaching		0	о	0	0.00	0.00	
00	Physician and Non		111, 196	0	111, 196			
0	Physician-Part B		0	0	0	0.00	0.00	
00	Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	e
	services Interns & residents (in an	21.00	0		0	0.00	0.00	
00	approved program)	21.00	0	0	0	0.00	0.00	
)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	
00	organization personnel SNF	44.00	0	0	0	0.00	0.00	
00	Excluded area salaries (see	11100	210, 028	398, 077	608, 105			
	instructions) OTHER WAGES & RELATED COSTS							
00	Contract Labor: Direct Patient		345, 335	0	345, 335	4, 805. 20	71.87	1
00	Care		0	0	0	0.00	0.00	1
00	Contract Labor: Top Level management and other		0	0	0	0.00	0.00	'.
	management and administrative							
00	services Contract Labor: Physician-Part		637, 894	0	637, 894	3, 556. 51	179. 36	1
~~	A - Administrative		·					
00	Home office and/or related organization salaries and wage-related costs		0	0	0	0. 00	0.00	1
01	Home office salaries		17, 104, 096	0	17, 104, 096		39. 39	
02 00	Related organization salaries Home office: Physician Part A		0	0	0	0.00 0.00	0. 00 0. 00	
00	- Administrative		0	0	0			
00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	1
01	Home office Physicians Part A		0	0	0	0.00	0.00	1
00	- Teaching		0	0	0	0.00	0.00	1
02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00	1 ''
	WAGE-RELATED COSTS Wage-related costs (core) (see		10 254 400	0	10 254 400			1.
00	instructions)		18, 254, 488	0	18, 254, 488			1
00	Wage-related costs (other)							1
00	(see instructions) Excluded areas		110, 863	0	110, 863			1
00	Non-physician anesthetist Part		0	Ő	0			20
00	A Non-physician anesthetist Part B		0	0	0			2
00	Physician Part A - Administrative		3, 090	0	3, 090			2
01	Physician Part A - Teaching		0	0	0			2
00 00	Physician Part B Wage-related costs (RHC/FQHC)		24, 330 0	0	24, 330 0			23
00	Interns & residents (in an		0	0	0			2
50	approved program)		E E33 000		E E33 000			2
50	Home office wage-related (core)		5, 533, 908	0	5, 533, 908			2
51	Related organization		0	0	0			2!
52	wage-related (core) Home office: Physician Part A		Ω	0	Ω			2
~ ~	- Administrative -		0	Ŭ	0			1 -

Heal th	Financial Systems		IU HEALTH WES	στ μοςρί ται		Inlie	u of Form CMS-2	2552-10
	TAL WAGE INDEX INFORMATION Provider CCN: 15-0158				Period: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part II Date/Time Pre 5/26/2022 3:1	pared:	
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6,00	
25. 53	Home office: Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARI		0	0		0	0.00	25.53
26.00	Employee Benefits Department	4.00	0	448, 337	448, 33	7 0.00	0.00	26.00
27.00	Administrative & General	5.00	5, 628, 779					27.00
28.00	Administrative & General under contract (see inst.)		611, 328		611, 32		93.77	28.00
29.00	Maintenance & Repairs	6.00	965, 378	-6, 285	959,09	3 35, 117, 97	27.31	29.00
30.00	Operation of Plant	7.00	790, 767				25.26	
31.00	Laundry & Linen Service	8.00	0	0		0 0.00		
32.00	Housekeeping	9.00	1, 413, 012	-35, 763	1, 377, 24			
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00		
34.00	Dietary	10.00	1, 457, 807	-611, 772	846, 03	5 48, 604. 57	17.41	34.00
35.00	Dietary under contract (see instructions)		0	0		0 0.00	0.00	35.00
36.00	Cafeteria	11.00	0	591, 896	591, 89	6 33, 850. 23	17.49	36.00
37.00	Maintenance of Personnel	12.00	0	0		0 0.00	0.00	37.00
38.00	Nursing Administration	13.00	8, 444, 859	-8, 716	8, 436, 14	3 76, 440. 97	110. 36	38.00
39.00	Central Services and Supply	14.00	433	0	43	3 10.66	40.62	39.00
40.00	Pharmacy	15.00	3, 271, 051	-45, 668	3, 225, 38	3 77, 574. 97	41.58	40.00
41.00	Medi cal Records & Medi cal Records Li brary	16.00	0	0		0 0.00	0.00	41.00
42.00	Social Service	17.00	0	0		0.00	0.00	42.00
43.00	Other General Service	18.00	170, 867	321	171, 18	8 10, 693. 86	16. 01	43.00

Heal th	Financial Systems		IU HEALTH WE	ST HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI	FAL 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 3:1	pared:	
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Paid Hours	Average		
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage		
				Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷		
				(from	3)	col. 4	col. 5)		
				Worksheet					
				A-6)					
		1.00	2.00	3.00	4.00	5.00	6.00		
	PART III - HOSPITAL WAGE INDEX	SUMMARY			_				
1.00	Net salaries (see		72, 898, 952	-252, 020	72, 646, 93	2 1, 794, 855. 37	40.48	1.00	
	instructions)								
2.00	Excluded area salaries (see		210, 028	398, 077	608, 10	5 14, 901. 14	40. 81	2.00	
	instructions)								
3.00	Subtotal salaries (line 1		72, 688, 924	-650, 097	72, 038, 82	7 1, 779, 954. 23	40.47	3.00	
	minus line 2)								
4.00	Subtotal other wages & related		18, 087, 325	0	18, 087, 32	5 442, 618. 18	40.86	4.00	
	costs (see inst.)								
5.00	Subtotal wage-related costs		23, 791, 486	0	23, 791, 48	6 0.00	33. 03	5.00	
	(see inst.)								
6.00	Total (sum of lines 3 thru 5)		114, 567, 735	-650, 097	113, 917, 63	8 2, 222, 572. 41	51.25	6.00	
7.00	Total overhead cost (see		22, 754, 281	-122, 315	22, 631, 96	6 502, 272. 55	45.06	7.00	
	instructions)								
						1	•		

Heal th	Financial Systems	IU HEALTH WEST	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	AL WAGE RELATED COSTS			CCN: 15-0158	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part IV	pared:
						Amount Reported	
						1.00	
	PART IV - WAGE RELATED COSTS						
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					2,607,560	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribu		0	2.00			
3.00	Nonqualified Defined Benefit Plan Cost (see i	0	3.00				
4.00	Qualified Defined Benefit Plan Cost (see ins		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 Plan					0	6.00
7.00	Employee Managed Care Program Administration	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 Third					0	
8.02	Health Insurance (Self Funded with a Third Pa	arty Administrato	or)			9, 816, 518	
8.03	Health Insurance (Purchased)					0	
9.00	Prescription Drug Plan					0	
10.00	Dental, Hearing and Vision Plan					195, 781	
11.00	Life Insurance (If employee is owner or benef					0	
12.00	Accident Insurance (If employee is owner or H					0	
13.00	Disability Insurance (If employee is owner or					334, 053	
14.00		er or beneficiary	()			0	
15.00	'Workers' Compensation Insurance					245, 161	
16.00		ar, not the extra	aordinary a	ccrual requir	ed by FASB 106.	0	16.00
	Non cumulative portion)						
17 00	TAXES					F 102 (00	17 00
	FICA-Employers Portion Only					5, 193, 698	
18.00	Medicare Taxes - Employers Portion Only Unemployment Insurance					0	
19.00	State or Federal Unemployment Taxes					0	
20.00	OTHER					0	20.00
21 00	Executive Deferred Compensation (Other Than F	Potiromont Cost P	Poportod on	lines 1 three	ugh 1 abovo (sod	0	21.00
21.00	instructions))	Kethement Cost F	tepoi teu on	Times I thro	ugii 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances					0	22.00
23.00	13.00 Tuition Reimbursement						
24.00	4.00 Total Wage Related cost (Sum of lines 1 -23) 18,392,771						
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)						25.00

Heal th	Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0158	Period: From 01/01/2021	Worksheet S-3 Part V	
				To 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared: <u>5 pm</u>
	Cost Center Description			Contract	Benefit Cost	
				Labor 1,00	2.00	
	PART V - Contract Labor and Benefit Cost			1100	2100	
	Hospital and Hospital-Based Component Identi	fi cati on:				
1.00	Total facility's contract labor and benefit	cost		0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider – IRF					4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
	Hospital-Based Health Clinic RHC					14.00
	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
	Renal Dialysis			0	0	
18.00	Other			0	0	18.00

Heal th	Financial Systems IU HEALTH WEST HO	SPI TAL		In Lie	u of Form CMS-2	2552-10	
		Provider CC	N: 15-0158	Period:	Worksheet S-1		
				From 01/01/2021	Data /Tima Dra	norod.	
				To 12/31/2021	Date/Time Pre 5/26/2022 3:1		
			I		0/20/2022 011	o piii	
					1.00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 colum	18)	0. 173525	1.00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				21, 084, 810		
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	al novmont	c from Modic	ai d2	N	3.00 4.00	
4.00 5.00	If line 4 is no, then enter DSH and/or supplemental payments fr				0	4.00 5.00	
6.00	Medicaid charges	Ulli Meur car	u		180, 509, 348	6.00	
7.00	Medicaid cost (line 1 times line 6)				31, 322, 885	7.00	
8.00							
	< zero then enter zero)		10, 238, 075	8.00			
	Children's Health Insurance Program (CHIP) (see instructions fo	r each lin	e)		•		
9.00	Net revenue from stand-alone CHIP				0	9.00	
	Stand-alone CHIP charges				0		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00	
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 mi	nus line 9;	f < zero then	0	12.00	
	enter zero)	rustions f	an agab ling	N N			
13.00	Other state or local government indigent care program (see inst Net revenue from state or local indigent care program (Not incl				90, 483	13 00	
14.00	Charges for patients covered under state or local indigent care				288, 732		
14.00	10)		Not Theradea		200,732	14.00	
15.00	State or local indigent care program cost (line 1 times line 14	•)			50, 102	15.00	
16.00	Difference between net revenue and costs for state or local ind		program (li	ne 15 minus line			
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and stat	e/local indi	gent care progra	ams (see		
17 00	instructions for each line)					17 00	
	Private grants, donations, or endowment income restricted to fu Government grants, appropriations or transfers for support of h				0	17.00 18.00	
	Total unreimbursed cost for Medicaid , CHIP and state and local			s (sum of lines	10, 238, 075		
17.00	8, 12 and 16)	rnu gent		s (suil of Thes	10, 230, 073	19.00	
			Uni nsured	Insured	Total (col. 1		
			patients	patients	+ col. 2)		
			1.00	2.00	3.00		
00.00	Uncompensated Care (see instructions for each line)		01 000 00	0 0 700 475	04 705 774	00.00	
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	iiity	21, 982, 29	9 2, 723, 475	24, 705, 774	20.00	
21.00	Cost of patients approved for charity care and uninsured discou	ints (soo	3, 814, 47	8 2, 723, 475	6, 537, 953	21 00	
21.00	instructions)	1113 (366	5, 014, 47	2, 123, 413	0, 337, 733	21.00	
22.00	Payments received from patients for amounts previously written	off as		o o	0	22.00	
	charity care						
23.00	Cost of charity care (line 21 minus line 22)		3, 814, 47	8 2, 723, 475	6, 537, 953	23.00	
					1.00		
24.00	Does the amount on line 20 column 2, include charges for patien		ond a length	of stay limit	N	24.00	
25 00	imposed on patients covered by Medicaid or other indigent care			n'a langth of		25 00	
25.00	If line 24 is yes, enter the charges for patient days beyond th stay limit	ie i nui gent	care progra	is rength of	0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see ins	structions)			12, 656, 022	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex				387, 304		
27.00	Medicare allowable bad debts for the entire hospital complex (s	•			595, 852		
28.00	Non-Medicare bad debt expense (see instructions)		- /		12, 060, 170		
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see	instructions)	2, 301, 289		
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				8, 839, 242		
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			19, 077, 317	31.00	

Health Financial Systems RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IU HEALTH WEST	T HOSPITAL Provider CC	CN: 15-0158 P	eriod:	u of Form CMS-2 Worksheet A	2552-10
			FI	rom 01/01/2021 0 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared: 5 pm
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
1. 00 OO100 NEW CAP REL COSTS-BLDG & FLXT	[0	0	7, 746, 586	7, 746, 586	1.00
1. 01 00101 MOB		896, 612	896, 612	413, 703	1, 310, 315	1.00
1. 02 00102 I NTEREST		0	0	882	882	1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	0	7, 149, 423	7, 149, 423	2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 00540 NONPATI ENT TELEPHONES	0	280, 927 9, 844	280, 927 9, 844	12, 047, 199 0	12, 328, 126 9, 844	4.00 5.01
5. 02 00550 DATA PROCESSING	0	9, 844	9, 844	0	9, 844	5.01
5. 03 00560 PURCHASI NG RECEI VI NG AND STORES	30	24, 730	24, 760	2, 227	26, 987	5.03
5. 04 00590 ADMI NI STRATI VE AND GENERAL	5, 628, 749	55, 363, 313	60, 992, 062	-5, 092, 362	55, 899, 700	5.04
6.00 00600 MAI NTENANCE & REPAI RS	965, 378	8, 596, 111	9, 561, 489	-5, 795, 240	3, 766, 249	6.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	790, 767	2, 787, 336 586, 890	3, 578, 103 586, 890	1, 649, 661 0	5, 227, 764 586, 890	7.00 8.00
9. 00 00900 HOUSEKEEPI NG	1, 413, 012	1, 550, 178	2, 963, 190	-450, 250	2, 512, 940	
10. 00 01000 DI ETARY	1, 457, 807	1, 732, 166	3, 189, 973	-1, 630, 038	1, 559, 935	
11. 00 01100 CAFETERI A	0	0	0	1, 086, 404	1, 086, 404	11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	8, 444, 859	3, 426, 399	11, 871, 258	-1, 317, 821	10, 553, 437	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	433 3, 271, 051	75, 873 7, 567, 190	76, 306 10, 838, 241	5, 520, 101 -6, 266, 597	5, 596, 407 4, 571, 644	14.00 15.00
17. 00 01700 SOCIAL SERVICE	3, 271, 031	4, 856	4, 856	-0, 200, 347	4, 371, 044	17.00
18.00 01080 TRANSPORTATI ON	170, 867	101, 440	272, 307	-30, 222	242, 085	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	18, 051, 724	13, 761, 150		-8,065,374		
31.00 03100 INTENSIVE CARE UNIT 35.00 02080 NEONATAL INTENSIVE CARE UNIT	3, 521, 085 1, 035, 720	2, 961, 535 290, 500	6, 482, 620 1, 326, 220	-892, 291 -201, 474	5, 590, 329 1, 124, 746	31.00 35.00
43. 00 04300 NURSERY	1,033,720	290, 300	1, 320, 220	421, 175	421, 175	43.00
ANCI LLARY SERVI CE COST CENTERS		- 1				
50.00 05000 OPERATING ROOM	4, 608, 816	18, 589, 365	23, 198, 181	-15, 319, 853		
51.00 05100 RECOVERY ROOM	3, 020, 524	1, 238, 531	4, 259, 055	-876, 740	3, 382, 315	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 5, 282, 385	0 5, 240, 196	0 10, 522, 581	3, 044, 943 -3, 938, 461	3, 044, 943 6, 584, 120	52.00 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 096, 464	1, 639, 778	2, 736, 242	-1, 014, 100	1, 722, 142	
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 408, 685	6, 208, 437	7, 617, 122	-4, 795, 786	2, 821, 336	59.00
60. 00 06000 LABORATORY	2,000	8, 731, 575	8, 733, 575	-4,378	8, 729, 197	
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0	606, 241	606, 241	-833	605, 408	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	2, 236, 190 1, 974, 414	1, 310, 184 705, 230	3, 546, 374 2, 679, 644	-810, 001 -522, 759	2, 736, 373 2, 156, 885	
67. 00 06700 OCCUPATI ONAL THERAPY	660, 628	133, 322	793, 950	-87, 171	706, 779	
68.00 06800 SPEECH PATHOLOGY	266, 943	67, 259	334, 202	-42, 856	291, 346	
69. 00 06900 ELECTROCARDI OLOGY	870, 118	851, 018	1, 721, 136	-283, 839	1, 437, 297	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	4, 671, 277 8, 205, 819	4, 671, 277 8, 205, 819	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	7, 584, 265	7, 584, 265	
74. 00 07400 RENAL DI ALYSI S	0	967, 024	967, 024	-14, 388	952, 636	
76.00 03950 OTHER ANCI LLARY SERVI CES	0	0	0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	240, 848	177, 562	418, 410	-148, 439	269, 971	76.97
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	497, 107	224, 546	721, 653	-171, 975	549, 678	90.01
90. 02 09002 SLEEP LAB	9, 977	613, 777	623, 754	-13, 595	610, 159	
91. 00 09100 EMERGENCY	4, 981, 626	6, 817, 779	11, 799, 405	-1, 841, 315	9, 958, 090	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	200 505	10/ 000	41/ 007	115 (20	201 1/0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) SPECIAL PURPOSE COST CENTERS	280, 585	136, 222	416, 807	-115, 639	301, 168	92.01
113. 00 11300 I NTEREST EXPENSE		0	0	0	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	72, 188, 792	154, 275, 096	226, 463, 888	-200, 132	226, 263, 756	118.00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	104, 381	220, 777	325, 158	-73, 567	251, 591	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 RETALL PHARMACY	5, 312 2, 065	4, 725 4, 015	10, 037 6, 080	-90 -62		192.00 192.01
192. 02 19202 MARKETI NG	2,003	339, 791	339, 791	40, 444	380, 235	
192. 03 19203 BACK AND NECK	98, 270	291, 699	389, 969	-284, 685	105, 284	192.03
192. 04 19204 TI PTON SERVICES	0	0	0	70, 850	70, 850	
192. 05 19205 NORTH SERVI CES 192. 06 19206 SAXONY SERVI CES	0	0	0	351, 842 95, 400	351, 842 95, 400	
200.00 TOTAL (SUM OF LINES 118 through 199)	72, 398, 820	155, 136, 103	227, 534, 923	95, 400	95, 400 227, 534, 923	
	, 0, 0, 020	,,	, 001, 720	9	,,	

	Financial Systems IFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IU HEALTH WES F EXPENSES	Provider CCN: 15-01	58 Period: Work	Form CMS-2552 sheet A
					/Time Prepare
	Cost Center Description	Adjustments	Net Expenses	5/26	/2022 3:15 pr
	cost center bescription	(See A-8)	For		
			Allocation		
		6.00	7.00		
	ENERAL SERVICE COST CENTERS	Γ			
	00100 NEW CAP REL COSTS-BLDG & FIXT	39, 969			1
	00101 MOB	-1,003,409			1
1	00102 INTEREST	4, 731, 906			1
	00200 NEW CAP REL COSTS-MVBLE EQUIP	1,031,803			2
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 445, 824			4
	00540 NONPATI ENT TELEPHONES	0			5
	00550 DATA PROCESSING	9, 983, 423			5
	00560 PURCHASING RECEIVING AND STORES	746, 650			5
	00590 ADMINI STRATI VE AND GENERAL	-26, 748, 270			5
	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	-128, 902			6
	0800 LAUNDRY & LINEN SERVICE	107, 619 0			
	00900 HOUSEKEEPING	0			8
	1000 DI ETARY	-91			
	01100 CAFETERI A	-145, 322	1, 559, 844 941, 082		10
	01300 NURSI NG ADMI NI STRATI ON	495, 525			13
	1400 CENTRAL SERVICES & SUPPLY	495, 525			13
	11400 CENTRAL SERVICES & SUPPLY	-21, 379			14
	1700 SOCI AL SERVI CE	-21, 3/9	1		17
	1080 TRANSPORTATI ON	0			18
	NPATIENT ROUTINE SERVICE COST CENTERS	0	242,003		
	33000 ADULTS & PEDIATRICS	-2,003,783	21, 743, 717		30
	03100 I NTENSI VE CARE UNI T	-1, 247, 568			31
	2080 NEONATAL INTENSIVE CARE UNIT	0			35
	04300 NURSERY	0			43
	NCILLARY SERVICE COST CENTERS	-	, . <u>.</u> .,,		
	5000 OPERATING ROOM	-870, 329	7,007,999		50
	05100 RECOVERY ROOM	-1,063			51
1	5200 DELIVERY ROOM & LABOR ROOM	0			52
	95400 RADI OLOGY-DI AGNOSTI C	166, 313			54
. 00 0	5500 RADI OLOGY-THERAPEUTI C	-298, 691	1, 423, 451		55
. 00 0	5900 CARDI AC CATHETERI ZATI ON	-1, 069, 130			59
. 00 0	06000 LABORATORY	0			60
. 00 0	6300 BLOOD STORING, PROCESSING, & TRANS.	0	605, 408		63
. 00 0	06500 RESPI RATORY THERAPY	0	2, 736, 373		65
00 0	06600 PHYSI CAL THERAPY	0	2, 156, 885		66
. 00 0	06700 OCCUPATI ONAL THERAPY	0	706, 779		67
. 00 0	06800 SPEECH PATHOLOGY	0	291, 346		68
. 00 0	06900 ELECTROCARDI OLOGY	-24, 162	1, 413, 135		69
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 671, 277		71
	7200 IMPL. DEV. CHARGED TO PATIENT	0			72
	7300 DRUGS CHARGED TO PATIENTS	0	.,		73
	07400 RENAL DIALYSIS	-1, 724	950, 912		74
	03950 OTHER ANCI LLARY SERVICES	0	0		76
	07697 CARDIAC REHABILITATION	0	269, 971		76
	UTPATIENT SERVICE COST CENTERS	-	-		
		0	-		90
	99001 BEHAVI ORAL HEALTH	0			90
	09002 SLEEP LAB	0	610, 159		90
	09100 EMERGENCY	-3, 209, 549	6, 748, 541		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-	201 1/0		92
	09201 OBSERVATION BEDS (DISTINCT PART)	0	301, 168		92
	PECIAL PURPOSE COST CENTERS				110
	1300 INTEREST EXPENSE	0			113
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	-18, 024, 340	208, 239, 416		118
	ONREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		251 501		100
		0			190
	9200 PHYSI CLANS' PRI VATE OFFI CES		9,947		192
	9201 RETAIL PHARMACY		6,018		192 192
	9202 MARKETING		380, 235		
	9203 BACK AND NECK		105, 284		192
	9204 TI PTON SERVICES		70, 850		192 192
	9205 NORTH SERVICES	0			
	9206 SAXONY SERVICES	^	95, 400		192

Heal th Financial Systems RECLASSI FI CATI ONS		IU HEALTH WE	ST HOSPITAL Provider CCN:	15-0158	In Lie Period:	u of Form CMS-2 Worksheet A-6	
					From 01/01/2021 To 12/31/2021	Date/Time Prej 5/26/2022 3: 1	pared:
Cost Center	I ncreases	Sal ary	Other				
2.00	3.00	4.00	5.00				
A - DEPRECIATION 1.00 NEW CAP REL COSTS-BLDG &	1.00	0	7, 103, 492				1.00
FLXT							
2.00 NEW CAP REL COSTS-MVBLE EQUI P	2.00	0	7,067,483				2.00
3.00 NEW CAP REL COSTS-BLDG &	1.00	0	161, 715				3.00
4.00 NEW CAP REL COSTS-MVBLE	2.00	0	2, 929				4.00
EQUI P	1.00						F 00
5.00 NEW CAP REL COSTS-BLDG & FIXT	1.00	0	37, 170				5.00
6.00 RENAL DI ALYSI S 7.00	74.00 0.00	0 0	1, 054 0				6.00 7.00
8.00	0.00	0	0				8.00
9.00	0.00	0	0				9.00
10. 00 11. 00	0.00 0.00	0	0				10.00 11.00
12.00	0.00	0	0				12.00
13.00	0.00	0	0				13.00
14. 00 15. 00	0.00 0.00	0	0				14.00 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 0.00		0				21.00 22.00
		0	14, 373, 843				
B - LEASE 1.00 NEW CAP REL COSTS-BLDG &	1.00	0	444, 209				1.00
FI XT	1 01		702.051				2 00
2.00 MOB 3.00 NEW CAP REL COSTS-MVBLE	1.01 2.00	0	702, 351 79, 011				2.00 3.00
EQUI P		-					
4.00 5.00	0.00 0.00	0	0				4.00 5.00
6.00	0.00	0	0				6.00
7.00	0.00	0	0				7.00
8.00 9.00	0.00 0.00	0	0				8.00 9.00
10.00	0.00	0	0				10.00
11.00	0.00 0.00	0	0				11.00 12.00
0		— — — ö	1, 225, 571				12.00
C - INTEREST 1.00 INTEREST	1.02	0	882				1.00
0		0					1.00
D - BENEFITS 1.00 EMPLOYEE BENEFITS DEPARTM	IENT 4.00	0	11, 598, 862				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	О	0				6.00
7.00 8.00	0.00 0.00	0	0 0				7.00 8.00
9.00	0.00	0	0				9.00
10.00	0.00	0	0				10.00
11.00	0.00 0.00	0	0				11.00 12.00
13.00	0.00	0	0				13.00
14. 00 15. 00	0.00 0.00	0	0				14.00 15.00
16.00	0.00	0	0				16.00
17.00	0.00	0	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	0.00 0.00	0	0				21.00 22.00
23.00	0.00	0	0				23.00
24.00	0.00	0	0				24.00
25.00	0.00	0	0				25.00

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

IU HEALTH WEST HOSPITAL Provider CCN: 15-0158 Period:

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

RECLAS	SI FI CATI ONS			Provider C	CN: 15-0158	Period: From 01/01/2021	Worksheet A-	6
						To 12/31/2021	Date/Time Pr 5/26/2022 3:	epared: 15 pm
		Increases		0.11				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
26.00	2.00	0.00	0	0				26.00
27.00		0.00	0	0				27.00
28.00 29.00		0.00 0.00	0	0				28.00 29.00
29.00 30.00		0.00	0	0				30.00
31.00		0.00	0	0				31.00
32.00		0.00	0	0				32.00
	U E – ACCRUED PTO		0	11, 598, 862				-
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	448, 337	0				1.00
2.00	NURSING ADMINISTRATION	13.00	30, 315	0				2.00
3.00	TRANSPORTATI ON RADI OLOGY-THERAPEUTI C	18.00 55.00	321	0 0				3.00
4.00 5.00	SPEECH PATHOLOGY	68.00	11, 168 4, 400	0				4.00 5.00
6.00	BACK AND NECK	192.03	2, 148	0				6.00
7.00		0.00	0	0				7.00
8.00 9.00		0.00 0.00	0	0 0				8.00 9.00
9.00 10.00		0.00	0	0				10.00
11.00		0.00	Ö	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0 0				13.00
14.00 15.00		0.00 0.00	0	0				14.00 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 0				18.00 19.00
20.00		0.00	0	0				20.00
21.00	L	0.00	0	0				21.00
	TOTALS		496, 689	0				_
1.00	F - LABOR & DELIVERY DELIVERY ROOM & LABOR ROOM	52.00	2, 682, 942	362, 001				1.00
1.00			2, 682, 942	362,001				1.00
	H - NURSERY							
1.00	<u>NURSERY</u>	43.00	<u>371, 103</u> 371, 103	5 <u>0,072</u> 50,072				1.00
	I – DIETARY	<u> </u>	371, 103	50, 072				1
1.00	CAFETERI A		<u> </u>	494, 508				1.00
	0		591, 896	494, 508				-
1.00	K - STD ADMINISTRATIVE AND GENERAL	5.04	0	5, 021				1.00
2.00	HOUSEKEEPING	9.00	Ö	1, 825				2.00
3.00	DI ETARY	10.00	0	3, 851				3.00
4.00 5.00	NURSING ADMINISTRATION PHARMACY	13.00	0	12, 064 14, 582				4.00 5.00
5.00 6.00	ADULTS & PEDIATRICS	15.00 30.00	0	14, 582 81, 358				6.00
7.00	INTENSIVE CARE UNIT	31.00	0	13, 375				7.00
8.00	OPERATI NG ROOM	50.00	0	15, 188				8.00
9.00 10.00	RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	51.00 54.00	0	15, 408 27, 236				9.00 10.00
10.00	RADI OLOGY - DI AGNOSTI C	55.00	0	27, 230				11.00
12.00	CARDI AC CATHETERI ZATI ON	59.00	0	3, 295				12.00
13.00	RESPI RATORY THERAPY	65.00	0	16, 635				13.00
14.00 15.00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66.00 69.00	0	11, 153 2, 374				14.00 15.00
16.00	BEHAVI ORAL HEALTH	90.01	0	2, 374 2, 958				16.00
17.00	EMERGENCY	91.00		2 <u>3, 0</u> 66				17.00
	0		0	252, 020				_
1.00	L - UTILITIES OPERATION OF PLANT	7.00	0	1, 832, 763				1.00
2.00		0.00	0	1,032,703				2.00
3.00		0.00	0	0				3.00
4.00	L	0.00	0	0				4.00
	U M – MARKETING	<u> </u>	0	1, 832, 763				-
1.00	MARKETING	192.02	0	40, 444				1.00
2.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	20				2.00
3.00	CANTEEN	0.00	0	o				3.00
5.00	0		<u>0</u>	40, 464				5.00
	•	· · ·						•

Heal th	Financial Systems		IU HEALTH WEST	F HOSPI TAL		In Lieu	u of Form CMS	S-2552-10
RECLAS	SIFICATIONS			Provider CC	N: 15-0158	Period:	Worksheet A	-6
						From 01/01/2021 To 12/31/2021	Date/Time P	repared
						10 12/31/2021	5/26/2022 3	
		Increases						
	Cost Center	Line #	Salary	Other				
		3.00	4.00	5.00		· · · ·		_
1.00	N - BILLABLE/NON-BILLABLE DRU PHARMACY	15.00	0	923, 448				1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	7, 584, 265				2.00
3.00	ADMINI STRATI VE AND GENERAL	5.04	0	7, 584, 285				3.00
4.00	ADMINISTRATIVE AND GENERAL	0.00	0	0				4.00
4.00 5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
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
14.00		0.00	0	0				14.00
16.00		0.00	0	0				16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20.00			0	0				
		0.00		0				20.00
21.00								21.00
	0 0 - MEDICAL SUPPLIES AND IMPL		U	8, 508, 221				-
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 863, 827				1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	4, 671, 277				2.00
2.00	PATIENTS	/1.00	0	4,071,277				2.00
3.00	IMPL. DEV. CHARGED TO	72.00	о	8, 205, 819				3.00
5.00	PATIENT	72.00	Ŭ	0,203,019				5.00
4.00	PURCHASING RECEIVING AND	5.03	0	2, 227				4.00
4.00	STORES	5.05	0	2,227				4.00
5.00	ADMINISTRATIVE AND GENERAL	5.04	0	86, 057				5.00
6.00	MAINTENANCE & REPAIRS	6.00	0	2, 102				6.00
7.00	OPERATION OF PLANT	7.00	0	44, 579				7.00
8.00	HOUSEKEEPING	9.00	0	382				8.00
9.00	GIFT, FLOWER, COFFEE SHOP &	190.00	Ő	7				9.00
	CANTEEN	170100	°,					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	22, 463				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
19.00		0.00	0	0				19.00
20.00		0.00	0	Ō				20.00
21.00		0.00	0	0				21.00
22.00		0.00	О	0				22.00
23.00		0.00	0	0				23.00
24.00		0.00	0	Ō				24.00
25.00		0.00	0	0				25.00
	0		0	18, 898, 740				
	P - ROUTINE COSTS	·						
1.00	ADULTS & PEDIATRICS	30.00	92, 565	14, 908				1.00
2.00		0.00	0	0				2.00
	0		92, 565	14, 908				
	Q - TIPTON, NORTH, SAXONY REC	CLASS						
I. 00	TI PTON SERVI CES	192.04	54, 278	16, 572				1.00
2 00	NORTH SERVICES	102 05	260 517	82 205				2 00

192.05 192.06

0.00

0.00

0.00

73, 086

0

0

0 396, 911

269, 547

4,632,106

82, 295

22, 314

121, 181

57, 774, 036

0

0

0

Health Financial Systems
RECLASSI FI CATI ONS

In Lieu of Form CMS-2552-10

2.00 3.00

4.00

5.00

6.00

500.00

NORTH SERVICES SAXONY SERVICES

500.00 Grand Total: Increases

2.00 3.00

4.00

5.00

6.00

0

Heal th	n Financial Systems		IU HEALTH V	VEST	HOSPI T
RECLAS	SSI FI CATI ONS				Provi
		Decreases			
	Cost Center	Line #	Sal ary		Other
	6.00	7.00	8.00		9.00
	A - DEPRECIATION				
1.00	MOB	1.01		0	26
2.00	ADMINISTRATIVE AND GENERAL	5.04	(0	3, 11
3.00	MAINTENANCE & REPAIRS	6.00		ol	3.79

