Health Financial Systems IU HEALTH	WHITE HOSPITAL	In Lieu	J of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b))). Failure to report can r	result in all interim	FORM APPROVED
payments made since the beginning of the cost reporting period	being deemed overpayments	; (42 USC 1395g).	OMB NO. 0938-0050
			EXPI RES 03-31-2022
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFIC. AND SETTLEMENT SUMMARY	ATION Provider CCN: 15-13	12 Period: From 01/01/2021	Worksheet S Parts -
AND SETTLEMENT SUMMART		To 12/31/2021	Date/Time Prepared:
			5/26/2022 3:45 pm
PART I - COST REPORT STATUS		D L E (0/ /00)	
Provider 1. [X] Electronically prepared cost report use only 2. []Manually prepared cost report		Date: 5/26/202	22 Time: 3:45 pm
3. [0] If this is an amended report enter the n	umber of times the provide	ar recubmitted this of	st report
4. [F] Medicare Utilization. Enter "F" for full	or "L" for low.	er resubmitted this co	st report
Contractor 5. [1] Cost Report Status 6. Date Received:		10. NPR Date:	
use only (1) As Submitted 7. Contractor No.		11. Contractor's Vendo	r Code: 4
(2) Settled without Audit 8. [N] Initial Rep	ort for this Provider CCN		
(3) Settled with Addit	t for this Provider CCN	number of tim	es reopened = 0-9.
(4) Reopened			
(5) Amended			
PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINI	STRATOR OR PROVIDER(S)		
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED			
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL			
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY	Y OF A KICKBACK OR WERE OI	HERWISE ILLEGAL, CRIM	INAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.			
CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR OF PROVIDER(S)		
I HEREBY CERTIFY that I have read the above certificat	ion statement and that I h	nave examined the acco	mpanyi ng
electronically filed or manually submitted cost report	and submitted cost report	t and the Balance Shee	et and
Statement of Revenue and Expenses prepared by IU HEALT	H WHITE HOSPITAL (15-1312	2) for the cost repor	ting period
beginning 01/01/2021 and ending 12/31/2021 and to the			
are true, correct, complete and prepared from the book			
applicable instructions, except as noted. I further ce			
regarding the provision of health care services, and t	hat the services identifie	ed in this cost report	were
provided in compliance with such laws and regulations.			
SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
1	2	SLGNATURE STATEMENT	

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONI C	
	1			SI GNATURE STATEMENT	
1	Todd Williams		1	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	Todd Williams			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-142, 769	-1, 445, 542	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	-63, 032	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-205, 801	-1, 445, 542	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.

)SPI	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provid	ler CCN: '		Period: From 01/01/	2021	Workshe Part I		
	T					To 12/31/		Date/Ti 5/26/20		
	1.00 Hospital and Hospital Health Care Co	2.00		3.00		2	. 00			
00	Street: 720 SOUTH SIXTH STREET	P0 Box:								1.0
00	City: MONTICELLO	State: IN Component Name	Zip Cod CCN	e: 47960 CBSA	Count Provi der	ty: WHITE Date	Daymo	nt Syste	om (D	2.0
			Number	Number	Type	Certified		0, or		
							V	XVIII	XIX]
	Hospital and Hospital-Based Componen	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospi tal	IU HEALTH WHITE	151312	99915	1	07/01/1966	N	0	0	3. (
~~		HOSPI TAL								
00 00	Subprovider - IPF Subprovider - IRF									4. 5.
00	Subprovi der - (Other)									6.
00	Swing Beds - SNF	IU HEALTH WHITE	15Z312	99915		02/16/1990	Ν	0	N	7.
00	Swing Beds - NF	HOSPI TAL								8.
00	Hospi tal - Based SNF									9.
. 00	Hospital-Based NF									10.
. 00 . 00	Hospital-Based OLTC Hospital-Based HHA	HOME CARE OF WHITE	157514	99915		03/01/1997	N	N	N	11.
. 00		COUNTY	137314	77713		03/01/177/	IN		11	12.
. 00	Separately Certified ASC									13.0
. 00 . 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC									14. 15.
. 00	Hospital -Based Health Clinic - FQHC									16.
. 00	Hospital-Based (CMHC) I									17.
00	Renal Dialysis Other									18.
. 00				1		From:		То	:	17.
						1.00		2.0		
00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/20)21	12/31/	2021	20.
						2				
						2				21.
	· · · · · · · · · · · · · · · · · · ·				1.00	2		3.0	00	21.
	Inpatient PPS Information	currently, receiving pa	vments for			2.00		3.0	0	
	· · · · · · · · · · · · · · · · · · ·				1.00 N			3.0	00	
	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fo	stment, in accordance w r yes or "N" for no. Is	ith 42 CFF this			2.00		3. 0	00	
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OSPI 1	I Financial Systems IU HEAL FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	CN: 15-1312	Peri od:			heet S-2	2
					From 01/ To 12/	01/2021 31/2021	Date/	 Time Pre <u>2022 3:</u> 4	epared 45 pm
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medic HMO d		Other ledi cai d days	
		1.00	2.00	3.00	4.00	5.0	0	6.00	
4.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	0			C		0	(24.0
	HMO paid and eligible but unpaid days in column 5.				Urban/	l Rural S	Date	of Geogr	-
(00	Enton your standard second is a 100 th 100 th	(ma) -+ '	ot the 1	innian C.	1.	00	2	2.00	
5.00 7.00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. age) status r"2" for r	at the end ural. If ap	of the cos		2	2		26.0
5.00	If this is a sole community hospital (SCH), enter the			CH status ir	n	(D		35. (
	effect in the cost reporting period.				Begi r	ni ng:	En	di ng:	
5.00	Enter applicable beginning and ending dates of SCH st	atus Subs	crint lino	26 for numb		00	2	2. 00	36.
5. 00	of periods in excess of one and enter subsequent date		cript rine	30 101 11000					30.
. 00 . 01	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for	ne MDH tran	sitional pa	ayment in	IS	()		37.
3. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.	s of MDH st	atus. Ifli	ne 37 is					38.
						/N	-	Y/N	-
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	ime in	<u>00</u> N		<u>2. 00</u> N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r"Y" for y			N		N	40.
						V 1.0	XVI I 0 2.0		-
5. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	t for dia-	roporti onct	o share in	accordance		N	N	45.
5. 00 5. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	ary circumst	ances		N	N	45.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.				-				
7.00 8.00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N	47. 48.
	Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic	e to column ograms in cable CRs)	1 is "Y", the prior y	or if this /ear or penu	hospital Iltimate				56.
. 00		umn 2							57.
	Enter "Y" for yes; otherwise, enter "N" for no in col	period duri yes or "N th of this (", complete	" for no ir cost report e Worksheet	n column 1. ing period?	lf column P Enter "Y				
	Enter "Y" for yes; otherwise, enter "N" for no in collf line 56 is yes, is this the first cost reporting pGME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N	period duri yes or "N th of this (", complet , if appli pursement fo	" for no ir cost report e Worksheet cable. or physicia	n column 1. ing period? E-4. lf co	If column ? Enter "Y olumn 2 is				58.

Health Financial Systems IU HEAL	LTH WHIT	TE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	5/26/2022 3:4 Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in col	.85? (s lumn 1. CR) NAHE	see If column 1	N	2.00		60.00
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
 column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 						61. 01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61. 03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the						61.04
 current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 						61. 05
 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) 						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
 b) The off the fries in fries of 1.05, specify duch how 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. 61.20 Of the FTEs in line 61.05, specify each expanded program special ty, if any, and the number of FTE 				0.00		61. 20
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.						
					1.00	
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital				od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruct 62.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC proc Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cent see instructior	ter (THC) into			62.01
63.00 Has your facility trained residents in nonprovide se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovid	der Settings	1.00 This base year	2.00 is your cost r	3.00 reporting	
64.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair n-primar all nor d non-pr n columr	30, 2010. med residents ty care provider mary care m 3 the ratio	0.00	-		64.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	TA Provider (eriod: rom 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre	
	Drogerse	Des recerción de la			5/26/2022 3:4	5 pm
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
_	1.00	2.00	Si te 3.00	4.00	5.00	-
5.00 Enter in column 1, if line 63	1.00	2.00	0.00			65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted		Ratio (col. 1/	·
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te		_,,,	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	gsEffective fo	or cost reporti	ng periods	
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 +	nweighted non-primar L. Enter in column 3 <u>column 2)). (see ins</u> Program Name	ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
7.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67 (
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
				1.00	2.00 3.00	-
Inpatient Psychiatric Facility PP					2.30 3.00	
0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.	chiatric Facility (I	PF), or does it cont	tain an IPF subp	rovider? N		70. (
.00 If line 70 is yes or N ior no. 01 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	yes or "N" for r s in a new teach yes or "N" for r	io. (see ii ng io.	0	71. (
5.00 Is this facility an Inpatient Reh	abilitation Facility	/(IRF), or does it o	contain an IRF	N		75.0
subprovider? Enter "Y" for yes a 5.00 If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t	the facility have ar ng on or before Nove	ember 15, 2004? Enter	r "Y" for yes or	"N" for	0	76.0

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet S- Part I Date/Time Pr 5/26/2022 3:	epared
				1.00	-
Long Term Care Hospital PPS				1	
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 1.00 Is this a LTCH co-located within another hospital for part or <u>"Y" for yes and "N" for no.</u> TEFRA Providers			g period? Enter	N N	80. C 81. C
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. C 86. C
7.00 Is this hospital an extended neoplastic disease care hospital	cl assi fi ed	under section		N	87.0
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			V	XIX	
			1.00	2.00	
Title V and XIX Services		1 II)/II C	N		
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	services? E	nter "Y" for	N	Y	90.0
1.00 Is this hospital reimbursed for title V and/or XIX through th full or in part? Enter "Y" for yes or "N" for no in the appli	cable column		Ν	N	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicab		ion)? (see		N	92.0
3.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.	ftitle V an		Ν	N	93.0
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	nd "N" for n	o in the	N	N	94.0
applicable column. 5.00 ffline 94 is "Y", enter the reduction percentage in the appl	icable colum	n	0, 00	0.00	95.0
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N	N	96. (
 If line 96 is "Y", enter the reduction percentage in the appl Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for 	0.00 Y	97.0			
column 1 for title V, and in column 2 for title XIX. 8.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit		Y	98. (
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or	culation of (observation	Ν	Y	98. (
for title V, and in column 2 for title XIX. 8.03 Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. (
<pre>for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.</pre>			N	Ν	98.0
8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co column 2 for title XIX.				Y	98.
8.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.	eimbursed fo 1 for title '	r Wkst. D, V, and in	N	Y	98.
Rural Providers 05.00Does this hospital qualify as a CAH?			Y		105. (
06.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive met	hod of paymen			106. (
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column			Ν		107. (
Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF Enter "Y" for yes or "N" for no in column 2. (see instruction	and/or IRF ns)	unit(s)?			
08.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sche	dul e? See 42	N		108.
	Physi cal	Occupationa		Respi ratory	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	<u>1.00</u> N	2.00 N	3.00 N	4.00 N	109. (
, , , , , , , , , , , , , , , , , , ,					
	Damage 1 11		4104	1.00	110
10.00 Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "Y complete Worksheet E, Part A, Lines 200 through 218, and Work	" for yes or	"N" for no.	lf yes,	N	110. (