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

ITAL vider CCN: 15-0158

Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 3:15 pm

		Decreases				
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
1.00	A - DEPRECIATION MOB	1.01	0	268, 84	7 9	1.00
2.00	ADMI NI STRATI VE AND GENERAL	5.04	0	3, 116, 39		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	3, 795, 14		3.00
4.00	OPERATION OF PLANT	7.00	0	12, 679	9 12	4.00
5.00	HOUSEKEEPI NG	9.00	0	2, 422		5.00
6.00		10.00	0	42, 120		6.00
7.00 8.00	NURSING ADMINISTRATION PHARMACY	13.00 15.00	0	778, 68 118, 408		7.00
8.00 9.00	ADULTS & PEDIATRICS	30.00	0	397,064		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	21, 532		10.00
11.00	OPERATI NG ROOM	50.00	0	2,029,403		11.00
12.00	RECOVERY ROOM	51.00	0	13, 442		12.00
13.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2,082,039		13.00
14.00	RADI OLOGY-THERAPEUTI C	55.00	0	503, 544		14.00
15. 00 16. 00	CARDI AC CATHETERI ZATI ON RESPI RATORY THERAPY	59.00 65.00	0	609, 292 82, 03		15.00
17.00	PHYSICAL THERAPY	66.00	0	17, 312		17.00
18.00	ELECTROCARDI OLOGY	69.00	0	96, 196		18.00
19.00	CARDI AC REHABI LI TATI ON	76.97	0	29, 328		19.00
20.00	SLEEP LAB	90. 02	0	465		20.00
21.00	EMERGENCY	91.00	0	349, 726		21.00
22.00	BACK_AND NECK	1 <u>92.</u> 03	0	7,762		22.00
	0 B - LEASE		0	14, 373, 843	5	-
1.00	ADMINI STRATI VE AND GENERAL	5.04	0	719, 86	1 10	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	245		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	32, 84		3.00
4.00	INTENSIVE CARE UNIT	31.00	0	24, 020		4.00
5.00	OPERATING ROOM	50.00	0	11, 76		5.00
6.00		54.00	0	1, 45		6.00
7.00 8.00	PHYSI CAL THERAPY CARDI AC REHABI LI TATI ON	66.00 76.97	0	39, 978 39, 978		7.00
9.00	BEHAVI ORAL HEALTH	90.01	0	69, 740		9.00
10.00	EMERGENCY	91.00	0	8, 688		10.00
11.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	31, 453		11.00
	CANTEEN					
12.00	BACK_AND NECK	<u> </u>	0	245,549		12.00
	C - INTEREST			1, 225, 57	I [1
1.00	OPERATION OF PLANT	7.00	0	882	2 11	1.00
	0		0			
	D – BENEFITS					
1.00	ADMI NI STRATI VE AND GENERAL	5.04	0	747, 123		1.00
2.00 3.00	MAINTENANCE & REPAIRS	6.00	0	183, 240		2.00
3.00 4.00	OPERATI ON OF PLANT HOUSEKEEPI NG	7.00 9.00	0	210, 12 ⁻ 414, 272		4.00
5.00	DI ETARY	10.00	0	484, 318		5.00
6.00	NURSING ADMINISTRATION	13.00	0	494, 212		6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	364, 140	0 0	7.00
8.00	PHARMACY	15.00	0	473, 043		8.00
9.00	TRANSPORTATI ON	18.00	0	30, 543		9.00
10.00	ADULTS & PEDIATRICS	30.00	0	2,810,660		10.00
11. 00 12. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31.00 35.00	0	509, 06 [°] 159, 900		11.00
12.00	OPERATI NG ROOM	50.00	0	904, 79		13.00
14.00	RECOVERY ROOM	51.00	0	581, 18		14.00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	866, 210		15.00
16.00	RADI OLOGY-THERAPEUTI C	55.00	0	234, 588		16.00
17.00	CARDIAC CATHETERIZATION	59.00	0	154, 91		17.00
18.00		60.00	0	195		18.00
19.00 20.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	285, 570 334, 460		19.00 20.00
20.00	OCCUPATIONAL THERAPY	67.00	0	82, 378		20.00
22.00	SPEECH PATHOLOGY	68.00	0	46, 85		22.00
23.00	ELECTROCARDI OLOGY	69.00	Ō	158, 958		23.00
24.00	CARDI AC REHABI LI TATI ON	76.97	0	76, 29	5 0	24.00
25.00	BEHAVIORAL HEALTH	90.01	0	95, 664		25.00
26.00	SLEEP LAB	90.02	0	538		26.00
27.00 28.00	EMERGENCY OBSERVATION BEDS (DISTINCT	91.00 92.01	0	779, 623 41, 156		27.00 28.00
∠0. UU	PART)	72. UI	0	41,100		20.00
29.00	GIFT, FLOWER, COFFEE SHOP &	190.00	о	41, 159	9 0	29.00
_	CANTEEN					
	· · · · · · · · · · · · · · · · · · ·					

CLAS	Financial Systems SIFICATIONS		IU HEALTH WEST		CCN: 15-0158	Period:	u of Form CMS-255 Worksheet A-6
						From 01/01/2021 To 12/31/2021	Date/Time Prepai 5/26/2022 3:15
		Decreases				·	
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	<u>.</u>	
. 00	PHYSI CLANS' PRI VATE OFFI CES	192.00	0.00	9.00 87		0	3
. 00	RETAIL PHARMACY	192.00	0	62		0	3
00	BACK AND NECK	192.03	o	33, 522		0	3
			o	11, 598, 862		1	
	E - ACCRUED PTO						
00	ADMI NI STRATI VE AND GENERAL	5.04	75, 701	0		0	
00	MAINTENANCE & REPAIRS	6.00	6, 285	0		0	
00	OPERATION OF PLANT	7.00	3, 999	0		0	
00	HOUSEKEEPING	9.00	33, 938	0		0	
00	DI ETARY	10.00	16, 025	0		0	
00	PHARMACY	15.00	31, 086	0		o	
00	ADULTS & PEDIATRICS	30.00	83, 793	0		0	
0	INTENSIVE CARE UNIT	31.00	18, 266	0		0	
00	NEONATAL INTENSIVE CARE UNIT	35.00	10, 669	0		0	
00	OPERATI NG ROOM	50.00	68, 397	0		0	1
00	RECOVERY ROOM	51.00	28, 110	0		0	1
00	RADI OLOGY-DI AGNOSTI C	54.00	25, 378	0		0	1
00	CARDI AC CATHETERI ZATI ON	59.00	7, 001	0		0	1
00	RESPI RATORY THERAPY	65.00	19, 782	0		0	1
00	PHYSI CAL THERAPY	66.00	5, 678	0		0	1
00	OCCUPATI ONAL THERAPY	67.00	4, 529	0		0	1
00	ELECTROCARDI OLOGY	69.00	9, 479	0		0	1
00	CARDI AC REHABI LI TATI ON	76. 97	2, 019	0		0	1
00	BEHAVIORAL HEALTH	90. 01	5, 311	0		0	1
00	EMERGENCY	91.00	40, 261	0		0	2
00	GIFT, FLOWER, COFFEE SHOP &	190.00	982	0		0	2
	CANTEEN						
	TOTALS		496, 689	0			
	F - LABOR & DELIVERY				1		
00	ADULTS & PEDI ATRI CS	<u>30.</u> 00	<u>2,682,9</u> 42	36 <u>2,0</u> 01		이	
	0		2, 682, 942	362, 001			
	H - NURSERY					-	
00	ADULTS & PEDIATRICS	<u>30.00</u>	37 <u>1,103</u>	5 <u>0,072</u>		Q	
			371, 103	50, 072			
~~	I - DIETARY	10.00	F01 00/	40.4 500	1		
00	DI ETARY	<u> </u>	<u>591, 896</u> 591, 896	49 <u>4,508</u> 494,508		0	
	K - STD		571,070	474, 300			
00	ADMINISTRATIVE AND GENERAL	5.04	5,021	0		o	
00	HOUSEKEEPING	9.00	1,825	0		0	
00	DI ETARY	10.00	3, 851	0		0	
00	NURSI NG ADMI NI STRATI ON	13.00	12,064	0		0	
00	PHARMACY	15.00	14, 582	0		0	
00	ADULTS & PEDIATRICS	30.00	81, 358	0		0	
00	I NTENSI VE CARE UNI T	31.00	13, 375	0		0	
00	OPERATI NG ROOM	50.00	15, 188	0		o	
00	RECOVERY ROOM	51.00	15, 408	0		0	
00	RADI OLOGY-DI AGNOSTI C	54.00	27, 236	0		0	1
00	RADI OLOGY-THERAPEUTI C	55.00	2,631	0		o	1
00	CARDI AC CATHETERI ZATI ON	59.00	3, 295	0		o	1
00	RESPI RATORY THERAPY	65.00	16, 635	0		ol	1
00	PHYSI CAL THERAPY	66.00	11, 153	0		o	1
00	ELECTROCARDI OLOGY	69.00	2, 374	0		o	1
00	BEHAVI ORAL HEALTH	90.01	2, 958	0		0	1
00	EMERGENCY	91.00	23,066	0		0	1
			252,020	0		1	'
	L - UTILITIES					а	
00	MOB	1.01	0	19, 801	1	0	
00	ADMINISTRATIVE AND GENERAL	5.04	0	222		0	
0	MAINTENANCE & REPAIRS	6.00	О	1, 812, 340		o	
0	SLEEP LAB	90. 02	0	400		o	
	0		0	1,832,763			
	M - MARKETING						
00	ADMINISTRATIVE AND GENERAL	5.04	0	40, 000		0	
00	MAINTENANCE & REPAIRS	6.00	0	314		o	
00	CENTRAL_SERVICES_&_SUPPLY	14.00	0	150		o	
	0		0	40, 464			
	N - BILLABLE/NON-BILLABLE DRUG						
00	PHARMACY	15.00	0	6, 535, 604		0	
00	MAINTENANCE & REPAIRS	6.00	0	16		o	
00	NURSING ADMINISTRATION	13.00	0	12		o	
00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 654		o	
20	ADULTS & PEDIATRICS	30.00	0	254, 594		0	
00 00	I NTENSI VE CARE UNI T	31.00	0	89, 445		o	

IU HEALTH WEST HOSPITAL Provider CCN: 15-0158

In Lieu of Form CMS-2552-10

Heal th	Financial Systems		IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CM	MS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-0158	Period:	Worksheet	A-6
						From 01/01/2021 To 12/31/2021	Date/Time	Proparod
						10 12/31/2021	5/26/2022	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	2.		
	6. 00	7.00	8.00	9.00	10.00			
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	3, 364		0		7.00
8.00	OPERATI NG ROOM	50.00	0	128, 106		0		8.00
9.00	RECOVERY ROOM	51.00	0	132, 722		0		9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	738, 283		0		10.00
11.00	RADI OLOGY-THERAPEUTI C	55.00	0	186, 312		0		11.00
12.00	CARDI AC CATHETERI ZATI ON	59.00	0	108, 911		0		12.00
13.00	BLOOD STORING, PROCESSING, &	63.00	0	75	5	0		13.00
	TRANS.	(5.00)						
14.00	RESPI RATORY THERAPY	65.00	0	20, 403		0		14.00
15.00	PHYSI CAL THERAPY	66.00	0	1, 154		0		15.00
16.00	ELECTROCARDI OLOGY	69.00	0	13, 482				16.00
17.00 18.00	RENAL DI ALYSI S	74.00 76.97	0	4, 124		0		17.00 18.00
18.00	CARDIAC REHABILITATION SLEEP LAB	90.02	0	331		0		19.00
20.00	EMERGENCY	90.02	0	283, 503	-	0		20.00
20.00	OBSERVATION BEDS (DISTINCT	92.01	0	6, 124		0		20.00
21.00	PART)	72.01	0	0, 122	+	0		21.00
	<u></u>			8, 508, 221	<u> </u>	-		
	0 - MEDICAL SUPPLIES AND IMPL	ANTS	0	0, 300, 22	1			_
1.00	DI ETARY	10.00	0	1, 165	5	0		1.00
2.00	NURSI NG ADMI NI STRATI ON	13.00	0	36, 762		0		2.00
3.00	OPERATI NG ROOM	50.00	0	12, 177, 387		0		3.00
4.00	PHARMACY	15.00	0	31, 904		0		4.00
5.00	ADULTS & PEDIATRICS	30.00	Ő	1, 127, 777		0		5.00
6.00	INTENSIVE CARE UNIT	31.00	Ő	229, 967		0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	27, 535		0		7.00
8.00	RECOVERY ROOM	51.00	0	75, 249		0		8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	225, 088		0		9.00
10.00	RADI OLOGY-THERAPEUTI C	55.00	0	100, 824		0		10.00
11.00	CARDI AC CATHETERI ZATI ON	59.00	0	3, 915, 667		0		11.00
12.00	LABORATORY	60.00	0	4, 183		0		12.00
13.00	BLOOD STORING, PROCESSING, &	63.00	0	758		0		13.00
	TRANS.							
14.00	RESPI RATORY THERAPY	65.00	0	402, 209	9	0		14.00
15.00	PHYSI CAL THERAPY	66.00	0	124, 177	7	0		15.00
16.00	OCCUPATI ONAL THERAPY	67.00	0	264	1	0		16.00
17.00	SPEECH PATHOLOGY	68.00	0	405	5	0		17.00
18.00	ELECTROCARDI OLOGY	69.00	0	5, 724	1	0		18.00
19.00	RENAL DI ALYSI S	74.00	0	11, 318	3	0		19.00
20.00	CARDI AC REHABI LI TATI ON	76.97	0	488	3	0		20.00
21.00	BEHAVIORAL HEALTH	90. 01	0	1, 260	D	0		21.00
22.00	SLEEP LAB	90. 02	0	12, 190	D	0		22.00
23.00	EMERGENCY	91.00	0	379, 514	1	0		23.00
24.00	OBSERVATION BEDS (DISTINCT	92.01	0	6, 922	2	0		24.00
	PART)							
25.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	<u>0</u>		<u> </u>	0		25.00
	0		0	18, 898, 740)			
	P - ROUTINE COSTS				. 1	-1		
1.00	RECOVERY ROOM	51.00	40, 075	5, 961		0		1.00
2.00	OBSERVATION BEDS (DISTINCT	92.01	52, 490	8, 947	/	0		2.00
	<u>PART)</u>		— — <u></u>		<u> </u>	-		
			92, 565	14, 908	5			_
1 00	Q - TIPTON, NORTH, SAXONY REC		F0 F04	15 000		0		1.00
1.00	ADMINI STRATI VE AND GENERAL	5.04	50, 591	15,000		0		1.00
2.00	NURSING ADMINISTRATION	13.00	3, 688	1, 572		0		2.00
3.00	ADMINI STRATI VE AND GENERAL	5.04	251, 233	74, 488		0		3.00
4.00 5.00	NURSING ADMINISTRATION	13.00	18, 313	7,807				4.00
5.00	ADMINI STRATI VE AND GENERAL	5.04	68, 120	20, 197		0		5.00
6.00	NURSING ADMINISTRATION	<u>13.</u> 00	<u>4, 966</u> 396, 911	<u>2, 117</u> 121, 181		빅		6.00
			JAD A11	171.18	11	1		1
500 00	Grand Total: Decreases		4, 884, 126	57, 522, 016		-		500.00

Health Financial Systems	IU HEALTH WES				u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021		pared:
			Acquisition	S		
	Begi nni ng	Purchases	Donati on	Total	Disposals and	
	Bal ances				Retirements	
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00 Land	0	0		0 0	0	1.00
2.00 Land Improvements	6, 800, 703	0		0 0	0	2.00
3.00 Buildings and Fixtures	76, 957, 802	0		0 0	0	3.00
4.00 Building Improvements	32, 014, 351	71, 458, 421		0 71, 458, 421	0	4.00
5.00 Fixed Equipment	0	0		0 0	0	5.00
6.00 Movable Equipment	77, 260, 628	17, 288, 236		0 17, 288, 236	1, 142, 788	6.00
7.00 HIT designated Assets	0	0		0 0	0	7.00
8.00 Subtotal (sum of lines 1-7)	193, 033, 484	88, 746, 657		0 88, 746, 657	1, 142, 788	8.00
9.00 Reconciling Items	0	0		0 0	0	9.00
10.00 Total (line 8 minus line 9)	193, 033, 484	88, 746, 657		0 88, 746, 657	1, 142, 788	10.00
	Endi ng	Fully		- · · ·		
	Bal ance	Depreciated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00 Land	0	0				1.00
2.00 Land Improvements	6, 800, 703	1, 595, 468				2.00
3.00 Buildings and Fixtures	76, 957, 802	0				3.00
4.00 Building Improvements	103, 472, 772	1, 686, 405				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	93, 406, 076	37, 733, 200				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	280, 637, 353	41, 015, 073				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	280, 637, 353	41,015,073				10.00

Health Financial Systems	IU HEALTH WE	ST_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2021 To 12/31/2021		pared:
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM W	ORKSHEET A, COLU	MN 2, LINES 1 a	and 2	-	1	
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
1.01 MOB	268, 847	356, 106		0 0	0	1.01
1.02 INTEREST	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)	268, 847			0 0	0	3.00
	SUMMARY C)F CAPI TAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at					
		9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM W	ORKSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01 MOB	271, 659	896, 612				1.01
1.02 INTEREST	0	0				1.02
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	271, 659	896, 612				3.00

Heal th	Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared:
		COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			107 001 07			
1. 00 1. 01 1. 02	NEW CAP REL COSTS-BLDG & FIXT MOB INTEREST	187, 231, 276 0 0		187, 231, 27	6 0. 667164 0 0. 000000 0 0. 000000	0	1.00 1.01 1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	93, 406, 076	0	93, 406, 07			2.00
3.00	Total (sum of lines 1-2)	280, 637, 352					3.00
		ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C		
	Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0			7, 143, 461	444, 209	1.00
1.01	MOB	0	0		0 -1,003,409		1.01
1.02	INTEREST	0	0		0 0	, v	1.02
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 8,099,286		2.00
3.00	Total (sum of lines 1-2)	0	U	JMMARY OF CAPI	D 14, 239, 338	1, 561, 876	3.00
			50	JININIART OF CAFT	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	·		(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		44.00	40.00	10.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00	NEW CAP REL COSTS-BLDG & FIXT	ENTERS 0	161, 715	37, 17		7, 786, 555	1.00
1.00	MOB	0	101,713		271,659		1.00
1.01	INTEREST	4, 732, 788	0		0 2,1,00,	4, 732, 788	1.01
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0			0	8, 181, 226	2.00
3.00	Total (sum of lines 1-2)	4, 732, 788			271, 659		3.00
	•						

Heal th	Fi nanci	al	Systems
	MENTS T		PENSES

JUSTMENTS TO EXPENSES				Period: From 01/01/2021	Worksheet A-8	
				o 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared: 5 pm
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
20 Lovestment income NEW CAD	1.00 A	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1 0
00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	A		FIXT	1.00	9	1.0
01 Investment income - MOB (chapter 2)	A	-1,003,409		1.01	9	1.C
02 Investment income - INTEREST (chapter 2) 00 Investment income - NEW CAP	В		INTEREST NEW CAP REL COSTS-MVBLE	1.02	11 0	1. (2. (
00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			EQUIP	2.00	0	2.0
00 Investment income - other (chapter 2)		0		0.00	0	3.0
00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	
00 Refunds and rebates of expenses (chapter 8) 00 Rental of provider space by	В	0	NEW CAP REL COSTS-BLDG &	0.00	0 10	5. (6. (
suppliers (chapter 8) Telephone services (pay	D	-	FIXT	0.00	0	7.0
stations excluded) (chapter 21)					-	
00 Television and radio service (chapter 21)		0		0.00	0	
00 Parking lot (chapter 21) 00 Provider-based physician adjustment	A-8-2	0 -15, 809, 110		0.00	0 0	9. 10.
.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. (
00 Related organization transactions (chapter 10)	A-8-1	24, 673, 033			0	
.00 Laundry and linen service .00 Cafeteria-employees and guests	В	0 -145, 322	CAFETERI A	0.00 11.00	0 0	13. 14.
.00 Rental of quarters to employee and others		0		0.00	0	
00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.
00 Sale of drugs to other than patients		0		0.00	0	17.
00 Sale of medical records and abstracts		0		0.00	0	18.
.00 Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.
.00 Vending machines .00 Income from imposition of		0		0. 00 0. 00	0 0	20. 21.
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.
repay Medicare overpayments 00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
limitation (chapter 14) 00 Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
therapy costs in excess of limitation (chapter 14) 00 Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.
(chapter 21) 00 Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1.00	0	26.
COSTS-BLDG & FIXT 01 Depreciation - MOB			FIXT MOB	1. 01	0	26.
.02 Depreciation - INTEREST		0	INTEREST	1.02	0	26.
.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.(
.00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28.

ealth Financ	cial Systems	
D ULCTHENITO		

Health Financial Systems		IU HEALTH WES	ST HOSPI TAL	In Lie	u of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8	1
				From 01/01/2021 To 12/31/2021	Date/Time Pre	
			Expense Classification on	Worksheet A	5/26/2022 3:1	5 pm
			To/From Which the Amount is			
				,		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
oust center bescription	(2)	Anodric		Line "	Ref.	
	1.00	2.00	3.00	4.00	5.00	
29.00 Physicians' assistant		0		0.00	0	29.00
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
instructions)	A-8-3	0	SPEECH PATHOLOGY	(0.00		21 00
31.00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest				0.00	, i i i i i i i i i i i i i i i i i i i	02.00
33.00 MISCELLANEOUS INCOME	В	-417, 121	ADMINISTRATIVE AND GENERAL	5.04	0	33.00
33.01 MISCELLANEOUS INCOME	В	30, 319	MAINTENANCE & REPAIRS	6.00	0	33.01
33. 02 MI SCELLANEOUS I NCOME	В	-177	NURSING ADMINISTRATION	13.00	0	33.02
33. 03 MI SCELLANEOUS I NCOME	В		PHARMACY	15.00	0	
33. 04 MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69.00	0	
33. 05 CONTRI BUTI ON EXPENSE	A		ADMINISTRATIVE AND GENERAL	5.04	0	
33. 06 CONTRIBUTION EXPENSE	A		NURSING ADMINISTRATION	13.00	0	33.06
33. 07 CONTRIBUTION EXPENSE 33. 08 HAF FEES	A		ADULTS & PEDIATRICS ADMINISTRATIVE AND GENERAL	30.00 5.04		
33.08 HAF FEES 33.09 EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT			
33. 10 TELEPHONE EQUI PMENT	A		DI ETARY	10.00		
33. 11 TELEPHONE EQUI PMENT	A		NURSING ADMINISTRATION	13.00	-	
33. 12 TELEPHONE EQUI PMENT	A		PHARMACY	15.00		
33. 13 TELEPHONE EQUI PMENT	A		ADULTS & PEDIATRICS	30.00	0	
33. 14 TELEPHONE EQUI PMENT	А	-6, 761	OPERATING ROOM	50.00	C	33.14
33. 15 TELEPHONE EQUI PMENT	А	-1, 063	RECOVERY ROOM	51.00	0	33.15
33. 16 TELEPHONE EQUI PMENT	А		RADI OLOGY-DI AGNOSTI C	54.00	C	001.10
33.17 TELEPHONE EQUI PMENT	А		RENAL DIALYSIS	74.00	0	
33.18 TELEPHONE EQUI PMENT	A		EMERGENCY	91.00	0	
33. 19 WEST EXPANSION	A		ADMINISTRATIVE AND GENERAL	5.04	0	
33. 20 WEST EXPANSION START-UP COST	A		ADMI NI STRATI VE AND GENERAL	5.04	0	
33. 21 UNWONTED SI TUATI ONS	A		ADMINI STRATI VE AND GENERAL	5.04	0	
33. 22 UNWONTED SI TUATI ONS 33. 23 UNWONTED SI TUATI ONS	A		ADULTS & PEDIATRICS EMERGENCY	30.00 91.00		33.22 33.23
50.00 TOTAL (sum of lines 1 thru 49)		-18, 024, 340		91.00	0	50.00
(Transfer to Worksheet A,		- 10, 024, 340				00.00
column 6, line 200.)						
(1) Description all chapter referen		Jump portoin t	o CMS Dub 1E 1			

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

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

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

Heal th	Financial Systems	IU HEALTH WE	ST HOSPI TAL	In Lie	eu of Form CMS-2	552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-0158	Peri od:	Worksheet A-8-	-1
OFFI CE	COSTS			From 01/01/2021 To 12/31/2021		aarad
				10 12/31/2021	5/26/2022 3: 15	5 nm
	Line No.	Cost Center	Expense Items	Amount of	Amount	<u> </u>
			•	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:					
1.00		NEW CAP REL COSTS-BLDG & FIX		847,680	444, 209	1.00
2.00			HO CR ALLOCATIONS	4, 441, 477	0	2.00
3.00		NEW CAP REL COSTS-MVBLE EQUI		1, 031, 803		3.00
4.00		EMPLOYEE BENEFITS DEPARTMENT		13, 044, 686		4.00
4.01			HO CR ALLOCATIONS	9, 983, 423	0	4.01
4.02		PURCHASING RECEIVING AND STO		746, 650	0	4.02
4.03			HO CR ALLOCATIONS	22, 541, 081	28, 424, 034	4.03
4.04			HO CR ALLOCATIONS	0	159, 221	4.04
4.05			HO CR ALLOCATIONS	527, 759	0	4.05
4.06	1.01		I NTERCOMPANY	300,000	300, 000	4.06
4.07		EMPLOYEE BENEFITS DEPARTMENT		13, 980	13, 980	4.07
4.08			I NTERCOMPANY	6, 589, 910		4.08
4.09				494, 687	494, 687	4.09
4.10				2, 380, 335		4.10
4.11				1, 260, 068		4.11
4.12 4.13		OPERATING ROOM		744, 509	744, 509	4. 12 4. 13
4.13 4.14		RECOVERY ROOM RADI OLOGY-DI AGNOSTI C	I NTERCOMPANY I NTERCOMPANY	58, 508		4.13 4.14
4.14			INTERCOMPANY	216, 180 367, 057	216, 180 367, 057	4.14 4.15
4.15		CARDI AC CATHETERI ZATI ON	INTERCOMPANY	1, 130, 462		4.15
4.10			INTERCOMPANY	8, 727, 001	8, 727, 001	4.10
4.17		BLOOD STORING, PROCESSING, &		55, 723	55, 723	4.17
4.18			INTERCOMPANY	7,466	7, 466	4.18
4.20			INTERCOMPANY	376, 110		4. 20
4.20			INTERCOMPANY	9, 702	9, 702	4.20
4.22			INTERCOMPANY	3, 790	3, 790	4.22
4.23			INTERCOMPANY	12, 500		4.23
4.24			INTERCOMPANY	575, 199		4.24
4.25		EMERGENCY	INTERCOMPANY	3, 378, 417		4.25
4.26		OBSERVATION BEDS (DISTINCT P		9,858		4.26
4.28			INTERCOMPANY	25, 134		4.28
4.29			INTERCOMPANY	-9, 260		4.29
4.30			NORTH ALLOCATION	258, 197	0	4.30
4.31			NORTH ALLOCATION	107, 619	-	4.31
4.32			NORTH ALLOCATION	170, 122	0	4.32
	0		0	80, 427, 833	55, 754, 800	5.00
-	amounts on lines 1-4 (and sub	scripts as appropriate) are	transforred in detail to Wor			

* 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		Ownershi p	
1.00	2.00	3.00	4.00	5.00	
 B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HC	ME OFFICE:			

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

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

rerinbur	sement under titte XVIII.					
6.00	В	IU HEALTH	100.00	IU HEALTH-HO	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	FINANCIAL				100.00
	non-financial) specify:					

Heal th	Financial Syste	ms		IU H	IEALTH	WEST	HOSPI TAL			In Lie	eu of Form CMS-	2552-10
	NT OF COSTS OF	SERVI CES	FROM RELATE	ORGANIZATION	S AND H	IOME	Provi der	CCN:	: 15-0158	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS									From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:	
								Rel	lated Organ	nization(s) and/	or Home Office	
	Symbol	(1)		Name		Per	centage o	f	Ν	lame	Percentage of	
						0	wnership				Ownership	
	1. (00		2.00			3.00		4	. 00	5.00	

(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 organi zati on.

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 provi der.

	Financial Syste		RELATED ORGANIZATIONS AND	HOME Provider	CCN: 15-0158	Period:	of Form CMS-255 Worksheet A-8-1
	COSTS	SERVICES FROM	RELATED ORGANIZATIONS AND	HOME Provider	CCN: 15-0158	From 01/01/2021	
						To 12/31/2021	Date/Time Prepar 5/26/2022 3:15 p
	Net	Wkst. A-7 Ref.					5/20/2022 5.15
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6,00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED AS A RESULT	OF TRANSACTIONS	S WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME
	OFFICE COSTS:						
00	403, 471	9					
00	4, 441, 477	11					
00	1, 031, 803	9					
00	13, 044, 686	0					
01	9, 983, 423	0					
02	746, 650	0					
03	-5, 882, 953	0					
04	-159, 221	0					
05	527, 759	0					
06	0	10					
07	0	0					
08	0	0					
09	0	0					
10	0	0					
11	0	0					
12	0	0					
13	0	0					
14	0	0					
15	0	0					
16	0	0					
17	0	0					
18	0	0					
19	0	0					
20	0	0					
21	0	0					
22	0	0					
23	0	0					
24	0	0					
25	0	0					
26	0	0					
28	0	0					
29	0	0					
30	258, 197	0					
31	107, 619	0					
32	170, 122	0					
00	24, 673, 033	0					
	amounts on line		1				

* The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which

has not been posted to Worksheet A,	columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.	
Related Organization(s)		
and/or Home Office		
Type of Business		
6, 00		
B INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

Ternibu		
6.00	HEALTHCARE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
10. 00 100. 00		100.00
	•	· · ·

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-0158	Peri od:	Worksheet A-8	-1
OFFICE COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
			10 12/31/2021	5/26/2022 3:1	5 pm
Related Organization(s) and/or Home Office					
Type of Business	-				
6.00					

(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 organi zati on.

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 provi der.

Heal th	Financial Syste	ems	IU HEALTH WE	EST HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (CCN: 15-0158	Period:	Worksheet A-8	3-2
						From 01/01/202 To 12/31/202		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.04	ADMINISTRATIVE AND GENERAL	7, 102, 152	7, 102, 152	(0 197, 500	0	1.00
2.00	13.00	NURSING ADMINISTRATION	26, 260	26, 260	(D 197, 500	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	1, 989, 673	1, 989, 673	(237,100	0	3.00
4.00	31.00	INTENSIVE CARE UNIT	1, 247, 568	1, 247, 568	(197, 500	0	4.00
5.00	50.00	OPERATING ROOM	863, 568	863, 568	(239,400	0	5.00
6.00	54.00	RADI OLOGY-DI AGNOSTI C	3, 305	3, 305	(271,900		6.00
7.00		RADI OLOGY-THERAPEUTI C	298, 691	298, 691		271,900		7.00
8.00		CARDIAC CATHETERIZATION	1,069,130			197, 500		8.00
9.00		EMERGENCY	3, 208, 763			197,500		9.00
10.00	0.00	EmertoErtoT	0,200,700	0,200,700				10.00
200.00	0.00		15, 809, 110	-				200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSL A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		Identifier			Continuing	Share of col.	Insurance	
				LI III L	Education	12	i iisui ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE AND GENERAL	0.00			0 0		1.00
2.00		NURSING ADMINISTRATION	0					
3.00		ADULTS & PEDIATRICS	0				, s	3.00
4.00		INTENSIVE CARE UNIT					0	4.00
4.00 5.00		OPERATING ROOM	0	0			0	5.00
			0				0	
6.00		RADI OLOGY-DI AGNOSTI C	0	0			0	6.00
7.00		RADI OLOGY-THERAPEUTI C	0	0			0	7.00
8.00		CARDIAC CATHETERIZATION	0	0		0 0	0	8.00
9.00		EMERGENCY	0	0	(0 0	0	9.00
10.00	0.00		0	0	(0 0	0	10.00
200.00			0	0		0 0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		ldentifier	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1(00	17.00	10.00	-	
1.00	1.00		15.00	16.00	17.00	18.00		1.00
1.00		ADMI NI STRATI VE AND GENERAL	0	-		7, 102, 152		1.00
2.00		NURSING ADMINISTRATION	0			26, 260		2.00
3.00		ADULTS & PEDIATRICS	0	-		1, 989, 673	•	3.00
4.00		INTENSIVE CARE UNIT	0	0		1, 247, 568	1	4.00
5.00		OPERATING ROOM	0			0 863, 568		5.00
6.00		RADI OLOGY-DI AGNOSTI C	0	0		3, 305		6.00
7.00		RADI OLOGY-THERAPEUTI C	0			298, 691	•	7.00
8.00		CARDIAC CATHETERIZATION	0	0		1, 069, 130		8.00
9.00		EMERGENCY	0	0		3, 208, 763		9.00
10.00	0.00		0	0	(0 0		10.00
200.00			0	0	(15, 809, 110		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH WES	T HOSPITAL Provider CCN		<u>In Lieu</u> riod: om 01/01/2021	u of Form CMS-2 Worksheet B Part I	
				То	12/31/2021	Date/Time Pre 5/26/2022 3:1	
				CAPI TAL RELA	ATED COSTS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FI XT	MOB	INTEREST	NEW MVBLE EQUI P	
		col. 7) 0	1.00	1.01	1.02	2.00	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FLXT 00101 MOB	7, 786, 555	7, 786, 555	609, 197			1.00
1.01 1.02	00102 I NTEREST	306, 906 4, 732, 788	302, 291 0	009, 197	4, 732, 788		1.01
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	8, 181, 226	-	-	.,,	8, 181, 226	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 773, 950	34, 930	0	22, 088	0	
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	9, 844 9, 983, 423	0	0	0	0	5.01 5.02
5.02	00560 PURCHASING RECEIVING AND STORES	773, 637	0	0	0	0	•
5.04	00590 ADMI NI STRATI VE AND GENERAL	29, 151, 430	492, 885	82, 786	311, 683	268, 426	5.04
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	3,637,347	1, 187, 643	0	751,024	953, 110 12, 676	
8.00	00800 LAUNDRY & LINEN SERVICE	5, 335, 383 586, 890	181, 149 25, 725	0	114, 552 16, 268	12,070	8.00
9.00	00900 HOUSEKEEPI NG	2, 512, 940	109, 123	9, 508	69, 005	0	9.00
	01000 DI ETARY	1, 559, 844	242, 525	4, 658	153, 365	29, 337	10.00
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	941, 082 11, 048, 962	168, 907 27, 762	0	106, 811 17, 556	20, 431 987, 147	11.00
	01400 CENTRAL SERVICES & SUPPLY	5, 596, 407	113, 660	0	71, 875	0	•
	01500 PHARMACY	4, 550, 265	129, 791	0	82, 076	126, 659	
	01700 SOCI AL SERVI CE 01080 TRANSPORTATI ON	4, 856 242, 085	0 0	0 0	0	0	17.00
18.00	INPATIENT ROUTINE SERVICE COST CENTERS	242,003	0	0	U	0	18.00
	03000 ADULTS & PEDIATRICS	21, 743, 717	1, 767, 573	0	1, 117, 750	290, 482	30.00
	03100 I NTENSI VE CARE UNI T	4, 342, 761	244, 674	0	154, 723	2, 795	
	02080 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	1, 124, 746 421, 175	56, 339 41, 023	0 0	35, 627 25, 941	0 11, 183	35.00 43.00
10.00	ANCI LLARY SERVICE COST CENTERS	121,170	11, 020		20, 711	11,100	10.00
	05000 OPERATING ROOM	7,007,999	703, 111	0	444, 623	1, 777, 826	
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	3, 381, 252 3, 044, 943	337, 535 296, 512	0 0	213, 446 187, 504	14, 501 80, 850	51.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	6, 750, 433	331, 905	0	209, 885	1, 965, 891	•
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 423, 451	177, 870	0	112, 479	503, 350	55.00
	05900 CARDI AC CATHETERI ZATI ON	1, 752, 206	90, 843	0	57, 446	633, 734	
	06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	8, 729, 197 605, 408	70, 044 0	0	44, 294 0	0	60.00 63.00
	06500 RESPI RATORY THERAPY	2, 736, 373	49, 598	0	31, 364	43, 777	65.00
	06600 PHYSI CAL THERAPY	2, 156, 885	3, 130	30, 053	1, 979	5, 960	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	706, 779 291, 346	3, 130 3, 130	30, 053 30, 053	1, 979 1, 979	0	•
	06900 ELECTROCARDI OLOGY	1, 413, 135	0	30, 033	0	95, 738	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 671, 277	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	8, 205, 819	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	7, 584, 265 950, 912	41, 171	0	26, 035	0	73.00
76.00	03950 OTHER ANCI LLARY SERVI CES	0	0	0	0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	269, 971	0	18, 317	0	29, 103	76.97
90.00	OUTPATI ENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90.01	09001 BEHAVI ORAL HEALTH	549, 678	Ő	22, 634	0 0	0	90.01
	09002 SLEEP LAB	610, 159	2, 741	67, 783	1,733	0	90.02
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 748, 541	416, 358	0	263, 291	320, 490	91.00 92.00
	09201 OBSERVATION BEDS (DISTINCT PART)	301, 168	83, 453	0	52, 773	0	•
	SPECIAL PURPOSE COST CENTERS			I	I		
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	208, 239, 416	7, 736, 531	295, 845	4, 701, 154	8, 173, 466	113.00
118.00	NONREIMBURSABLE COST CENTERS	200, 239, 410	7,730,331	275, 645	4,701,134	0, 173, 400	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	251, 591	0	64, 248	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	9, 947	0	124, 327	0		192.00
	19201 RETAIL PHARMACY 19202 MARKETING	6, 018 380, 235	0	42, 792 7, 327	0		192.01 192.02
	19203 BACK AND NECK	105, 284	ő	74, 658	0		192.02
	19204 TI PTON SERVI CES	70, 850	6, 834	0	4, 322		192.04
192.05	19205 NORTH SERVI CES 19206 SAXONY SERVI CES	351, 842 95, 400	33, 985 9, 205	0	21, 491 5, 821		192.05 192.06
			7.200	U	J. 0Z []	0	1172.00
		707 100	.,	-			200.00
192.06	Cross Foot Adjustments Negative Cost Centers	209, 510, 583	0 7, 786, 555	0 609, 197	0 4, 732, 788		200. 00 201. 00

	Financial Systems	IU HEALTH WES				u of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2021	Worksheet B Part I	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
	Cost Center Description	EMPLOYEE BENEFI TS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	PURCHASING RECEIVING AND STORES	Subtotal	
		4.00	5.01	5.02	5.03	5A. 03	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 MOB						1.00
1.02	00102 I NTEREST						1.02
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 830, 968					4.00
5. 01 5. 02	00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSI NG	0	9, 844	0 002 42	2		5.01 5.02
5.02 5.03	00560 PURCHASING RECEIVING AND STORES	6	0	9, 983, 42	3 0 773, 643		5.02
5.04	00590 ADMI NI STRATI VE AND GENERAL	998, 878	533	540, 30		31, 847, 126	1
6.00	00600 MAI NTENANCE & REPAI RS	185, 014	183	185, 97		6, 900, 299	
7.00	00700 OPERATION OF PLANT	151, 771	163	164, 93		5, 960, 729	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 0	628, 883	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	265, 678	419 254	425, 39		3, 392, 065	1
10.00	01100 CAFETERI A	163, 204 114, 180	177	257, 48 179, 25		2, 410, 701 1, 530, 867	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 627, 374	399	404, 89		14, 115, 556	
	01400 CENTRAL SERVICES & SUPPLY	84	0	11		5, 784, 000	
	01500 PHARMACY	622, 193	405	410, 95	8 1, 515	5, 923, 862	15.00
	01700 SOCI AL SERVI CE	0	0		0 0	4, 856	
18.00	01080 TRANSPORTATION	33, 023	56	56, 63	1 0	331, 795	18.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2, 879, 101	2, 202	2, 235, 37	0 31, 007	30, 067, 202	30.00
31.00	03100 I NTENSI VE CARE UNI T	673, 131	458	464, 17		5, 890, 216	
	02080 NEONATAL INTENSIVE CARE UNIT	197, 737	114	115, 90		1, 531, 574	
43.00	04300 NURSERY	71, 588	44	44, 40	1 671	616, 026	43.00
	ANCI LLARY SERVICE COST CENTERS	070.040	7.10	750.00	0 400 000	11 (00 100	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	872, 940 566, 549	740 430	750, 08 435, 85		11, 688, 130 4, 952, 466	
51.00	05200 DELIVERY ROOM & LABOR ROOM	500, 549 517, 553	430 317	435,85 321,16		4, 453, 695	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1,008,849	698	707, 55		10, 986, 748	
55.00	05500 RADI OLOGY-THERAPEUTI C	213, 160	139	141, 02		2, 574, 652	
59.00	05900 CARDI AC CATHETERI ZATI ON	269, 756	163	165, 15		3, 002, 792	
60.00	06000 LABORATORY	386	261	265, 08		9, 109, 431	
63.00 65.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY	0 424, 347	0 266	269, 38	0 30 2 15, 985	605, 438 3, 571, 092	
66.00	06600 PHYSI CAL THERAPY	377, 628	250	255, 72		2, 833, 285	
67.00	06700 OCCUPATI ONAL THERAPY	126, 565	81	82, 30		950, 902	
68.00	06800 SPEECH PATHOLOGY	52, 343	30	30, 51	9 16	409, 416	68.00
69.00	06900 ELECTROCARDI OLOGY	165, 564	115	116, 34		1, 791, 144	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 184, 543	4, 855, 820	
	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0	0		0 324, 182 0 0	8, 530, 001 7, 584, 265	
	07400 RENAL DI ALYSI S	0	0		0 269	1, 018, 387	
	03950 OTHER ANCI LLARY SERVICES	0	0		0 0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	46, 071	45	46, 05	4 36	409, 597	76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C 09001 BEHAVI ORAL HEALTH	0 04 200	0 81		0 0	0 748 508	
	09002 SLEEP LAB	94, 299 1, 925	18	81, 75 1, 54		748, 508 686, 338	
	09100 EMERGENCY	948, 764	735	745, 45		9, 457, 136	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	44, 001	33	33, 05	3 209	514, 690	92.01
	SPECIAL PURPOSE COST CENTERS	[]					
	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	12 712 442	0 705	0 022 04	2 77 200	207, 669, 690	113.00
118.00	NONREIMBURSABLE COST CENTERS	13, 713, 662	9, 795	9, 933, 84	3 773, 622	201, 009, 090	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 946	27	27,43	4 0	363, 246	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	1, 025	0	11		135, 409	
	19201 RETAIL PHARMACY	398	0		0 0		192.01
	19202 MARKETI NG	0	0		0 0	387, 562	
400 -	19203 BACK AND NECK	19, 371 10, 470	0	2 07	0 21	207, 094	
	10201 TIDTON SEDVICES	10 4/0	3	2, 97	5 0	95, 454	1172.04
192.04	19204 TI PTON SERVI CES		15	1/ 00	4 0	171 211	192 05
192.04 192.05	19205 NORTH SERVICES	51, 997	15 4	14, 98 4, 07		474, 314 128, 606	
192.04 192.05	19205 NORTH SERVICES 19206 SAXONY SERVICES		15 4	14, 98 4, 07		128, 606	192.06
192.04 192.05 192.06	19205 NORTH SERVICES 19206 SAXONY SERVICES Cross Foot Adjustments Negative Cost Centers	51, 997	15 4 0 9, 844		7 O O O	128, 606 0 0	192.06 200.00 201.00

Heal th	Financial Systems	IU HEALTH WES	Γ ΗΩSPI ΤΑΙ		Inlie	u of Form CMS-2	2552-10
	LOCATION - GENERAL SERVICE COSTS		Provi der C		eriod:	Worksheet B	2002 10
				F T	rom 01/01/2021 o 12/31/2021	Part I Date/Time Pre	pared:
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/26/2022 3: 1 HOUSEKEEPI NG	5 pm
		E AND GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5.04	6.00	7.00	8.00	9.00	
	DO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	DO101 MOB						1.01
	DO102 INTEREST						1.02
	DO2OO NEW CAP REL COSTS-MVBLE EQUIP DO4OO EMPLOYEE BENEFITS DEPARTMENT						2.00
	20540 NONPATI ENT TELEPHONES						5.01
	DO550 DATA PROCESSI NG						5.02
	DO560 PURCHASING RECEIVING AND STORES						5.03
	DO590 ADMINI STRATI VE AND GENERAL DO600 MAI NTENANCE & REPAI RS	31, 847, 126 1, 236, 913	8, 137, 212				5.04 6.00
	DOTOD OPERATION OF PLANT	1, 068, 490	255, 520				7.00
1	DO800 LAUNDRY & LI NEN SERVI CE	112, 730	36, 286				8.00
	DO900 HOUSEKEEPI NG	608, 045	153, 923			4, 296, 298	•
	D1000 DI ETARY	432, 130	342,095		0	191, 087 133, 082	
	D1100 CAFETERIA D1300 NURSI NG ADMI NI STRATI ON	274, 416 2, 530, 284	238, 252 39, 160		-	21, 874	
	D1400 CENTRAL SERVICES & SUPPLY	1, 036, 811	160, 324		0	89, 553	•
	D1500 PHARMACY	1, 061, 882	183, 078		0	102, 263	•
	D1700 SOCIAL SERVICE	870	0			0	•
-	D1080 TRANSPORTATION NPATIENT ROUTINE SERVICE COST CENTERS	59, 476	0	0	0	0	18.00
	D3000 ADULTS & PEDI ATRI CS	5, 389, 758	2, 493, 256	2, 304, 418	481, 196	1, 392, 681	30.00
	D3100 I NTENSI VE CARE UNI T	1, 055, 851	345, 125			192, 780	•
	D2080 NEONATAL INTENSIVE CARE UNIT	274, 542	79, 470		804	44, 390	
	D4300 NURSERY ANCILLARY SERVICE COST CENTERS	110, 426	57, 865	53, 482	0	32, 322	43.00
	D5000 OPERATI NG ROOM	2,095,156	991, 775	916, 659	55, 749	553, 984	50.00
	D5100 RECOVERY ROOM	887, 754	476, 112		0	265, 946	1
	D5200 DELIVERY ROOM & LABOR ROOM	798, 347	418, 247			233, 624	•
	05400 RADI OLOGY-DI AGNOSTI C	1, 969, 430	468, 170		150, 874	261, 510	•
	D5500 RADI OLOGY-THERAPEUTI C D5900 CARDI AC CATHETERI ZATI ON	461, 519 538, 265	250, 896 128, 139			140, 145 71, 576	
	D6000 LABORATORY	1, 632, 911	98, 801			55, 188	•
	D6300 BLOOD STORING, PROCESSING, & TRANS.	108, 528	0	-	-	0	
		640, 136	69, 960		0	39, 078	•
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	507, 881 170, 454	4, 415 4, 415		0	2, 466 2, 466	
	D6800 SPEECH PATHOLOGY	73, 390	4, 415		0	2,466	•
	D6900 ELECTROCARDI OLOGY	321, 072	0	0	0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	870, 430	0		0	0	
	D7200 I MPL. DEV. CHARGED TO PATI ENT D7300 DRUGS CHARGED TO PATI ENTS	1, 529, 045 1, 359, 517	0				•
	07400 RENAL DI ALYSI S	182, 551	58, 074		0	32, 439	
	03950 OTHER ANCI LLARY SERVICES	0	0		0	0	
	07697 CARDI AC REHABI LI TATI ON	73, 422	0	0	12	0	76.97
	DUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	90.00
	09001 BEHAVI ORAL HEALTH	134, 174	0		-	0	
	D9002 SLEEP LAB	123, 030	3, 866	3, 574	4, 375	2, 160	•
	D9100 EMERGENCY	1, 695, 239	587, 296	542, 814	108, 334	328, 051	1
	D9200 OBSERVATION BEDS (NON-DISTINCT PART) D9201 OBSERVATION BEDS (DISTINCT PART)	02.241	117 716	100,000	0	4E 7E2	92.00
	SPECIAL PURPOSE COST CENTERS	92, 261	117, 715	108, 800	0	65, 753	92.01
	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 517, 136	8, 066, 650	7, 219, 522	811, 437	4, 256, 884	118.00
	NONREIMBURSABLE COST CENTERS	45 114	0	0	0	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	65, 114 24, 273	0				190.00 192.00
	19201 RETAIL PHARMACY	8, 821	0	0	0		192.01
192.02	19202 MARKETI NG	69, 472	0	0	0	0	192.02
1	19203 BACK AND NECK	37, 123	0	0	0		192.03
	19204 TI PTON SERVI CES 19205 NORTH SERVI CES	17, 111 85, 023	9, 640 47, 938			5, 385 26, 777	192.04 192.05
	19206 SAXONY SERVICES	23, 053	12, 984		0		192.05
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	, s	-		201.00
202.00	TOTAL (sum lines 118 through 201)	31, 847, 126	8, 137, 212	7, 284, 739	811, 437	4, 296, 298	202.00

CDST ALLOCATION - GRIERAL STRVICT COSTS Provider CCP, 15 (0.5) Provid	Health Financial Systems	IU HEALTH WEST	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
Cost Center Description DIETARY CAFETERIA MUNING ID Carteria 100 Coordig Mar Carvia Controller 10.00 11.00 13.00 14.00 15.00 100 Coordig Mar Carvia Lossis-selb C a FTXF 1.00 13.00 14.00 15.00 14.00 100 Coordig Mar Carvia Lossis-selb C a FTXF 1.00 1.0	COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	Fr	om 01/01/2021	Part I Date/Time Pre	pared:
Image: state of a const or interes: I.O. 00 I.I. 00 I.I. 00 I.I. 00 I.O. 00 1.00 DOTOD NAR CAP HEL COSTS FLUE & FLXI I.O. 00 I	Cost Center Description	DI ETARY	CAFETERIA	NURSI NG	CENTRAL		5 pm
DENEMAL SERVICE COST CENTERS 10.00 13.00 14.00 14.00 13.00 14.00 15.00 1.00 DUTOR IRS AFR LL 00T3-BLD & FIXT 1.00 1.00 1.00 1.00 1.00 DOTOR IRS AFR LL 00T3-BLD & FIXT 1.00 1.00 1.00 1.00 1.00 DOTOR IRS AFR LL 00T3-BLD & FIXT 1.00							
1.00 DOTOR, NAR, CAP, REL, COSTS, HUBE, A FLAXI, TO, DOTOR, INTERSIT, ST, MURE, FLAU, PE, LOSTS, MURE, FLAU, PE, ME, LOSTS, MURE, FLAU, MURE, ME, ALMININ, STRATION 1.00 0.000000 CHIRARY, AL LINES SELVICE 0.010000 1.17, 718 1.6, 860, 986 1.10, 00 13.000 0.00000 CHIRARY, AL LINES SELVICE 0.01000 1.17, 400 0.00000 1.000 10.000 0.00000 CHIRARY, AL LINES SELVICE 0.0117, 400 0.7, 218, 600 1.000 10.000 0.00000 CHIRARY, AL LINES SELVICE 0.000000 1.000 1.000 1.000 10.000 0.000000 0.000000 1.000000000000000000000000000000000000		10.00	11.00			15.00	
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118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 692, 198 2, 382, 385 16, 860, 986 7, 218, 705 7, 667, 858 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 7, 990 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 32 0 0 192.00 192.01 19201 RETAI L PHARMACY 0 0 0 192.01 192.02 MARKETI NG 0 0 0 0 192.02 192.03 19203 BACK AND NECK 0 0 0 0 192.03 192.04 19204 TI PTON SERVICES 0 0 0 0 192.03 192.05 19205 NORTH SERVICES 0 4, 364 0 0 192.05 192.06 19206 SAXONY SERVICES 0 1, 187 0 0 192.05 192.05 NORTH SERVICES 0 1, 187 0 00.00 192.		1		1 1			112 00
NONREI MBURSABLE COST CENTERS 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 7,990 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 32 0 0 0 192.00 192.01 19201 RETAI L PHARMACY 0 0 0 0 192.01 192.02 19202 MARKETI NG 0 0 0 0 0 192.02 192.03 19203 BACK AND NECK 0 0 0 0 192.03 192.04 19204 TI PTON SERVI CES 0 866 0 0 192.04 192.05 19205 NORTH SERVI CES 0 4,364 0 0 192.04 192.06 5AXONY SERVI CES 0 1,187 0 0 192.06 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.0		3, 692, 198	2, 382, 385	16, 860, 986	7, 218, 705	7,667,858	•
192.00 PHYSI CI ANS' PRI VATE OFFICES 0 32 0 0 192.00 192.01 19201 RETAIL PHARMACY 0 0 0 0 192.01 192.02 19202 MARKETI NG 0 0 0 0 192.02 192.03 19203 BACK AND NECK 0 0 0 192.03 192.04 19204 TI PTON SERVI CES 0 866 0 0 192.04 192.05 19205 NORTH SERVI CES 0 4,364 0 0 192.05 192.06 19206 SAXONY SERVI CES 0 1,187 0 0 192.05 200.00 Cross Foot Adj ustments 200.00 0 0 0 201.00	NONREI MBURSABLE COST CENTERS						
192.01 RETAIL PHARMACY 0 0 0 192.01 192.02 19202 MARKETING 0 0 0 0 192.02 192.03 19203 BACK AND NECK 0 0 0 192.03 192.03 192.04 19204 TI PTON SERVI CES 0 866 0 0 192.04 192.05 19205 NORTH SERVI CES 0 4,364 0 0 192.05 192.06 19206 SAXONY SERVI CES 0 1,187 0 0 192.00 200.00 Cross Foot Adj ustments							
192.03 BACK AND NECK 0 0 192.03 19203 192.04 19204 TI PTON SERVICES 0 866 0 0 192.04 192.05 19205 NORTH SERVICES 0 4,364 0 0 192.05 192.06 19206 SAXONY SERVICES 0 1,187 0 0 192.06 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		0	32 0	0			
192.04 19204 TI PTON SERVICES 0 866 0 0 192.04 192.05 19205 NORTH SERVICES 0 4,364 0 0 192.05 192.06 19206 SAXONY SERVICES 0 1,187 0 0 192.06 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00		0	0	0	-		
192.05 NORTH SERVICES 0 4, 364 0 0 192.05 192.06 19206 SAXONY SERVICES 0 1, 187 0 0 192.06 200.00 Cross Foot Adjustments 0 0 0 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0			0 866				
200.00 Cross Foot Adjustments 200.00	192. 05 19205 NORTH SERVICES	0	4, 364	0	0 0	0	192.05
201.00 Negative Cost Centers 0 </td <td></td> <td>0</td> <td>1, 187</td> <td>0</td> <td>0</td> <td>0</td> <td></td>		0	1, 187	0	0	0	
		0	0	0	О	0	
	202.00 TOTAL (sum lines 118 through 201)	3, 692, 198	2, 396, 824	16, 860, 986	7, 218, 901	7, 667, 858	202.00

Health Financial Systems	IU HEALTH WE	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-0158	Period:	Worksheet B	
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	
		OTHER GENERAL			5/26/2022 3:1	5 pm
		SERVI CE				
Cost Center Description	SOCI AL	TRANSPORTATI 0	Subtotal	Intern &	Total	
	SERVI CE	N		Residents Cost & Post		
				Stepdown		
	17.00	18.00	24.00	Adjustments 25.00	26.00	
GENERAL SERVICE COST CENTERS	17.00	10.00	24.00	23.00	20.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 MOB 1. 02 00102 I NTEREST						1.01 1.02
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00540 NONPATI ENT TELEPHONES						5.01
5. 02 00550 DATA PROCESSI NG 5. 03 00560 PURCHASI NG RECEI VI NG AND STORES						5.02 5.03
5. 04 00590 ADMINI STRATI VE AND GENERAL						5.04
6.00 00600 MAI NTENANCE & REPAI RS						6.00
7.00 00700 0PERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
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 13.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY						13.00
15.00 01500 PHARMACY						15.00
17.00 01700 SOCIAL SERVICE	5, 726					17.00
18. 00 01080 TRANSPORTATION I NPATIENT ROUTINE SERVICE COST CENTERS	0	407, 763				18.00
30. 00 03000 ADULTS & PEDIATRICS	4, 800	45, 376	53, 819, 60	5 0	53, 819, 605	30.00
31.00 03100 I NTENSI VE CARE UNI T	571		10, 046, 25		10, 046, 255	31.00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT 43. 00 04300 NURSERY	118 237		2, 597, 03 1, 184, 19		2, 597, 037 1, 184, 192	35.00 43.00
ANCI LLARY SERVICE COST CENTERS	237	707	1, 104, 17	2 0	1, 104, 172	43.00
50. 00 05000 OPERATI NG ROOM	0		19, 412, 11		19, 412, 114	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0		8, 836, 25 7, 374, 10		8, 836, 258 7, 374, 101	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		14, 850, 60		14, 850, 602	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	18, 171	4, 200, 17	7 0	4, 200, 177	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		4, 629, 71		4, 629, 716 11, 088, 266	
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0		11, 088, 26 715, 42		715, 425	60.00 63.00
65. 00 06500 RESPI RATORY THERAPY	0		4, 620, 97		4, 620, 972	
66.00 06600 PHYSI CAL THERAPY	0	-/	3, 445, 84		3, 445, 841	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0		1, 157, 57 503, 32		1, 157, 575 503, 328	
69. 00 06900 ELECTROCARDI OLOGY	0		2, 263, 99	с С	2, 263, 994	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	12, 202	7, 468, 65	6 0	7, 468, 656	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	29, 274	13, 127, 69		13, 127, 693	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S		31, 768 867	15, 811, 77 1, 348, 87		15, 811, 775 1, 348, 870	
76.00 03950 OTHER ANCI LLARY SERVI CES	0	1	., ,	0 0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	1, 272	544, 89	1 0	544, 891	76.97
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C	0	0		0 0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0		954, 42		954, 429	
90. 02 09002 SLEEP LAB	0		830, 51		830, 516	90.02
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	63, 093	15, 308, 83	9 0	15, 308, 839	91.00 92.00
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT FART)	0	1, 048	1, 008, 74	-	1, 008, 745	
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 726	407, 763	207, 149, 87	2 0	207, 149, 872	113.00
NONREIMBURSABLE COST CENTERS	J 3,720	407,703	207, 149, 87	<u> </u>	201, 149, 072	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		436, 35		436, 350	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	159, 71		159, 714	
192. 01 19201 RETALL PHARMACY 192. 02 19202 MARKETI NG		0	58, 02 457, 03		58, 029 457, 034	
192. 03 19203 BACK AND NECK	0	0	244, 41		244, 413	
192. 04 19204 TI PTON SERVI CES	0	0	137, 36		137, 366	
192. 05 19205 NORTH SERVI CES 192. 06 19206 SAXONY SERVI CES	0	0	682, 72 185, 08		682, 723 185, 082	
200.00 Cross Foot Adjustments		0		0 0		200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	5, 726	407, 763	209, 510, 58	3 0	209, 510, 583	202.00

LLOCAT	ION OF CAPITAL RELATED COSTS		Provider CCI		riod: om 01/01/2021	u of Form CMS- Worksheet B Part II	
				To		Date/Time Pre 5/26/2022 3:1	epared:
				CAPITAL REL	ATED COSTS	<u>, 5, 20, 2022</u> J. I	5 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	MOB	I NTEREST	NEW MVBLE EQUI P	
		0	1.00	1.01	1. 02	2.00	
	GENERAL SERVICE COST CENTERS						1.0
. 01 0 . 02 0 2. 00 0 4. 00 0 5. 01 0 5. 02 0 5. 03 0 5. 04 0 6. 00 0 7. 00 0 8. 00 0	00101 MOB 00101 MOB 00102 I NTEREST 00200 NEW CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00540 NONPATI ENT TELEPHONES 00550 DATA PROCESSING 00550 PURCHASING RECEI VING AND STORES 00590 ADMI NI STRATI VE AND GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATION OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPING		34, 930 0 0 492, 885 1, 187, 643 181, 149 25, 725 109, 123	0 0 0 82, 786 0 0 0 9, 508	22, 088 0 0 311, 683 751, 024 114, 552 16, 268 69, 005	0 0 268, 426 953, 110 12, 676 0 0	1.0 1.0 2.0 4.0 5.0 5.0 5.0 5.0 6.0 7.0 8.0
0.00 1.00 3.00 4.00	01000 DI ETARY 011000 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY		242, 525 168, 907 27, 762 113, 660 129, 791	4, 658 0 0 0	153, 365 106, 811 17, 556 71, 875 82, 076	0 29, 337 20, 431 987, 147 0 126, 659	10. 0 11. 0 13. 0 14. 0
7.00 0 8.00 0	01300 PHANMAG 01700 SOCIAL SERVICE 01080 TRANSPORTATION NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0 0 0	82,078 0 0	0	17.0
80.00 81.00 85.00 83.00	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT D2080 NEONATAL INTENSIVE CARE UNIT D4300 NURSERY	0 0 0 0	1, 767, 573 244, 674 56, 339 41, 023	0 0 0 0	1, 117, 750 154, 723 35, 627 25, 941	290, 482 2, 795 0 11, 183	31.0 35.0
i0.00 i i1.00 i i2.00 i i4.00 i i5.00 i i5.00 i i0.00 i i1.00 i i2.00 i i3.00 i i4.00 i i4.00 i i4.00 i i0.00 i i0.00	ANCILLARY SERVICE COST CENTERS DS000 OPERATING ROOM D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM D5200 RADIOLOGY-DIAGNOSTIC D5500 RADIOLOGY-THERAPEUTIC D5900 CARDIAC CATHETERIZATION D6000 LABORATORY D6300 BLOOD STORING, PROCESSING, & TRANS. D6500 RESPIRATORY THERAPY D6400 PHYSICAL THERAPY D6600 PHYSICAL THERAPY D6600 OCCUPATIONAL THERAPY D6600 ELECTROCARDIOLOGY D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS D7200 IMPL. DEV. CHARGED TO PATIENT D7300 DRUGS CHARGED TO PATIENTS D7400 RENAL DIALYSIS D3950 OTHER ANCILLARY SERVICES D7697 CARDIAC REHABILITATION DUTPATIENT SERVICE COST CENTERS D9000 CLINIC D9001 BEHAVIORAL HEALTH D9002 SLEEP LAB D9100 EMERGENCY D9201 OBSERVATION BEDS (NON-DISTINCT PART) D9201 OBSERVATION BEDS (DISTINCT PART)		703, 111 337, 535 296, 512 331, 905 177, 870 90, 843 70, 044 0 49, 598 3, 130 3, 130 3, 130 3, 130 0 0 0 0 41, 171 0 0 0 41, 171 0 0 0 2, 741 416, 358 83, 453	0 0 0 0 0 0 0 0 0 0 30, 053 30, 053 30, 053 30, 053 30, 053 30, 053 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	444, 623 213, 446 187, 504 209, 885 112, 479 57, 446 44, 294 0 31, 364 1, 979 1, 979 1, 979 0 0 0 26, 035 0 0 0 1, 733 263, 291 52, 773	1, 777, 826 14, 501 80, 850 1, 965, 891 503, 350 633, 734 0 43, 777 5, 960 0 43, 777 5, 960 0 95, 738 0 0 0 0 29, 103	51.0 52.0 54.0 55.0 60.0 63.0 65.0 63.0 65.0 68.0 68.0 68.0 71.0 72.0 73.0 73.0 74.0 73.0 76.9 90.0 90.0 90.0 90.0 91.0 92.0
13. 00 1 18. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0	7, 434, 240	295, 845	4, 701, 154	8, 173, 466	113. (
90.00 92.00 92.01 92.02 92.03 92.03 92.04 92.05	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 RETAIL PHARMACY 19202 MARKETING 19203 BACK AND NECK 19204 TIPTON SERVICES 19205 NORTH SERVICES 19205 SAXONY SERVICES Cross Foot Adjustments Negative Cost Centers TOTAL (sum Lines 118 through 201)		0 0 0 6, 834 33, 985 9, 205 0 7, 484, 264	64, 248 124, 327 42, 792 7, 327 74, 658 0 0 0 0 0 0 0 0	0 0 0 4, 322 21, 491 5, 821 0 4, 732, 788	0 0 0 7, 760 0 0 0 0	190. 0 192. 0 192. 0 192. 0 192. 0 192. 0 192. 0 200. 0 201. 0