Health Financial Systems IU HEALTH WHITE HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCI	N: 15-1312 Pe	In Li∈ riod:	worksheet S-	
		om 01/01/2021	Part I Date/Time Pr	epared:
			5/26/2022 3:	45 pm
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Con Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, et integration prong of the FCHIP demo in which this CAH is participating in of Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter enter the column 2.	1.00 N	2.00	111.00
-	1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for 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 ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
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 column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	Ν			0115.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Ν			117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00
	Premi ums	Losses 2.00	I nsurance	_
118.01 List amounts of malpractice premiums and paid losses:	34, 577	2.00		0 118. 01
	-	1.00	2.00	-
 18.02 Are malpractice premiums and paid losses reported in a cost center other the Administrative and General? If yes, submit supporting schedule listing contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the 	st centers rision in ACA for yes or	N	N	118. 02 119. 00 120. 00
Hold Harmless provision in ACA §3121 and applicable amendments? (see instru- Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implantable devices	uctions)	Y		121.00
patients? Enter "Y" for yes or "N" for no.	0	Y	5.00	121.00
22.00 Does the cost report contain healthcare related taxes as defined in §1903(Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.		1	5.00	122.0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N"	for no. If	N		125. 0
yes, enter certification date(s) (mm/dd/yyyy) below.	ication date			126. 0
				127.00
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified	cation date			100.00
 in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certified liver transplant center. 				128.00
 in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific. 	cation date			
 in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certification date, if applicable, in column 2. 	cation date ation date in			129. 00
 in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the cert date in column 1. 	cation date ation date in ification			129. 00 130. 00
 in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 31.00 If this is a Medicare certified intestinal transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 32.00 If this is a Medicare certified intestinal transplant center, enter the cert date in column 1 and termination date, if applicable, in column 2. 	cation date ation date in ification ertification			129.00 130.00 131.00
 127.00 If this is a Medicare certified heart transplant center, enter the certificing in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certificing in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certificing column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certificate in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certified intestinal transplant center, enter the certified termination date, if applicable, in column 2. 	cation date ation date in ification ertification cation date			128. 00 129. 00 130. 00 131. 00 132. 00 133. 00 134. 00

	EX IDENTIFICATION DATA	<u>I WHITE HC</u> P	rovider CC	N: 15-1312		riod: om 01/01/20		S-2 Prepared:
1.00		2.00				3.00)	
If this facility is part of a cha home office and enter the home of 141.00Name: INDIANA UNIVERSITY HEALTH		and contra		er.		e and addre s Number: O		141.00
42.00 Street: 340 WEST 10TH STREET	PO Box:	ic. wi 5		Contr	actor	3 Number . 0	0101	142.00
143.00 City: INDIANAPOLIS	State:	IN		Zip C	ode:	4	6202	143.00
							1.00	
144.00 Are provider based physicians' co	sts included in worksr	neet A?					Y	144.00
					F	1.00	2.00	_
 45.00 If costs for renal services are constant inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodol of Enter "Y" for yes or "N" for no i 	" for yes or "N" for r clude Medicare utiliza for no in column 2. gy changed from the pr	no in colu ation for reviously	mn 1. lf c this cost filed cost	olumn 1 i reporting report?]	N		145.00
yes, enter the approval date (mm/		ub. 15 2,	chapter 4	0, 34020)	•••			
47.00Was there a change in the statist	ical basis? Enton "V"	for yor a	r "N" for	20			1.00 N	147.00
147.00Was there a change in the statist 148.00Was there a change in the order o							N	147.00
149.00Was there a change to the simplif					for no).	N	149.00
	5		Part A	Part	В	Title V	Title XI>	(
			1.00	2.00		3.00	4.00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or 55.00 Hospi tal	N TOP NO TOP Each co	omponent i	N N	and Part N	B. (Se	<u>e 42 CFR 9</u> N	N	155. 0
56.00 Subprovi der – IPF			N	N		N	N	156.0
57.00 Subprovider - IRF			N	Ν		N	N	157.0
58. 00 SUBPROVI DER								158.00
			N	N		N	N	159.00
60. OO HOME HEALTH AGENCY 61. OO CMHC			N	N N		N N	N	160. 00 161. 00
								101.00
							1.00	
Multicampus 65.00 Is this hospital part of a Multic	ampus hospital that ha	as one or	more campu	ses in di	fferer	t CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Name	Со	unty	State	Zip C	code CBSA	A FTE/Campu	s
	0		. 00	2.00	3.0			
66.00 If line 165 is yes, for each campus enter the name in column							0	. 00 166. 00
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							1.00	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	T) incentive in the Ar	nerican Re	ecovery and	Rei nvest	tment /	Act	1.00	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1	er under §1886(n)? Ent 05 is "Y") and is a me	er "Y" fo aningful	r yes or "	N" for no).		1.00 Y	
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru	er "Y" fo aningful ctions)	r yes or " user (line	N" for no 167 is "). 'Υ"), ε	enter the		168. 0
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru not a meaningful user,	er "Y" fo aningful uctions) does thi	r yes or " user (line s provider	N" for no 167 is " qualify). 'Υ"), ε for a	enter the		168.00
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" fo eaningful uctions) does thi "N" for	r yes or " user (line s provider no. (see i	N" for no 167 is " qualify nstructio). 'Y"), ∈ for a ons)	enter the hardship	Y	168. 00 168. 0
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" fo eaningful uctions) does thi "N" for	r yes or " user (line s provider no. (see i	N" for no 167 is " qualify nstructio). 'Y"), ∈ for a ons)	enter the hardship), enter tl	Y he 0	168. 00 168. 0 ⁻
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y")	er "Y" fo eaningful uctions) does thi "N" for	r yes or " user (line s provider no. (see i	N" for no 167 is " qualify nstructio). 'Y"), ∈ for a ons)	enter the hardship), enter tl Beginning	he 0 g Ending	167. 00 168. 01 168. 01 . 00169. 00
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful use 68.00 If this provider is a CAH (line 1 reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 69.00 If this provider is a meaningful transition factor. (see instructi	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" fo eaningful uctions) does thi "N" for and is n	r yes or " user (line s provider no. (see i ot a CAH (N" for nc 167 is " qualify nstructic line 105). 'Y"), ∈ for a ons)	enter the hardship), enter tl	Y he 0	168.00 168.0 [°] .00169.00
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the 168.01 If this provider is a CAH and is exception under §413.70(a) (6) (ii) 169.00 If this provider is a meaningful transition factor. (see instructi	r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons)	er "Y" fo eaningful uctions) does thi "N" for and is n	r yes or " user (line s provider no. (see i ot a CAH (N" for nc 167 is " qualify nstructic line 105). 'Y"), ∈ for a ons)	enter the hardship), enter tl Beginning	he 0 g Ending	168. 00 168. 01

Health Financial Systems IU HEALTH WHITE HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1312 Peri od: Worksheet S-2 From 01/01/2021 Part II Date/Time Prepared: То 12/31/2021 5/26/2022 3:45 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 6.00 is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν 16.00 Ν If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/01/2022 Y 04/01/2022 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed

Ν

19.00

Ν

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

but are not included on the PS&R Report used to file this

Health Financial System

ealth Financial Systems IU HEALTH WHI	TE HOSPITAL	eu of Form CM	S-2552-10		
IOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAI RE	Provi der C		Period: From 01/01/2021	Worksheet S	
			To 12/31/2021		
	Descri	ption	Y/N	Y/N	
	()	1.00	3.00	
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
21.00 Was the cost report prepared only using the provider's	1.00 N	2.00	3.00 N	4.00	21.00
records? If yes, see instructions.					
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	EPT CHILDRENS H	OSPI TALS)			
22.00 Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22.00
3.00 Have changes occurred in the Medicare depreciation expense		als made duri	ng the cost	N	23.00
reporting period? If yes, see instructions.4.00 Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	orting period?	N	24.00
If yes, see instructions 00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see					25.00
instructions. 26.00 Were assets subject to Sec.2314 of DEFRA acquired during th	N	26.00			
i nstructi ons.		5 1	J		
17.00 Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? IT	yes, submit	N	27.00
28.00 Were new Loans, mortgage agreements or letters of credit en	ntered into dur	ing the cost	reporting	N	
period? If yes, see instructions. 9.00 Did the provider have a funded depreciation account and/or		0		N	29.00
treated as a funded depreciation account? If yes, see instr	ructions				
0.00 Has existing debt been replaced prior to its scheduled matu instructions.	N	30.00			
B1.00 Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31.00
Purchased Services B2.00 Have changes or new agreements occurred in patient care ser	vices furnishe	d through con	tractual	N	32.00
arrangements with suppliers of services? If yes, see instru	uctions.				33.00
no, see instructions.		g to competit			
Provider-Based Physicians 4.00 Are services furnished at the provider facility under an ar	rangement with	providor bac	od physicians?	Y	34.00
If yes, see instructions.	rangement with	provider-bas	eu physicians:		54.00
35.00 If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ts with the p	rovi der-based	N	35.00
physicians during the cost reporting period: in yes, see in			Y/N	Date	
			1.00	2.00	
Home Office Costs 36.00 Were home office costs claimed on the cost report?			Y		36.00
7.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office?	Ý		37.00
8.00 If line 36 is yes, was the fiscal year end of the home off			Ν		38.00
9.00 If line 36 is yes, did the provider render services to othe			N		39.00
see instructions. 10.00 fline 36 is yes, did the provider render services to the		5	N		40.00
instructions.			TV		10.00
	1.	00	2.	00	
	Cost Report Preparer Contact Information				
	RHONDA		LITTER		1 1 00
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA I NDI ANA UNI VER	SITY HEALTH	UTTER		
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 		SITY HEALTH	UTTER RUTTER@I UHEALT	TH. ORG	41.00 42.00 43.00

Heal th	Financial Systems	IU HEALTH WHIT	TE HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	Provi der	CCN: 15-1312	Period:	Worksheet S-2	
					From 01/01/2021 To 12/31/2021		pared: 5 pm
		_			_		
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the titl	e/position (GOVERNMENT P	ROGRAMS DI RECTO)R		41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respectively.						
42.00	Enter the employer/company name of the cost	report					42.00
	preparer.						
43.00	Enter the telephone number and email address	s of the cost					43.00
	report preparer in columns 1 and 2, respecti	vel y.					

Heal th	Financial Systems	IU HEALTH WHIT	TE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1312	Period: From 01/01/2021	Worksheet S-3 Part I	
					To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 3:4	
						I/P Days / O/P	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Visits / Trips Title V	
	component	Line Number	NO. OI DEUS	Avai I abl e	CAIT HOULS	intre v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9, 1	25 61, 440. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						2.00 3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		25	9, 1	25 61, 440. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10. 00 11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 1	25 61, 440. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00 20.00	SKILLED NURSING FACILITY NURSING FACILITY						19.00 20.00
20.00	OTHER LONG TERM CARE						20.00
22.00	HOME HEALTH AGENCY	101.00				0	21.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	101100					23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
	FEDERALLY QUALIFIED HEALTH CENTER	89.00	05			0	26.25
27.00 28.00	Total (sum of lines 14-26) Observation Bed Days		25			0	27.00 28.00
28.00	Ambul ance Trips					0	28.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. UI	LTCH site neutral days and discharges	I		l	1		33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1312		eriod: com 01/01/2021 o 12/31/2021	Worksheet S-3 Part I Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E	<u>5/26/2022_3:4</u> Equi val ents	5 pm
	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)	1, 160	37	2, 50	60			1.00
2.00	HMO and other (see instructions)	691	170					2.00
3.00	HMO IPF Subprovider	0	0					3.00
4.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	380	0	38	80			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	38	88			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 540	37	3, 32	28			7.00
8.00	INTENSIVE CARE UNIT							8.00
9.00	CORONARY CARE UNIT							9.00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	1, 540	37	3, 32	28	0.00	141.75	
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00 22.00	OTHER LONG TERM CARE	0	0		0	0.00	0.00	21.00 22.00
22.00	HOME HEALTH AGENCY	0	U		U	0.00	0.00	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							23.00
24.00	HOSPICE HOSPICE (non-distinct part)				36			24.00
24.10	CMHC - CMHC				30			24.10
26.00	RURAL HEALTH CLINIC							26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0	0.00	141.75	
28.00	Observation Bed Days		3	5(61	0.00	111.70	28.00
29.00	Ambul ance Trips	0	0		0.			29.00
30.00	Employee discount days (see instruction)				0			30.00
31.00	Employee discount days - IRF				0			31.00
32.00	Labor & delivery days (see instructions)	0	0		0			32.00
32.01	Total ancillary labor & delivery room	0	0		0			32.01
01	outpatient days (see instructions)				Ŭ			
33.00	LTCH non-covered days	0						33.00
22 01	LTCH site neutral days and discharges	0						33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-1312	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S-3 Part I Date/Time Pre	pared:
		Full Time		Di s	charges	5/26/2022 3:4	5 pm
		Equi val ents				T 1 1 411	
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 20.00 21.00 22.00 23.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 26.00 24.00 26.00 26.00 27.	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 IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00	0	24	20 10 53 54 0 0 20 10	677	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 20.00 21.00 22.00 23.00 24.00 25.00 26.00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00 0. 00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH si te neutral days and discharges				0 0		33. 00 33. 01