Heal th	Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-0158 P	eriod: rom 01/01/2021	Worksheet B Part II	
					o 12/31/2021	Date/Time Pre	pared:
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	NONPATI ENT TELEPHONES	DATA PROCESSI NG	5/26/2022 3: 1 PURCHASI NG RECEI VI NG AND STORES	5 pili
		2A	4.00	5.01	5.02	5. 03	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.00	00100 NEW CAP REL COSTS-BEDG & FIXT						1.00
1.02	00102 I NTEREST						1.02
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	57, 018	57, 018				2.00 4.00
5. 01	00540 NONPATI ENT TELEPHONES	0	0	0			5.01
5.02	00550 DATA PROCESSING	0	0	0	0		5.02
5.03 5.04	00560 PURCHASI NG RECEI VI NG AND STORES 00590 ADMI NI STRATI VE AND GENERAL	0 1, 155, 780	0 4, 117		0	0	5.03 5.04
5.04 6.00	00600 MAINTENANCE & REPAIRS	2, 891, 777	4, 117 762		0	0	6.00
7.00	00700 OPERATION OF PLANT	308, 377	625	0	0	0	7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE	41, 993	0	0		0	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	187, 636 429, 885	1, 095 673		-	0	9.00 10.00
11.00	01100 CAFETERI A	296, 149	471	0	-	0	11.00
13.00	01300 NURSING ADMINISTRATION	1, 032, 465	6, 707	0	0	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	185, 535 338, 526	0 2, 564	0	0	0	14.00 15.00
17.00	01700 SOCI AL SERVI CE	336, 520	2, 504		-	0	17.00
18.00	01080 TRANSPORTATI ON	0	136	0		0	18.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0.475.005	11 000				
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	3, 175, 805 402, 192	11, 882 2, 774	0		0	30.00 31.00
35.00	02080 NEONATAL I NTENSI VE CARE UNI T	91, 966	815			0	35.00
43.00	04300 NURSERY	78, 147	295	0	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	2, 925, 560	3, 598	0	0	0	50.00
50.00	05100 RECOVERY ROOM	2, 925, 560 565, 482	3, 598 2, 335			0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	564, 866	2, 133			0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 507, 681	4, 158	0	-	0	54.00
55.00 59.00	05500 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON	793, 699 782, 023	878 1, 112	0		0	55.00 59.00
60.00	06000 LABORATORY	114, 338	2	0	-	0	60.00
63.00	06300 BLOOD STORING, PROCESSING, & TRANS.	0	0	0	0	0	63.00
65.00 66.00	06500 RESPIRATORY THERAPY	124, 739	1,749	0	0	0	65.00
67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	41, 122 35, 162	1, 556 522		0	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	35, 162	216	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	95, 738	682	0	0	0	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		0	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DI ALYSI S	67, 206	0	0	-	0	74.00
76.00	03950 OTHER ANCI LLARY SERVICES	0 47, 420	0 190	0		0	76.00 76.97
70.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	47,420	190	0	0	0	70.97
90.00	09000 CLI NI C	0	0	-		0	90.00
90. 01 90. 02	09001 BEHAVI ORAL HEALTH 09002 SLEEP LAB	22,634	389	0	0	0	90.01
90.02 91.00	09002 SLEEP LAB 09100 EMERGENCY	72, 257 1, 000, 139	8 3, 910		0	0	90.02 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	-,	_		_	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	136, 226	181	0	0	0	92.01
113 00	SPECIAL PURPOSE COST CENTERS						113.00
118.00		20, 604, 705	56, 535	0	0	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES	64, 248 124, 327	82	0	-		190. 00 192. 00
	19201 RETAIL PHARMACY	42, 792	2	0	0		192.00
192.02	19202 MARKETI NG	7, 327	0	0	0	0	192. 02
	19203 BACK AND NECK	82, 418	80	0	0		192.03
	19204 TI PTON SERVI CES 19205 NORTH SERVI CES	11, 156 55, 476	43 214				192. 04 192. 05
	19206 SAXONY SERVICES	15, 026	58		0		192.06
200.00	Cross Foot Adjustments	0					200.00
201.00 202.00		0 21, 007, 475	0 57, 018	0	0		201.00 202.00
202.00		21,007,475	57,018	1 0	u U	0	202.00

Health Financial Systems	IU HEALTH WES				u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	Fi	eriod: rom 01/01/2021	Worksheet B Part II	
					5/26/2022 3:1	pared: 5 pm
Cost Center Description	ADMI NI STRATI V M E AND GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	5.04	6.00	7.00	8.00	9.00	
1.00 OO100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 MOB						1.01
1.02 00102 INTEREST						1.02
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5.01 00540 NONPATI ENT TELEPHONES						5.01
5. 02 00550 DATA PROCESSING						5.02
5. 03 00560 PURCHASI NG RECEI VI NG AND STORES 5. 04 00590 ADMI NI STRATI VE AND GENERAL	1, 159, 897					5.03 5.04
6. 00 00600 MAI NTENANCE & REPAI RS	45, 052	2, 937, 591				6.00
7.00 00700 OPERATION OF PLANT	38, 918	92, 244		(1.005		7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	4, 106 22, 147	13, 100 55, 567		61, 225 0	275, 041	8.00 9.00
10. 00 01000 DI ETARY	15, 739	123, 499		0	12, 233	
11. 00 01100 CAFETERI A	9, 995	86, 011		0	8, 520	
13. 00 01300 NURSING ADMINISTRATION	92, 160	14, 137		0	1,400	
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	37, 764 38, 677	57, 878 66, 092		0	5, 733 6, 547	14.00 15.00
17. 00 01700 SOCI AL SERVI CE	32	0		0	0	17.00
18.00 01080 TRANSPORTATION	2, 166	0	0	0	0	18.00
30. 00 03000 ADULTS & PEDIATRICS	196, 242	900, 082	139, 239	36, 307	89, 158	30.00
31. 00 03100 I NTENSI VE CARE UNI T	38, 457	124, 593		0	12, 341	31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT	10, 000	28, 689		61	2, 842	35.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	4, 022	20, 890	3, 232	0	2,069	43.00
50. 00 05000 OPERATING ROOM	76, 312	358, 038	55, 387	4, 206	35, 465	50.00
51.00 05100 RECOVERY ROOM	32, 335	171, 880	26, 589	0	17, 025	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	29,078	150, 990		0	14, 956	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	71, 732 16, 810	169, 013 90, 575		11, 384 762	16, 741 8, 972	
59. 00 05900 CARDI AC CATHETERI ZATI ON	19, 605	46, 259		0	4, 582	59.00
	59, 475	35, 668		0	3, 533	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS. 65. 00 06500 RESPIRATORY THERAPY	3, 953 23, 316	0 25, 256	-	0	0 2, 502	63.00 65.00
66. 00 06600 PHYSI CAL THERAPY	18, 499	1, 594		0	158	
67.00 06700 OCCUPATI ONAL THERAPY	6, 208	1, 594		0	158	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	2, 673 11, 694	1, 594 0		0	158 0	68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	31, 704	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	55, 692	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	49, 518	0 20, 965	-	0	0	73.00 74.00
74. 00 07400 RENAL DIALYSIS 76. 00 03950 OTHER ANCI LLARY SERVICES	6, 649 0	20, 965		0	2,077	
76. 97 07697 CARDI AC REHABI LI TATI ON	2, 674	0		1	0	•
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C		0	0	0	0	90.00
90. 00 09000 CLI NI C 90. 01 09001 BEHAVI ORAL HEALTH	0 4, 887	0	-	0	0	90.00
90. 02 09002 SLEEP LAB	4, 481	1, 396		330	138	90.02
91.00 09100 EMERGENCY	61, 746	212, 018	32, 798	8, 174	21, 001	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	3, 360	42, 496	6, 574	0	4, 209	92.00 92.01
SPECIAL PURPOSE COST CENTERS	5, 500	42,470	0,374	0	4,207	72.01
113.00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 147, 878	2, 912, 118	436, 224	61, 225	272, 518	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 372	0	0	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	884	0	-	0		192.00
192. 01 19201 RETALL PHARMACY 192. 02 19202 MARKETI NG	321	0	0	0		192.01 192.02
192. 02 19202 MARKETING 192. 03 19203 BACK AND NECK	2, 530 1, 352	0	0	0		192.02
192. 04 19204 TI PTON SERVI CES	623	3, 480	538	o		192.04
192. 05 19205 NORTH SERVICES	3, 097	17, 306		0		192.05
192.06 19206 SAXONY SERVICES 200.00 Cross Foot Adjustments	840	4, 687	725	0	464	192.06 200.00
201.00 Negative Cost Centers	0	0	0	О		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 159, 897	2, 937, 591	440, 164	61, 225	275, 041	202.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		riod: com 01/01/2021 0 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 3:1	pared:
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	
	10.00	11.00	13.00	14.00	15.00	
1.00 OC100 NEW CAP REL COSTS-BLDG & FLXT	[1.00
1.01 00101 MOB 1.02 00102 INTEREST 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5.01 00540 NONPATI ENT TELEPHONES 5.02 00550 DATA PROCESSI NG 5.04 00590 ADMI NI STRATI VE AND 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 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 17.00 01700 SOCI AL SERVI CE	601, 134 0 0 0 0	414, 451 20, 390 6 20, 695 0	1, 169, 446 0 6, 497 0	295, 869 582 0	490, 404 0	$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 2. \ 00 \\ 4. \ 00 \\ 5. \ 01 \\ 5. \ 02 \\ 5. \ 03 \\ 5. \ 04 \\ 6. \ 00 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 17. \ 00 \end{array}$
18. 00 01080 TRANSPORTATI ON I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	2, 852	0	0	0	18.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 35.00 02080 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY	503, 822 59, 983 12, 400 24, 929	112, 565 23, 375 5, 837 2, 236	110, 448 32, 485	11, 915 2, 882 425 258	10, 090 4, 226 172 0	31.00 35.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	37, 773	110, 448	50, 266	1, 235	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0 0	21, 949 16, 173	107, 199 64, 969	1, 113 1, 865	6, 582 0	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	35, 631 7, 102		4, 432 1, 221	2, 358 10, 293	•
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	8, 317	22, 739	12, 869	3, 669	59.00
60.00 06000 LABORATORY 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	0	13, 349 0		63 12	0	60.00 63.00
65.00 06500 RESPIRATORY THERAPY	0	13, 566		6, 143	42	65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	12, 878 4, 145		645 5	3	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 537	0	6	0	68.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	5, 859 0		95 70, 915	470 0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		124, 564	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0	0	0 103	437, 216 23	
76. 00 03950 OTHER ANCI LLARY SERVICES	0	0	0	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	2, 319	3, 248	14	0	76.97
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0	4, 117		25	0	90.01
90. 02 09002 SLEEP LAB 91. 00 09100 EMERGENCY	0	78 37, 540		174 5, 189	0 13, 819	90.02 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0	1, 664	6, 497	80	206	92.01
113.0011300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	601, 134	411, 953	1, 169, 446	295, 861	490, 404	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 382	0	0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	6	0	0		192.00
192. 01 19201 RETAIL PHARMACY 192. 02 19202 MARKETI NG	0	0	0	0		192. 01 192. 02
192. 03 19203 BACK AND NECK	0	0	0	8	0	192.03
192. 04 19204 TI PTON SERVI CES 192. 05 19205 NORTH SERVI CES	0	150 755		0		192.04 192.05
192. 06 19205 NORTH SERVICES 192. 06 19206 SAXONY SERVICES	0	205		0		192.05
200.00 Cross Foot Adjustments		-		_	-	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 601, 134	0 414, 451	0 1, 169, 446	0 295, 869	0 490, 404	201.00 202.00
		,		,,		

Heal th Financial Systems	IU HEALTH WE				u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre	
		OTHER GENERAL			5/26/2022 3:1	5 pm
Cost Center Description	SOCI AL SERVI CE	SERVICE TRANSPORTATIO N	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	18.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 MOB 1.02 00102 INTEREST 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00550 DATA PROCESSI NG 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00590 ADMI NI STRATI VE AND 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 CAFETERIA 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 17.00 01700 SOCI AL SERVI CE 18.00 01080 TRANSPORTATI ON	32 0					$\begin{array}{c} 1.00\\ 1.01\\ 1.02\\ 2.00\\ 4.00\\ 5.01\\ 5.02\\ 5.03\\ 5.04\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 14.00\\ 15.00\\ 17.00\\ 18.00\\ \end{array}$
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	27	531	5, 704, 17	1 0	5, 704, 171	30.00
31. 00 03100 INTENSI VE CARE UNI T 35. 00 02080 NEONATAL INTENSI VE CARE UNI T 43. 00 04300 NURSERY	3		3, 704, 17 800, 66 190, 14 145, 83	8 0 7 0	800, 668 190, 147 145, 836	31.00 35.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	632	2 (50 02	0 0	2 (50 020	50.00
51. 00 05100 RECOVERY ROOM	0		3, 658, 92 952, 62		3, 658, 920 952, 622	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	92	868, 48	0 0	868, 480	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0	500 213	2, 862, 77 964, 02		2, 862, 770 964, 028	54.00 55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	271	908, 60		908, 602	59.00
60. 00 06000 LABORATORY	0	256	232, 20	2 0	232, 202	60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	14	3, 97		3, 979	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	83	201, 30 76, 74		201, 303 76, 743	
67. 00 06700 OCCUPATI ONAL THERAPY	0		48, 05		48, 055	
68.00 06800 SPEECH PATHOLOGY	0	Ŭ	41, 59		11/0//	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	170 143	121, 20 102, 76		121, 205 102, 762	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	342	180, 59		180, 598	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	372	487, 10		487, 106	
74. 00 07400 RENAL DI ALYSI S 76. 00 03950 OTHER ANCI LLARY SERVI CES	0	10	100, 27	6 0 0 0	100, 276 0	74.00 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		55, 88		55, 881	76.97
OUTPATIENT SERVICE COST CENTERS	-					
90. 00 09000 CLINIC 90. 01 09001 BEHAVI ORAL HEALTH	0		35, 30	0 0	0 35, 306	90.00 90.01
90. 02 09002 SLEEP LAB	0		79, 10		79, 107	90.01
91. 00 09100 EMERGENCY	0	1, 121	1, 533, 89		1, 533, 890	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		10	001 50	0	004 505	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART) SPECIAL PURPOSE COST CENTERS	0	12	201, 50	5 0	201, 505	92.01
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	32	5, 154	20, 557, 76	1 0	20, 557, 761	113. 00 118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	68, 08	4 0	68, 084	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0		125, 22		125, 221	192.00
192. 01 19201 RETAIL PHARMACY	0	0	43, 11		43, 115	
192. 02 19202 MARKETING 192. 03 19203 BACK_AND_NECK	0	0	9, 85 83, 85		9, 857 83, 858	192.02 192.03
192. 04 19204 TI PTON SERVICES	0	o	16, 33		16, 335	
192. 05 19205 NORTH SERVICES	0	o o	81, 23	9 0	81, 239	192.05
192. 06 19206 SAXONY SERVICES	0	0	22, 00		22,005	
200.00Cross Foot Adjustments201.00Negative Cost Centers	_	0		0 0		200. 00 201. 00
202.00 TOTAL (sum Lines 118 through 201)	32		21,007,47			202.00

	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2021	Worksheet B-1	2552-1
				Te		Date/Time Pre 5/26/2022 3:1	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	NEW BLDG & FLXT (SQUARE FEET)	MOB (MOB SQUARE FEET)	I NTEREST (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	
		1.00	1.01	1.02	2.00	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	420, 430					1.00
1.00	00100 NEW CAP REL COSTS-BEDG & FIXT	420, 430	66, 184				1.0
1. 02	00102 I NTEREST	0	0	404, 108			1.02
2.00 4.00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1 004	0	1 004	8, 182, 925	71 600 462	2.00
4.00 5.01	00540 NONPATIENT TELEPHONES	1, 886 0	0	1, 886 0	0	71, 698, 463 0	5.0
5. 02	00550 DATA PROCESSING	0	0	0	0	0	5.0
5.03 5.04	00560 PURCHASING RECEIVING AND STORES 00590 ADMINISTRATIVE AND GENERAL	0	0 8, 994	0	0	5 179 092	5.0
5.04 6.00	00600 MAINTENANCE & REPAIRS	26, 613 64, 126	8, 994		268, 482 953, 308	5, 178, 083 959, 093	6.0
7.00	00700 OPERATION OF PLANT	9, 781	0	9, 781	12, 679	786, 768	
8.00	00800 LAUNDRY & LINEN SERVICE	1, 389	0	.,	0	0	
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	5, 892 13, 095	1, 033 506		0 29, 343	1, 377, 249 846, 035	9.0
11.00	01100 CAFETERI A	9, 120	0		20, 435	591, 896	
	01300 NURSING ADMINISTRATION	1, 499	0	1, 499	987, 352	8, 436, 143	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	6, 137 7, 008	0	6, 137 7, 008	0 126, 685	433 3, 225, 383	
	01700 SOCI AL SERVI CE	7,008	0		120, 005	3, 225, 363	
	01080 TRANSPORTATI ON	0	0		0	171, 188	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	05 420	0	05 420	200 542	14 025 002	
30.00 31.00	03100 INTENSIVE CARE UNIT	95, 439 13, 211	0	95, 439 13, 211	290, 542 2, 796	14, 925, 093 3, 489, 444	
35.00	02080 NEONATAL INTENSIVE CARE UNIT	3, 042	0		0	1, 025, 051	35.00
43.00	04300 NURSERY	2, 215	0	2, 215	11, 185	371, 103	43.00
50.00	ANCI LLARY SERVICE COST CENTERS	37, 964	0	37, 964	1, 778, 196	4, 525, 231	50.00
51.00	05100 RECOVERY ROOM	18, 225	0		14, 504	2, 936, 931	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	16, 010	0	16, 010	80, 867	2, 682, 942	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	17, 921 9, 604	0	17, 921 9, 604	1, 966, 297 503, 455	5, 229, 771 1, 105, 001	54.00 55.00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 905	0	4, 905	633, 866	1, 398, 389	
60.00	06000 LABORATORY	3, 782	0	3, 782	0	2,000	
63.00 65.00	06300 BLOOD STORI NG, PROCESSI NG, & TRANS. 06500 RESPI RATORY THERAPY	0 2, 678	0	0 2, 678	0 43, 786	0 2, 199, 773	63.0 65.0
66.00	06600 PHYSI CAL THERAPY	169	3, 265		5, 961	1, 957, 583	
67.00	06700 OCCUPATI ONAL THERAPY	169	3, 265		0	656, 099	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	169	3, 265	169	0 95, 758	271, 343 858, 265	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	⁹ 5, 758 0	050,205	71.0
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	0	0	0	73.0
76.00	03950 OTHER ANCI LLARY SERVICES	2, 223	0	2, 223	0	0	76.0
	07697 CARDI AC REHABI LI TATI ON	0	1, 990	0	29, 109	238, 829	
00 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	
90. 00 90. 01	09000 CLI NI C 09001 BEHAVI ORAL HEALTH	0	2, 459		0	0 488, 838	90.00 90.0
90. 02	09002 SLEEP LAB	148	7, 364	148	0	9, 977	90.0
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	22, 481	0	22, 481	320, 557	4, 918, 299	91.00 92.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 506	0	4, 506	0	228, 095	
	SPECIAL PURPOSE COST CENTERS		-				
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	417, 729	27 141	401, 407	0 175 140	71 000 250	113.00
110.00	NONREIMBURSABLE COST CENTERS	417,729	32, 141	401, 407	8, 175, 163	71, 090, 358	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 980		0	103, 399	
	19200 PHYSICIANS' PRIVATE OFFICES	0	13, 507		0		192.00
	19201 RETAIL PHARMACY 19202 MARKETING	0	4, 649 796		0		192.0 ² 192.02
	19203 BACK AND NECK	0	8, 111		7, 762	100, 418	
192.04	19204 TIPTON SERVICES	369	0	369	0	54, 278	192. 04
	19205 NORTH SERVICES 19206 SAXONY SERVICES	1, 835 497	0	1, 835 497	0	269, 547 73, 086	
192.06 200.00	Cross Foot Adjustments	497	0	497	0	13,000	200.00
							201.00
201. 00 202. 00	8	7, 786, 555	609, 197	4, 732, 788	8, 181, 226	13, 830, 968	1

Health Fin	ancial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared: 5 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	NEW BLDG &	MOB	I NTEREST	NEW MVBLE	EMPLOYEE	
		FLXT	(MOB SQUARE	(SQUARE FEET) EQUI P	BENEFI TS	
		(SQUARE FEET)	FEET)		(DOLLAR	DEPARTMENT	
					VALUE)	(GROSS	
						SALARI ES)	
		1.00	1.01	1.02	2.00	4.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 520455	9. 204596	11. 71169	0. 999792	0. 192905	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)					57, 018	204.00
205.00	Unit cost multiplier (Wkst. B, Part					0. 000795	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 Finand	cial Systems TON - STATISTICAL BASIS	IU HEALTH WES	T HOSPITAL Provider C	CN: 15-0158 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2021 o 12/31/2021	Date/Time Pre	pared:
	Cost Center Description	NONPATI ENT TELEPHONES (FTES)	DATA PROCESSI NG (FTES)	PURCHASI NG RECEI VI NG AND STORES (PURCHASED REQ)	Reconciliatio n	5/26/2022 3: 1 ADMI NI STRATI V E AND GENERAL (ACCUM. COST)	5 pm
		5. 01	5.02	5.03	5A. 04	5.04	
	AL SERVICE COST CENTERS			1			1 00
$\begin{array}{ccccc} 1. 01 & 00101 \\ 1. 02 & 00102 \\ 2. 00 & 00200 \\ 4. 00 & 00400 \\ 5. 01 & 00540 \\ 5. 02 & 00550 \\ 5. 03 & 00560 \\ 5. 04 & 00590 \\ 6. 00 & 00600 \\ 7. 00 & 00700 \\ 8. 00 & 00800 \\ 9. 00 & 00900 \\ 10. 00 & 01000 \\ 11. 00 & 01000 \\ 11. 00 & 01100 \\ 13. 00 & 01300 \\ 14. 00 & 01400 \\ 15. 00 & 01500 \\ 17. 00 & 01700 \\ 18. 00 & 01080 \\ \end{array}$	I NTEREST NEW CAP REL COSTS-MVBLE EQUI P EMPLOYEE BENEFI TS DEPARTMENT NONPATI ENT TELEPHONES DATA PROCESSI NG PURCHASI NG RECEI VI NG AND STORES ADMI NI STRATI VE AND GENERAL MAI NTENANCE & REPAI RS OPERATI ON OF PLANT LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY PHARMACY SOCI AL SERVI CE TRANSPORTATI ON	90, 613 0 4, 904 1, 688 1, 497 0 3, 861 2, 337 1, 627 3, 675 1 3, 730 0 514	90, 613 0 4, 904 1, 688 1, 497 0 3, 861 2, 337 1, 627 3, 675 1 3, 730 0 514	19, 582, 965 5, 031 0 2, 562 0 35 816 568 36, 893 47, 174 38, 358 0	-31, 847, 126 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	177, 663, 457 6, 900, 299 5, 960, 729 628, 883 3, 392, 065 2, 410, 701 1, 530, 867 14, 115, 556 5, 784, 000 5, 923, 862 4, 856 331, 795	
	ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	20, 289	20, 289	784, 871	0	30, 067, 202	30.00
	INTENSIVE CARE UNIT	4, 213	4, 213			5, 890, 216	
35.00 02080	NEONATAL INTENSIVE CARE UNIT	1, 052	1, 052	27, 970	0	1, 531, 574	
	NURSERY	403	403	16, 989	0	616, 026	43.00
ANCI LL 50.00 05000 51.00 05100 52.00 05200 54.00 05400 55.00 05500 55.00 05500 55.00 05500 60.00 06000 63.00 06300 65.00 06600 67.00 06700 68.00 06800 69.00 07200 73.00 07300 74.00 07400 76.00 03950 76.97 007697 0UTPA 90.00 99001 90.01 090002 91.00 09100 92.01 09200 92.01 92.01	ARY SERVICE COST CENTERS OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC CARDIAC CATHETERIZATION LABORATORY BLOOD STORING, PROCESSING, & TRANS. RESPIRATORY THERAPY PHYSICAL THERAPY OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS RENAL DIALYSIS OTHER ANCILLARY SERVICES CARDIAC REHABILITATION TIENT SERVICE COST CENTERS CLINIC BEHAVIORAL HEALTH SLEEP LAB EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	6, 808 3, 956 2, 915 6, 422 1, 280 1, 499 2, 406 0 2, 445 2, 321 747 277 1, 056 0 0 0 0 0 0 0 0 418 0 742 14 6, 766 300	403 6, 808 3, 956 2, 915 6, 422 1, 280 1, 499 2, 406 0 2, 445 2, 321 747 277 1, 056 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 311, 123 73, 286 122, 827 291, 966 80, 424 847, 692 4, 153 758 404, 629 42, 470 336 405 6, 227 4, 671, 277 8, 205, 819 0 6, 804 0 917 0 1, 638 11, 472 341, 797		11, 688, 130 4, 952, 466 4, 453, 695 10, 986, 748 2, 574, 652 3, 002, 792 9, 109, 431 605, 438 3, 571, 092 2, 833, 285 950, 902 409, 416 1, 791, 144 4, 855, 820 8, 530, 001 7, 584, 265 1, 018, 387 0 409, 597 0 748, 508 686, 338 9, 457, 136 514, 690	50.00 51.00 52.00 54.00 55.00 60.00 63.00 65.00 66.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 74.00 76.97 90.00 90.01 90.02 91.00 92.00
113. 00 11300 118. 00	AL PURPOSE COST CENTERS INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	90, 163	90, 163	19, 582, 437	-31, 847, 126	175, 822, 564	113.00 118.00
190. 00 19000 192. 00 19200 192. 01 19201 192. 02 19202 192. 03 19203 192. 04 19204 192. 05 19205 192. 06 19206 200. 00 201. 00 202. 00	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES RETAIL PHARMACY MARKETING BACK AND NECK TIPTON SERVICES NORTH SERVICES SAXONY SERVICES Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	249 1 0 0 27 136 37 9, 844	249 1 0 0 27 136 37 9, 983, 423	0 0 528 0 0 0	0 0 0 0 0 0		192.00 192.01 192.02 192.03 192.04 192.05 192.06 200.00 201.00
	Unit cost multiplier (Wkst. B, Part I)	0. 108638	110. 176498	0. 039506		0. 179255	203.00

Health Fir	nancial Systems	IU HEALTH WES	T HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
	Cost Center Description	NONPATI ENT	DATA	PURCHASI NG	Reconciliatio		
		TELEPHONES	PROCESSI NG	RECEI VI NG ANI) n	E AND GENERAL	
		(FTES)	(FTES)	STORES		(ACCUM.	
				(PURCHASED		COST)	
				REQ)			
		5.01	5.02	5.03	5A. 04	5.04	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0		0	1, 159, 897	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000000	0.00000	0	0. 006529	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 WE	ST HOSPITAL		eriod:	u of Form CMS-: Worksheet B-1	
				rom 01/01/2021 o 12/31/2021		
Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	PLANT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	5/26/2022 3: 1 DI ETARY (TOTAL PATI ENT DAYS)	5 pm
	6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS			1	1		1 1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 MOB 1.02 00102 INTEREST 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00550 DATA PROCESSI NG 5.02 00550 DATA PROCESSI NG 5.03 00560 PURCHASI NG RECEI VI NG AND STORES 5.04 00590 ADMI NI STRATI VE AND 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 17.00 01700 SOCI AL SERVI CE 18.00 01080 TRANSPORTATI ON INPATI ENT ROUTI NE SERVI CE COST CENTERS INPATI ENT ROUTI NE SERVI CE <td>311, 483 9, 781 1, 389 5, 892 13, 095 9, 120 1, 499 6, 137 7, 008 0 0</td> <td>301, 702 1, 389 5, 892 13, 095 9, 120 1, 499 6, 137 7, 008 0</td> <td>662, 852 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>294, 421 13, 095 9, 120 1, 499 6, 137 7, 008 0</td> <td>0 0 0</td> <td>13.00 14.00 15.00 17.00</td>	311, 483 9, 781 1, 389 5, 892 13, 095 9, 120 1, 499 6, 137 7, 008 0 0	301, 702 1, 389 5, 892 13, 095 9, 120 1, 499 6, 137 7, 008 0	662, 852 0 0 0 0 0 0 0 0 0 0 0 0	294, 421 13, 095 9, 120 1, 499 6, 137 7, 008 0	0 0 0	13.00 14.00 15.00 17.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSI VE CARE UNI T 35.00 02080 NEONATAL INTENSI VE CARE UNI T 43.00 04300 NURSERY	95, 439 13, 211 3, 042 2, 215	13, 211 3, 042	0 657	3, 042	4, 194 867	31.00 35.00
ANCI LLARY SERVICE COST CENTERS	27.0(4	27.044	45 541	27.044		
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 55.00 05500 RADI OLOGY-THERAPEUTI C 59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 63.00 06300 BLODD STORI NG, PROCESSI NG, & TRANS. 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 66.00 06600 PHYSI CAL THERAPY 68.00 06200 ELECTROCARDI OLOGY 71.00 06700 OCCUPATI ONAL THERAPY 68.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 74.00 07400 RENAL DI ALYSI S 76.00 03950 OTHER ANCI LLARY SERVICES 76.97 07697 CARDI AC REHABI LI TATI ON	37, 964 18, 225 16, 010 17, 921 9, 604 4, 905 3, 782 0 2, 678 169 169 169 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18, 225 16, 010 17, 921 9, 604 4, 905 3, 782 0 2, 678 169 169 169 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 123, 247 8, 245 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 010 17, 921 9, 604 4, 905 3, 782 0 2, 678 169 169 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 54.\ 00\\ 55.\ 00\\ 63.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 76.\ 00\\ \end{array}$
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90.00 09001 BEHAVI ORAL HEALTH 90.01 09001 BEHAVI ORAL HEALTH 90.02 09002 SLEEP LAB 91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92.01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 92.01 OSERVATI ON BEDS (DI STI NCT PART) SPECI AL PURPOSE COST CENTERS	0 0 148 22, 481 4, 506	0 148 22, 481	0 3, 574 88, 497	0 148 22, 481	0 0 0	90. 01 90. 02
113. 00 I 11300 I NTEREST EXPENSE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	308, 782	299, 001	662, 852	291, 720	42, 031	113.00 118.00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 192.01 19201 RETAI L PHARMACY 192.02 19202 MARKETI NG 192.03 19203 BACK AND NECK 192.04 19204 TI PTON SERVI CES 192.05 19205 NORTH SERVI CES 192.06 19206 SAXONY SERVI CES 200.00 Cross Foot Adj ustments	0 0 0 0 0 369 1,835 497	0 0 0 0 369 1, 835		0 0 0 0 369 1, 835 497	0 0 0 0 0 0	190.00 192.00 192.01 192.02 192.03 192.04 192.05 192.06 200.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I)	8, 137, 212	7, 284, 739	811, 437	4, 296, 298	3, 692, 198	201.00 202.00
203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II)	26. 124097 2, 937, 591				87. 844638 601, 134	