Heal th	Financial Systems	IU HEALTH WHITE	HOSPI TAL		In Li€	eu of Form CMS-	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA			CN: 15-1312	Peri od:	Worksheet S-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
						1.00	
	Uncompensated and indigent care cost computat	i on				1.00	
1.00	Cost to charge ratio (Worksheet C, Part lir Medicaid (see instructions for each line)		vided by li	ne 202 column	n 8)	0. 283993	1.00
2.00	Net revenue from Medicaid					3, 460, 874	2.00
3.00	Did you receive DSH or supplemental payments					N	3.00
4.00	If line 3 is yes, does line 2 include all DSH				ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supple	emental payments f	rom Medicai	d		0	
6.00	Medicaid charges					22, 134, 053	
7.00 8.00	Medicaid cost (line 1 times line 6)	Modical d program	(line 7 min	Nuc cum of Liv	oc 2 and E. if	6, 285, 916	
8.00	Difference between net revenue and costs for < zero then enter zero)		•			2, 825, 042	8.00
9.00	Children's Health Insurance Program (CHIP) (s Net revenue from stand-alone CHIP	see instructions i	or each inn	le)		0	9.00
9.00 10.00	Stand-al one CHIP charges						
11.00	Stand-alone CHIP cost (line 1 times line 10)					0	
12.00	Difference between net revenue and costs for	stand-alone CHIP	(line 11 mi	nus line 9: i	f < zero then	0	
121 00	enter zero)		(1110 11	100 1110 77 1	2010 11011		12100
	Other state or local government indigent care	e program (see ins	tructions f	or each line)			
13.00	Net revenue from state or local indigent care	e program (Not inc	luded on li	nes 2, 5 or 9))	18, 696	13.00
14.00	Charges for patients covered under state or I 10)	ocal indigent car	re program (Not included	in lines 6 or	190, 614	14.00
15.00	State or local indigent care program cost (li	ne 1 times line 1	4)			54, 133	15.00
16.00	Difference between net revenue and costs for	state or local in	ndigent care	e program (lin	ne 15 minus line	35, 437	16.00
	13; if < zero then enter zero)						
	Grants, donations and total unreimbursed cost	: for Medicaid, CH	IP and stat	e/local indig	jent care prograi	ns (see	
17.00	instructions for each line) Private grants, donations, or endowment incom	no roctricted to f	Funding char	si tu cara		0	17.00
17.00	Government grants, appropriations or transfer					0	
19.00	Total unreimbursed cost for Medicaid , CHIP a 8, 12 and 16)				s (sum of lines	2, 860, 479	
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col. 2)	
				1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each			2 500 0	2/4 100	2 055 007	1 20 00
20.00	Charity care charges and uninsured discounts (see instructions)	for the entire ra	ici i ty	2, 590, 98	37 364, 100	2, 955, 087	20.00
21.00	Cost of patients approved for charity care ar	nd uninsured disco	unts (see	735, 8	364, 100	1, 099, 922	21.00
21.00	instructions)		unts (see	/ 33, 0.	504, 100	1,077,722	21.00
22.00	Payments received from patients for amounts p	oreviously writter	off as		0 0	0	22.00
	charity care	,			-		
23.00	Cost of charity care (line 21 minus line 22)			735, 8	364, 100	1, 099, 922	23.00
						1.00	
24.00	Does the amount on line 20 column 2, include	charges for patie	ent days bev	ond a length	of stay limit	N 1.00	24.00
25.00	imposed on patients covered by Medicaid or of If line 24 is yes, enter the charges for pati	ther indigent care	e program?	5	3	0	
25.00	stay limit	ent days beyond i	the multigent		i s rength of	0	23.00
26.00	Total bad debt expense for the entire hospita	al complex (see in	nstructions)			3, 079, 043	26.00
27.00	Medicare reimbursable bad debts for the entir					436, 572	
27.01	Medicare allowable bad debts for the entire h					671, 649	
28.00	Non-Medicare bad debt expense (see instruction	ons)				2, 407, 394	28.00
29.00	Cost of non-Medicare and non-reimbursable Med		pense (see	instructions)		918, 760	
30.00	Cost of uncompensated care (line 23 column 3					2, 018, 682	
31.00	Total unreimbursed and uncompensated care cos	st (line 19 plus l	ine 30)			4, 879, 161	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	IU HEALTH WHIT	Provider C	°N· 15_1312	Peri od:	u of Form CMS-2 Worksheet A	2552-10
RECLAS	STFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider co	JN. 10-1312	From 01/01/2021	WUI KSHEEL A	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Cost Center Description	Sal ari es	Other		1 Reclassi ficati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		0 0	0	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL		0		0 2, 553, 994	2, 553, 994	
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB		0		0 233, 328	233, 328	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-966	39, 894	38, 92	1, 795, 251	1, 834, 179	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	478, 642	8, 839, 169	9, 317, 81	1 -1, 809, 701	7, 508, 110	5.00
7.00	00700 OPERATION OF PLANT	458, 047	1, 903, 913	2, 361, 96	-1, 844, 131	517, 829	7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	0	0		0 1, 656, 991	1, 656, 991	
7.02	00702 OPERATION OF PLANT - TLMOB	0	0		0 345, 403	345, 403	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	0	0		0 61, 977	61, 977	
9.00	00900 HOUSEKEEPI NG	348, 394	408, 996			597, 819	
10.00	01000 DI ETARY	433, 807	585, 286	1, 019, 09		749, 610	
11.00	01100 CAFETERI A	0	0		0 149, 440	149, 440	1
13.00	01300 NURSING ADMINISTRATION	1, 165, 425	363, 242	1, 528, 66		1, 190, 991	
14.00	01400 CENTRAL SERVICES & SUPPLY	-83	-25, 256			206, 829	
15.00	01500 PHARMACY	438, 512	4, 795, 038	5, 233, 55		881,605	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 000 (50	1 202 5/2	2 1 (2 2)	2 27 004	0 707 100	1 20 00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 880, 659	1, 282, 563	3, 163, 22	-376, 094	2, 787, 128	30.00
50.00	05000 OPERATING ROOM	401,041	794, 795	1, 195, 83	-355, 543	840, 293	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	281, 166	292, 994			326, 259	1
55.00	05500 RADI OLOGY-THERAPEUTI C	55, 136	114, 080			116, 547	
56.00	05600 RADI OI SOTOPE	139, 811	74, 807	214, 61		155, 027	
57.00	05700 CT SCAN	426, 358	225, 653			462, 777	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	183, 094	321, 563	504, 65	-111, 682	392, 975	58.00
60.00	06000 LABORATORY	0	1, 654, 138	1, 654, 13	-727	1, 653, 411	60.00
66.00	06600 PHYSI CAL THERAPY	453, 308	128, 692	582, 00	-101, 186	480, 814	66.00
67.00	06700 OCCUPATI ONAL THERAPY	163, 052	32, 107	195, 15	59 -17, 126	178, 033	67.00
68.00	06800 SPEECH PATHOLOGY	94, 704	25, 277	119, 98	-18, 695	101, 286	68.00
69.00	06900 ELECTROCARDI OLOGY	136, 015	69, 617	205, 63	-56, 094	149, 538	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 77, 206	77, 206	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 11, 626	11, 626	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 077, 598		
73.01	07301 ONCOLOGY DRUGS	0	0		0 3, 409, 704	3, 409, 704	
76.00	03160 CARDI OPULMONARY	531, 764	294, 884			743, 733	
76.97	07697 CARDI AC REHABI LI TATI ON	103, 076	59, 646	162, 72	-43, 868	118, 854	76.97
00.00	OUTPATIENT SERVICE COST CENTERS	011 004	400 7/4		00 (00	044,000	00.00
90.00		211, 304	122, 764				
91.00	09100 EMERGENCY	1, 255, 494	2,002,290	3, 257, 78	-429, 464	2, 828, 320	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	0	92.00
92.01	09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0		0 0	0	92.01
101 00	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS		0	<u> </u>	0 0		
118.00		9, 637, 760	24, 406, 152	34, 043, 91	2 599, 710	34, 643, 622	118.00
	NONREIMBURSABLE COST CENTERS	· · · ·					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	67, 635	42, 133	109, 76		86, 848	192.00
100 00	19202 MOB	0	576, 790	576, 79	-576, 790		192.02
			0	1	0 0		192.03
192.03	19203 ARNETT SURGERY OFFICE	U	0		0 0		
192.03 192.04	19201 OCCUPATI ONAL MEDI CI NE	0	0		0 0	0	192.04
192.03 192.04	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0 0 0 9, 705, 395	0 0 25, 025, 075	34, 730, 47	0 0	0	192. 04 193. 00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPI TAL	In Lie	eu of Form CMS-2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provider CCN: 15		Worksheet A
				From 01/01/2021	
				To 12/31/2021	Date/Time Prepared: 5/26/2022 3:45 pm
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS	I	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT	58, 198			1.00
1.01	00101 CAP REL COSTS-BLDG & FLXT - HOSPITAL	217, 466			1.01
1.02 4.00	00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT	291, 695 -69, 231			1.02
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	743, 365			5.00
7.00	00700 OPERATION OF PLANT	-19, 833			7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	99, 499			7.01
7.02	00702 OPERATION OF PLANT - TLMOB	0			7.02
8.00	00800 LAUNDRY & LINEN SERVICE	0			8.00
9.00	00900 HOUSEKEEPI NG	0	597, 819		9.00
10.00	01000 DI ETARY	-315, 504	434, 106		10.00
11.00	01100 CAFETERI A	-11, 455	137, 985		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	104, 230			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-4,835			14.00
15.00	01500 PHARMACY	337, 773			15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	-219, 296	2, 567, 832		30.00
30.00	ANCI LLARY SERVICE COST CENTERS	-219, 290	2, 307, 632		30.00
50.00	05000 OPERATI NG ROOM	-129, 114	711, 179		50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-707	325, 552		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0			55.00
56.00	05600 RADI OI SOTOPE	0			56.00
57.00	05700 CT SCAN	0	462, 777		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	392, 975		58.00
60.00	06000 LABORATORY	0			60.00
66.00	06600 PHYSI CAL THERAPY	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0			67.00
68.00	06800 SPEECH PATHOLOGY	0			68.00
69.00	06900 ELECTROCARDI OLOGY	0			69.00
71.00 72.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS				72.00
73.00	07301 ONCOLOGY DRUGS	0			73.00
76.00	03160 CARDI OPULMONARY	77, 459	-,		76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0			76.97
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	244, 388		90.00
91.00	09100 EMERGENCY	43, 490	2, 871, 810		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		92.01
	OTHER REIMBURSABLE COST CENTERS	-			
101.00	10100 HOME HEALTH AGENCY	0	0		101.00
110.00	SPECIAL PURPOSE COST CENTERS	1 202 200	25.044.022		110.00
118.00		1, 203, 200	35, 846, 822		118. 00
100 00	NONREIMBURSABLE COST CENTERS	0	0		190.00
	19100 RESEARCH				191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			191.00
	2 19202 MOB	0			192.00
	19203 ARNETT SURGERY OFFICE	0	-		192.03
	19201 OCCUPATIONAL MEDICINE	0			192.04
	19300 NONPALD WORKERS	0	0		193.00
200.00	TOTAL (SUM OF LINES 118 through 199)	1, 203, 200	35, 933, 670		200.00

_ASSI F	nancial Systems FICATIONS			Provider CCN: 15-1312	From 01/01/2021	Worksheet A-6
					To 12/31/2021	Date/Time Prepare 5/26/2022 3:45 pm
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	- CAFETERIA	11.00	(0, (01)	00.750		1
) <u>CA</u> 0	AFETERI A	<u>11.00</u>	<u>60, 6</u> 81 60, 681	<u>88, 7</u> 59 88, 759		1.
-	- DRUGS EXPENSE		00,001	00,737		
	RUGS CHARGED TO PATIENTS	73.00	0	1, 077, 598		1.
) ON	NCOLOGY DRUGS	73.01	0	3, 409, 704		2.
)		0.00	0	0		3.
		0.00	0	0		4.
		0.00 0.00	0	0 0		5.
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00		0.00	0	0		12.
00		0.00 0.00	0	0 0		13.
		0.00	0	0		15.
0			— — — d	4,487,302		
	- MEDICAL SUPPLIES AND REBAT	ES				
	ENTRAL SERVICES & SUPPLY	14.00		244, 263		1.
	EDI CAL SUPPLI ES CHARGED TO	71.00		77, 206		2.
	ATIENTS MPL. DEV. CHARGED TO	72.00		11, 626		3.
	ATLENTS	72.00		11, 020		5
	NPLOYEE BENEFITS DEPARTMENT	4.00		3		4
) AD	DMINISTRATIVE & GENERAL	5.00		1, 317		5.
	ETARY	10.00		144		6.
	ADI OLOGY-THERAPEUTI C	55.00		950		7
		57.00 67.00		1, 921		8
	CCUPATIONAL THERAPY	76.97		16 15		10
		0.00	o	0		11
00		0.00	0	Ö		12.
00		0.00	0	0		13.
00		0.00	0	0		14.
00		0.00	0	0		15.
00		0.00	0	0		16.
00		0.00 0.00	0	0 0		17.
0			— — — o			10.
D	- LAUNDRY	I		· · · · · · · · · · · · · · · · · · ·		
) LA	AUNDRY & LINEN SERVICE	8.00	0	6 <u>1, 9</u> 77		1.
0			0	61, 977		
	- DEPRECIATION	1 01		1 5/5 017		1
	AP REL COSTS-BLDG & FIXT -	1.01		1, 565, 017		1.
	AP REL COSTS-BLDG & FIXT -	1.02		217, 226		2.
	LMOB	1.02		,		
		0.00	0	0		3.
)		0.00	0	0		4.
)		0.00	0	0		5.
		0.00	0	0		6
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		0.00	0	0		18.
		0.00	0	0		19
00		0.00	0	0		20
0			0	1, 782, 243		
	- OTHER CAPITAL EXPENSES		_1	0/0 510		
	AP REL COSTS-BLDG & FIXT -	1.01	0	963, 513		1.
	OSPITAL AP REL COSTS-BLDG & FIXT -	1.01	0	25, 464		2.
		1.01	0	20, 707		

	Financial Systems SIFICATIONS		IU HEALTH WHI	TE HOSPITAL Provider CCN: 15-13	In Lieu of For 312 Period: Workshe From 01/01/2021	
					To 12/31/2021 Date/Ti	me Prepared:)22 3:45 pm
		Increases				522 0. 10 pm
	Cost Center	Line #	Salary	Other 5.00		
3.00	2.00 CAP REL COSTS-BLDG & FIXT -	3.00	4.00	5.00		3.00
0100	TLMOB					
	0		0	1,005,079		
1.00	G - OPERATION OF PLANT OPERATION OF PLANT -	7.01	0	1, 656, 991		1.00
1.00	HOSPITAL	7.01	0	1,050,991		1.00
2.00	OPERATION OF PLANT - TLMOB	7.02	0	345, 403		2.00
	0		0	2,002,394		
1.00	H - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 777, 983		1.00
2.00	EMPLOTEE BENEFITS DEPARTMENT	0.00	0	1, 777, 983		2.00
3.00		0.00	0	õ		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00 8.00		0.00 0.00	0 0	0 0		7.00
9.00		0.00	0	0		9.00
10.00		0.00	0	ŏ		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 15.00		0.00 0.00	0 0	0 0		14.00 15.00
16.00		0.00	0	Ö		16.00
17.00		0.00	0	Ö		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0 0	0		20.00
21. 00 22. 00		0.00 0.00	0	0		21.00 22.00
22.00	0			1, 777, 983		22100
	I - HOUSEKEEPING SUPPLIES					
1.00 2.00	HOUSEKEEPI NG	9.00 0.00	0 0	11, 014 0		1.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00 8.00		0.00 0.00	0 0	0		7.00
9.00		0.00	0	0		9.00
10.00		0.00	0	õ		10.00
11.00		0.00	0	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	Ö		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	Q		18.00
	O K - CNO		0	11, 014		
1.00	NURSING ADMINISTRATION	13.00	130, 438	0		1.00
	0		130, 438			
1 00	L - ACCRUED PTO		40 (3-1			
1.00 2.00	EMPLOYEE BENEFITS DEPARTMENT HOUSEKEEPING	4.00 9.00	18, 679 335	0 0		1.00
2.00	DI ETARY	9.00 10.00	335 12, 371	0		3.00
4.00	PHARMACY	15.00	12, 371	0		4.00
5.00	OPERATING ROOM	50.00	5, 867	Ö		5.00
6.00	RADI OLOGY-THERAPEUTI C	55.00	10, 478	0		6.00
7.00	OCCUPATIONAL THERAPY	67.00	2, 221	0		7.00
8.00	EMERGENCY	91.00	9, 285	0		8.00
9. 00 10. 00	PHYSICIANS' PRIVATE OFFICES	192.00 0.00	324 0	0		9.00 10.00
10.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
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14.00	<u> </u>			<u>0</u>		14.00
	0	I	12,025	U U		I

Heal th	Financial Systems		IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1312	Period: From 01/01/2021	Worksheet A-	6
						To 12/31/2021	Date/Time Pr 5/26/2022 3:	epared: 45 pm
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	N - INVENTORY MANAGEMENT							
1.00	CENTRAL SERVICES & SUPPLY	14.00	83	0				1.00
	TOTALS		83	0				
	0 - EMERGENCY PREPAREDNESS							
1.00	ADULTS & PEDIATRICS	30.00	180, 170	15, 149				1.00
2.00	CARDI OPULMONARY	76.00	75, 957	6, 387				2.00
3.00	EMERGENCY	91.00	2, 292	193				3.00
	TOTALS		258, 419	21, 729				
500.00	Grand Total: Increases		521, 646	11, 575, 941]			500.00

7.00	RADI OLOGY – THERAPEUTT C	55.00		7, 333	0	
8.00	RADI OI SOTOPE	56.00		10, 426	0	
9.00	CT SCAN	57.00		70, 568	0	
10.00	MAGNETIC RESONANCE IMAGING	58.00		13, 177	0	
10.00	(MRI)	56.00		13, 177	0	
11.00	ELECTROCARDI OLOGY	69.00		2, 567	0	
12.00	CARDI OPULMONARY	76.00		4, 924	0	
13.00	CARDIAC REHABILITATION	76.97		33	0	
14.00	CLINIC	90.00		10, 450	0	
15.00	EMERGENCY	91.00		58, 757	0	
				4, 487, 302		
	C - MEDICAL SUPPLIES AND REBA	TES		11 1011 002	1	
1.00	CENTRAL SERVICES & SUPPLY	14.00		1, 809	0	
2.00	OPERATION OF PLANT	7.00		21, 939	0	
					-	
3.00	HOUSEKEEPI NG	9.00	1	777	0	
4.00	NURSING ADMINISTRATION	13.00		31	0	
5.00	PHARMACY	15.00		7,434	0	
6.00	ADULTS & PEDIATRICS	30.00		46, 952	0	
7.00	OPERATING ROOM	50.00		119, 691	0	
					0	
8.00	RADI OLOGY-DI AGNOSTI C	54.00	1	977	O	
9.00	RADI OI SOTOPE	56.00		5, 726	0	
10.00	MAGNETIC RESONANCE IMAGING	58.00		523	0	
	(MRI)					
11.00	LABORATORY	60.00		727	0	
					0	
12.00	PHYSI CAL THERAPY	66.00		1, 899	0	
13.00	SPEECH PATHOLOGY	68.00		2	0	
14.00	ELECTROCARDI OLOGY	69.00		7,863	0	
15.00	CARDI OPULMONARY	76.00		28, 999	0	
16.00	CLINIC	90.00			0	
			1	17, 620	-	
17.00	EMERGENCY	91.00	1	74, 425	0	
18.00	PHYSICIANS' PRIVATE OFFICES	192.00		67	0	
	0		0	337, 461		
	D – LAUNDRY					
1.00	HOUSEKEEPI NG	9.00	0	61, 977	0	
				61, 977		
	E - DEPRECIATION		-		1	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1, 414	9	
2.00	ADMI NI STRATI VE & GENERAL	5.00	1	649, 417	9	
3.00	OPERATION OF PLANT	7.00	1	60, 780	0	
4.00	DI ETARY	10.00		26, 238	0	
5.00	NURSING ADMINISTRATION	13.00		6, 840	0	
6.00	PHARMACY	15.00	1 1	27, 616	0	
			1		0	
7.00	ADULTS & PEDIATRICS	30.00		125, 750	-	
8.00	OPERATING ROOM	50.00		161, 693	0	
9.00	RADI OLOGY-DI AGNOSTI C	54.00		182, 260	0	
10.00	RADI OLOGY-THERAPEUTI C	55.00		29, 334	0	
11.00	RADI OI SOTOPE	56.00	1	6, 999		
					0	
12.00	CT SCAN	57.00		79, 336	0	
	MACHETIC DESCNANCE IMACING	E0 00		77 100		

Heal th Financial	Systems
RECLASSI FI CATI ON	S

- CAFETERIA

B - DRUGS EXPENSE

NURSING ADMINISTRATION

ADULTS & PEDIATRICS

RADI OLOGY-DI AGNOSTI C

RADI OLOGY-THERAPEUTI C

OPERATING ROOM

CENTRAL SERVICES & SUPPLY

DI ETARY

PHARMACY

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Provider CCN: 15-1312 Peri od:

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From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 3:45 pm

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MAGNETIC RESONANCE I MAGING

PHYSI CAL THERAPY

ELECTROCARDI OLOGY

CARDIAC REHABILITATION

PHYSICIANS' PRIVATE OFFICES

- OTHER CAPITAL EXPENSES

ADMI NI STRATI VE & GENERAL

ADMINISTRATIVE & GENERAL

CARDI OPULMONARY

	SI FI CATI ONS			Provider CCN			neet A-6
							ime Prepar
		Decreases				5/26/2	2022 3:45 pi
	Cost Center	Li ne #	Salary	Other Wk	st. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	G - OPERATION OF PLANT						
00	OPERATION OF PLANT	7.00	0	1, 656, 991	0		1
00	MOB	1 <u>92.</u> 02	0	345, 403	Q		2
	O H - EMPLOYEE BENEFITS		U	2,002,394			
00	ADMI NI STRATI VE & GENERAL	5.00		40, 320	0		1
00	OPERATION OF PLANT	7.00		102, 013	o		
00	HOUSEKEEPING	9.00		108, 166	Ő		
00	DI ETARY	10.00		99, 951	0		
00	NURSING ADMINISTRATION	13.00		172, 992	0		5
00	PHARMACY	15.00		62, 673	0		6
00	ADULTS & PEDIATRICS	30.00		344, 857	0		1
00	OPERATING ROOM	50.00		70, 329	0		8
00	RADI OLOGY-DI AGNOSTI C	54.00		56, 553	0		Ç
. 00	RADI OLOGY-THERAPEUTI C	55.00		27, 430	0		10
. 00	RADI OI SOTOPE	56.00		34, 750	0		11
. 00	CT SCAN	57.00		41, 227	0		12
. 00	MAGNETIC RESONANCE IMAGING (MRI)	58.00		18, 887	U		13
. 00	PHYSICAL THERAPY	66.00		91, 567	0		14
	OCCUPATIONAL THERAPY	67.00		19, 363	ő		15
. 00	SPEECH PATHOLOGY	68.00		18, 245	ŏ		16
. 00	ELECTROCARDI OLOGY	69.00		38, 312	Ö		17
. 00	CARDI OPULMONARY	76.00		117, 365	0		18
. 00	CARDI AC REHABI LI TATI ON	76.97		32, 649	0		19
. 00	CLINIC	90.00		59, 868	0		20
. 00	EMERGENCY	91.00		199, 240	0		21
. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00		21, 226	0		22
	0		0	1, 777, 983			
~~	I - HOUSEKEEPING SUPPLIES	5.00			0		
00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00 7.00		4	0		1
00 00	DI ETARY	10.00		6, 369	0		2
	NURSING ADMINISTRATION	13.00		126	0		4
00	CENTRAL SERVICES & SUPPLY	14.00		120	0		5
00	PHARMACY	15.00		2, 282	0		6
00	ADULTS & PEDIATRICS	30.00		1, 324	0		
00	OPERATING ROOM	50.00		9	0		3
00	RADI OLOGY-DI AGNOSTI C	54.00		55	0		ç
. 00	RADI OI SOTOPE	56.00		168	0		10
. 00	CT SCAN	57.00		16	0		11
. 00	PHYSICAL THERAPY	66.00		19	0		12
	ELECTROCARDI OLOGY	69.00		27	0		13
	CARDI OPULMONARY	76.00		128	0		14
	CARDI AC REHABI LI TATI ON	76. 97		4	0		15
. 00		90.00		18	0		16
		91.00		452	0		17
. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00		10	엑		18
	K - CNO		0	11, 014			
00	ADMI NI STRATI VE & GENERAL	5.00	130, 438	0	0		1
			130, 438	0	- — — ĭ		
	L - ACCRUED PTO		,	<u> </u>	I		
00	ADMI NI STRATI VE & GENERAL	5.00	1, 862	0	0		1
00	OPERATION OF PLANT	7.00	2, 406	0	0		2
00	NURSING ADMINISTRATION	13.00	7, 829	0	o		3
00	ADULTS & PEDIATRICS	30.00	32, 184	О	O		
00	RADI OLOGY-DI AGNOSTI C	54.00	3, 861	0	0		5
00	RADI OI SOTOPE	56.00	1, 522	0	0		6
00	CT SCAN	57.00	8	0	0		
00	MAGNETIC RESONANCE I MAGING	58.00	1, 962	0	0		8
20							.
00	PHYSICAL THERAPY	66.00	7, 174	U	U U		10
	SPEECH PATHOLOGY	68.00	448	U	U U		10
		69.00 76.00	3, 435	U	U O		11
	CARDI OPULMONARY CARDI AC REHABI LI TATI ON	76.00 76.97	6, 208 1, 402	U	U O		12
. 00	CARDIAC REHABILITATION	76.97 90.00	1, 402				12
. 00			<u>1, 724</u> 72, 025	0	4		14
	N - INVENTORY MANAGEMENT	<u> </u>	12,020	V			