Health Finan	cial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provider C		Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(SQUARE FEET)	(TOTAL	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF		PATIENT DAYS)	
				LAUNDRY)			
		6. 00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part)	9. 430983	1. 458936	0. 09236	6 0. 934176	14. 302158	205.00
	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 WE	ST HOSPITAL	N: 15 0159	In Lie Period:	u of Form CMS- Worksheet B-1	
COST ALLOCATION - STATISTICAL DASIS				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared:
Cost Center Description	CAFETERI A (FTES)	NURSI NG ADMI NI STRATI O N (DI RECT NURS FTES)	CENTRAL SERVI CES & SUPPLY (PURCHASED REQ)	PHARMACY (COSTED REQUI S.)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	
	11.00	13.00	14.00	15.00	17.00	
GENERAL SERVICE COST CENTERS		1			- -	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.01 00101 MOB 1.02 00102 INTEREST 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 00590 ADMI NI STRATI VE AND 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 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	74, 699 3, 675 1	360 0	19, 489, 88			$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\\ 5.\ 04\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 14.\ 00\\ \end{array}$
15. 00 01500 PHARMACY	3, 730		38, 35		42,021	15.00
17. 00 01700 SOCI AL SERVI CE 18. 00 01080 TRANSPORTATI ON	0 514			0 0 0 0	42, 031 0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	011	٩ ١		<u> </u>	0	10.00
30. 00 03000 ADULTS & PEDI ATRI CS	20, 289		784, 87			30.00
31.00 03100 INTENSIVE CARE UNIT 35.00 02080 NEONATAL INTENSIVE CARE UNIT	4, 213 1, 052		189, 85 27, 97		4, 194 867	31.00
43. 00 04300 NURSERY	403		16, 98		1, 743	•
ANCILLARY SERVICE COST CENTERS					· · · · · · · · · · · · · · · · · · ·	
50. 00 05000 OPERATI NG ROOM	6, 808					•
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 956 2, 915		73, 28 122, 82		0	51.00 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6, 422		291, 96		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 280		80, 42			55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 499		847,69		0	59.00
60.00 06000 LABORATORY 63.00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	2, 406 0		4, 15 75		0	60.00 63.00
65. 00 06500 RESPIRATORY THERAPY	2, 445		404, 62		0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 321		42, 47		0	66.00
67. 00 06700 0CCUPATI 0NAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	747 277		33 40		0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 056		6, 22			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			7 0	0	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	8, 205, 81	9 0	0	•
73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S	0	0	6, 80	0 7, 584, 265 4 396	0	
76.00 03950 OTHER ANCI LLARY SERVICES	0		0,00	0 0	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	418	1	91	7 0	0	76.97
0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C				0	0	90.00
90. 00 09000 CETNIC 90. 01 09001 BEHAVI ORAL HEALTH	0 742		1, 63	0 0 8 0	0	90.00
90. 02 09002 SLEEP LAB	14		11, 47		0	90.02
91.00 09100 EMERGENCY	6, 766	42	341, 79	7 239, 708	0	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	300	2	5, 29	8 3, 570	0	92.00 92.01
SPECIAL PURPOSE COST CENTERS	500		5,27	5, 570	0	72.01
113.00 11300 INTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	74, 249	360	19, 489, 35	8 8, 506, 900	42, 031	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	249	0		0 0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1	Ő		0 0		192.00
192. 01 19201 RETAIL PHARMACY	0	0		0 0		192.01
192.02 19202 MARKETING 192.03 19203 BACK_AND_NECK	0	0	52	0 0		192.02 192.03
192. 04 19203 BACK AND NECK 192. 04 19204 TI PTON SERVICES	27		52	0 0		192.03
192. 05 19205 NORTH SERVICES	136	0		0 0	0	192.05
192. 06 19206 SAXONY SERVICES	37	0		0 0	0	192.06
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	2, 396, 824	16, 860, 986	7, 218, 90	1 7, 667, 858	5 726	201.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	32. 086427	46, 836. 072222	0. 37039	0. 901369	0. 136233	203.00

Health Fir	nancial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provider CO	CN: 15-0158	Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	SOCI AL	
		(FTES)	ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	SERVI CE (TOTAL	
			(DI RECT	(PURCHASED	RECOID.)	PATIENT DAYS)	
			NURS FTES)	REQ)		· · · · ·	
		11.00	13.00	14.00	15.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	414, 451	1, 169, 446	295, 86	490, 404	32	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	5. 548280	3, 248. 461111	0. 01518	0. 057648	0. 000761	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 OCATION - STATISTICAL BASIS	IU HEALTH WEST	Provi der CCN: 15-0158	Peri od:	u of Form CMS-2552-1 Worksheet B-1
001 1122				From 01/01/2021 To 12/31/2021	Date/Time Prepared:
				10 12/31/2021	5/26/2022 3:15 pm
		OTHER GENERAL SERVI CE			
	Cost Center Description	TRANSPORTATI 0			
	•	N			
		(GROSS			
		CHARGES)			
GE	NERAL SERVICE COST CENTERS	18.00			
	100 NEW CAP REL COSTS-BLDG & FIXT				1.0
	101 MOB				1.0
	102 INTEREST				1.0
	200 NEW CAP REL COSTS-MVBLE EQUIP 2400 EMPLOYEE BENEFITS DEPARTMENT				2.0
	1540 NONPATI ENT TELEPHONES				5.0
	550 DATA PROCESSI NG				5.0
03 00	560 PURCHASING RECEIVING AND STORES				5.0
	590 ADMI NI STRATI VE AND GENERAL				5.0
	600 MAINTENANCE & REPAIRS				6.0
	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE				7.0
	1900 HOUSEKEEPI NG				9.0
	000 DI ETARY				10.0
	100 CAFETERI A				11.0
	300 NURSING ADMINISTRATION				13.0
	400 CENTRAL SERVICES & SUPPLY				14.0
	500 PHARMACY 700 SOCI AL SERVI CE				15. 0 17. 0
	080 TRANSPORTATI ON	1, 193, 775, 576			18.0
	PATIENT ROUTINE SERVICE COST CENTERS				
	000 ADULTS & PEDIATRICS	132, 676, 929			30.0
	100 I NTENSI VE CARE UNI T	30, 115, 236			31.0
	080 NEONATAL INTENSIVE CARE UNIT 300 NURSERY	3, 967, 617			35.0
	CILLARY SERVICE COST CENTERS	2, 892, 099			43.0
	000 OPERATING ROOM	158, 089, 594			50.0
1.00 05	100 RECOVERY ROOM	33, 195, 248			51.0
	200 DELIVERY ROOM & LABOR ROOM	23, 018, 977			52.0
	400 RADI OLOGY-DI AGNOSTI C	124, 962, 658			54.0
	500 RADI OLOGY-THERAPEUTI C 5900 CARDI AC CATHETERI ZATI ON	53, 130, 927 67, 864, 185			55. 0 59. 0
	000 LABORATORY	63, 974, 530			60.0
	300 BLOOD STORING, PROCESSING, & TRANS.	3, 444, 913			63.0
	500 RESPI RATORY THERAPY	20, 636, 776			65.0
	600 PHYSI CAL THERAPY	10, 131, 284			66.0
	0700 OCCUPATIONAL THERAPY 0800 SPEECH PATHOLOGY	3, 403, 832 1, 527, 218			67.0 68.0
	900 ELECTROCARDI OLOGY	42, 604, 490			69.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 676, 903			71.0
	200 IMPL. DEV. CHARGED TO PATIENT	85, 596, 954			72.0
	300 DRUGS CHARGED TO PATIENTS	92, 888, 633			73.0
	400 RENAL DI ALYSI S 1950 OTHER ANCI LLARY SERVI CES	2, 535, 899			74.0
	'697 CARDI AC REHABI LI TATI ON	0 3, 718, 624			76.0 76.9
	TPATIENT SERVICE COST CENTERS	0,710,021			/0./
0. 00 09	2000 CLINIC	0			90.0
	001 BEHAVI ORAL HEALTH	1, 451, 655			90.0
	1002 SLEEP LAB	7, 235, 767			90.0
	200 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART)	185, 969, 329			91.0 92.0
	2001 OBSERVATION BEDS (NON-DISTINCT PART)	3, 065, 299			92.0
	ECIAL PURPOSE COST CENTERS	3, 300, 2,7			/2.0
3.0011	300 INTEREST EXPENSE				113.0
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 193, 775, 576			118.0
	NREIMBURSABLE COST CENTERS				100.0
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2000 PHYSICIANS' PRIVATE OFFICES	0			190. 0 192. 0
	2001 RETAIL PHARMACY	0			192.0
	202 MARKETI NG	0			192.0
2. 03 19	203 BACK AND NECK	0			192.0
	204 TI PTON SERVI CES	0			192.0
	205 NORTH SERVICES	0			192.0
92.06 19 00.00	206 SAXONY SERVICES	0			192. 0 200. 0
00.00 01.00	Cross Foot Adjustments Negative Cost Centers				200.0
	Cost to be allocated (per Wkst. B,	407, 763			201.0
12.00	CUST TO DE ALLOCATEU (DEL WKST, D.				
02.00	Part I)	107,700			

Heal th F	inancial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CCN: 15-0158	Period:	Worksheet B-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		OTHER GENERAL				
		SERVI CE				
	Cost Center Description	TRANSPORTATI 0				
		N				
		(GROSS				
		CHARGES)				
		18.00				
204.00	Cost to be allocated (per Wkst. B, Part II)	5, 154				204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 000004				205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)					206.00
207.00	NAHE unit cost´multiplier (Wkst. D, Parts III and IV)					207.00

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0158	Period: From 01/01/2021	Worksheet C Part I	
				To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Title	XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj.		Di sal I owance		
	B, Part I,					
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	53, 819, 605		53, 819, 60		53, 819, 605	
31. 00 03100 INTENSIVE CARE UNIT	10, 046, 255		10, 046, 25		10, 046, 255	
35.00 02080 NEONATAL INTENSIVE CARE UNIT	2, 597, 037		2, 597, 03		2, 597, 037	35.00
43. 00 04300 NURSERY	1, 184, 192		1, 184, 19	92 0	1, 184, 192	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	19, 412, 114		19, 412, 11	14 0	19, 412, 114	50.00
51.00 05100 RECOVERY ROOM	8, 836, 258		8, 836, 25	58 0	8, 836, 258	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 374, 101		7, 374, 10		7, 374, 101	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 850, 602		14, 850, 60	02 0	14, 850, 602	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 200, 177		4, 200, 17		4, 200, 177	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 629, 716		4, 629, 71	0	4, 629, 716	59.00
60. 00 06000 LABORATORY	11, 088, 266		11, 088, 26	6 0	11, 088, 266	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	715, 425		715, 42	25 0	715, 425	63.00
65.00 06500 RESPI RATORY THERAPY	4, 620, 972	0	4, 620, 97	72 0	4, 620, 972	65.00
66.00 06600 PHYSI CAL THERAPY	3, 445, 841	0	3, 445, 84	1 0	3, 445, 841	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 157, 575	0	1, 157, 57	75 0	1, 157, 575	67.00
68.00 06800 SPEECH PATHOLOGY	503, 328	0	503, 32	28 0	503, 328	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 263, 994		2, 263, 99	94 0	2, 263, 994	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 468, 656		7, 468, 65	56 0	7, 468, 656	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 127, 693		13, 127, 69	93 0	13, 127, 693	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15, 811, 775		15, 811, 77	75 0	15, 811, 775	73.00
74.00 07400 RENAL DIALYSIS	1, 348, 870		1, 348, 87	0 0	1, 348, 870	74.00
76.00 03950 OTHER ANCI LLARY SERVICES	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	544, 891		544, 89	0	544, 891	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0			0 0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	954, 429		954, 42	29 0	954, 429	90.01
90. 02 09002 SLEEP LAB	830, 516		830, 51		830, 516	
91.00 09100 EMERGENCY	15, 308, 839		15, 308, 83		15, 308, 839	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 341, 593		3, 341, 59		3, 341, 593	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	1,008,745		1, 008, 74		1, 008, 745	
SPECIAL PURPOSE COST CENTERS	.,,		.,		.,,,	1
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	210, 491, 465	0	210, 491, 46	5 0	210, 491, 465	•
201.00 Less Observation Beds	3, 341, 593		3, 341, 59		3, 341, 593	•
202.00 Total (see instructions)	207, 149, 872					•
					,,	

Health Financial Systems	IU HEALTH WES	T HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:1	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
		·	+ col. 7)	Rati o	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1 1					
30. 00 03000 ADULTS & PEDI ATRI CS	120, 198, 312		120, 198, 3			30.00
31.00 03100 I NTENSI VE CARE UNI T	30, 115, 236		30, 115, 2			31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT	3, 967, 617		3, 967, 6			35.00
43. 00 04300 NURSERY	2, 892, 099		2, 892, 0	79		43.00
ANCI LLARY SERVI CE COST CENTERS		447 004 070	150,000 5		0.00000	
50. 00 05000 OPERATING ROOM	40, 805, 324	117, 284, 270				
51.00 05100 RECOVERY ROOM	5, 531, 228	27, 664, 020				
52.00 05200 DELIVERY ROOM & LABOR ROOM	17, 130, 422	5, 888, 555				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	24, 909, 222	100, 053, 436			0.00000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 588, 747	48, 542, 180			0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	32, 631, 241	35, 232, 944			0.00000	
60. 00 06000 LABORATORY	34, 465, 172	29, 509, 358			0.00000	
63. 00 06300 BLOOD STORI NG, PROCESSI NG, & TRANS.	2, 702, 847	742,066			0.00000	
65. 00 06500 RESPI RATORY THERAPY	13, 754, 148	6, 882, 628			0.00000	
66.00 06600 PHYSI CAL THERAPY	4, 588, 268	5, 543, 016			0.00000	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 366, 209	1,037,623			0.00000	
68. 00 06800 SPEECH PATHOLOGY	1, 135, 689	391, 529			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	20, 170, 194	22, 434, 296			0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	12, 381, 009	23, 295, 894			0. 000000 0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	34, 375, 617 65, 237, 668	51, 221, 337 27, 650, 965			0. 000000	
73.00 07400 RENAL DIALYSIS						
76.00 03950 OTHER ANCI LLARY SERVICES	2, 350, 137	185, 762 0	2,000,0	0 0.000000		
76. 97 07697 CARDI AC REHABI LI TATI ON	65, 168	3, 653, 456	3, 718, 6			1
OUTPATIENT SERVICE COST CENTERS	05, 100	3,003,400	5,710,0	24 0. 140550	0.00000	/0.9/
90. 00 09000 CLINIC	0	0		0 0.00000	0. 000000	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0	1, 451, 655				
90. 02 09002 SLEEP LAB	0	7, 235, 767	7, 235, 7			
91. 00 09100 EMERGENCY	43, 666, 051	142, 303, 278			0. 000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	293, 470	12, 185, 147				
92. 01 09201 OBSERVATION BEDS (NON-DISTINCT PART)	63, 269	3, 002, 030				
SPECIAL PURPOSE COST CENTERS	03, 209	5,002,030	5,005,2	,, 0.327003	0.00000	12.01
113. 00 11300 I NTEREST EXPENSE						1113.00
200.00 Subtotal (see instructions)	520, 384, 364	673, 391, 212	1, 193, 775, 5	76		200.00
201.00 Less Observation Beds	520,001,001	2,0,0,1,212	., ., ., ., ., ., ., .			201.00
202.00 Total (see instructions)	520, 384, 364	673, 391, 212	1, 193, 775, 5	76		202.00
		,, בוב	,,, .	- 1		1

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0158	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pro 5/26/2022 3:	epared:
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT					35.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 122792				50.00
51.00 05100 RECOVERY ROOM	0. 266190				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 320349				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 118840				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 079053				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 068220				59.00
60. 00 06000 LABORATORY	0. 173323				60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 207676				63.00
65.00 06500 RESPI RATORY THERAPY	0. 223919				65.00
66.00 06600 PHYSI CAL THERAPY	0. 340119				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 340080				67.00
68.00 06800 SPEECH PATHOLOGY	0. 329572				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 053140				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 209341				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 153366				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 170223				73.00
74. 00 07400 RENAL DI ALYSI S	0. 531910				74.00
76. 00 03950 OTHER ANCI LLARY SERVICES	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 146530				76.97
OUTPATIENT SERVICE COST CENTERS	0.110000				/0. //
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 BEHAVI ORAL HEALTH	0. 657476				90.01
90. 02 09002 SLEEP LAB	0. 114779				90.02
91. 00 09100 EMERGENCY	0. 082319				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 267786				92.00
92. 01 09201 OBSERVATION BEDS (NON DISTINCT PART)	0. 329085				92.00
SPECIAL PURPOSE COST CENTERS	0. 327003				/2.01
113.00 11300 I NTEREST EXPENSE					113.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	1				202.00

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0158	Peri od:	Worksheet C	
				From 01/01/2021	Part I	
				To 12/31/2021	Date/Time Pre	epared:
		T: +1	e XIX	Hospi tal	5/26/2022 3: 1 PPS	5 pm
		1111		Costs	PP5	
Cost Contor Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
Cost Center Description	(from Wkst.	Adj.	TOTAL COSTS	Di sal I owance	TOTAL COSTS	
		Auj.		DISALIOWALICE		
	B, Part I,					
	<u>col. 26)</u> 1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	E2 010 (OF		E2 010 (()5 0	E2 010 40E	1 20 00
	53, 819, 605		53, 819, 60		53, 819, 605	1
	10, 046, 255		10, 046, 25		10, 046, 255	1
35. 00 02080 NEONATAL INTENSIVE CARE UNIT	2, 597, 037		2, 597, 03		2, 597, 037	1
43.00 04300 NURSERY	1, 184, 192		1, 184, 19	02 0	1, 184, 192	43.00
ANCI LLARY SERVI CE COST CENTERS	10 110 111		10 110 11			
50. 00 05000 OPERATING ROOM	19, 412, 114		19, 412, 11			
51.00 05100 RECOVERY ROOM	8, 836, 258		8, 836, 25		8, 836, 258	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 374, 101		7, 374, 10		7, 374, 101	1
54.00 05400 RADI OLOGY-DI AGNOSTI C	14, 850, 602		14, 850, 60		14, 850, 602	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 200, 177		4, 200, 17		4, 200, 177	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	4, 629, 716		4, 629, 71	6 0	4, 629, 716	59.00
60. 00 06000 LABORATORY	11, 088, 266		11, 088, 26	6 0	11, 088, 266	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	715, 425		715, 42	25 0	715, 425	63.00
65. 00 06500 RESPI RATORY THERAPY	4, 620, 972	0	4, 620, 97	2 0	4, 620, 972	65.00
66.00 06600 PHYSI CAL THERAPY	3, 445, 841	0	3, 445, 84	1 0	3, 445, 841	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 157, 575	0	1, 157, 57	75 0	1, 157, 575	67.00
68.00 06800 SPEECH PATHOLOGY	503, 328	0	503, 32	28 0	503, 328	68.00
69.00 06900 ELECTROCARDI OLOGY	2, 263, 994		2, 263, 99	04 0	2, 263, 994	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 468, 656		7, 468, 65	6 0	7, 468, 656	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 127, 693		13, 127, 69	03 0	13, 127, 693	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15, 811, 775		15, 811, 77		15, 811, 775	
74.00 07400 RENAL DI ALYSI S	1, 348, 870		1, 348, 87		1, 348, 870	
76.00 03950 OTHER ANCI LLARY SERVICES	0			0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	544, 891		544, 89	0	544, 891	
OUTPATIENT SERVICE COST CENTERS					,	
90. 00 09000 CLINIC	0			0 0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	954, 429		954, 42		954, 429	
90. 02 09002 SLEEP LAB	830, 516		830, 51		830, 516	1
91. 00 09100 EMERGENCY	15, 308, 839		15, 308, 83		15, 308, 839	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 341, 593		3, 341, 59		3, 341, 593	1
92. 01 09201 OBSERVATION BEDS (NOVEDISTINCT PART)	1, 008, 745		1, 008, 74		1, 008, 745	
SPECIAL PURPOSE COST CENTERS	1,008,743		1,000,74	0	1,000,745	92.01
113. 00 11300 I NTEREST EXPENSE	1			1		113.00
200.00 Subtotal (see instructions)	210, 491, 465	0	210, 491, 46	5 0	210, 491, 465	1
201.00 Less Observation Beds	3, 341, 593		3, 341, 59		3, 341, 593	
201.00 Total (see instructions)	207, 149, 872					1
	207, 147, 072	I 0	201, 147, 0	- U	201, 147, 0/2	1202.00

5/26/202	e Prepared: 2 3:15 pm PPS
Title XIX Hospital Charges	PPS
Charges	
Cost Center Description Inpatient Outpatient Total (col 6 Cost or Other TEER	
	nt
+ col. 7) Ratio Inpatio	
Ratio	
6.00 7.00 8.00 9.00 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 120, 198, 312 120, 198, 312	30.00
31. 00 03100 I NTENSI VE CARE UNI T 30, 115, 236 30, 115, 236	31.00
35. 00 02080 NEONATAL I NTENSI VE CARE UNI T 3, 967, 617 3, 967, 617	35.00
43. 00 04300 NURSERY 2, 892, 099 2, 892, 099	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 40, 805, 324 117, 284, 270 158, 089, 594 0. 122792 0. 0	0000 50.00
	00000 50.00 00000 51.00
	0000 51.00
	0000 52.00
	0000 55.00
	0000 59.00
	0000 59.00
	0000 63.00
	0000 65.00
	0000 66.00
	0000 67.00
	0000 68.00
	0000 69.00
	0000 71.00
	0000 72.00
	0000 73.00
	0000 74.00
	0000 76.00
	0000 76.97
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 0 0. 000000 0. 0	0000 90.00
90. 01 09001 BEHAVI ORAL HEALTH 0 1, 451, 655 0. 657476 0. 0	0000 90.01
90. 02 09002 SLEEP LAB 0 7, 235, 767 7, 235, 767 0. 114779 0. 0	0000 90.02
91. 00 09100 EMERGENCY 43, 666, 051 142, 303, 278 185, 969, 329 0. 082319 0. 0	0000 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 293, 470 12, 185, 147 12, 478, 617 0. 267786 0. 0	0000 92.00
	0000 92.01
SPECIAL PURPOSE COST CENTERS	
113.00 11300 INTEREST EXPENSE	113.00
200.00 Subtotal (see instructions) 520, 384, 364 673, 391, 212 1, 193, 775, 576	200.00
201.00 Less Observation Beds	201.00
202. 00 Total (see instructions) 520, 384, 364 673, 391, 212 1, 193, 775, 576	202.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL	In Lieu	ı of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pro 5/26/2022 3:	epared:
		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
31.00 03100 INTENSIVE CARE UNIT					31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT					35.00
43.00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 122792				50.00
51.00 05100 RECOVERY ROOM	0. 266190				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 320349				52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 118840				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.079053				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 068220				59.00
60. 00 06000 LABORATORY	0. 173323				60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 207676				63.00
65. 00 06500 RESPI RATORY THERAPY	0. 223919				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 340119				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 340080				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 329572				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.053140				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 209341				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 153366				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 170223				73.00
74. 00 07400 RENAL DIALYSIS	0. 531910				74.00
76. 00 03950 OTHER ANCI LLARY SERVICES	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 146530				76.97
OUTPATIENT SERVICE COST CENTERS	0. 140550				/0. 7/
90. 00 09000 CLINIC	0. 000000				90.00
90. 00 09000 CETNIC 90. 01 09001 BEHAVI ORAL HEALTH	0. 657476				90.00
90. 02 09001 BERAVIORAL HEALTH 90. 02 09002 SLEEP LAB	0. 114779				90.01
90. 02 109002 SLEEP LAB 91. 00 109100 EMERGENCY					90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.082319				91.00
	0. 267786				
	0. 329085				92.01
SPECIAL PURPOSE COST CENTERS					112.00
113.00 11300 I NTEREST EXPENSE					113.00
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	WEST H	HOSPI TAL			In Lieu	u of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST	TO CHARGE RATIOS NET OF		Provider C	CN: 15-0158		ri od:	Worksheet C	
REDUCTIONS FOR MEDICAID ONLY						om 01/01/2021	Part II	
					To	12/31/2021	Date/Time Pre 5/26/2022 3:1	epared:
			Ti †I	e XIX		Hospi tal	PPS	
Cost Center Description	Total Cost	t Ca	apital Cost	Operating		Capital	Operating	
	(Wkst. B,		(Wkst. B,	Cost Net of	F	Reduction	Cost	
	Part I, col		art II col.	Capital Cos			Reducti on	
	26)		26)	(col. 1 -			Amount	
			,	col. 2)				
	1.00		2.00	3.00		4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00 05000 OPERATI NG ROOM	19, 412, 1	114	3, 658, 920	15, 753, 1	94	0	0	50.00
51.00 05100 RECOVERY ROOM	8, 836, 2	258	952, 622	7, 883, 6	36	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 374, 1	101	868, 480	6, 505, 6	21	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	14, 850, 6	502	2, 862, 770	11, 987, 8	32	0	0	54.00
55.00 05500 RADI OLOGY-THERAPEUTI C	4, 200, 1	177	964, 028	3, 236, 1	49	0	0	55.00
59.00 05900 CARDI AC CATHETERI ZATI ON	4, 629, 7	716	908, 602	3, 721, 1	14	0	0	59.00
60.00 06000 LABORATORY	11, 088, 2	266	232, 202	10, 856, 0	64	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING,	& TRANS. 715, 4	425	3, 979	711, 4	46	0	0	63.00
65.00 06500 RESPI RATORY THERAPY	4, 620, 9	972	201, 303	4, 419, 6	69	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	3, 445, 8	341	76, 743	3, 369, 0	98	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 157, 5	575	48, 055	1, 109, 5	20	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	503, 3	328	41, 599	461, 7	29	0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	2, 263, 9	994	121, 205	2, 142, 7	89	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO	PATI ENTS 7, 468, 6	556	102, 762	7, 365, 8	94	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIE	NT 13, 127, 6	593	180, 598	12, 947, 0	95	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	15, 811, 7	775	487, 106	15, 324, 6	69	0	0	73.00
74.00 07400 RENAL DIALYSIS	1, 348, 8	370	100, 276	1, 248, 5	94	0	0	74.00
76.00 03950 OTHER ANCI LLARY SERVICES		0	0		0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	544,8	391	55, 881	489, 0	10	0	0	76.97
OUTPATIENT SERVICE COST CENTERS								
90. 00 09000 CLINIC		0	0		0	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	954, 4	429	35, 306	919, 1	23	0	0	90.01
90. 02 09002 SLEEP LAB	830, 5	516	79, 107	751, 4	09	0	0	90.02
91.00 09100 EMERGENCY	15, 308, 8	339	1, 533, 890	13, 774, 9	49	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTI	NCT PART) 3, 341, 5	593	354, 165	2, 987, 4	28	0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT	PART) 1,008,7	745	201, 505	807, 2	40	0	0	92.01
SPECIAL PURPOSE COST CENTERS								
113.00 11300 INTEREST EXPENSE								113.00
200.00 Subtotal (sum of lines 50 t			14, 071, 104			0		200.00
201.00 Less Observation Beds	3, 341, 5		354, 165			0		201.00
202.00 Total (line 200 minus line	201) 139, 502, 7	783	13, 716, 939	125, 785, 8	44	0	0	202.00

ealth Financial Systems ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATIOS NET OF	Provi der C	CN: 15-0158	Period: From 01/01/2021	Worksheet C Part II	2552-1
EDUCTIONS FOR MEDICAID ONLY				To 12/31/2021		bared 5 pm
	_		e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,				
	Operati ng	Part I,	Charge Ratio	C		
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS			I			
0.00 05000 OPERATING ROOM	19, 412, 114					50. C
1.00 05100 RECOVERY ROOM	8, 836, 258					51.C
2.00 05200 DELIVERY ROOM & LABOR ROOM	7, 374, 101					52.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 850, 602					54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	4, 200, 177					55.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	4, 629, 716					59.0
0. 00 06000 LABORATORY	11, 088, 266					60.0
3.00 06300 BLOOD STORING, PROCESSING, & TRANS.	715, 425					63.0
5. 00 06500 RESPI RATORY THERAPY	4, 620, 972					65.0
6. 00 06600 PHYSI CAL THERAPY	3, 445, 841	10, 131, 284				66. (
7.00 06700 OCCUPATI ONAL THERAPY	1, 157, 575					67.(
8.00 06800 SPEECH PATHOLOGY	503, 328					68.0
9. 00 06900 ELECTROCARDI OLOGY	2, 263, 994	42, 604, 490	0. 05314	40		69. (
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 468, 656	35, 676, 903	0. 20934	41		71.(
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	13, 127, 693	85, 596, 954	0. 15336	56		72.(
3.00 07300 DRUGS CHARGED TO PATIENTS	15, 811, 775	92, 888, 633	0. 17022	23		73.(
4.00 07400 RENAL DIALYSIS	1, 348, 870	2, 535, 899	0. 5319	10		74.0
6. 00 03950 OTHER ANCI LLARY SERVICES	0	0	0.0000	00		76.(
6. 97 07697 CARDI AC REHABI LI TATI ON	544, 891	3, 718, 624	0. 14653	30		76. 9
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	0	0.0000	00		90.0
0. 01 09001 BEHAVI ORAL HEALTH	954, 429	1, 451, 655	0.6574	76		90. (
0. 02 09002 SLEEP LAB	830, 516	7, 235, 767	0. 1147	79		90. (
1.00 09100 EMERGENCY	15, 308, 839	185, 969, 329	0. 0823	19		91.(
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 341, 593	12, 478, 617	0. 26778	36		92. (
2.01 09201 OBSERVATION BEDS (DISTINCT PART)	1,008,745			35		92. (
SPECIAL PURPOSE COST CENTERS	•					
13.00 11300 INTEREST EXPENSE					1	113. (
00.00 Subtotal (sum of lines 50 thru 199)	142, 844, 376	1, 036, 602, 312			2	200. (
01.00 Less Observation Beds	3, 341, 593				2	201. (
02.00 Total (line 200 minus line 201)		1,036,602,312			2	202.0

Health Financial Systems	IU HEALTH WE	ST_HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	AL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	5/26/2022 3:1	
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5, 704, 171	0	5, 704, 17	1 37, 559	151.87	30.00
31.00 INTENSIVE CARE UNIT	800, 668		800, 66	8 4, 194	190. 91	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	190, 147		190, 14	7 867	219. 32	35.00
43.00 NURSERY	145, 836		145, 83	6 1, 743	83.67	43.00
200.00 Total (lines 30 through 199)	6, 840, 822		6, 840, 82	2 44, 363		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	11, 869	1, 802, 545				30.00
31.00 INTENSIVE CARE UNIT	1, 201	229, 283				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35.00
43.00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	13, 070	2, 031, 828				200.00

APPORTLONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider COX: 15-0158 Period: From U/01/2021 To 12/31/2021 Worksheet D Part II Date TI me Prepared: 5/26/2022 3: 15 pm 0/2020 Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 22) Total Charges Total Charges Total Charges Col II + col. 2) Ratio of Cost (col II + col. 2) Capital Cost Center Description Worksheet D Part II Date TI Col II + col. 22) MACILLARY SERVICE COST CENTERS Total Charges (Col II + col. 22) Ratio of Cost (col II + col. 2) Capital Cost Center Description Capital Col II + col. 22) Cost Center Description Capital Col III + col. 20) Cost Col II + col. 2) Capital Costs Col IIII + Col. 1 + col. 2) Capital Costs Col IIII + Col III + Col IIII + Col III + Col III + Col I	Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Image: construct of the second seco	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS	Provider C	CN: 15-0158			
ANCI LLARY SERVICE COST CENTERS Capital Related Cost (from Wkst. col. 2b) Total (col. 1) col. 2b) Total (col. 1) col. 2b) Inpatient (col. 1) col. 2b) Capital (col. 2b) Capital (col. 2b) Capital (col. 1) col. 2b) Capital (col. 2b) ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATI NG ROOM 05000 (PERATI NG ROOM 52.00 3.658.920 (5200 DELI VERY ROOM & LABOR ROOM 52.00 3.658.920 (5200 DALI VERY ROOM & LABOR ROOM 52.00 3.658.920 (5200 CRADI LLOCY-DI AGNOSTI C 2.862.770 (124, 962.656 0.023145 (70, 1144, 1, 625, 121 (24, 126, 121 (24, 126, 121 (24, 121, 129, 486, 55.00 (55.00 55.00 55.00 05500 CRADI LLOCY-THERAPEUTI C 9.0500 CLADI AC CATHETREI ZATI ON (500 06500 CLADI AC CATHETREI ZATI ON (500 06500 RESPI RATORY (500 06500 RESPI RATORY (500 06500 RESPI RATORY (500 00500 RESPI RATORY (500 00500 RESPI RATORY (510 005700 RESPI RATORY (510 005700 RESPI RATORY (510 005700 RESPI RATORY (510 00575 1, 778, 599 (13, 344, 613 (51, 00 (510 00 0500 RESPI RATORY (510 000755 1, 778, 599 (13, 344, 613 (51, 00 (510 00 0500 RESPI RATORY (51, 730 0) (513, 741, 620 (71, 00 (71, 00 (7200 RESPI RATORY (513, 344, 613 (71, 00 (71, 00 (720 0) (71, 73, 73, 00 (71, 00 (71, 00 (720 0) (71, 737, 73 (7							narod
Cost Center Description Capital Related Cost (from Wkst. (from Wkst. (c) Total Charges (col. 1, b) Hospital (col. 2) PPS ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 (PERATING ROOM 952, 622 33, 195, 248 0.023145 13, 761, 870 318, 518 50.00 50.00 05000 (PERATING ROOM 962, 622 33, 195, 248 0.023145 13, 761, 870 318, 518 50.00 50.00 05000 (PERATING ROOM 962, 622 33, 195, 248 0.023145 13, 761, 870 318, 518 50.00 50.00 05000 RADIOLOGY-DIACNOSTIC 2, 862, 770 124, 962, 658 0.022909 8, 484, 207 144, 365, 54.00 59.00 05900 CARDIAC CATHETERIZATION 968, 602 67, 864, 185 0.013389 9, 104, 670 121, 902 59.00 60.00 06000 BLOOD STORIN, R. PROCESSING, & TRANS. 3, 979 3, 444, 913 0.00155 91, 343, 324 63.00 63.00 06300 OSPOC CARDIAC CATHETERIZATION 968, 602 67, 864, 185 0.00755 1, 778, 599					10 12/31/2021	5/26/2022 3: 1	5 pm
Rel ated Cost (from Wkst. B, Part II, col. 26) Rel ated Cost (C, Part I, col. 26) C, Part I, col. 20 Program (col I + col. 2) (col um 3 x col um 4) MACI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 05000 OPERATI NG ROOM 3,658,920 158,089,594 0.023145 13,761,870 318,518 50.00 51.00 05000 OPERATI NG ROOM 2,862,770 124,962,658 0.023145 1,718,720 49,324 51.00 52.00 05400 RADI OLGY-DI AGNOSTI C 2,862,770 124,962,658 0.023145 1,718,720 49,324 55.00 55.00 05500 CADI OLGY-THERAPEUTI C 964,022 53,310,927 0.018144 1,625,121 29,466 55.00 65.00 06000 LABDRATORY 232,202 63,974,530 0.003630 10,488,441 37,964 60.00 65.00 06500 RESPI RATORY THERAPY 76,743 10,131,284 0.007575 1,778,599 13,345 66.00 66.00 066000 PHYSI CAL THERAPY 76,743 10,172,285 10,027238 489,950 13,345						PPS	
ANCILLARY SERVICE COST CENTERS (col. 26) (col. 20) (col. 2) (col. 2) (col. 2) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATING ROOM 3,658,920 158,089,594 0.023145 13,761,870 318,518 50.00 51.00 05100 RECOVERY ROOM 868,480 23,018,977 0.037229 107,821 4,068 52.00 52.00 05500 RADIOLOGY-THERAPEUTIC 2,862,770 124,962,658 0.022909 8,484,207 194,365 54.00 59.00 05500 RADIOLOGY-THERAPEUTIC 964,028 53,130,927 0.018144 1,625,121 29,486 55.00 50.00 05500 RADIAC CATHETERIZATION 908,602 63,776 0.03339 9,104,670 121,902 59.00 63.00 06300 REDOR TORY TRANS. 3,979 3,444,913 0.001755 1,778,599 13,434 66.00 66.00 06600 SPECOLPATINOK THERAPY 48,655 <t< td=""><td>Cost Center Description</td><td></td><td></td><td></td><td></td><td></td><td></td></t<>	Cost Center Description						
Image: Problem Strip Image: Pr							
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 50.00 05000 0PERATI NG ROOM 3,658,920 158,089,594 0.023145 13,761,870 318,518 50.00 51.00 05000 DEELVERY ROOM 3,658,920 158,089,594 0.028698 1,718,720 49,324 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 868,480 23,018,977 0.037729 107,821 4,068 52.00 55.00 05500 RADI LOCGY - THERAPEUTI C 964,028 53,130,927 0.013389 9,104,670 121,902 59.00 59.00 05000 CABOR ADD LOGY - THERAPEUTI C 964,028 53,30,927 0.033389 9,104,670 121,902 59.00 63.00 D6300 BLOOD STORING, PROCESSI NG, & TRANS. 3,979 3,444,913 0.001155 918.024 1,060 63.00 65.00 06500 RESPI RATORY THERAPY 76,743 10,131,284 0.00755 1,778,599 13,345 66.00 66.00 06600 PHYSI CAL THERAPY <td></td> <td></td> <td></td> <td></td> <td>Charges</td> <td>column 4)</td> <td></td>					Charges	column 4)	
I. 00 2.00 3.00 4.00 5.00 MACILLARY SERVICE COST CENTERS			col. 8)	col. 2)			
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 658, 920 158, 089, 594 0.023145 13, 761, 870 318, 518 50.00 51.00 05100 RECOVERY ROOM 952, 622 33, 195, 248 0.0238698 1, 718, 720 49, 324 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 868, 480 23, 018, 977 0.037729 107, 821 4, 068 55.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 2, 862, 770 124, 962, 658 0.022909 8, 484, 207 194, 365 54.00 59.00 05500 RADI OLOGY-THERAPEUTI C 964, 028 53, 130, 927 0.018144 1, 625, 121 29, 486 55.00 60.00 06000 DAGONO LABORATORY 232, 202 63, 974, 530 0.00330 10.458, 441 37, 964, 60.00 63.00 DESOD RESPI RATORY THERAPY 26, 776 0.00755 4, 030, 352 39, 316 65.00 66.00 06600 PESPI RATORY THERAPY 76, 743 10, 131, 284 0.007575 1, 778, 599						5 00	
50.00 05000 0PERATI NG ROOM 3, 658, 920 158, 089, 594 0.023145 13, 761, 870 318, 518 50.00 51.00 RECOVERY ROOM 49, 324 51.00 028698 1, 718, 720 49, 324 51.00 52.00 D5L VERY ROOM & LABOR ROOM 868, 480 23, 018, 977 0.037729 107, 821 40, 685 52.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 2, 862, 770 124, 962, 658 0.022909 8, 484, 207 194, 365 54.00 55.00 05500 CARDI AC CATHETERI ZATI ON 908, 602 67, 864, 185 0.013389 9, 104, 670 121, 902 59, 00 60.00 06500 RABU DAD STORI NG, PROCESSI NG, & TRANS. 3, 979 3, 444, 913 0.00155 918, 024 1, 060 63.00 65.00 06500 RESPI RATORY THERAPY 76, 743 10, 131, 1284 0.007575 1, 778, 599 13, 3473 66.00 0 6600 06600 PHYSI CAL THERAPY 74, 743 10, 131, 1284 0.007575 1, 778, 599 13, 345 68.00 68.00 06900 0.0000CUPHATI IONAL THERAPY 121, 202 52, 6		1.00	2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM 952, 622 33, 195, 248 0.028698 1, 718, 720 49, 324 51.00 52.00 DELIVERY ROOM & LABOR ROOM 868, 480 23, 018, 977 0.037729 107, 821 4, 068 52.00 55.00 05500 RADI OLOGY-DI AGNOSTI C 2, 862, 770 124, 962, 658 0.022909 8, 484, 207 194, 365 54.00 59.00 05500 RADI OLOGY-THERAPEUTI C 964, 028 53, 130, 927 0.018144 1, 625, 121 29, 486 55.00 60.00 06000 LABORATORY 232, 202 63, 974, 530 0.00330 10, 458, 41 37, 964 60.00 65.00 DESDOR RATORY 201, 303 20, 636, 776 0.00755 4, 030, 352 39, 316 65.00 66.00 OK500 RESPI RATORY THERAPY 76, 743 10, 131, 284 0.007575 4, 030, 352 39, 316 65.00 67.00 06700 CCUPATI ONAL THERAPY 76, 743 10, 131, 284 0.007575 1, 78, 599 13, 345 68.00 68.00 OBG00 EESPI RATORY THERAPY 15, 576, 903 0.002845		2 (50,020	150 000 504	0.0221	E 12 7/1 070	210 510	
52.00 DELIVERY ROM & LABOR ROM 866, 480 23,018,977 0.33729 107,821 4,068 52.00 54.00 O5500 RADI OLOGY-DI AGNOSTI C 2,862,770 124,962,658 0.022909 8,484,207 194,365 54.00 55.00 O5500 RADI OLOGY-THERAPEUTI C 964,028 53,130,927 0.018144 1,625,121 29,486 55.00 60.00 LABORATORY 232,202 63,974,530 0.003630 10,458,441 37,964 60.00 63.00 06300 BLODD STORI NG, PROCESSI NG, & TRANS. 3,979 3,444,913 0.001155 918,024 1,066 63.00 65.00 06500 RESPI RATORY THERAPY 201,303 20,636,776 0.009755 4,030,352 39,316 65.00 66.00 06700 0CCUPATI ONAL THERAPY 76,743 10,131,284 0.007575 1,778,599 13,343 68.00 67.00 06700 ELCTROCARDI OLOGY 41,599 1,527,218 0.02286 7,283,643 20,722 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 102,762 35,676,903 0.002845							
54.00 05400 RADI OLOGY-DI AGNOSTI C 2,862,770 124,962,658 0.022909 8,484,207 194,365 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 964,028 53,130,927 0.018144 1,625,121 29,486 55.00 60.00 06000 LABORATORY 232,202 63,974,530 0.003630 10,458,441 37,964 60.00 63.00 06300 BLOD STORI NG, PROCESSI NG, & TRANS. 3,979 3,444,913 0.00155 918,024 1,060 63.00 65.00 06500 RESPI RATORY THERAPY 201,303 20,636,776 0.007575 1,778,599 13,434 66.00 66.00 06600 PHYSI CAL THERAPY 48,055 3,403,832 0.014118 923,205 13,034 67.00 67.00 06700 OCUPATI ONAL THERAPY 48,055 3,403,832 0.014118 923,205 13,345 68.00 69.00 06900 ELECTROCARDI OLOGY 121,205 42,604,490 0.002845 7,283,643 20,722 69.00 71.00 07100 MEDI ALSUPPLIES CHARGED TO PATI ENTS 1897,106							
55:00 05500 RADI OLOGY-THERAPEUTI C 964, 028 53, 130, 927 0.018144 1, 625, 121 29, 486 55.00 59:00 05900 CARDI AC CATHETERI ZATI ON 908, 602 67, 864, 185 0.013389 9, 104, 670 121, 902 59.00 60:00 DABORATORY 232, 202 63, 974, 530 0.003630 10, 458, 441 37, 964 60.00 63:00 06500 RESPI RATORY THERAPY 201, 303 20, 636, 776 0.009755 4, 030, 352 39, 316 65.00 66:00 06600 PHYSI CAL THERAPY 76, 743 10, 131, 284 0.007575 1, 778, 599 13, 343 66.00 67:00 05000 CEUPATI ONAL THERAPY 76, 743 10, 131, 284 0.007575 1, 778, 599 13, 345 68.00 69:00 06900 ELECTROCARDI OLOGY 41, 599 1, 527, 218 0.027238 489, 950 13, 345 68.00 71:00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 102, 762 35, 676, 954 0.002110 12, 671, 009 26, 736 72.00 73.00 73.00 7300 07300 DRUGS CHARG							
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72.00 07200 IMPL. DEV. CHARGED TO PATIENT 180, 598 85, 596, 954 0.002110 12, 671, 009 26, 736 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 487, 106 92, 888, 633 0.005244 18, 642, 800 97, 763 73.00 74.00 07400 RENAL DI ALYSI S 100, 276 2, 535, 899 0.039543 894, 828 35, 384 74.00 76.00 03950 OTHER ANCI LLARY SERVICES 0 0 0.000000 0 76.00 76.97 OTAPT CARDIAC REHABILITATION 55, 881 3, 718, 624 0.015027 14, 428 217 76.97 000 09000 CLINIC 0 0 0.000000 0 90.01 90.00 09001 BEHAVI ORAL HEALTH 35, 306 1, 451, 655 0.010933 0 90.02 90.100 O9100 EMERGENCY 1, 533, 890 185, 969, 329 0.008248 14, 385, 618 118, 653 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 354, 165 12, 478, 617 0.028382 65, 091 1, 847 92.00 <							
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74.00 07400 RENAL DI ALYSI S 100, 276 2, 535, 899 0.039543 894, 828 35, 384 74.00 76.00 03950 OTHER ANCI LLARY SERVI CES 0 0 0.000000 0 0 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 55, 881 3, 718, 624 0.015027 14, 428 217 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 90.00 90.							
76. 00 03950 OTHER ANCI LLARY SERVICES 0 0 0.000000 0 0 76. 00 76. 00 76. 97 O7697 CARDI AC REHABI LI TATI ON 55, 881 3, 718, 624 0.015027 14, 428 217 76. 97 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0 0 90. 00 90. 00 09000 CLINIC 0 0 0.000000 0 90. 00 90. 01 09001 BEHAVI ORAL HEALTH 35, 306 1, 451, 655 0.024321 0 0 90. 02 90. 02 09002 SLEEP LAB 79, 107 7, 235, 767 0.010933 0 90. 02 91. 00 09100 EMERGENCY 1, 533, 890 185, 969, 329 0.008248 14, 385, 618 118, 653 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 354, 165 12, 478, 617 0.028382 65, 091 1, 847 92. 00 92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 201, 505							
76. 97 07697 CARDI AC_REHABILITATION 55, 881 3, 718, 624 0.015027 14, 428 217 76. 97 OUTPATIENT_SERVICE_COST_CENTERS 0 00000 CLI NI C 0 0.000000 0 00 90.00 90.00 90.00 90.00 90.00 0 0.000000 0 90.00<							
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.00000 0.00000 0 90.00 90.10 09001 BEHAVIORAL HEALTH 35,306 1,451,655 0.024321 0 90.00 90.20 09002 SLEEP LAB 79,107 7,235,767 0.010933 0 90.02 91.00 09100 EMERGENCY 1,533,890 185,969,329 0.008248 14,385,618 118,653 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 354,165 12,478,617 0.028382 65,091 1,847 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 201,505 3,065,299 0.065737 19,437 1,278 92.01		55, 881	3, 718, 624			217	
90. 00 09000 CLINIC 0 0.00000 0.000000 0 90. 00 90. 01 09001 BEHAVI ORAL HEALTH 35, 306 1, 451, 655 0.024321 0 0 90. 01 90. 02 09002 SLEEP LAB 79, 107 7, 235, 767 0.010933 0 90. 02 91. 00 09100 EMERGENCY 1, 533, 890 185, 969, 329 0.008248 14, 385, 618 118, 653 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 354, 165 12, 478, 617 0.028382 65, 091 1, 847 92. 00 92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 201, 505 3, 065, 299 0.065737 19, 437 1, 278 92. 01							
90. 0209002SLEEP LAB79, 1077, 235, 7670. 010933090. 0291. 0009100EMERGENCY1, 533, 890185, 969, 3290. 00824814, 385, 618118, 65391. 0092. 00092000BSERVATI ON BEDS (NON-DI STI NCT PART)354, 16512, 478, 6170. 02838265, 0911, 84792. 0092. 01092010BSERVATI ON BEDS (DI STI NCT PART)201, 5053, 065, 2990. 06573719, 4371, 27892. 01		0	0	0.0000	0 0	0	90.00
91. 0009100EMERGENCY1,533,890185,969,3290.00824814,385,618118,65391.0092. 00092000BSERVATI ON BEDS (NON-DI STI NCT PART)354,16512,478,6170.02838265,0911,84792.0092. 01092010BSERVATI ON BEDS (DI STI NCT PART)201,5053,065,2990.06573719,4371,27892.01	90. 01 09001 BEHAVI ORAL HEALTH	35, 306	1, 451, 655	0. 02432	1 0	0	90.01
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 354, 165 12, 478, 617 0. 028382 65, 091 1, 847 92. 00 92. 01 09201 0BSERVATI ON BEDS (DI STINCT PART) 201, 505 3, 065, 299 0. 065737 19, 437 1, 278 92. 01	90. 02 09002 SLEEP LAB	79, 107	7, 235, 767	0. 01093	3 0	0	90.02
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 201, 505 3, 065, 299 0. 065737 19, 437 1, 278 92. 01	91.00 09100 EMERGENCY	1, 533, 890	185, 969, 329	0. 00824	8 14, 385, 618	118, 653	91.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 201, 505 3, 065, 299 0. 065737 19, 437 1, 278 92. 01	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	354, 165	12, 478, 617	0. 02838	65, 091	1, 847	92.00
200 00 Total (Lines 50 through 199) 14 071 104 1 036 602 312 110 909 068 1 148 625 200 00	92.01 09201 OBSERVATION BEDS (DISTINCT PART)	201, 505	3, 065, 299	0.06573	19, 437		
	200.00 Total (lines 50 through 199)	14, 071, 104	1, 036, 602, 312		110, 909, 068	1, 148, 625	200.00

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (OTHER PASS THROUGH COS		-	Period: From 01/01/2021 Fo 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Title	× XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	Cost	Medi cal	
	Post-Stepdown	-	Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTER	S		•			
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	l o	31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT	0	0		0	0	
43. 00 04300 NURSERY	0	0		0	0	
200.00 Total (lines 30 through 199)	0	0			-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	200.00
oost oenter bescription	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	buys	col. 6)		
		minus col. 4)		001.0)		
	4.00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTER		0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS	0	0	37, 55	9 0.00	11, 869	30.00
31. 00 03100 I NTENSI VE CARE UNI T		0	4, 19			
35. 00 02080 NEONATAL INTENSIVE CARE UNIT		0	86			
43. 00 04300 NURSERY			1, 74			
200.00 Total (lines 30 through 199)		0			-	200.00
Cost Center Description	I npati ent	0	44, 30,		13,070	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7					
	<u>x col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTER						
30. 00 03000 ADULTS & PEDIATRICS	.3					30,00
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT	0					35.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	IU HEALTH WEST HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 15-0158		d: 01/01/2021 12/31/2021	Worksheet D Part IV Date/Time Prepared: 5/26/2022 3:15 pm	
			Title XVIII		spi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursi ng	Nursi ng			Allied Health	
		Program Post-Stepdown	Program		-Stepdown ustments		
		Adjustments		,,	dotilionto		
	1.00	2A	2.00		ЗA	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00 O5000 OPERATING ROOM	0	0		0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY	0	0		0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0	0	0	63.00
65.00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	0		0	0	0	73.00 74.00
74.00 07400 RENAL DIALYSIS 76.00 03950 OTHER ANCI LLARY SERVICES	0	0		0	0	0	74.00
76. 00 03950 0THER ANGI LLARY SERVICES 76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	0	0		U	0	0	/0. 7/
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0	0		0	0	0	90.01
90. 02 09002 SLEEP LAB	0	0		0	0	0	90.02
91. 00 09100 EMERGENCY	0	0		0	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		Ō	Ū	0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	0	0	92.01
200.00 Total (lines 50 through 199)	0	0		0	0	0	200.00
				·		-	

Health Financial Systems	IU HEALTH WE	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS		S Provider C	Provider CCN: 15-0158		Worksheet D	
THROUGH COSTS				From 01/01/2021	Part IV Date/Time Prepared:	
				To 12/31/2021	5/26/2022 3:1	
		Title XVIII		Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	Č, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	1			- 1		
50.00 O5000 OPERATI NG ROOM	0			0 158, 089, 594		
51.00 05100 RECOVERY ROOM	0	0		0 33, 195, 248		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 23, 018, 977		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 124, 962, 658	0.000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 53, 130, 927		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 67, 864, 185		
60. 00 06000 LABORATORY	0	0		0 63, 974, 530		
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 3, 444, 913		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 20, 636, 776		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 131, 284		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 403, 832		
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 527, 218		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 42, 604, 490		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 35, 676, 903		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 85, 596, 954		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 92, 888, 633		
74.00 07400 RENAL DI ALYSI S	0	0		0 2, 535, 899		
76.00 03950 OTHER ANCI LLARY SERVI CES	0	-		0 0		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 3, 718, 624	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS		1	-	- 1		
90. 00 09000 CLI NI C	0			0 0		
90. 01 09001 BEHAVI ORAL HEALTH	0	0		0 1, 451, 655		
90. 02 09002 SLEEP LAB	0	0		0 7, 235, 767		
91.00 09100 EMERGENCY	0	0		0 185, 969, 329		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 12, 478, 617		
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	-		0 3, 065, 299		
200.00 Total (lines 50 through 199)	0	0	1	0 1,036,602,312		200.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provider C	CN: 15-0158	Peri od		Worksheet D	
THROUGH COSTS					01/01/2021	Part IV	
				To '	12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Title	XVIII	Но	spi tal	PPS	5 pili
Cost Center Description	Outpati ent	Inpatient	I npati ent	Ou	tpati ent	Outpati ent	
	Ratio of Cost	Program	Program	F	rogram	Program	
	to Charges	Charges	Pass-Throug	h C	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	r						
50.00 05000 OPERATING ROOM	0. 000000	13, 761, 870		0	18, 245, 000		50.00
51.00 05100 RECOVERY ROOM	0. 000000	1, 718, 720		0	5, 586, 468	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	107, 821		0	26, 504	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	8, 484, 207		0	18, 281, 997	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	1, 625, 121		0	13, 622, 011	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 104, 670		0	7,865,503	0	59.00
60. 00 06000 LABORATORY	0. 000000	10, 458, 441		0	2, 386, 023	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	918, 024		0	142, 447	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	4, 030, 352		0	1, 564, 110	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 778, 599		0	245, 300	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	923, 205		0	5, 981	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	489, 950		0	4, 085	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	7, 283, 643		0	8, 438, 900	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	3, 531, 234		0	5, 866, 719	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	12, 671, 009		0	11, 468, 116	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	18, 642, 800		0	5, 614, 419	0	73.00
74.00 07400 RENAL DIALYSIS	0. 000000	894, 828		0	7, 272	0	74.00
76.00 03950 OTHER ANCI LLARY SERVICES	0. 000000	0		0	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	14, 428		0	898, 261	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0. 000000	0		0	0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0. 000000	0		0	39, 635	0	90.01
90. 02 09002 SLEEP LAB	0. 000000	0	1	0	1, 343, 290	0	90.02
91.00 09100 EMERGENCY	0. 000000	14, 385, 618		0	16, 771, 456	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	65, 091		0	1, 064, 482	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	19, 437		0	470, 543	0	92.01
200.00 Total (lines 50 through 199)		110, 909, 068		0 1	19, 958, 522	0	200. 00

Health Financial Systems	IU HEALTH WE	ST_HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 3:1	
		Title	XVIII	Hospi tal	PPS	<u>o p</u>
			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	. 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. 122792			0 0	2, 240, 340	50.00
51.00 05100 RECOVERY ROOM	0. 266190			0 0	1, 487, 062	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 320349	26, 504		0 0	8, 491	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 118840	18, 281, 997	17	75 0	2, 172, 633	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 079053	13, 622, 011		0 0	1, 076, 861	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 068220	7, 865, 503		0 0	536, 585	59.00
60. 00 06000 LABORATORY	0. 173323	2, 386, 023		0 0	413, 553	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 207676	142, 447		0 0	29, 583	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 223919	1, 564, 110		0 0	350, 234	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 340119	245, 300		0 0	83, 431	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 340080	5, 981		0 0	2, 034	67.00
68.00 06800 SPEECH PATHOLOGY	0. 329572	4, 085		0 0	1, 346	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 053140	8, 438, 900		0 0	448, 443	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 209341	5, 866, 719		0 0	1, 228, 145	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 153366	11, 468, 116		0 0	1, 758, 819	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 170223	5, 614, 419		0 22, 929	955, 703	73.00
74.00 07400 RENAL DI ALYSI S	0. 531910	7, 272		0 0	3, 868	74.00
76.00 03950 OTHER ANCI LLARY SERVI CES	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 146530	898, 261		0 0	131, 622	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000			0 0		90.00
90. 01 09001 BEHAVI ORAL HEALTH	0. 657476	39, 635		0 0	26, 059	90.01
90. 02 09002 SLEEP LAB	0. 114779	1, 343, 290		0 0	154, 181	90.02
91.00 09100 EMERGENCY	0. 082319	16, 771, 456		0 0	1, 380, 609	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 267786	1, 064, 482		0 0	285, 053	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 329085	470, 543		0 0	154, 849	92.01
200.00 Subtotal (see instructions)		119, 958, 522	17	22, 929	14, 929, 504	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		110 050				
202.00 Net Charges (line 200 - line 201)		119, 958, 522	17	22, 929	14, 929, 504	202.00

Health Financial Systems	IU HEALTH WE	ST HOSPI TAL		In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider CO		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Prepare 5/26/2022 3:15 pm	əd:
			XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						~~
50.00 O5000 OPERATING ROOM	0					. 00
51.00 05100 RECOVERY ROOM	0					. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	-				. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	21	0				. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				. 00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0				. 00
60. 00 06000 LABORATORY	0	0				. 00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0				. 00
65. 00 06500 RESPI RATORY THERAPY	0	0				. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				. 00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				. 00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 903				. 00
74.00 07400 RENAL DIALYSIS	0	0				. 00
76.00 03950 OTHER ANCI LLARY SERVICES	0					. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			/6.	. 97
OUTPATIENT SERVICE COST CENTERS	0	0	1			00
	0					. 00
90. 01 09001 BEHAVI ORAL HEALTH	0	0				. 01
90. 02 09002 SLEEP LAB	0	0				. 02
91.00 09100 EMERGENCY	0	0				. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	-				. 01
200.00 Subtotal (see instructions)	21				200.	
201.00 Less PBP Clinic Lab. Services-Program	0				201.	. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	21	3, 903			202.	00
202.00 met charges (The 200 - The 201)	21	3, 903	I		202.	. 00

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider C		Period: From 01/01/2021 To 12/31/2021		
			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	5, 704, 171	0	5, 704, 17	1 37, 559	151.87	30.00
31.00 INTENSIVE CARE UNIT	800, 668		800, 66	8 4, 194	190. 91	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	190, 147		190, 14	7 867	219. 32	35.00
43.00 NURSERY	145, 836		145, 83	6 1, 743	83.67	43.00
200.00 Total (lines 30 through 199)	6, 840, 822		6, 840, 82	2 44, 363		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	520					30.00
31.00 INTENSIVE CARE UNIT	552	105, 382				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	122	26, 757				35.00
43.00 NURSERY	918	76, 809				43.00
200.00 Total (lines 30 through 199)	2, 112	287, 920				200.00

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0158	Period:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part II Date/Time Pre	nared
				10 12/31/2021	5/26/2022 3: 1	
			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)	0.00	0.00	1.00	F 00	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	2 (50,020	158, 089, 594	0. 02314	465, 386	10 771	50.00
	3, 658, 920 952, 622					
	868, 480					52.00 54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	2, 862, 770					54.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	964, 028 908, 602					55.00
60. 00 06000 LABORATORY	232, 202					60.00
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.	3, 979					63.00
65. 00 06500 RESPIRATORY THERAPY	201, 303					65.00
66. 00 06600 PHYSI CAL THERAPY	76, 743					66.00
67. 00 06700 0CCUPATI ONAL THERAPY	48, 055					67.00
68. 00 06800 SPEECH PATHOLOGY	48, 033					68.00
69. 00 06900 ELECTROCARDI OLOGY	121, 205					69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	102, 762					71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	180, 598					
73. 00 07300 DRUGS CHARGED TO PATIENTS	487, 106					73.00
74. 00 07400 RENAL DI ALYSI S	100, 276					74.00
76. 00 03950 OTHER ANCI LLARY SERVICES	0					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	55, 881	3, 718, 624			-	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000	0 0	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	35, 306	1, 451, 655	0. 02432	21 0	0	90.01
90. 02 09002 SLEEP LAB	79, 107			33 0	0	90.02
91.00 09100 EMERGENCY	1, 533, 890	185, 969, 329	0. 00824	632, 860	5, 220	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	354, 165					92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	201, 505	3, 065, 299	0. 06573	37 0	0	92.01
200.00 Total (lines 50 through 199)	14, 071, 104	1, 036, 602, 312		4, 791, 804	57, 966	200. 00

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE O	THER PASS THROUGH COS			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown	-	Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0 0	l o	31.00
35.00 02080 NEONATAL INTENSIVE CARE UNIT	0	0		0 0	0	
43. 00 04300 NURSERY	0	0			0	
200.00 Total (lines 30 through 199)	0	0			-	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	200.00
	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,	buys	col. 6)		
		minus col. 4)		001.0)		
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	37, 55	9 0.00	520	30.00
31. 00 03100 I NTENSI VE CARE UNI T	Ŭ	0	4, 19			
35. 00 02080 NEONATAL INTENSIVE CARE UNIT		0	86			
43. 00 04300 NURSERY			1,74			
200.00 Total (lines 30 through 199)		0				200.00
Cost Center Description	I npati ent	0	44, 30	J	2,112	200.00
cost center bescription	Program					
	Pass-Through					
	Cost (col. 7					
	<u>x col. 8)</u> 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
	-					
31.00 03100 INTENSIVE CARE UNIT	0					31.00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT	0					35.00
43.00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00

Health Financial Systems	IU HEALTH WES	T HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2027 To 12/31/2027	Date/Time Pre 5/26/2022 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursi ng Program	Allied Health Post-Stepdown	Allied Health	
		Post-Stepdown		Adjustments		
	1.00	Adjustments 2A	2,00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
51. 00 05100 RECOVERY ROOM	0	0			-	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				52.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0		0 0		60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 0		63.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0		65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0 (66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 (0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 (0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 (0 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 (o o	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
74.00 07400 RENAL DIALYSIS	0	0		0 (0 0	74.00
76.00 03950 OTHER ANCI LLARY SERVICES	0	0		0 (0 0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 (0 0	76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0 0		90.00
90. 01 09001 BEHAVI ORAL HEALTH	0	0		0 (0 0	90.01
90. 02 09002 SLEEP LAB	0	0		0 (0 0	90.02
91.00 09100 EMERGENCY	0	0		0 (0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 (-	92.01
200.00 Total (lines 50 through 199)	0	0	1	0 0	0 0	200.00

Health Financial Systems	IU HEALTH WE	ST HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021		norod.
				To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	cols. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0		0 158, 089, 594		
51.00 05100 RECOVERY ROOM	0	0		0 33, 195, 248	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 23, 018, 977	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 124, 962, 658	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 53, 130, 927	0.000000	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 67, 864, 185	0.000000	59.00
60. 00 06000 LABORATORY	0	0		0 63, 974, 530	0.000000	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0	0		0 3, 444, 913	0.000000	63.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 20, 636, 776	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 10, 131, 284	0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 3, 403, 832	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 1, 527, 218		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 42, 604, 490		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 35, 676, 903		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 85, 596, 954		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 92, 888, 633		
74.00 07400 RENAL DI ALYSI S	0	0		0 2, 535, 899		
76.00 03950 OTHER ANCI LLARY SERVI CES	0	-		0 0		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 3, 718, 624	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS	1	1			1	
90. 00 09000 CLINIC	0	0		0 0		
90. 01 09001 BEHAVI ORAL HEALTH	0	0		0 1, 451, 655		
90. 02 09002 SLEEP LAB	0	0		0 7, 235, 767		
91.00 09100 EMERGENCY	0	0		0 185, 969, 329		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 12, 478, 617		
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	-		0 3, 065, 299		
200.00 Total (lines 50 through 199)	0	0		0 1,036,602,312		200.00

Health Financial Systems	IU HEALTH WEST	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		CN: 15-0158	Period: From 01/01/2021 To 12/31/2021		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h 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 OPERATI NG ROOM	0. 000000	465, 386		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	75, 756		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	312, 537		0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	382, 091		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	66, 339		0 0	0	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	275, 603		0 0	0	59.00
60.00 06000 LABORATORY	0. 000000	567,677		0 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.	0. 000000	35, 181		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	339, 457		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	51, 404		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	31, 251		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	18, 766		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	224, 427		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	117, 024		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	292, 964		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	865, 304		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0. 000000	37,089		0 0	0	74.00
76.00 03950 OTHER ANCI LLARY SERVICES	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	688		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 000000	0		0 0	0 0	90.00
90. 01 09001 BEHAVI ORAL HEALTH	0. 000000	0		0 0	0	90.01
90. 02 09002 SLEEP LAB	0. 000000	0		0 0	0 0	90.02
91.00 09100 EMERGENCY	0. 000000	632, 860		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	92.01
200.00 Total (lines 50 through 199)		4, 791, 804		0 0	0 0	200.00

	Financial Systems IU HEALTH WEST ATION OF INPATIENT OPERATING COST IU HEALTH WEST	Provi der CCN: 15-0158	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Title XVIII	Hospi tal	PPS	<u>5 pii</u>
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	(a avaluding nawharn)		27 550	1 1
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			37, 559 37, 559	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
~~	do not complete this line.		-	05 007	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	35, 227 0	4
00	reporting period	Join days) thi ough beceind		0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)		- 01 -6	0	_
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	11, 869	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc			Ũ	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room days)	0	12
. 00	through December 31 of the cost reporting period	x only (ther during priva	te room uays)	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including priva	te room days)	0	13
~ ~	after December 31 of the cost reporting period (if calendar y				
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	res after December 31 of	the cost	0.00	18
	reporting period			0100	
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 o	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as after December 31 of	the cost	0.00	20
. 00	reporting period	a ter becember 51 01	the cost	0.00	
. 00	Total general inpatient routine service cost (see instruction	าร)		53, 819, 605	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost repor	ting period (line	0	22
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reporti	ng period (line A	0	23
. 00	x line 18)		ng period (rine d	0	20
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reportin	a pariod (line 9	0	25
. 00	x line 20)	Si di the cost reportin		0	20
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		53, 819, 605	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bod o	harges)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed c	nai yes)	0	29
	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	31
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	34
	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	35
	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 d	ifferential (line	53, 819, 605	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see			1, 432. 93	38
. 00	Program general inpatient routine service cost (line 9 x line	e 38)		17,007,446	39
. 00	Medically necessary private room cost applicable to the Progr	. ,		0	40
. 00	Total Program general inpatient routine service cost (line 39			17,007,446	