	Financial Systems		IU HEALTH WHI			-	u of Form CMS	
RECLASS	SEFECATIONS			Provider (CCN: 15-1312	Peri od:	Worksheet A-	6
						From 01/01/2021 To 12/31/2021	Date/Time Pr 5/26/2022 3:	epared: 45 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6.00	7.00	8.00	9.00	10.00			
	0 - EMERGENCY PREPAREDNESS							
1.00	NURSING ADMINISTRATION	13.00	258, 419	21, 729		0		1.00
2.00		0.00	0	0		0		2.00
3.00		0.00	0	0		0		3.00
	TOTALS		258, 419	21, 729		1		1
500.00	Grand Total: Decreases		521, 563	11, 576, 024				500.00

	Financial Systems	IU HEALTH WHI	TE_HOSPITAL			u of Form CMS-	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1312	Period: From 01/01/2021 To 12/31/2021		pared:
				Acqui si ti on	S		
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	T	1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET				- 1		
1.00	Land	954, 570	0		0 0	0	
2.00	Land Improvements	813, 560	0		0 0	109, 360	
3.00	Buildings and Fixtures	0	0		0 0	0	0.00
4.00	Building Improvements	38, 459, 462	0		0 0	93, 828	4.00
5.00	Fixed Equipment	0	0		0 0	0	
6.00	Movable Equipment	8, 744, 361	2, 549, 817		0 2, 549, 817	5, 188	6.00
7.00	HIT designated Assets	15, 000	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	48, 986, 953	2, 549, 817		0 2, 549, 817	208, 376	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	48, 986, 953	2, 549, 817		0 2, 549, 817	208, 376	10.00
		Endi ng Bal ance	Fully				
		-	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	954, 570	0				1.00
2.00	Land Improvements	704, 200	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	38, 365, 634	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	11, 288, 990	3, 238, 793				6.00
7.00	HIT designated Assets	15, 000	15, 000				7.00
8.00	Subtotal (sum of lines 1-7)	51, 328, 394	3, 253, 793				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	51, 328, 394	3, 253, 793				10.00

Heal th	Financial Systems	IU HEALTH WHI	TE_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1312	Period: From 01/01/2021	Worksheet A-7 Part II	
					To 12/31/2021	Date/Time Pre	
				-		5/26/2022 3:4	5 pm
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	40.00	11.00	instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEEL A, COLUM	N 2, LINES 1 a	ind 2	-	-	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0		0 0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0		0 0	0	1.02
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY OF	F CAPI TAL				
	Cost Center Description	0ther -	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0				1.01
1.02	CAP REL COSTS-BLDG & FIXT - TLMOB	0	0				1.02
3.00	Total (sum of lines 1-2)	0	0)			3.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 3:45	
	COMI	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)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		1				
1.00 CAP REL COSTS-BLDG & FIXT	1, 658, 770		1,000,770		0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	34, 739, 609		34, 739, 609		0	1.01
1.02 CAP REL COSTS-BLDG & FIXT - TLMOB	14, 930, 016		14, 930, 016			1. 02
3.00 Total (sum of lines 1-2)	51, 328, 395		51, 328, 395			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	1	1			
1.00 CAP REL COSTS-BLDG & FIXT	0	0	C	30, 355		1.00
1.01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	C	1, 844, 297		1.01
1.02 CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	C	508, 921	0	1. 02
3.00 Total (sum of lines 1-2)	0	0	0	2, 383, 573	0	3.00
		Sl	JMMARY OF CAPI1	TAL		
Cost Center Description	Interest	Insurance (see		Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		1	1			
1.00 CAP REL COSTS-BLDG & FIXT	27, 843		C C	0	58, 198	1.00
1.01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	901, 699	25, 464		0 0	2, 771, 460	1.01
1.02 CAP REL COSTS-BLDG & FIXT - TLMOB	0	0	16, 102		525, 023	1.02
3.00 Total (sum of lines 1-2)	929, 542	25, 464	16, 102	0	3, 354, 681	3.00

	Financial Systems MENTS TO EXPENSES		IU HEALTH WHI	TE HOSPITAL Provider CCN: 15-1312	In Lie Period:	u of Form CMS-2 Worksheet A-8	2552-10
100001					From 01/01/2021 To 12/31/2021	Date/Time Prep	pared:
				Expense Classification of		5/26/2022 3:4	
				To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL			CAP REL COSTS-BLDG & FLXT HOSPLTAL	- 1.01	0	1. 01
1. 02	(chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - TLMOB			CAP REL COSTS-BLDG & FIXT T TLMOB	- 1.02	0	1. 02
2.00	(chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted **	* 2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	
10.00	Provider-based physician adjustment	A-8-2	-476, 165		0.00	0	
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	
12.00	Related organization transactions (chapter 10)	A-8-1	4, 856, 254		0.00		12.00
13.00 14.00	Laundry and linen service Cafeteria-employees and guests		0 -11, 455	CAFETERI A	0.00 11.00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18. 00	Sale of medical records and abstracts		0		0.00	0	18.00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
	Vending machines		0		0.00		20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted **	* 65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted **	* 114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	А	30, 355	CAP REL COSTS-BLDG & FIXT	1.00	9	26.00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL	А		CAP REL COSTS-BLDG & FIXT	- 1.01	9	26. 01
26. 02	COSTS-BLDG & FIXT - HOSPITAL Depreciation - CAP REL	А		HOSPITAL CAP REL COSTS-BLDG & FIXT	- 1.02	9	26. 02
27.00	COSTS-BLDG & FIXT - TLMOB Depreciation - CAP REL		0	TLMOB *** Cost Center Deleted **:	* 2.00	0	27.00
	COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted **			28.00
	Physicians' assistant		0		0.00		29.00

Health Financial Systems		IU HEALTH WHI	TE HOSPI TAL	In Lie	eu of Form CMS-:	2552-10
ADJUSTMENTS TO EXPENSES				Period: From 01/01/2021 To 12/31/2021	Worksheet A-8 Date/Time Pre 5/26/2022 3:4	pared:
			Expense Classification or			
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
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 instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess of						
limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32.00
Depreciation and Interest						
33.00 EMPLOYEE BENEFITS	A	-1, 777, 945	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	33.00
33.01 LOSS ON ABANDONMENT	Α		CAP REL COSTS-BLDG & FIXT -	1.01	9	33. 01
			HOSPI TAL			
33.02 MEDICAID HAF FEES	А	-1, 689, 698	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03 MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
33.04 MI SCELLANEOUS I NCOME	В	-4,835	CENTRAL SERVICES & SUPPLY	14.00	0	33.04
33.05 MI SCELLANEOUS I NCOME	В	-3, 712	PHARMACY	15.00	0	33.05
33.06 MI SCELLANEOUS I NCOME	В	-707	RADI OLOGY-DI AGNOSTI C	54.00	0	
33.07 WIC PROGRAM COSTS	А	-268, 074		10.00		00.07
33.08 WIC PROGRAM BENEFIT COSTS	А	-39, 987	EMPLOYEE BENEFITS DEPARTMEN	Г 4.00	0	33.08
33.09 CONTRIBUTION EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00		00.07
33.10 TELEPHONE EXPENSE	A	-523	ADULTS & PEDIATRICS	30.00	0	00.10
33.11 MARKETING	А	-50	ADMINISTRATIVE & GENERAL	5.00	0	33. 11
50.00 TOTAL (sum of lines 1 thru 49)		1, 203, 200				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
 Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	IU HEALTH WH	ITE HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1312	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2021 To 12/31/2021	Date/Time Pre	narod
				10 12/31/2021	5/26/2022 3:4	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00			1.00	5	
			3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1.00		CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	935, 442	997, 256	1, 00
2.00			HOME OFFICE ALLOCATION	1, 748, 701	777,230	2.00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5, 776, 561	4, 559, 968	3.00
3.01			POOLED CAPITAL - H.O.	289, 747	1,007,700	3.01
4.00			RELATED PARTY	1, 715, 484	779,635	4.00
4.01	7.00		RELATED PARTY	0	19, 833	4.01
4.02	7.01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	130, 380	30, 881	4. 02
4.03	10.00	DI ETARY	RELATED PARTY	21, 636	69,066	4.03
4.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	140, 849	36, 619	4.04
4.05	15.00	PHARMACY	RELATED PARTY	608, 938	267, 453	4.05
4.06	30.00	ADULTS & PEDIATRICS	RELATED PARTY	191, 868	115, 388	4.06
4.07	50.00	OPERATING ROOM	RELATED PARTY	208, 258	156, 460	4.07
4.08			RELATED PARTY	161, 393	83, 934	4.08
4.09			RELATED PARTY	125, 997	82, 507	4.09
4.10			SHARED EMPLOYEES	119	119	4.10
4.11			SHARED EMPLOYEES	420	420	4.11
4.12			SHARED EMPLOYEES	327, 063		4.12
4.13			SHARED EMPLOYEES	178, 545		4.13
4.14			SHARED EMPLOYEES	1, 554, 672		
4.15		PHYSI CAL THERAPY	SHARED EMPLOYEES	96, 605		
5.00	TOTALS (sum of lines 1-4).			14, 212, 678	9, 356, 424	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

nas not	been posted to worksheet A,	columns I and/or 2, ti	ne amount	t allowable sh	ould be indicated in colum	1 4 of this part.	
					Related Organization(s) a	nd/or Home Office	
					o i <i>i i</i>		
	Symbol (1)	Name		Percentage of	Name	Percentage of	
	Symbol (1)	Name			Name	5	
				Ownership		Ownership	
	1.00	2.00		3.00	4.00	5.00	
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

rerinbur	Schone under trette Avrit.				
6.00	В	IU HEALTH	100.00	0.00	6.00
7.00	В	IUH ARNETT	1.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

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

Health Financial Systems IU HEALTH WHITE HOSPITAL	In Lieu of Form CMS-2552-10
	01/01/2021 12/31/2021 Date/Time Prepared:

	-					5/26/2022 3:45	pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
	A. COSTS INCUR	RED AND ADJUSTN	ENTS REQUIRED AS A RESULT OF TRANSA	CTIONS WITH RELATED OF	RGANIZATIONS OR C	CLAIMED	
	HOME OFFICE CO	STS:					
1.00	-61, 814	11					1.00
2.00	1, 748, 701	0					2.00
3.00	1, 216, 593	0					3.00
3.01	289, 747	0					3.01
4.00	935, 849	0					4.00
4.01	-19, 833	0					4.01
4.02	99, 499	0					4.02
4.03	-47,430	0					4.03
4.04	104, 230						4.04
4.05	341, 485						4.05
4.06	76, 480						4.06
4.07	51, 798						4.07
4.08	77, 459						4.08
4.09	43, 490						4.09
4.10	0	0					4.10
4.11	0	0					4.11
4.12	0	0					4.12
4.13	l o	0					4.13
4.14	l o	0					4.14
4.15	l o	0					4.15
5.00	4, 856, 254						5.00
			appinta an appropriate) and transfe			<pre>/ !!</pre>	

* 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.