Health Financial System COMPUTATION OF INPATIE		IU HEALTH WES		CN: 15-0158	Period:	u of Form CMS- Worksheet D-1	
Some Of ALL ON OF THEALTE					From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
				e XVIII	Hospi tal	PPS	
Cost Cente	r Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title)		0	C	0.0	0 0		42.00
	ype Inpatient Hospital Units				-		
43.00 I NTENSI VE CARE U 44.00 CORONARY CARE U		10, 046, 255	4, 194	2, 395. 3	1, 201	2, 876, 863	
44.00 CORONARY CARE UI 45.00 BURN INTENSIVE							44.00
46. 00 SURGI CAL I NTENS							46.00
47.00 NEONATAL INTENS	VE CARE UNIT	2, 597, 037	867	2, 995. 4	3 0	0	47.00
Cost Cente	r Description					1.00	
48.00 Program inpatie	nt ancillary service cost (Wk	ct D 2 col 2	Lino 200)			1.00 15,855,072	48.00
	npatient costs (sum of lines			ons)		35, 739, 381	
PASS THROUGH COS		(the child ought roy (0110)		00,707,001	
ũ	sts applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	2, 031, 828	50.00
						1 1 10 105	
51.00 Pass through cos and IV)	sts applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	1, 148, 625	51.00
	cludable cost (sum of lines	50 and 51)				3, 180, 453	52.00
	npatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	32, 558, 928	
	on costs (line 49 minus line	52)		-			
	ID LIMIT COMPUTATION						
54.00 Program discharg 55.00 Target amount po						0.00	
	ine 54 x line 55)					0.00	
58.00 Bonus payment (see instructions)							58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th							59.00
60.00 Lesser of lines	53/54 or 55 from prior year	cost report up	dated by the	markat baskat		0.00	60.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by							61.00
	costs (line 53) are less tha						
	, otherwise enter zero (see	instructions)			-		
	(see instructions)						
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							63.00
	ped SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.00
	tle XVIII only)	Ū.			0 1 1		
	bed SNF inpatient routine cos	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
instructions)(ti 66.00 Total Medicare	tie XVIII only) swing-bed SNF inpatient routi	ne costs (line	64 nlus lino	65) (titlo XV/	LL only) For	0	66.00
CAH (see instrue	5	ne costs (inne	o4 prus rine	05)(11118 XVI	ri oniy). Tor		00.00
	swing-bed NF inpatient routin	ne costs through	December 31	of the cost r	eporting period	0	67.00
(line 12 x line							
	swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.00
69.00 Total title V or	XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.00
	ED NURSING FACILITY, OTHER N						
	facility/other nursing facil)		70.00
	inpatient routine service of		ine 70 ÷ line	2)			71.00
U U	service cost (line 9 x line sary private room cost applic		(line 14 v l	ing 35)			72.00
3	eneral inpatient routine serv	0	•				73.00
5 5	cost allocated to inpatient				Part II, column		75.00
26, line 45)				•			
	-related costs (line 75 ÷ li						76.00
<u> </u>	-related costs (line 9 x line ne service cost (line 74 minu						77.00
	es to beneficiaries for exces		rovi der recor	ds)			79.00
55 5 5	butine service costs for comp				nus line 79)		80.00
81.00 Inpatient routi	ne service cost per diem limi	tation					81.00
	ne service cost limitation (I		· .				82.00
	tient routine service costs (s)				83.00
	nt ancillary services (see in ew - physician compensation		ns)				84.00
	npatient operating costs (sum						86.00
<u>J</u>	ATION OF OBSERVATION BED PAS						
	on bed days (see instructions					2, 332	
3	inpatient routine cost per cost (line 87 x line 88) (se	•	line 2)			1, 432. 93 3, 341, 593	
00 00 00 00 00 00 00 00 00 00 00 00 00	COST LING ST V LING SS) (SO						

Health Financial Systems	ST HOSPI TAL	HOSPITAL In Lie			u of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provider C		Period: From 01/01/2021	Worksheet D-1		
					Date/Time Pre 5/26/2022 3:1	
		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	5, 704, 171	53, 819, 605	0. 10598	7 3, 341, 593	354, 165	90.00
91.00 Nursing Program cost	0	53, 819, 605	0.00000	0 3, 341, 593	0	91.00
92.00 Allied health cost	0	53, 819, 605	0.00000	0 3, 341, 593	0	92.00
93.00 All other Medical Education	0	53, 819, 605	0.00000	0 3, 341, 593	0	93.00

OMPUT	Financial Systems IU HEALTH WEST ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0158	Peri od: From 01/01/2021 To 12/31/2021	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/26/2022 3:1	pared
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		37, 559	1.0
. 00	Inpatient days (including private room days, excluding swing			37, 559	2.0
8.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3. C
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation l	hed days)		35, 227	4. C
5.00	Total swing-bed SNF type inpatient days (including private re		er 31 of the cost		5.0
	reporting period				
. 00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.0
. 00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	0	7.0
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8.0
. 00	Total inpatient days including private room days applicable	to the Program (excludin	ig swing-bed and	520	9.0
	newborn days) (see instructions)	0 1	0 0		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII (room days)	0	10. (
1.00	through December 31 of the cost reporting period (see instruction Swing-bed SNF type inpatient days applicable to title XVIII of the title XVIII o		room davs) after	0	11.0
	December 31 of the cost reporting period (if calendar year, o	enter 0 on this line)	•		
2.00	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	ite room days)	0	12.
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	te room days)	0	13.
	after December 31 of the cost reporting period (if calendar	year, enter O on this li	ne)	C C	
	Medically necessary private room days applicable to the Program	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			1, 743	15. 16.
0.00	SWING BED ADJUSTMENT			710	10.
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost	0.00	17.
8.00	reporting period Medicare rate for swing-bed SNF services applicable to service	and after December 21 of	the cost	0.00	10
0.00	reporting period	ces arter becember 31 01	the cost	0.00	10.
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 c	of the cost	0.00	19.
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	os aftar Dacambar 21 of	the cost	0.00	20.
.0. 00	reporting period	es arter becember 31 01	the cost	0.00	20.1
	Total general inpatient routine service cost (see instruction			53, 819, 605	
2.00	Swing-bed cost applicable to SNF type services through Decem	ber 31 of the cost repor	ting period (line	0	22.
3.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	r 31 of the cost reporti	ng period (line 6	0	23.
	x line 18)			-	
4. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reportin	a period (line 8	0	25.
	x line 20)		.g por loa (1110 o	Ū.	20.
6.00	Total swing-bed cost (see instructions)	(11 01 1 1 0()		0	26.
7.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		53, 819, 605	27.
8. 00	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.
	Private room charges (excluding swing-bed charges)			0	29.
	Semi-private room charges (excluding swing-bed charges)	· Lino 29)		0	30.
1.00 2.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- 1111e 20)		0. 000000 0. 00	31. 32.
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.
	Average per diem private room charge differential (line 32 mi		icti ons)	0.00	34.
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ine 31)		0.00	35. 36.
	General inpatient routine service cost net of swing-bed cost	and private room cost d	lifferential (line	-	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILICTMENTS			
8.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 432. 93	38.
	Program general inpatient routine service cost per diem (se			745, 124	
	Medically necessary private room cost applicable to the Prog			0	40.
1.00	Total Program general inpatient routine service cost (line 3)	9 + line 40)		745, 124	41.

	n Financial Systems TATION OF INPATIENT OPERATING COST	IU HEALTH WES	Provider C	CN: 15-0158	In Lie Period:	u of Form CMS- Worksheet D-1	
COMPU	TATION OF THEATTENT OF ERATING COST		FIOVIDEI C		From 01/01/2021		
					To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00		1, 184, 192	1, 743	679.4	0 918	623, 689	42.00
	Intensive Care Type Inpatient Hospital Units	40.044.055		0.005.0	0 550	1 000 055	1
43.00 44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	10, 046, 255	4, 194	2, 395. 3	9 552	1, 322, 255	43.00
44.00							44.00
46.00							46.00
47.00	NEONATAL INTENSIVE CARE UNIT	2, 597, 037	867	2, 995. 4	3 122	365, 442	47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wk	st D-3 col 3	Line 200)	-		1.00 763,465	48.00
49.00				ons)		3, 819, 975	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	n Wkst. D, su	m of Parts I and	287, 920	50.00
E1 00)	ationt anaillan	w convioco (f	com Wkot D	our of Dorto II	E7 044	E1 00
51.00	Pass through costs applicable to Program inpl and IV)	atrent anchiar	y services (T	UNI WKSL. D,	Sum OF PARTS II	57, 966	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				345, 886	52.00
53.00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	3, 474, 089	53.00
	medical education costs (line 49 minus line 1	52)					-
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	5					0.00	
56.00			0				
57.00	5 1 1	ing cost and ta	irget amount (ine 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)		0				
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996,	updated and c	ompounded by the	0.00	59.00
60.00		cost report, up	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line	s 55, 59 or 60	enter the less	ser of 50% of	the amount by	0	61.00
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% o	f the target		
62.00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
63.00		ent (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00		ts through Dece	ember 31 of th	e cost report	ing period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to after Decomb	or 21 of the	act reportin	a portiod (Soo	0	65.00
05.00	instructions) (title XVIII only)	ts after Deceniu		Jost reportin	y period (see	0	05.00
66.00		ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)						
67.00	· · · · · · · · · · · · · · · · · · ·	e costs through	December 31	of the cost r	eporting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost rep	orting period	0	68.00
00.00	(line 13 x line 20)			the boot top	or tring por roa		
69.00						0	69.00
70 00	PART III - SKILLED NURSING FACILITY, OTHER NU				<u>\</u>		70.00
70.00 71.00	5 5 5	2		•)		70.00
72.00	Program routine service cost (line 9 x line		The 70 - The	2)			72.00
73.00	5		line 14 x l	ne 35)			73.00
74.00	Total Program general inpatient routine serv						74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B,	Part II, column		75.00
76.00		ne 2)					76.00
77.00							77.00
78.00							78.00
79.00	55 5 5 6 6 5 6 6 6 6 6 6 6 6 6 6 6 6 6	N 1		· ·	nuc line 70)		79.00
80.00 81.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost i i mitati o	ι (IINe /δ MI	nus i ne 79)		80.00
82.00)				82.00
83.00	Reasonable inpatient routine service costs (83.00
84.00	Program inpatient ancillary services (see in		`				84.00
85.00	Utilization review - physician compensation	•					85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		n ougri 85)			<u> </u>	86.00
87.00	Total observation bed days (see instructions					2, 332	87.00
	5 .		Lino 2)			1, 432. 93	
88.00	Observation bed cost (line 87 x line 88) (see					3, 341, 593	

Health Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1		
				From 01/01/2021 To 12/31/2021			
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(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	5, 704, 171	53, 819, 605	0. 10598	7 3, 341, 593	354, 165	90.00	
91.00 Nursing Program cost	0	53, 819, 605	0.00000	0 3, 341, 593	0	91.00	
92.00 Allied health cost	0	53, 819, 605	0.00000	0 3, 341, 593	0	92.00	
93.00 All other Medical Education	0	53, 819, 605	0.00000	0 3, 341, 593	0	93.00	

Health Financial Systems IU HEALT	H WEST HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0158	Peri od:	Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
	Title	XVIII	Hospi tal	PPS	<u>5 piii</u>
Cost Center Description	IIIC	Ratio of Cos		Inpatient	
Cost center bescription		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			charges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			39, 142, 608		30.00
31. 00 03100 I NTENSI VE CARE UNI T			8, 388, 802		31.00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT			0		35.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS				I	
50.00 05000 OPERATING ROOM		0. 1227	92 13, 761, 870	1, 689, 848	50.00
51.00 05100 RECOVERY ROOM		0. 2661	90 1, 718, 720	457, 506	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3203	49 107, 821	34, 540	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1188			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0790			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0682			59.00
60. 00 06000 LABORATORY		0. 1733			
63. 00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 2076			
65. 00 06500 RESPIRATORY THERAPY		0. 2239			
66. 00 06600 PHYSI CAL THERAPY		0. 3401			
67.00 06700 OCCUPATI ONAL THERAPY		0.3400			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 3295			
69. 00 06900 ELECTROCARDI OLOGY		0.0531			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2093			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 1533			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 1702			
74. 00 07400 RENAL DI ALYSI S		0. 5319			
76.00 03950 OTHER ANCI LLARY SERVICES		0.0000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1465		-	76.97
OUTPATIENT SERVICE COST CENTERS		011100	11,120		/ 0. //
90. 00 09000 CLINIC		0.0000	0 00	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH		0.6574		0	90.01
90. 02 09002 SLEEP LAB		0. 1147			90.02
91. 00 09100 EMERGENCY		0. 0823		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2677			
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 3290			
200.00 Total (sum of lines 50 through 94 and 96 through	98)	0.0270	110, 909, 068		
201.00 Less PBP Clinic Laboratory Services-Program only			0		201.00
202.00 Net charges (line 200 minus line 201)	charges (True 01)		110, 909, 068		201.00
		I	110, 707, 000	I	1-02.00

	IU HEALTH WEST HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0158	Peri od:	Worksheet D-3	
			From 01/01/2021		
			To 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared:
		e XIX	Hospi tal	PPS	<u>o pili</u>
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		l lo ondi goo	Charges	(col. 1 x	
			ondriges	col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 721, 783		30.00
31.00 03100 INTENSIVE CARE UNIT			658, 521		31.00
35. 00 02080 NEONATAL INTENSIVE CARE UNIT			491, 017		35.00
43. 00 04300 NURSERY			130, 879		43.00
ANCILLARY SERVICE COST CENTERS					1
50.00 05000 OPERATING ROOM		0. 1227	92 465, 386	57, 146	50.00
51.00 05100 RECOVERY ROOM		0. 2661	90 75, 756	20, 165	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3203	49 312, 537	100, 121	52.00
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 1188	40 382, 091	45, 408	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 0790	53 66, 339	5, 244	55.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0682	20 275, 603	18, 802	59.00
60. 00 06000 LABORATORY		0. 1733	23 567, 677	98, 391	60.00
63.00 06300 BLOOD STORING, PROCESSING, & TRANS.		0. 2076		7, 306	63.00
65. 00 06500 RESPIRATORY THERAPY		0. 2239	339, 457	76, 011	
66. 00 06600 PHYSI CAL THERAPY		0. 3401		17, 483	
67.00 06700 OCCUPATI ONAL THERAPY		0. 3400	30 31, 251	10, 628	67.00
68.00 06800 SPEECH PATHOLOGY		0. 3295		6, 185	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0531		11, 926	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 2093		24, 498	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 1533		44, 931	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1702		147, 295	
74.00 07400 RENAL DI ALYSI S		0. 5319		19, 728	
76.00 03950 OTHER ANCI LLARY SERVICES		0.0000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1465		101	76.97
OUTPATI ENT SERVI CE COST CENTERS					
90. 00 09000 CLINIC		0.0000	0 00	0	90.00
90. 01 09001 BEHAVI ORAL HEALTH		0.6574	76 0	0	90.01
90. 02 09002 SLEEP LAB		0. 1147	79 0	0	90.02
91. 00 09100 EMERGENCY		0.0823		52,096	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 2677		0	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0. 3290		0	92.01
200.00 Total (sum of lines 50 through 94 and 96	through 98)		4, 791, 804	763, 465	
201.00 Less PBP Clinic Laboratory Services-Prog			0		201.00
202.00 Net charges (line 200 minus line 201)	j j (- 110 01)		4, 791, 804		202.00
		1	.,,		

1.01 DBC amounts other than outlier payments for discharges occurring prior to October 1 (see 16, 564,734 1.0 1.02 DPC amounts other than outlier payments for discharges occurring on or after October 1 (see 6, 397,392 1.0 1.03 DPC amounts other than outlier payments for Model 4 BPC1 for discharges occurring on or after 0 1.0 1.04 DPC amounts other than outlier payment for Model 4 BPC1 for discharges occurring on or after 0 1.0 1.05 DPC amounts other payments for discharges occurring on or after the payments for discharges occurring prior to October 1 (see instructions) 0 <th></th> <th>Financial Systems IU HEALTH WEST ATION OF REIMBURSEMENT SETTLEMENT</th> <th>Provi der CCN: 15-0158</th> <th>Peri od:</th> <th>u of Form CMS-2 Worksheet E</th> <th>2002-10</th>		Financial Systems IU HEALTH WEST ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0158	Peri od:	u of Form CMS-2 Worksheet E	2002-10
Title XVIII Hearital PPS Note: A = INPATION HOSPITAL SERVICES UNDER IPPS 1.00 Note: A = INPATION HOSPITAL SERVICES UNDER IPPS 1.00 Note: A = INPATION HOSPITAL SERVICES UNDER IPPS 0 1.01 DRG amounts other than outline payments for discharges occurring on or after October 1 (see Instructions) 0 0.5,567,734 1.02 DRG amounts other than outline payments for discharges occurring on or after October 1 (see Instructions) 0 1.0 1.03 DRG for forderal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see Instructions) 0 2.0 1.04 DRT for discharges occurring on or after October 1 (see Instructions) 0 2.0 1.04 DRT for discharges occurring on or after October 1 (see Instructions) 0 2.0 1.05 DRT for discharges occurring on or after October 1 (see Instructions) 1.48 2.0 2.05 Outline payments for discharges occurring on or after October 1 (see Instructions) 1.48 2.0 2.06 DRT for discharges occurring on or after October 1 (see Instructions) 1.48 2.0 2.06 DRT for discharges occuring on or after October 1 (see Instructions) 1.					Date/Time Pre	
PART A. INPATION F03PTIAL SERVICES UNDER IPPS 0 1.00 DRG Amounts Other than outlier payments for discharges occurring prior to 0ctober 1 (see Instructions) 10, 564,734 10, 564,734 1.01 DRG Amounts other than outlier payments for discharges occurring on or after Dctober 1 (see Instructions) 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,			Title XVIII	Hospi tal		5 pm
PART A. INPATION F03PTIAL SERVICES UNDER IPPS 0 1.00 DRG Amounts Other than outlier payments for discharges occurring prior to 0ctober 1 (see Instructions) 10, 564,734 10, 564,734 1.01 DRG Amounts other than outlier payments for discharges occurring on or after Dctober 1 (see Instructions) 10, 10, 10, 10, 10, 10, 10, 10, 10, 10,					1 00	
1.01 DRG amounts other than outlier payments for discharges occurring on a fier Detober 1 (see instructions) 16.664.724 1.0 1.02 DRG amounts other than outlier payments for discharges occurring on a fier Detober 1 (see instructions) 6.399.322 1.0 1.03 DRG for other specific to operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) 0 0.1 2.00 Duttier payments for discharges (see instructions) 0 0.1 2.00 Duttier payments for discharges occurring on or after Detober 1 (see instructions) 0 0.2 2.00 Duttier payments for discharges occurring or or after Detober 1 (see instructions) 0 0.48.56 2.00 Duttier payments for discharges occurring or or the the ost reporting period (see instructions) 0 0.6 3.00 Bed days available divided by number of days in the cost reporting period see instructions) 188.868 0.00 3.00 The fore 12/3/1/96, (see instructions) 188.76 0.00 0.00 0.00 3.00 The fore 12/3/1/96, (see instructions) 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <t< td=""><td></td><td>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</td><td></td><td></td><td>1.00</td><td></td></t<>		PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1.00	
1.02 BRG amounts other than outline payments for discharges occurring on or after October 1 (see instructions) 6,399,392 1.0 1.03 URK for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) 0 0 1.04 URK for federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 0 1.0 1.05 URT for federal specific operating payment for to October 1 (see instructions) 52.2 0 2.00 URT for payment for discharges for Model 4 BPCI (see instructions) 52.2 0 2.01 URT for payment for discharges for Model 4 BPCI (see instructions) 52.2 0 2.01 URT for payment for discharges for Model 4 BPCI (see instructions) 52.4 0 0 3.00 Wanaged Cares simulated Hayments 10 0.0 10.0 50.0 118.0 0.0 50.0 10 0.00 0.0 0.00 <td></td> <td>DRG amounts other than outlier payments for discharges occur</td> <td>ring prior to October 1</td> <td>(see</td> <td>-</td> <td>1.00 1.01</td>		DRG amounts other than outlier payments for discharges occur	ring prior to October 1	(see	-	1.00 1.01
1.33 DBC for Tedoral specific operating payment for Model 4 BPC1 for discharges occurring prior to October 1 (see instructions) Control of the payment for ideal 4 BPC1 for discharges occurring on or after Control of the payment for discharges occurring on prior to October 1 (see instructions) 2.01 0 2.00 Outli ler reconcil action amount Control of ischarges occurring on or after Control of ischarges occurring on or after	1. 02	DRG amounts other than outlier payments for discharges occur	ring on or after October	1 (see	6, 399, 392	1.02
1.04 DBC for federal specific operating payment for Model 4 BPCI for discharges occurring on or after operating payments for discharges. (see instructions) 2.0 2.00 Dutilier payments for discharges. (see instructions) 2.0 2.01 Dutilier payments for discharges. (see instructions) 2.0 2.03 Dutilier payments for discharges occurring on or after 0ctober 1 (see instructions) 388.682 2.04 Dutilier payments for discharges occurring on or after 0ctober 1 (see instructions) 148.74 3.05 Managed Care Simulated Payments 148.74 4.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on enveropmas in accordance with 42.74 (20) 0.00 0.00 5.00 FIE count for all opathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42.74 (20) 0.00	1.03	DRG for federal specific operating payment for Model 4 BPCI	for discharges occurring	prior to October	0	1.03
2 00 Outlier payments for discharges (see instructions) 2.0 2 00 Unitier payments for discharges occurring period to October 1 (see instructions) 2.0 2 00 Unitier payments for discharges occurring period to October 1 (see instructions) 138, 868 2 00 Unitier payments for discharges occurring period to October 1 (see instructions) 148, 94 2 00 Unitier payments for discharges occurring period (see instructions) 148, 94 4 00 Instructions 148, 94 5 07 Fice count for all opayments for discharges occurring period (see instructions) 0.00 6 07 Fice count for all opayments for the next recent cost reporting period ending of or before 12/31/1996 (see instructions) 0.00 0 07 Fice count for all opayments for the INE cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00 0.00 0 08 As \$553 reduction amount to the INE cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00 0.00 1 08 Addi period structure and addiction amount to the INE cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the 0.00 0.00 1 0909, and 57 R 5006 (August 1, 2002). 1000 Fice count for allopayments for addiction amount to the INE cap as specifica payments addiction amount of increase if the hospital was awarded FIE cap slots under \$5000 of ALC (see instructions) 0.00	1.04	DRG for federal specific operating payment for Model 4 BPCI	for discharges occurring	on or after	0	1.04
2.02 Outlier payment for discharges occurring prior to October 1 (see instructions) 0 2.0 2.00 Utilier payments for discharges occurring prior to October 1 (see instructions) 138,882 2.0 3.00 Managed Care Simulated Payments 149,92 4.0 Bed days avail able divided by number of days in the cost reporting period (see instructions) 149,92 4.0 FIE count for allegathic and sctepathic programs for the most recent cost reporting period ending of 0.00 5.00 6.0 OFFE count for allegathic and sctepathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 431.70(2) 0.00 0.00 0.00 0.00 7.0 0.01 Add ssteent for allegathic and sctepathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 431.70(2) 0.00 7.0 0.00<		Outlier payments for discharges. (see instructions)				2.00
2.03 Outlier payments for discharges occurring prior to foctober 1 (see instructions) 542,455 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 138,868 2.03 3.00 Managed Care Simulated Payments 138,868 2.03 0.01 Bed days available divided by number of days in the cost reporting period (see instructions) 148,93 0.01 File count for al lopathic and oscopathic programs for the most recent cost reporting period ending of 0.00 0.00 0.01 File count for al lopathic and oscopathic programs that meet the criteria for an add-on to the cap for 0.00 0.00 0.00 0.01 File count for al lopathic and oscopathic programs for the most recent cost report straidies July 1, 2011 then see Instructions. 0.00 0.00 0.00 0.01 Add straides July 1, 2021 then see Instructions. 0.00 0.00 0.00 0.00 0.02 The amount of increase if the hospital was awarded FIE cap slots under \$ 5503 of the ACA. If the cost 0.00 0.00			tions)			2.01
2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 138.868 2.03 3.00 Managed Care Simulated Payments 148.93 4.00 5.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/VPG (see instructions) 148.93 4.00 6.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/VPG (see instructions) 0.00 5.0 6.00 FIE count for all opathic and osteopathic programs for the most recent cost reporting period (way 12, 1000) 0.00 7.0 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) if the or affiliated programs in accordance with 42 CFR 413.75(b), 413.77(c)(2)(iv), 64 FR 26360 (May 12, 1000) 0.00 8.0 8.00 Adjustment (increase or decrease) to the FIE count for all opathic and osteopathic programs for report straddles July 1, 2013, see instructions. 0.00 8.0 9.00 FIE count for all opathic and osteopathic programs. 0.00 8.0 9.01 The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under \$ 5503 of the ACA. If the cost 0.00 10.00 9.02 The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital 0.00			-		-	2.02
4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 148.93 4.0 5.00 FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 0.00 5.0 6.00 FTE count for allopathic and osteopathic programs that meet the criteria for an addo-n to the cap for new programs in accordance with 42 CFR 413/19(e) 0.00 0.00 7.0 7.00 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(1)(9(2)(1) 0.00 7.0 7.01 ACA Sistos reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(1)(9(2)(2)(1) 0.00 7.0 7.02 MAA Section 422 reduction amount to the IME cap as specified under 42 CFR 412.105(f)(1)(1)(9(2)(2)(1) 0.00 7.0 7.03 MAA Sistement (increase ir the heapt tal warded FTE cap slots under § 550.3 of the ACA. If the cost 0.00 8.0 8.01 The amount of increase ir the heapt tal warded FTE cap slots from a closed teaching hospital under § 550 of fACA. (see instructions) 0.00 8.0 9.02 Sum of tines 59 is of the prior year. 0.00 10.00 7.0 0.04 FE count for releval and podiatric programs. 0.00 10.00 10.00 1.05 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
Indirect Medical Education Adjustment Indirect Medical Education Adjustment 0.0 OF FFE count for allopathic and osteopathic programs for the most recent cost reporting period ending of or before 12/31/1996. (see instructions) 0.00 5.0 0.0 File Count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(c) 0.00 7.0 0.00 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddle sJuly 1, 2011 then see instructions 0.00 7.0 8.00 AcA § 5503 reduction amount to The IME Cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddle sJuly 1, 2011. See instructions. 0.00 8.0 8.01 And OY F Boode (August 1, 2002) Fift The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddle sJuly 1, 2011. See instructions. 0.00 0.		5				3.00
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Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA23.00Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1050.0023.00(f) (1) (iv) (C).0.0024.00IME FTE Resident Count Over Cap (see instructions)0.0025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.00IME add-on adjustment factor. (see instructions)0.00000028.00IME add-on adjustment amount (see instructions)0.00000028.01IME add-on adjustment amount (see instructions)029.00Total IME payment (sum of lines 22 and 28)029.01Total IME payment – Managed Care (sum of lines 22.01 and 28.01)029.02Disproportionate Share Adjustment30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6631.00Sum of lines 30 and 3119.6532.00Allowable disproportionate share percentage (see instructions)5.52						
(f) (1) (iv) (C)	22.01		22 of the MMA		0	22.01
24.00IME FTE Resident Count Over Cap (see instructions)0.0024.025.00If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see0.0025.026.00Resident to bed ratio (divide line 25 by line 4)0.00000026.027.00IME payments adjustment factor. (see instructions)0.00000027.028.00IME add-on adjustment amount (see instructions)0.00000028.028.01IME add-on adjustment amount - Managed Care (see instructions)028.029.00Total IME payment (sum of lines 22 and 28)029.029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.029.01Disproportionate Share Adjustment26.630.030.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.032.00Sum of lines 30 and 3119.6532.033.00Allowable disproportionate share percentage (see instructions)5.5233.0	23.00	la l	dent cap slots under 42	CFR 412.105	0.00	23.00
26.00Resident to bed ratio (divide line 25 by line 4)0.00000026.0027.00IME payments adjustment factor. (see instructions)0.00000027.0028.00IME add-on adjustment amount (see instructions)028.0028.01IME add-on adjustment amount - Managed Care (see instructions)028.0029.01Total IME payment (sum of lines 22 and 28)029.0029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.0029.01Disproportionate Share Adjustment029.0130.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.0031.00Percentage of Medicaid patient days (see instructions)2.6630.0031.0032.00Sum of lines 30 and 3119.6532.0033.004llowable disproportionate share percentage (see instructions)5.5233.00			lower of line 23 or lin	ne 24 (see		
27.00IME payments adjustment factor. (see instructions)0.00000027.028.00IME add-on adjustment amount (see instructions)028.028.01IME add-on adjustment amount - Managed Care (see instructions)028.029.00Total IME payment (sum of lines 22 and 28)029.029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.029.01Disproportionate Share Adjustment20.020.030.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.031.00Percentage of Medicaid patient days (see instructions)16.9931.032.00Sum of lines 30 and 3119.6532.033.00Allowable disproportionate share percentage (see instructions)5.5233.0	26 00			·		
28.00IME add-on adjustment amount (see instructions)028.0128.01IME add-on adjustment amount - Managed Care (see instructions)028.0129.00Total IME payment (sum of lines 22 and 28)029.0229.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.02Disproportionate Share Adjustment028.0129.0230.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.0231.00Percentage of Medicaid patient days (see instructions)16.9931.0232.00Sum of lines 30 and 3119.6532.0233.00Allowable disproportionate share percentage (see instructions)5.5233.02						
29.00Total IME payment (sum of lines 22 and 28)029.0029.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.01Disproportionate Share Adjustment029.0130.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.031.00Percentage of Medicaid patient days (see instructions)16.9931.032.00Sum of lines 30 and 3119.6532.033.00Allowable disproportionate share percentage (see instructions)5.5233.0						28.00
29.01Total IME payment - Managed Care (sum of lines 22.01 and 28.01)029.01Disproportionate Share AdjustmentDisproportionate Share Adjustment0030.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.031.00Percentage of Medicaid patient days (see instructions)16.9931.032.00Sum of lines 30 and 3119.6532.033.00Allowable disproportionate share percentage (see instructions)5.5233.0	28.01	IME add-on adjustment amount - Managed Care (see instruction	s)		0	28.01
Disproportionate Share Adjustment30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.0031.00Percentage of Medicaid patient days (see instructions)16.9931.0032.00Sum of lines 30 and 3119.6532.0033.00Allowable disproportionate share percentage (see instructions)5.5233.00						29.00
30.00Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)2.6630.031.00Percentage of Medicaid patient days (see instructions)16.9931.032.00Sum of Lines 30 and 3119.6532.033.00Allowable disproportionate share percentage (see instructions)5.5233.0	29.01		01)		0	29.01
31.00Percentage of Medicaid patient days (see instructions)16.9931.032.00Sum of Lines 30 and 3119.6532.033.00Allowable disproportionate share percentage (see instructions)5.5233.0	30.00		patient days (see instru	ictions)	2.66	30.00
33.00Allowable disproportionate share percentage (see instructions)5.5233.0			, , , , , , , , , , , , , , , , , , , ,	<i>,</i>		
			s)			