Tids not been posted to worksheet	A, cordinario 1 and/or 2, the amount arrowable should be marcated in cordinaria of this part.	
Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
51		
6.00		
B. INTERRELATIONSHIP TO R	LATED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ei iibui s			
6.00		6.00	
7.00		7.00	
8.00		8.00	
9.00		9.00	
10. 00 100. 00		10.00	
100.00		100.00	
(1) 11	the fellowing cymhole to ind	i coto interrelationabie to related ergonizationa	

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

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

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

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

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

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

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

Heal th	Financial Syste	ems	IU HEALTH WH	ITE HOSPITAL		In Li	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-1312	Peri od:	Worksheet A-8	
						From 01/01/2021		
						To 12/31/2021		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/26/2022 3: 4 Physi ci an/Prov	
	WKSL A LINE #	I denti fi er	Remuneration	Component	Component	KCE AIIOUITE	ider Component	
		ruentinei	Kelliuner attron	Component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	295, 253					1.00
2.00		OPERATING ROOM	180, 912					
3.00		EMERGENCY	1, 200, 233			-	-	
4.00	0.00		0				-	
5.00	0, 00		0	-			0	
6.00	0.00		0	-			, s	
7.00	0.00		0				0	7.00
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10.00	0.00		0	Ŭ Ŭ			0	
200.00	0.00		1, 676, 398	, s	1, 200, 23		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	intot. A Erno #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
			2	Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0		0 0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	(0 0	0	2.00
3.00	91.00	EMERGENCY	0	0	(o o	0	3.00
4.00	0.00		0	0	(0 0	0	4.00
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6.00	0.00		0	0	(o o	0	6.00
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8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(o o	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 #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADULTS & PEDIATRICS	0			295, 253		1.00
2.00		OPERATING ROOM	0			180, 912		2.00
3.00		EMERGENCY	0	0	(0 0		3.00
4.00	0.00		0	, v		0 0		4.00
5.00	0.00		0	0		0 0		5.00
6.00	0.00		0	0	(0 0		6.00
7.00	0.00		0			0 0		7.00
8.00	0.00		0	0	(0 0		8.00
9.00	0.00		0	0	(o o		9.00
10.00	0.00		0	0	(o o		10.00
200.00			0	0	(476, 165		200. 00

COST ALLOCATION - CENERAL SERVICE COSTS Provider CDN: 15-1312 Provider CDN: 15	Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Net Expenses (Cost Cost All caction color (Cost All caction (Cost All caction color (Cost All caction color (Cost All caction (Cost All caction (Cost All caction (Cost All caction (Cost All caction (Cost Al						Period: From 01/01/2021	Worksheet B Part I Date/Time Pre	pared:
For Cost (rrow West A coll 7) HoSPITAL (rrow West A coll 7) HOSPITAL (rrow West A coll 7) TLMOB (rrow West A coll 7) BENETITS (rrow West A coll 7) 0 0.00 1.00 1.00 1.00 1.00 1.00 1.00 00010 CAP REL COSTS BLDS & FIXT (rrow West A coll 7) 59, 190 (rrow West A coll 7) 1.00 1.00 1.00 1.00 0.00 00000 EMPLOYEE BENETITS DEPARTMENT (rrow West A coll 7) 2, 771, 460 (rrow West A coll 7) 2, 771, 460 (rrow West A coll 7) 2, 771, 460 (rrow West A coll 7) 55, 100 (rrow West A coll 7) 1.00 (rrow West A col 7) 1.00 (rrow West A coll 7)				CAP	TAL RELATED	COSTS		
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1.00 00700 (AP REL COSTS-BLDG & FLXT - HOSP HL 2,771,460 0 1.0 1.01 00700 (AP REL COSTS-BLDG & FLXT - HUMB 525,023 0 0 555,023 1.0 1.00 00700 (DRHLOYEE BELFT) TS DEPARTMENT 1.764,948 0 0 0 63,009 0 555,023 1.0 0.00 00500 ADMIN STRATIVE & GENERAL 8.251,475 5.351 113,411 89,556 63,009 5.0 0.00 00FERATION OF PLANT 497,996 0 0 0.8,00 7.0 7.0 7.00 7.00 7.00 7.00 7.00 7.00 0.00 8.04 631,240 0 0 8.04 633,210 7.0 7.0 0.00 000000 LAUNDRY & LINEN SERVICE 519,971 259 2.240 0 15,659 11.055 11.05 10.05 11.05				1.00	1.01	1. 02	4.00	
1. 01 00101 CAP REL COSTS-BLDG & FLXT - TLWDB 2. 771, 460 0 2. 771, 460 1. 02 00102 CAP REL COSTS-BLDG & FLXT - TLWDB 525, 023 0 0 525, 023 1.0 1. 00 00000 EMERLETS DEPARTMENT 1. 764, 948 0 0 0 0 0 53, 098 5.0 7. 00 00000 DEFLATT ION OF PLANT 497, 996 0 1.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 7.0 0 0 0 0 0.0 0 0.0 0			50,400	50.400				1 1 00
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7.00 00700 OPERATION OF PLANT 497,996 O O 083,010 7.00 7.01 00701 OPERATION OF PLANT - HOSPITAL 1.756,490 8.044 631,640 0 0 7.00 00702 OPERATION OF PLANT - TLMOB 345,403 4.376 631,640 0 0 0.0 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 0.00 0.00 0.00 0.00 0.00 0.01 0.0100 0.0100 0.0100 0.0100 0.0100 0.0100 0.0100 0.0100 0.01100 0.01300 0.01300 0.01300 0.01300 0.01400 Central, Service Sort Centres 0 0 0 0 0 0 0 0 0 0.0160 0.01600 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 0.01400 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0 0</td> <td>1, 764, 948</td> <td>•</td>				0		0 0	1, 764, 948	•
7. 01 00701 [DEERATI ON OF PLANT - HOSPI TAL 1, 756, 490 8, 04 631, 640 0 0, 7, 0 7. 02 00702 (DEPRATI ON OF PLANT - HUNGS 345, 403 4, 376 0 100, 321 0 7, 0 8, 00 00000 (LUMDRY & LINEN SERVICE 61, 977 259 20, 340 0 0 8, 00 63, 532 9, 0 10, 00 01000, DIETARY 434, 106 2, 228 0 51, 082 770, 231 10, 0 11, 00 0100 (AFETERI A 13, 965 692 0 15, 859 11, 0, 651 10 14, 00 14, 00 10, 295, 221 337 33, 305 9, 471 187, 576 13, 0 10, 00 01400 CENTRAL SERVICES & SUPPLY 201, 994 2, 290 179, 780 0 0 16, 10 10, 00 11400 11600 BERNI EX SERVICES & SUPPLY 2, 567, 832 4, 933 387, 323 0 324, 933 387, 323 0 32, 695, 697 30 30, 00 11600 REAL SERVICE COST CENTERS 2, 567, 832 4, 933 387, 323 0 34, 403 55, 552				5, 351	113, 41			•
7. 02 00702 0PERATION OF PLANT - TLNOB 345, 403 4, 376 0 100, 321 0 7.00 80.00 00800 LNNENY SERVICE 547, 819 864 62, 321 1, 604 635, 322 9.00 10.00 01000 DID OD LETARY 434, 106 2, 228 0 15, 859 11, 055 11.0 13.00 01300 NURSI NG ADMINI STRATION 1, 295, 221 837 33, 305 9, 471 187, 578 13.0 0 0 0 14.0 14.00 DIO KENTRAL SERVICES & SUPPLY 201, 994 2, 290 179, 780 0 0 14.0 15.00 DISDO PREMATINE SERVICE COST CENTERS 0				0	(01.(1	<u> </u>		•
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11.00 01100 CARETERIA 137,985 692 0 15.859 11.055 11.0 13.00 01300 NURSING ADMINISTATION 1,295,221 837 33.305 9,471 187,578 13.0 14.00 01400 CENTRAL SERVICES & SUPPLY 201,994 2,290 179,780 0 0 0 14.0 15.00 01500 PHARMACY 1,219,378 978 76,780 0								•
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58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 392,975 428 33,594 0 32,999 58.0 60.00 06000 LABORATORY 1,653,411 1,423 111,772 0 0 60.0 66.00 PHYSI CAL THERAPY 480,814 1,379 108,302 0 81,278 66.0 67.00 0CCUPATI ONAL THERAPY 178,033 110 8,628 0 30,110 67.0 68.00 06800 SPECH PATHOLOGY 101,286 52 4,049 0 17,172 68.0 69.00 06900 ELCTROARD IOLOGY 101,286 52 4,049 0 70 0 70 70 70 70 70 71,72 68.0 70 70 70 70 71,72 69.0 0 0 71,72 69.0 71,712 68.0 73.0 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 74.98 2,871,810 3,067 240,800 0 73.0								
66.00 06600 PHYSI CAL THERAPY 480, 814 1, 379 108, 302 0 81, 278 66.0 67.00 06700 0CCUPATI ONAL THERAPY 178, 033 110 8, 628 0 30, 110 67.0 68.00 06800 SPEECH PATHOLOGY 101, 286 52 4, 049 0 17, 172 68.0 69.00 0 06900 ELECTROCARDI OLOGY 1449, 538 328 25, 738 0 24, 154 69.0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 77, 206 0 0 0 71.0 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 077, 598 0 0 0 73.0 0 0 0 73.0 0 73.0 0 70.0 73.00 0 0 0 73.0 0 70.0 73.0 0 0 0 0 73.0 76.0 76.0 78.0 78.0 18.013 18, 523 76.0 78.0 78.0 78.0 78.0 78.0 78.0 78.0 79.0 79.0								
67.00 06700 0CCUPATI ONAL THERAPY 178,033 110 8,628 0 30,110 67.0 68.00 06800 SPEECH PATHOLOGY 101,286 52 4,049 0 17,172 68.0 69.00 06900 ELECTROCARDI OLOGY 149,538 328 25,738 0 24,154 69.0 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 77,206 0 0 0 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11,626 0 0 0 73.0 73.00 07300 DRUGS CHARGED TO PATIENTS 1,077,598 0 0 0 73.0 76.00 03160 CARDI OPULMONARY 821,192 648 50,898 0 109,585 76.0 70.697 CARDI AC REHABI LITATI ON 118,854 786 0 18,013 18,523 76.9 0UTPATI ENT SERVICE COST CENTERS 2,871,810 3,067 240,800 0 230,839 91.0 92.00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0	60.00	06000 LABORATORY	1, 653, 411	1, 423	111, 77	2 0	0	60.00
68.00 06800 SPEECH PATHOLOGY 101,286 52 4,049 0 17,172 68.0 69.00 06900 ELECTROCARDI OLOGY 149,538 328 25,738 0 24,154 69.0 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 77,206 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 11,626 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,077,598 0 0 0 73.0 73.01 07301 ONCOLOGY DRUGS 3,409,704 0 0 0 73.0 76.07 074697 CARDI AC REHABI LI TATI ON 118,854 786 0 18.013 18.523 76.9 00179ATI ENT SERVI CE COST CENTERS 2,44,388 2,138 167,875 0 38,182 90.0 90.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 20.0 2,871,810 3,067 240,800 230,839 91.0 92.00 09200 OBSERVATI ON BEDS (DI STI NCT PART) </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
69.00 06900 ELECTROCARDIOLOGY 149,538 328 25,738 0 24,154 69.0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 77,206 0 0 0 71.0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11,626 0 0 0 72.0 73.00 07300 DRUGS CHARGED TO PATIENTS 1,077,598 0 0 0 73.0 76.00 03160 CARDIOPULMONARY 821,192 648 50,898 0 109,585 76.0 76.97 07697 CARDI AC REHABILITATION 118,854 786 0 18,013 18,523 76.9 09.00 09000 CLINIC 244,388 2,138 167,875 0 38,182 90.0 91.00 09100 EMERGENCY 2,871,810 3,067 240,800 0 92.0 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.0 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0 0								1
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 77, 206 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 11, 626 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 11, 626 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 077, 598 0 0 0 0 73.00 73.01 0NCOLOGY DRUGS 3, 409, 704 0 0 0 0 73.00 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 821, 192 648 50, 898 0 109, 585 76.07 76.97 70.797 CARDI AC REHABI LI TATI ON 118, 854 786 0 18, 013 18, 523 76.97 0000 09000 CLI NI C 244, 388 2, 138 167, 875 0 38, 182 90.00 92.0 92.00 9200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 92.0 0 0 0 0 0								
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 11,626 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,077,598 0 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 3,409,704 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 821,192 648 50,898 0 109,585 76.00 76.97 07697 CARDI AC REHABILI TATION 118,854 786 0 18,013 18,523 76.90 0UTPATIENT SERVICE COST CENTERS 0 09000 CLINIC 244,388 2,138 167,875 0 38,182 90.00 91.00 09100 EMERGENCY 2,871,810 3,067 240,800 0 230,839 91.00 92.01 09200 OBSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.00 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.00 92.01 092010 DSERVATION BEDS (DISTINCT PART)								
73.00 07300 DRUGS CHARGED TO PATIENTS 1,077,598 0 0 0 73.0 73.01 07301 ONCOLOGY DRUGS 3,409,704 0 0 0 73.0 76.00 03160 CARDI OPULMONARY 821,192 648 50,898 0 109,585 76.0 76.07 ORADI AC REHABILITATION 118,854 786 0 18,013 18,523 76.9 0UTPATIENT SERVICE COST CENTERS 244,388 2,138 167,875 0 38,182 90.0 90.00 09000 CLINIC 244,388 2,871,810 3,067 240,800 0 230,839 91.0 92.00 09200 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 92.0 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 92.0 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0 0 0 92.0 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0 0 0						0 0		1
76.00 03160 CARDI OPULMONARY 821, 192 648 50, 898 0 109, 585 76.0 76.07 07697 CARDI AC REHABI LI TATI ON 118, 854 786 0 18, 013 18, 523 76.9 00 09000 CLI NI C 244, 388 2, 138 167, 875 0 38, 182 90.0 91.00 09100 EMERGENCY 2, 871, 810 3, 067 240, 800 0 230, 839 91.0 92.00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.0 92.01 09201 DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 92.01 09201 DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 92.01 09201 DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 010100 HOME REALTH AGENCY 0 0 0 0 0 0 101.0 SPECI AL PURPOSE SUBTOTALS SUM OF LINES 1 t				0		0 0	0	•
76. 97 07697 CARDI AC REHABI LI TATI ON 118,854 786 0 18,013 18,523 76.9 90. 00 09000 CLI NI C 244,388 2,138 167,875 0 38,182 90.0 91. 00 09100 EMERGENCY 2,871,810 3,067 240,800 0 230,839 91.0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92.0 92. 01 09201 DBSERVATI ACENCY 0 0 0 0 0 92.0 92. 01 00 I118.00 NOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			3, 409, 704	0		0 0	0	73.01
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLI NI C 244, 388 2, 138 167, 875 0 38, 182 90. 0 91.00 09100 EMERGENCY 2, 871, 810 3, 067 240, 800 0 230, 839 91. 0 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 0 92.01 09201 DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92. 0 92.01 09201 DBSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92. 0 01000 HOME HEALTH AGENCY 0 0 0 0 101. 0 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 35, 846, 822 47, 768 2, 771, 460 285, 906 1, 752, 567 118. 00 NONREI MBURSABLE COST CENTERS								
90.00 09000 CLINIC 244,388 2,138 167,875 0 38,182 90.0 91.00 09100 EMERGENCY 2,871,810 3,067 240,800 0 230,839 91.0 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.0 92.01 09200 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 92.0 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.0 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.0 92.01 09201 0BSERVATION BEDS (DISTINCT PART) 0 0 0 0 0 92.0 010.00 HOME HEALTH AGENCY 0 0 0 0 0 1010.0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,846,822 47,768 2,771,460 285,906 1,752,567 118.0 NONREI MBURSABLE COST CENTERS 118.00 117.0			118, 854	786		0 18, 013	18, 523	76.97
91. 00 09100 EMERGENCY 2, 871, 810 3, 067 240, 800 0 230, 839 91. 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92. 0 92. 01 09200 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92. 0 92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0 0 0 0 92. 0 01 00 HBURSABLE COST CENTERS 0 0 0 0 0 101. 0 SPECI AL PURPOSE COST CENTERS 5 5 5 5 118. 0 NONREI MBURSABLE COST CENTERS 118. 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 35, 846, 822 47, 768 2, 771, 460 285, 906 1, 752, 567 118. 0			244 388	2 128	167.87	5 0	38 182	
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 09201 0 0 0 0 92.0 92.01 09201 0BSERVATI ON BEDS (DI STINCT PART) 0THER REI MBURSABLE COST CENTERS 0 0 0 0 92.0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.0 SPECI AL PURPOSE COST CENTERS								
OTHER REI MBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS SUBM OF LI NES 1 through 117) 35, 846, 822 47, 768 2, 771, 460 285, 906 1, 752, 567 118.0 NONREI MBURSABLE COST CENTERS			_, _, , , , ,		,	-		92.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS SUBTOTALS SUM OF LINES 1 through 117) 35, 846, 822 47, 768 2, 771, 460 285, 906 1, 752, 567 118.0 NONREI MBURSABLE COST CENTERS			0	0		0 0	0	92.01
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 35,846,822 47,768 2,771,460 285,906 1,752,567 NONREI MBURSABLE COST CENTERS	-							1.0.0.00
Substant			0	0		0 0	0	101.00
NONREI MBURSABLE COST CENTERS		SUBTOTAL S (SUM OF LINES 1 through 117)	35 846 822	47 768	2 771 46	0 285 906	1 752 567	118 00
		VONREI MBURSABLE COST CENTERS	00,010,022	11,700	2,771,10	200, 700	1, 702, 007	110.00
			0	0		0 0	0	190.00
191. 00 19100 RESEARCH 0 0 0 0 191. 0			0	0		-		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 86, 848 1, 830 0 41, 964 12, 381 192. 0			86, 848					
192. 02 19202 MOB 0 6, 792 0 155, 710 0 192. 0			0					
192.03 19203 ARNETT SURGERY OFFICE 0 1,808 0 41,443 0 192.0 192.04 19201 OCCUPATI ONAL MEDI CINE 0 0 0 0 192.0			0	1,808		41,443		
192. 04 19201 OCCOPATIONAL MEDICINE 0 0 0 0 0 0 0 0 192. 0								
			0			ĭ I	0	200.00
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	201.00			0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201) 35,933,670 58,198 2,771,460 525,023 1,764,948 202.0	202.00	TOTAL (sum lines 118 through 201)	35, 933, 670	58, 198	2, 771, 46	0 525, 023	1, 764, 948	202.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2021	Worksheet B Part I	
					0 12/31/2021	Date/Time Pre	
	Cost Center Description	Subtotal	ADMI NI STRATI VE		OPERATION OF	5/26/2022 3:4 OPERATION OF	5 pm
	Cost center bescription	Subtotal	& GENERAL	PLANT	PLANT -	PLANT - TLMOB	
					HOSPI TAL		
		4A	5.00	7.00	7.01	7.02	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	8, 522, 891	8, 522, 891				5.00
7.00	00700 OPERATION OF PLANT	581,006					7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	2, 396, 174		115, 941	3, 257, 162	(50.400	7.01
7.02 8.00	00702 OPERATION OF PLANT - TLMOB 00800 LAUNDRY & LINEN SERVICE	450, 100				653, 120 0	7.02 8.00
8.00 9.00	00900 HOUSEKEEPING	82, 576 726, 140				3, 126	
10.00	01000 DI ETARY	557,647				99, 548	
11.00	01100 CAFETERI A	165, 591				30, 906	
13.00	01300 NURSING ADMINISTRATION	1, 526, 412			53, 533	18, 456	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	384,064		32, 999	288, 971	0	
15.00	01500 PHARMACY	1, 379, 296		14, 093		0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	3, 329, 675	1,035,303	71, 094	622, 565	0	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	3, 329, 075	ij 1,035,303	/1,094	022, 505	0	30.00
50.00	05000 OPERATI NG ROOM	1, 114, 648	346, 580	59, 690	522, 705	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	500, 787		22, 604		0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	154, 127				0	55.00
56.00	05600 RADI OI SOTOPE	197, 891		3, 203		0	56.00
57.00	05700 CT SCAN	564, 564		4, 370		0	57.00
58.00 60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	459, 996 1, 766, 606		6, 166 20, 516		0	58.00 60.00
66.00	06600 PHYSI CAL THERAPY	671, 773				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	216, 881				0	67.00
68.00	06800 SPEECH PATHOLOGY	122, 559				0	68.00
69.00	06900 ELECTROCARDI OLOGY	199, 758	62, 111	4, 724	41, 370	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	77, 206		0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	11, 626		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,077,598			0	0	73.00
73. 01 76. 00	07301 ONCOLOGY DRUGS 03160 CARDI OPULMONARY	3, 409, 704 982, 323			0 81, 811	0	73.01 76.00
76.00	07697 CARDI AC REHABI LI TATI ON	962, 323 156, 176				35, 102	
/0. //	OUTPATIENT SERVICE COST CENTERS	100,170	10,000	11, 021		00,102	/0. //
90.00	09000 CLI NI C	452, 583	140, 723	30, 814	269, 836	0	90.00
91.00	09100 EMERGENCY	3, 346, 516	1, 040, 539	44, 199	387, 051	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
92.01	09201 OBSERVATI ON BEDS (DI STI NCT PART)	0	0	0	0	0	92.01
101 00	OTHER REIMBURSABLE COST CENTERS		0		0	0	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	<u>ı</u> 0	0	0	0	101.00
118.00		35, 584, 894	8, 414, 446	611, 332	3, 257, 162	187, 138	118 00
	NONREI MBURSABLE COST CENTERS	0010011071	0,111,110	011/002	0/20//102	1017100	1.101.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19100 RESEARCH	0	0	0	0	0	191.00
	19200 PHYSICIANS' PRIVATE OFFICES	143, 023			0		192.00
	19202 MOB	162, 502		97, 891	0	303, 443	
	19203 ARNETT SURGERY OFFICE	43, 251	13, 448	26, 054	0	80, 762	
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0			0		192. 04 193. 00
200.00					0	0	200.00
200.00		0	0	0	0	0	200.00
202.00		35, 933, 670	8, 522, 891	761, 659	3, 257, 162		
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Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2021	Worksheet B Part I	
					To 12/31/2021	Date/Time Pre	epared:
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	5/26/2022 3: 4 NURSI NG	5 pm
		LINEN SERVICE	inocoencer into	5121740	0,1121211111	ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
1 00	GENERAL SERVICE COST CENTERS					1	1 4 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
1.01	00102 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	144, 678					8.00
9.00	00900 HOUSEKEEPI NG	0	1, 067, 666				9.00
10.00	01000 DI ETARY	0	31, 982	894, 68			10.00
11.00		0	9, 906		0 267, 861		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	4, 697		0 25, 526		
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	10, 461		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	0	13, 109 0		0 11,009 0 0		
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	V		0 0	0	10.00
30.00	03000 ADULTS & PEDIATRICS	144, 678	202, 013	894, 68	56, 956	1, 183, 185	30.00
	ANCI LLARY SERVICE COST CENTERS					.,	
50.00	05000 OPERATING ROOM	0	148, 168		0 12, 775	175, 050	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	56, 364		0 10, 767	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	5, 423		0 1, 621	0	55.00
56.00	05600 RADI OI SOTOPE	0	7, 985		0 3, 895		
57.00	05700 CT SCAN	0	10, 888		0 14, 614		
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	15, 372		0 5, 831	0	
60.00		0	28, 481		0 23, 735		
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	31, 214 2, 477		0 13,065 0 4,839		
68.00	06800 SPEECH PATHOLOGY	0	2, 477		0 4, 839 0 2, 419		
69.00	06900 ELECTROCARDI OLOGY	0	16, 653		0 4,839		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 035		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
73.01	07301 ONCOLOGY DRUGS	0	0		0 0	0	73.01
76.00	03160 CARDI OPULMONARY	0	17, 592		0 17, 783	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	14, 603		0 4, 016	0	76.97
	OUTPATIENT SERVICE COST CENTERS	1					
90.00	09000 CLINIC	0	59, 353		0 8, 492		
91.00	09100 EMERGENCY	0	191, 039		0 41, 276	644, 635	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92.01	09201 OBSERVATI ON BEDS (DI STI NCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	92.01
101 00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	V		0 0	0	101.00
118.00		144, 678	878, 933	894, 68	263, 458	2, 115, 301	118.00
	NONREI MBURSABLE COST CENTERS					•	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	42, 358		0 4, 403		192.00
		0	102, 608		0		192.02
	19203 ARNETT SURGERY OFFICE	0	43, 767		0		192.03
	19201 OCCUPATI ONAL MEDI CI NE	0	0				192. 04 193. 00
200.00	19300 NONPAID WORKERS Cross Foot Adjustments	0	0		0		200.00
200.00		0	0		0	0	200.00
201.00		144, 678	1, 067, 666	894, 68	267, 861		
202.00		1 11,070	.,,	0,1,00	207,001		1-02.00