ALCUL	Financial Systems IU HEALTH WES	Provider CCN: 15-0158	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2021		nore
			To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompanyated Care Adjustment		1.00	2.00	
5.00	Uncompensated Care Adjustment Total uncompensated care amount (see instructions)		8 200 014 521	7, 192, 008, 710	35.
5.00	Factor 3 (see instructions)		0. 000225560		
5.02		enter zero on this line) (se			
0.02	instructions)		1,007,070	1, 001, 000	00.
5.03	Pro rata share of the hospital uncompensated care payment	amount (see instructions)	1, 398, 577	379, 107	35.
6.00	Total uncompensated care (sum of columns 1 and 2 on line 3	(5.03)	1, 777, 684		36.
	Additional payment for high percentage of ESRD beneficiary	discharges (lines 40 throu	igh 46)		1
0.00	Total Medicare discharges (see instructions)		0		40.
1. 00	Total ESRD Medicare discharges (see instructions)		0		41.
1.01	Total ESRD Medicare covered and paid discharges (see instr	ructions)	0		41.
2.00	Divide line 41 by line 40 (if less than 10%, you do not qu	ualify for adjustment)	0.00		42.
3.00	Total Medicare ESRD inpatient days (see instructions)		0		43.
4.00	Ratio of average length of stay to one week (line 43 divid	led by line 41 divided by 7	0. 000000		44.
F 00	days)	>	0.00		
5.00	Average weekly cost for dialysis treatments (see instructi	-	0.00		45.
6.00		e 41.01)			46.
7.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH	l small rural bosnitals	25, 740, 038		47. 48.
0.00	only. (see instructions)	i, silari rurar nospitars	0		40.
				Amount	
				1.00	
9.00	Total payment for inpatient operating costs (see instructi			25, 740, 038	
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I			2, 020, 644	
1.00	Exception payment for inpatient program capital (Wkst. L,			0	
2.00		Time 49 see instructions).		0	
3.00 4.00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			0 381, 350	
4.00	Islet isolation add-on payment			381, 330	
5.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin	ne 69)		0	55.
6.00	Cost of physicians' services in a teaching hospital (see i	-		0	
	Routine service other pass through costs (from Wkst. D, Pt		hrough 35)	0	
7.00		: III. column 9. lines 30 1			15/
			in ough 55).	0	
8.00	Ancillary service other pass through costs from Wkst. D, P		in ough 35).	0	58
8.00 9.00				-	58 59
8.00 9.00 0.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58)	Pt. IV, col. 11 line 200)	ni ough 55).	0 28, 142, 032	58 59 60
3.00 9.00 0.00 1.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments	Pt. IV, col. 11 line 200)	ni ough 55).	0 28, 142, 032 0	58 59 60 61
8.00 9.00 0.00 1.00 2.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi	Pt. IV, col. 11 line 200)	ni ougit 55).	0 28, 142, 032 0 28, 142, 032	58 59 60 61 62
3.00 9.00 0.00 1.00 2.00 3.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries	Pt. IV, col. 11 line 200)	ni ougit 55).	0 28, 142, 032 0 28, 142, 032 2, 349, 024	58 59 60 61 62 63
3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	°t. IV, col. 11 line 200) nus line 60)	ni ougit 55).	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952	58 59 60 61 62 63 64 65
8.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i	°t. IV, col. 11 line 200) nus line 60)	ni odgit (SS).	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779	58 59 60 61 62 63 64 65 66
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63)	rt. IV, col. 11 line 200) nus line 60) nstructions)		0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454	58 59 60 61 62 63 64 65 66 67
3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f	rt. IV, col. 11 line 200) nus line 60) nstructions) For applicable to MS-DRGs (s	ee instructions)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0	58 59 60 61 62 63 64 65 66 67 68
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9	rt. IV, col. 11 line 200) nus line 60) nstructions) For applicable to MS-DRGs (s	ee instructions)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0	58 59 60 61 62 63 64 65 66 67 68 69
3. 00 9. 00 9. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 3. 00 9. 00 9. 00 9. 00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Pt. IV, col. 11 line 200) nus line 60) nstructions) For applicable to MS-DRGs (s M6). (For SCH see instruction	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70
3.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 3.00 9.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo	Pt. IV, col. 11 line 200) nus line 60) for applicable to MS-DRGs (s 26). (For SCH see instruction postration) adjustment (see	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 50 0. 87	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati	Pt. IV, col. 11 line 200) nus line 60) for applicable to MS-DRGs (s 6). (For SCH see instruction postration) adjustment (see on	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70 70
8.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only	Pt. IV, col. 11 line 200) nus line 60) for applicable to MS-DRGs (s 6). (For SCH see instruction onstration) adjustment (see on	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70
8.00 9.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 0.50 0.87 0.88 0.89	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see i	Pt. IV, col. 11 line 200) nus line 60) For applicable to MS-DRGs (s P6). (For SCH see instruction onstration) adjustment (see on r) nstructions)	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.50 0.87 0.88 0.89 0.90	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions	Pt. IV, col. 11 line 200) nus line 60) For applicable to MS-DRGs (s P6). (For SCH see instruction onstration) adjustment (see on r) nstructions)	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0 0 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.50 0.50 0.50 0.87 0.88 0.89 0.90 0.91	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	Pt. IV, col. 11 line 200) nus line 60) For applicable to MS-DRGs (s P6). (For SCH see instruction onstration) adjustment (see on r) nstructions)	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58 59 60 61 62 63 64 65 66 67 68 69 70 70 70 70 70 70 70 70 70 70 70 70
0.00 0.50 0.87 0.88 0.89 0.90 0.91 0.91	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	Pt. IV, col. 11 line 200) nus line 60) For applicable to MS-DRGs (s P6). (For SCH see instruction onstration) adjustment (see on r) nstructions)	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 0.50 0.50 0.87 0.87 0.89 0.90 0.91 0.92	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 mi Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices f Outlier payments reconciliation (sum of lines 93, 95 and 9 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo Demonstration payment adjustment amount before sequestrati SCH or MDH volume decrease adjustment (contractor use only Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	Pt. IV, col. 11 line 200) nus line 60) For applicable to MS-DRGs (s P6). (For SCH see instruction onstration) adjustment (see on r) nstructions)	ee instructions) s)	0 28, 142, 032 0 28, 142, 032 2, 349, 024 139, 506 221, 464 143, 952 23, 779 25, 797, 454 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 70. 70. 70. 70. 70. 70. 70. 70. 70

LCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0158	Peri od:	Worksheet E	
			From 01/01/2021 To 12/31/2021	Part A Date/Time Pre	
	Ti tl c	XVIII	Hospi tal	5/26/2022 3: 1 PPS	5 pm
	II LI E		(yyyy)	Amount	
			0	1.00	
. 96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1)			0	0	70.
1.97 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period ending on or a	in column O		0	0	70.
98 Low Volume Payment-3				0	70.
.99 HAC adjustment amount (see instructions)				0	70.
.00 Amount due provider (line 67 minus lines 68 plus/minus lines	s 69 & 70)			25, 850, 123	71.
.01 Sequestration adjustment (see instructions)				0	
. 02 Demonstration payment adjustment amount after sequestration				0	
. 03 Sequestration adjustment-PARHM pass-throughs				05 500 040	71.
.00 Interim payments				25, 523, 940	
.01 Interim payments-PARHM .00 Tentative settlement (for contractor use only)				0	72.
. 01 Tentative settlement-PARHM (for contractor use only)				0	73.
. 00 Balance due provider/program (line 71 minus lines 71.01, 71.	02.72. and			326, 183	
73)				,	
.01 Balance due provider/program-PARHM (see instructions)					74.
.00 Protested amounts (nonallowable cost report items) in accord	lance with			413, 612	75.
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	6 0 00	1			
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum plus 2.04 (see instructions)	n of 2.03			0	90.
.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91.
. 00 Operating outlier reconciliation adjustment amount (see inst	ructions)			0	
.00 Capital outlier reconciliation adjustment amount (see instru	,			0	93.
.00 The rate used to calculate the time value of money (see inst				0.00	
.00 Time value of money for operating expenses (see instructions	5)			0	95.
.00 Time value of money for capital related expenses (see instru	uctions)			0	96.
			Prior to 10/1 1.00	<u>0n/After 10/1</u> 2.00	
HSP Bonus Payment Amount					
0.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100.
1.00 HVBP adjustment factor (see instructions)			0. 0000000000	0. 000000000	1101
2.00 HVBP adjustment amount for HSP bonus payment (see instruction	ns)		0.0000000000000000000000000000000000000		102.
HRR Adjustment for HSP Bonus Payment	,			0	1.02.
3.00 HRR adjustment factor (see instructions)			0.0000	0.0000	103.
3.00 HRR adjustment factor (see instructions) 4.00 HRR adjustment amount for HSP bonus payment (see instruction	าร)		0.0000		
4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons	stration) Adj				
4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p	stration) Adj			0	104.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. 	stration) Adj			0	104.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 	stration) Adj beriod under			0	104. 200.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 	stration) Adj beriod under			0	104. 200. 201.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 	stration) Adj beriod under			0	104. 200. 201. 202.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 	stration) Adj period under ne 49)	the 21st		0	104. 200. 201. 202.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 	stration) Adj period under ne 49)	the 21st		0	103. 104. 200. 201. 202. 203.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 	stration) Adj period under ne 49)	the 21st		0 tration	104. 200. 201. 202.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 	stration) Adj period under ne 49) n first year	the 21st		0 tration	104. 200. 201. 202. 203. 203. 204. 205.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205) 	stration) Adj period under ne 49) n first year	the 21st		0 tration	104. 200. 201. 202. 203. 204.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 	ne 49) n first year	the 21st		0 tration	104. 200. 201. 202. 203. 204. 205. 206.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see instruction) 	stration) Adj period under ne 49) n first year 5) structions)	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206. 207.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see ins 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 	stration) Adj period under ne 49) n first year 5) structions)	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206. 207. 208.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 204) 6.00 Medicare part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see ins 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 	stration) Adj period under ne 49) n first year 5) structions)	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A i period) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see ins 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 	stration) Adj period under ne 49) n first year 5) structions) A, line 59)	the 21st		0 tration	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see ins 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 	stration) Adj period under ne 49) n first year 5) structions) A, line 59)	the 21st		0 tration	104. 200. 201. 202. 203. 204. 205. 206. 207.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see inst 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions) 	ne 49) n first year	the 21st		0 tration	104. 200. 201. 202. 203. 204. 205. 206. 206. 207. 208. 209. 210. 211.
 4.00 HRR adjustment amount for HSP bonus payment (see instruction Rural Community Hospital Demonstration Project (§410A Demons 0.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement 1.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, Ii 2.00 Medicare discharges (see instructions) 3.00 Case-mix adjustment factor (see instructions) 3.00 Case-mix adjustment factor (see instructions) 4.00 Medicare target amount 5.00 Case-mix adjusted target amount (line 203 times line 204) 6.00 Medicare inpatient routine cost cap (line 202 times line 205 Adjustment to Medicare Part A Inpatient Reimbursement 7.00 Program reimbursement under the §410A Demonstration (see ins 8.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 	ne 49) n first year	the 21st		0 trati on	104. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210.

W VC	Financial Systems			Provider C		Period:	u of Form CMS-2 Worksheet E	
						From 01/01/2021 To 12/31/2021		pare
				Title	e XVIII	Hospi tal	5/26/2022 3: 1 PPS	5 pr
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 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	16, 564, 734	0	16, 564, 73	4	16, 564, 734	1
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1.02	6, 399, 392	0		6, 399, 392	6, 399, 392	1
)3	occurring on or after October 1 DRG for Federal specific	1.03	0	0		0	0	1
	operating payment for Model 4 BPCI occurring prior to October 1							
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1
0	Outlier payments for	2.00						2
01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2.02	0	0		o o	0	2
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	542, 455	0	542, 45	5	542, 455	2
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	138, 868	0		138, 868	138, 868	2
0	Operating outlier reconciliation	2. 01	0	0		0 0	0	3
0	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0		0 0	0	4
0	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0.00000	0 0. 000000		5
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	0	0		o o	0	6
)1	IME payment adjustment for managed care (see	22.01	0	0		0 0	0	6
	instructions) Indirect Medical Education Adju	istment for th	e Add-on for Se	oction 422 of	the MMA			
0	IME payment adjustment factor (see instructions)	27.00	0. 000000	0. 000000		0 0.000000		7
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
)1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
00	Total IME payment (sum of lines 6 and 8)	29.00	0	0		0 0	0	9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0		0 0	0	9
	Disproportionate Share Adjustme				1	-		
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0552	0. 0552	0. 055	2 0. 0552		10
00	Disproportionate share adjustment (see instructions)	34.00	316, 905	0		3 88, 312	316, 905	11
01	Uncompensated care payments Additional payment for high per	36.00 centage of ES	1, 777, 684 RD beneficiary	0 di scharges	1, 398, 57	7 379, 107	1, 777, 684	11
00	Total ESRD additional payment	46.00	0	0		0 0	0	12
00 00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	25, 740, 038 0	0	18, 734, 35	9 7, 005, 679 0 0	25, 740, 038 0	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)	.0.00		0				
00	Total payment for inpatient operating costs (see instructions)	49.00	25, 740, 038	0	18, 734, 35	9 7, 005, 679	25, 740, 038	15

	Financial Systems LUME CALCULATION EXHIBIT 4		IU HEALTH WES	Provider C	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021		t 4 epared:
				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	2, 020, 644	0	1, 490, 58	83 530, 061	2, 020, 644	16.0
7.00	Special add-on payments for new technologies	54.00	381, 350	0	288, 8	98 92, 452	381, 350	
17.01	Net organ aquisition cost							17.C
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0		0 0	0	17.0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	0	18.0
19 00	SUBTOTAL			0	20, 513, 8	40 7, 628, 192	28, 142, 032	19 C
7.00		W/S L, line	(Amounts from L)		20,010,0	10 1,020,172	20, 112, 002	
		0	1.00	2.00	3.00	4.00	5.00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1. 00 1. 01	1, 741, 402 0	0 0		14 477, 788 0 0		
21.00	Capital DRG outlier payments	2.00	208, 541	0	175, 6	66 32, 875	208, 541	21.0
1. 01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0		0 0		
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000				22.0
3.00	Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	0	23.0
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0406	0. 0406	0.040	0. 0406		24.0
25.00	Disproportionate share adjustment (see instructions)	11.00	70, 701	0	51, 30	03 19, 398	70, 701	25.0
26.00	Total prospective capital payments (see instructions)	12.00	2, 020, 644	0	1, 490, 58	83 530, 061	2, 020, 644	26.0
		W/S E, Part A						
		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, Pt. A, line)	70. 96			0. 0000	0 0. 000000	0	27.0 28.0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. (
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 0

SPI 1	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	pared
			Title		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	
)0)1	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1.00 1.01	16, 564, 734	16, 564, 73		16, 564, 734	1.C
	discharges occurring prior to October 1			10, 304, 73			
)2	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	6, 399, 392		6, 399, 392		1.(
)3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.
)4	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1.
00	Outlier payments for discharges (see instructions)	2.00					2.
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.
)2	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	542, 455	542, 45	5	542, 455	2.
)3	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	138, 868		138, 868	138, 868	2.
00	Operating outlier reconciliation	2.01	0		0 0 0 0	0	3.
00	Managed care simulated payments	3.00	0		0 0	0	4.
0	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, Line 21	21.00	0. 000000	0.00000	0 0.000000		5.
0	(see instructions) IME payment adjustment (see instructions)	22.00	0			0	6.
)1	IME payment adjustment for managed care (see instructions)		-		0 0	0	6.
0	Indirect Medical Education Adjustment for the IME payment adjustment factor (see	27.00	0. 000000	0. 00000	0 0.000000		7.
	instructions)						
)0)1	IME adjustment (see instructions) IME payment adjustment add on for managed	28. 00 28. 01	0		0 0 0 0	0	8. 8.
0	care (see instructions) Total IME payment (sum of lines 6 and 8)	29.00	0		o o	0	9.
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0 0	0	9.
	Disproportionate Share Adjustment						
00	Allowable disproportionate share percentage (see instructions)	33.00	0. 0552	0. 055	2 0.0552		10.
00	Disproportionate share adjustment (see instructions)	34.00	316, 905	228, 59	3 88, 312	316, 905	11.
01	Uncompensated care payments Additional payment for high percentage of ESD	36.00	1, 777, 684	1, 398, 57	7 379, 107	1, 777, 684	11.
00		46.00	0		0 0	0	12.
00	Subtotal (see instructions)	47.00	25, 740, 038	18, 734, 35	9 7, 005, 679		
00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.
00	Total payment for inpatient operating costs (see instructions)	49.00	25, 740, 038	18, 734, 35	9 7, 005, 679	25, 740, 038	15.
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2, 020, 644	1, 490, 58	3 530, 061	2, 020, 644	16.
00 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	381, 350	288, 89	8 92, 452	381, 350	17. 17.
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0		17.
00	Capital outlier reconciliation adjustment	93.00	0		0 0	0	18.
	amount (see instructions)					28, 142, 032	

Health F	Financial Systems	IU HEALTH WES	ST HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI TA	L ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:1	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, 741, 402	1, 263, 6	14 477, 788	1, 741, 402	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0		
21.00	Capital DRG outlier payments	2.00	208, 541	175, 6	66 32, 875	208, 541	21.00
21.01 N	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
	Indirect medical education percentage (see	5.00	0. 0000	0.00	0.0000		22.00
23. 00 I	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00 A	Allowable disproportionate share percentage (see instructions)	10.00	0. 0406	0. 04	0. 0406		24.00
25.00 E	Disproportionate share adjustment (see instructions)	11.00	70, 701	51, 3	03 19, 398	70, 701	25.00
26.00 1	Total prospective capital payments (see instructions)	12.00	2, 020, 644	1, 490, 5	83 530, 061	2, 020, 644	26.00
I.		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 L	Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00 L	Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	119, 746	119, 7	46 0	119, 746	30.00
	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
	HRR adjustment (see instructions)	70, 94	-67,077	-32, 0	21 -35, 056	-67,077	31.00
31. 01 H	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32.00
100.001	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Ν				100.00

	Financial Systems IU HEALTH WEST H ATION OF REIMBURSEMENT SETTLEMENT	OSPITAL Provider CCN: 15-0158	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
			From 01/01/2021 To 12/31/2021	Part B Date/Time Pre	
		Title XVIII	Hospi tal	5/26/2022 3: 1 PPS	<u>5 piii</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)	:)		3, 924	•
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	TONS)		14, 929, 504 14, 340, 487	•
4.00	Outlier payment (see instructions)			47, 035	•
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	tions)		0.000	1
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	•
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			3, 924	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			00.404	1 1 0 00
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li	ne 69)		23, 104 0	
	Total reasonable charges (sum of lines 12 and 13)			23, 104	•
	Customary charges				
15.00 16.00	Aggregate amount actually collected from patients liable for p			0	
10.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		on a chargebasis	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0.000000	17.00
18.00	Total customary charges (see instructions)		11) (23, 104	
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	y IT IINE 18 exceeds I	ne II) (see	19, 180	19.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds l	ne 18) (see	0	20.00
21 00	instructions)			2 024	21 00
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			3, 924 0	•
23.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			14, 387, 522	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions	•)		0	25.00
26.00	Deductibles and coinsurance amounts (for CAR, see fisting to amount on line	-	ructions)	2, 592, 283	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 2	2 and 23] (see	11, 799, 163	
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	no 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	
30.00	Subtotal (sum of lines 27 through 29)			11, 799, 163	•
	Primary payer payments			5, 793	•
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		11, 793, 370	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
	Allowable bad debts (see instructions)			374, 388	
35.00 36.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		243, 352 161, 037	•
	Subtotal (see instructions)			12, 036, 722	
	MSP-LCC reconciliation amount from PS&R			208	•
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	•)		0	39.00 39.50
	Demonstration payment adjustment amount before sequestration	•)		0	1
39.98	Partial or full credits received from manufacturers for replac	ed devices (see instru	ctions)	0	1
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			12, 036, 514 0	1
	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			12, 030, 208	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01
42.01	Tentative settlement-PARHM (for contractor use only)			0	42.01
43.00	Balance due provider/program (see instructions)			6, 306	1
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordan	ICA with CMS Dub 15 2	chanter 1	2 014	43.01
44. UU	§115. 2	ice with GWS PUD. 15-2,	chapter I,	2, 846	44.00
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	91.00 92.00
	international and an and the trime variate of money				
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021		
			XVIII	Hospi tal	PPS	•
		Inpati 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	Total interim payments paid to provider		25, 523, 94	10	12, 030, 208	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2.00
3.00	List separately each retroactive lump sum adjustment					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	<u> </u>				
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3.01
3. 02				0	0	3.02
3. 03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.99
3. 77	3. 50-3. 98)			0	0	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		25, 523, 94	10	12, 030, 208	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as				,,	
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				-	
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
5. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.01	TENTATIVE TO PROVIDER			0	0	5.02
5.03				0	0	5.03
0.00	Provider to Program	II				0.00
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
,	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		326, 18	22	6, 306	6.01
6. 01 6. 02	SETTLEMENT TO PROVIDER		JZ0, 10	0	0, 300	6.02
7.00	Total Medicare program liability (see instructions)		25, 850, 12	23	12, 036, 514	
			20,000,12	Contractor	NPR Date	,
				Number	(Mo/Day/Yr)	
		С)	1.00	2.00	
8.00	Name of Contractor					8.00

Heal th	Financial Systems	IU HEALTH WEST HOSPITAL	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0158	Period: From 01/01/2021 To 12/31/2021		epared:
		Title XVIII	Hospi tal	PPS	<u>o piii</u>
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	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, sur		for cost		2.00
	reporting periods beginning on or after 10/0				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. reporting periods beginning on or after 10/0		nd plus for cost		4.00
5.00	Total hospital charges from Wkst C, Pt. I, c	bl. 8 line 200			5.00
6.00	Total hospital charity care charges from Wks	t. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for line 168	the purchase of certified HIT technolog	y Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (se	e instructions)			8.00
9.00	Sequestration adjustment amount (see instruc	ti ons)			9.00
10.00	Calculation of the HIT incentive payment af	er sequestration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS 8	CAH			
30.00	Initial/interim HIT payment adjustment (see	nstructions)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) mi	nus line 30 and line 31) (see instructi	ons)		32.00

	Financial Systems IU HEALTH WES E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		In Lie eriod: fom 01/01/2021 0 12/31/2021	Worksheet G Date/Time Pre 5/26/2022 3:1	pared:
		General Fund	Speci fi c Purpose Fund	Endowment Fund	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
I. 00	Cash on hand in banks	408, 947, 194	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
1.00	Accounts receivable Other receivable	35, 195, 658	0	0	0	4.00
5.00 5.00	Allowances for uncollectible notes and accounts receivable	2, 585, 635	0	0	0	5.00 6.00
7.00	Inventory	4, 161, 727	Ű	0	0	7.00
3.00	Prepai d expenses	652, 883	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
0.00	Due from other funds	0	0	0	0	10.00
1.00	Total current assets (sum of lines 1-10)	451, 543, 097	0	0	0	11.00
	FIXED ASSETS	0	0	0	0	1 1 2 00
2.00 3.00	Land Land improvements	6, 800, 703		0	0	12.00 13.00
	Accumulated depreciation	-5, 842, 403		0	0	14.00
	Buildings	179, 168, 805	0	0	0	15.00
	Accumulated depreciation	-51, 564, 766	0	0	0	16.00
7.00	Leasehold improvements	1, 261, 768	0	0	0	17.00
	Accumulated depreciation	-1, 129, 034	0	0	0	18.00
	Fixed equipment	0	0	0	0	19.00
	Accumulated depreciation	0	0	0	0	20.00
	Automobiles and trucks	101, 218 -91, 812		0	0	21.00
	Accumulated depreciation Major movable equipment	93, 304, 858		0	0	22.00
	Accumulated depreciation	-66, 055, 839	0	0	0	24.00
	Minor equipment depreciable	00,000,007	0	0	0	25.00
	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
	Accumulated depreciation	0	0	0	0	28.00
	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	155, 953, 498	0	0	0	30.00
21 00	OTHER ASSETS Investments	0	0	0	0	31.00
	Deposits on Leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7, 273, 255	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7, 273, 255		0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	614, 769, 850	0	0	0	36.00
	CURRENT LI ABI LI TI ES	26 222 620	0	0	0	
	Accounts payable Salaries, wages, and fees payable	26, 222, 629 4, 372, 898		0	0	37.00 38.00
39.00	Payrol I taxes payable	4, 372, 070		0	0	39.00
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	41.00
	Accelerated payments	0				42.00
	Due to other funds	0	0	0	0	
	Other current liabilities	2, 295, 018		0	0	
15.00	Total current liabilities (sum of lines 37 thru 44)	32, 890, 545	0	0	0	45.00
16.00	Mortgage payable	0	0	0	0	46.00
	Notes payable	0	0 0	Ő	0	47.00
	Unsecured Loans	0	0	0	0	48.00
19.00	Other long term liabilities	1, 237, 729		0	0	49.00
	Total long term liabilities (sum of lines 46 thru 49)	1, 237, 729		0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	34, 128, 274	0	0	0	51.00
	CAPITAL ACCOUNTS	E00 (41 E7(1			50.00
	General fund balance Specific purpose fund	580, 641, 576	0			52.00 53.00
	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement,				0	58.00
	replacement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	580, 641, 576	0	0	0	59.00
	Total liabilities and fund balances (sum of lines 51 and	614, 769, 850	0	0	0	60.00

	Financial Systems	IU HEALTH WEST				u of Form CMS-	
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet G-1 Date/Time Pre 5/26/2022 3:1	epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 517, 186, 474 63, 455, 104 580, 641, 578 0 580, 641, 578 2 580, 641, 576	3.00	4.00 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 5. \ 00 \\ 6. \ 00 \\ 7. \ 00 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 12. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund	_		
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) 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) Deductions (debit adjustments) (specify) ROUNDING	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

Heal th	Financial Systems IU HEALTH WEST	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-0158	Period: From 01/01/2021 To 12/31/2021		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
1.00	General Inpatient Routine Services Hospital		123, 090, 4	11	123, 090, 411	1.00
2.00	SUBPROVI DER – I PF		123, 090, 4	11	123, 090, 411	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	6.00
7.00	SKILLED NURSING FACILITY			0		7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		123, 090, 4	11	123, 090, 411	10.00
	Intensive Care Type Inpatient Hospital Services		-			
11.00	I NTENSI VE CARE UNI T		30, 115, 2	36	30, 115, 236	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	NEONATAL INTENSIVE CARE UNIT		3, 967, 6		3, 967, 617	1
16.00	Total intensive care type inpatient hospital services (sum of	lines	34, 082, 8	53	34, 082, 853	16.00
17.00	11-15)	`	157 172 0	(A	157 172 244	17.00
17.00	Total inpatient routine care services (sum of lines 10 and 16 Ancillary services))	157, 173, 2 319, 188, 3		157, 173, 264 826, 401, 645	
19.00	Outpatient services		44, 022, 7			
20.00	RURAL HEALTH CLINIC		44,022,7	0 100, 177, 077		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0		1
22.00	HOME HEALTH AGENCY			0	Ŭ	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	520, 384, 3	64 673, 391, 212	1, 193, 775, 576	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			227, 534, 923		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00 32.00				0		31.00 32.00
32.00				0		32.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		227, 534, 923		43.00
	to Wkst. G-3, line 4)		l			

	Financial Systems	IU HEALTH WEST	HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0158	Period: From 01/01/2021 To 12/31/2021	Worksheet G-3 Date/Time Pre	
				10 12/31/2021	5/26/2022 3:1	
					1.00	
1.00	Total patient revenues (from Wkst. G-2				1, 193, 775, 576	1.00
2.00	Less contractual allowances and discou		ts		910, 418, 258	2.00
3.00	Net patient revenues (line 1 minus lin				283, 357, 318	
4.00	Less total operating expenses (from Wk		43)		227, 534, 923	
5.00	Net income from service to patients (I	ine 3 minus line 4)			55, 822, 395	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, et	C			0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other misc		services		0	
9.00	Revenue from television and radio serv	ce			0	
10.00	Purchase discounts				0	10.00
11.00 12.00	Rebates and refunds of expenses Parking lot receipts				0	11.00 12.00
12.00	Revenue from Laundry and Linen service				0	12.00
13.00	Revenue from meals sold to employees a	ad quests			0	13.00
14.00	Revenue from rental of living quarters	nu guests			0	14.00
16.00	Revenue from sale of medical and surgi	cal cumpling to other t	han nationto		0	16.00
17.00	Revenue from sale of drugs to other th		nan patrents		0	
	Revenue from sale of medical records a				0	
	Tuition (fees, sale of textbooks, unif				0	
20.00	Revenue from gifts, flowers, coffee sh				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
	MI SCELLANEOUS I NCOME				2, 337, 894	
	COVI D-19 PHE Fundi ng				5, 294, 815	
	Total other income (sum of lines 6-24)				7, 632, 709	
	Total (line 5 plus line 25)				63, 455, 104	
	OTHER EXPENSES (SPECIFY)				00, 100, 101	
	Total other expenses (sum of line 27 a	nd subscripts)			Ő	28.00
	Net income (or loss) for the period (I				63, 455, 104	

ALCULATION OF CAPITAL PAYMENT	Provider CCN: 15-0158	Period: From 01/01/2021	Worksheet L Parts I-III	
		To 12/31/2021	Date/Time Pre 5/26/2022 3:1	
	Title XVIII	Hospi tal	PPS	5 pin
			1.00	
PART I - FULLY PROSPECTIVE METHOD				-
CAPITAL FEDERAL AMOUNT 00 Capital DRG other than outlier			1, 741, 402	1 1.
01 Model 4 BPCI Capital DRG other than outlier			1, 741, 402	
00 Capital DRG outlier payments			208, 541	
01 Model 4 BPCI Capital DRG outlier payments			200, 041	
00 Total inpatient days divided by number of days in the	cost reporting period (see ins	tructions)	111.75	
00 Number of interns & residents (see instructions)	cost roper tring porred (cost ris		0.00	
00 Indirect medical education percentage (see instructio	ns)		0.00	
00 Indirect medical education adjustment (multiply line		1. columns 1 and	0	
1.01) (see instructions)				
00 Percentage of SSI recipient patient days to Medicare 30) (see instructions)	Part A patient days (Worksheet	E, part A line	2.66	7.
00 Percentage of Medicaid patient days to total days (se	e instructions)		16. 99	8
00 Sum of lines 7 and 8			19.65	9
.00 Allowable disproportionate share percentage (see inst	ructions)		4.06	
.00 Disproportionate share adjustment (see instructions)			70, 701	
.00 Total prospective capital payments (see instructions)			2, 020, 644	12.
			1.00	
PART II - PAYMENT UNDER REASONABLE COST			1.00	
00 Program inpatient routine capital cost (see instructi	ons)		0	1 1.
00 Program inpatient ancillary capital cost (see instruc			0	
00 Total inpatient program capital cost (line 1 plus lin			0	
00 Capital cost payment factor (see instructions)			0	
00 Total inpatient program capital cost (line 3 x line 4)		0	
			1.00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00 Program inpatient capital costs (see instructions)			0	1
00 Program inpatient capital costs for extraordinary cir			0	
00 Net program inpatient capital costs (line 1 minus lin	e 2)		0	
00 Applicable exception percentage (see instructions)			0.00	
00 Capital cost for comparison to payments (line 3 x lin	· ·		0	
00 Percentage adjustment for extraordinary circumstances			0.00	
5 5	ordinary circumstances (line 2 ·	x line 6)	0	
00 Adjustment to capital minimum payment level for extra				-
00 Adjustment to capital minimum payment level for extra 00 Capital minimum payment level (line 5 plus line 7)	5		0	
00 Adjustment to capital minimum payment level for extra 00 Capital minimum payment level (line 5 plus line 7) 00 Current year capital payments (from Part I, line 12,	as applicable)		0	
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le 	as applicable) vel to capital payments (line 8		0	10.
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment leve Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) 	as applicable) vel to capital payments (line 8 I over capital payment (from pr	ior year	0 0 0	10. 11.
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) Not comparison of capital minimum payment level to ca 	as applicable) vel to capital payments (line 8 I over capital payment (from pr pital payments (line 10 plus lin	ior year ne 11)	0 0 0	10. 11. 12.
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to ca Current year exception payment (if line 12 is positiv) 	as applicable) vel to capital payments (line 8 l over capital payment (from pr pital payments (line 10 plus lin e, enter the amount on this line	ior year ne 11) e)	0 0 0 0 0	10 11 12 13
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, Current year comparison of capital minimum payment le Carryover of accumulated capital minimum payment leve Worksheet L, Part III, line 14) Current year exception payment (if line 12 is positiv Carryover of accumulated capital minimum payment level to ca 	as applicable) vel to capital payments (line 8 l over capital payment (from pr pital payments (line 10 plus lin e, enter the amount on this lin l over capital payment for the	ior year ne 11) e)	0 0 0	10 11 12 13
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, 000 Current year comparison of capital minimum payment leve Worksheet L, Part III, line 14) Not comparison of capital minimum payment level to ca 8.00 Current year exception payment (if line 12 is positiv Carryover of accumulated capital minimum payment level (if line 12 is negative, enter the amount on this line 12) 	as applicable) vel to capital payments (line 8 l over capital payment (from pr pital payments (line 10 plus lin e, enter the amount on this line l over capital payment for the e)	ior year ne 11) e)	0 0 0 0 0 0	10 11 12 13 14
 Adjustment to capital minimum payment level for extra Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, loco Current year comparison of capital minimum payment leve Worksheet L, Part III, line 14) Not Current year exception payment (if line 12 is positiv Loco Carryover of accumulated capital minimum payment level to ca 	as applicable) vel to capital payments (line 8 l over capital payment (from pr pital payments (line 10 plus line e, enter the amount on this line l over capital payment for the e) (see instructions)	ior year ne 11) e)	0 0 0 0 0	10. 11. 12. 13. 14. 15.