Heal th	Financial Systems	IU HEALTH WHITI	E HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 3:4	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00 1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1. 02
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL						7.00
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	835, 913					13.00 14.00
14.00	01500 PHARMACY	20, 197	1, 989, 984				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	97, 448	5, 809		0 7, 643, 407	0	30.00
50,00	ANCI LLARY SERVI CE COST CENTERS	165, 145	2, 481		0 2, 547, 242	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 275	122		0 947, 571	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	54	77		0 254, 543	0	
56.00	05600 RADI OI SOTOPE	15, 561	1, 339		0 319, 450	0	56.00
57.00	05700 CT SCAN	4, 938	2, 458		0 815, 644	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 834	971		0 687, 195	0	
60.00		1,860	0		0 2, 570, 150	0	60.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	5, 920	0		0 1, 124, 807 0 307, 084	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	8	0		0 171, 498	0	68.00
69.00	06900 ELECTROCARDI OLOGY	20, 343	0		0 349, 798	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	197, 528	0		0 298, 740	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	29, 745	0		0 44, 986	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	468, 764		0 1, 881, 422	0	
73.01	07301 ONCOLOGY DRUGS	0	1, 483, 248		0 5, 953, 140	0	
76.00 76.97	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	76, 143 182	0		0 1, 490, 430 0 269, 975		76.00
/0.9/	OUTPATIENT SERVICE COST CENTERS	182	12		0 269, 975	0	76.97
90.00	09000 CLINIC	44,026	3, 508		0 1, 121, 766	0	90.00
91.00	09100 EMERGENCY	151, 442	21, 195		0 5, 867, 892	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
101 00	OTHER REIMBURSABLE COST CENTERS		0		0 0	0	101.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	835, 649	1, 989, 984		0 34, 666, 740	0	118.00
100.00	NONREI MBURSABLE COST CENTERS				0		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00 191. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	264	0		0 342,677		191.00
	19202 MOB	204	0		0 716, 971		192.00
	19203 ARNETT SURGERY OFFICE	Ö	o		0 207, 282		192.03
192.04	19201 OCCUPATI ONAL MEDI CI NE	О	О		0 0	0	192. 04
	19300 NONPAI D WORKERS	О	0		0 0		193.00
200.00	,	_	_		0		200.00
201.00 202.00		0 835, 913	0 1, 989, 984		0 0 0 35, 933, 670		201. 00 202. 00
202.00	TOTAL (sum lines 118 through 201)	030, 713	1, 707, 784	I	u 30, 933, 070	1 0	202.00

	Financial Systems	IU HEALTH WHITE	HOSPITAL	In Lieu	u of Form CMS-2552-1
COST AI	LLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Prepared: 5/26/2022 3:45 pm
	Cost Center Description	Total 26.00			
	GENERAL SERVICE COST CENTERS	20.00		<u> </u>	
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.0
. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.0
. 02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB				1.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.0
. 00	00500 ADMI NI STRATI VE & GENERAL				5.0
. 00	00700 OPERATION OF PLANT				7.0
. 01	00701 OPERATION OF PLANT - HOSPITAL				7.0
. 02	00702 OPERATION OF PLANT - TLMOB				7.0
00	00800 LAUNDRY & LINEN SERVICE				8.0
00	00900 HOUSEKEEPI NG				9.0
0. 00	01000 DI ETARY				10.0
1.00	01100 CAFETERI A				11.0
3.00	01300 NURSING ADMINISTRATION				13.0
1.00	01400 CENTRAL SERVICES & SUPPLY				14.0
5.00	01500 PHARMACY				15.0
6.00	01600 MEDI CAL RECORDS & LI BRARY				16.0
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDIATRICS	7, 643, 407			30.0
	ANCI LLARY SERVI CE COST CENTERS	2 5 4 7 2 4 2			F0.0
		2, 547, 242			50.0
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	947, 571			54. 0 55. 0
	05600 RADI OLOGI - THERAPEOTIC 05600 RADI OI SOTOPE	254, 543			56.0
	05700 CT SCAN	319, 450			57.0
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	815, 644 687, 195			57.0
	06000 LABORATORY	2, 570, 150			60.0
	06600 PHYSI CAL THERAPY	1, 124, 807			66.0
	06700 OCCUPATI ONAL THERAPY	307, 084			67.0
	06800 SPEECH PATHOLOGY	171, 498			68.0
	06900 ELECTROCARDI OLOGY	349, 798			69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	298, 740			71.0
	07200 I MPL. DEV. CHARGED TO PATIENTS	44, 986			72.0
	07300 DRUGS CHARGED TO PATIENTS	1, 881, 422			73.0
	07301 ONCOLOGY DRUGS	5, 953, 140			73.0
	03160 CARDI OPULMONARY	1, 490, 430			76.0
6. 97	07697 CARDI AC REHABI LI TATI ON	269, 975			76.9
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	1, 121, 766			90.0
	09100 EMERGENCY	5, 867, 892			91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.0
	09201 OBSERVATION BEDS (DISTINCT PART)	0			92.0
	OTHER REIMBURSABLE COST CENTERS	-1			
	10100 HOME HEALTH AGENCY	0			101. 0
18.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	34, 666, 740			118.0
+	NONREI MBURSABLE COST CENTERS	34,000,740			110.0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190. 0
	19100 RESEARCH	0			191.0
	19200 PHYSI CLANS' PRI VATE OFFI CES	342, 677			192.0
	19202 MOB	716, 971			192.0
	19203 ARNETT SURGERY OFFICE	207, 282			192.0
	19201 OCCUPATI ONAL MEDI CI NE	0			192.0
	19300 NONPAID WORKERS	0			193.0
0. 00		0			200. 0
01.00	Negative Cost Centers	0			201.0

Health Finar	ncial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION	OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 3:4	
			CAPI	TAL RELATED	COSTS		
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT HOSPITAL	- BLDG & FIXT - TLMOB	Subtotal	
		0	1.00	1.01	1. 02	2A	
1.00 00100 1.01 00101 1.02 00102 4.00 00400 5.00 00500 7.00 00701 7.01 00701 7.02 00702 8.00 00800 9.00 00900 10.00 01000 11.00 01100 13.00 01300	AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - HOSPITAL CAP REL COSTS-BLDG & FIXT - TLMOB EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT OPERATION OF PLANT - HOSPITAL OPERATION OF PLANT - TLMOB LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION	0 289, 747 0 0 0 0 0 0 0 0 0 0 0	0 5, 351 0 8, 044 4, 376 259 864 2, 228 692 837	20, 34 62, 32 33, 30	0 0 0 0 0 100, 321 0 0 1 1, 604 0 51, 082 0 15, 859 5 9, 471	0 498, 065 0 639, 684 104, 697 20, 599 64, 789 53, 310 16, 551 43, 613	$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 4. \ 00\\ 5. \ 00\\ 7. \ 00\\ 7. \ 01\\ 7. \ 02\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ \end{array}$
	CENTRAL SERVICES & SUPPLY PHARMACY	0	2, 290			182, 070	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	978 0		0 0 0 0	77, 758 0	15. 00 16. 00
30.00 03000	I ENT_ROUTI NE_SERVI CE_COST_CENTERS ADULTS & PEDI ATRI CS	0	4, 933	387, 32	3 0	392, 256	30. 00
	LARY SERVICE COST CENTERS	0	4, 142	325, 19	5 0	329, 337	50.00
55.00 05500 56.00 05600 57.00 05700 58.00 05800	RADIOLOGY-DIAGNOSTIC RADIOLOGY-THERAPEUTIC RADIOISOTOPE CT SCAN MAGNETIC RESONANCE IMAGING (MRI) LABORATORY		1, 568 322 222 303 428 1, 423	123, 14 25, 30 17, 44 23, 81 33, 59	7 0 4 0 8 0 0 0 4 0	124, 715 25, 626 17, 670 24, 113 34, 022 113, 195	54.00 55.00 56.00 57.00 58.00 60.00
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	0	1, 379 110			109, 681 8, 738	66.00 67.00
68.00 06800 69.00 06900 71.00 07100 72.00 07200 73.00 07300	SPEECH PATHOLOGY ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS		52 328 0 0 0	4, 04 25, 73	9 0 8 0 0 0 0 0 0 0	4, 101 26, 066 0 0 0	68.00 69.00 71.00 72.00 73.00
	ONCOLOGY DRUGS CARDI OPULMONARY	0	0 648	50, 89	0 0 8 0	0 51, 546	73.01 76.00
76.97 07697	CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	0	786		0 18, 013	18, 799	76. 97
90.00 09000 91.00 09100 92.00 09200	CLINIC	000000000000000000000000000000000000000		240, 80		170, 013 243, 867 0 0	91. 00 92. 00
101.0010100	REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	0	0		0 0	0	101. 00
118.00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	289, 747	47, 768	2, 771, 46	0 285, 906	3, 394, 881	118. 00
	IMBURSABLE COST CENTERS		0			0	190 00
191.00 19100 192.00 19200 192.02 19202 192.03 19203 192.04 19201 193.00 19300 200.00 19300	PHYSICIANS' PRIVATE OFFICES MOB ARNETT SURGERY OFFICE OCCUPATIONAL MEDICINE NONPAID WORKERS Cross Foot Adjustments	0 0 0 0 0 0	0 0 1, 830 6, 792 1, 808 0 0		0 0 0 0 0 41, 964 0 155, 710 0 41, 443 0 0 0 0 0	0 43, 794 162, 502 43, 251 0 0 0	192. 02 192. 03 192. 04 193. 00 200. 00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	289, 747	0 58, 198	2, 771, 46	0 0 0 525, 023	0 3, 644, 428	201. 00 202. 00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	F	eriod: rom 01/01/2021 o 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 3:4	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - TLMOB	
	GENERAL SERVICE COST CENTERS	4.00	5.00	7.00	7.01	7.02	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.00
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	C					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	C	498, 065				5.00
7.00	00700 OPERATION OF PLANT	C	10, 557	10, 557			7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	C	43, 538	1, 610	684, 832		7.01
7.02	00702 OPERATION OF PLANT - TLMOB	C	8, 178			113, 749	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	C	1, 500	52		0	8.00
9.00	00900 HOUSEKEEPI NG	C	13, 194			544	9.00
10.00	01000 DI ETARY	C	10, 132			17, 337	10.00
11.00	01100 CAFETERIA		3,009	138		5, 383	
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY		27, 735 6, 978			3, 214 0	13.00 14.00
14.00	01500 PHARMACY			195		0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0		0		0	16.00
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		, <u> </u>				10100
30.00	03000 ADULTS & PEDI ATRI CS	C	60, 500	985	130, 897	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	C				0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C				0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	C	_,	64		0	55.00
56.00	05600 RADI OI SOTOPE	C	3, 596			0	56.00
57.00	05700 CT SCAN	(10, 258			0	57.00
58.00 60.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY		8, 358	85		0	58.00 60.00
66.00	06600 PHYSI CAL THERAPY		32, 099 12, 206			0	66.00
67.00	06700 OCCUPATIONAL THERAPY		3, 941	270		0	67.00
68.00	06800 SPEECH PATHOLOGY		2,227	10		0	68.00
69.00	06900 ELECTROCARDI OLOGY	C	3, 630	65		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	1, 403	0		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	211	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	19, 580	0	0	0	73.00
73.01	07301 ONCOLOGY DRUGS	C	61, 967	0	0	0	73.01
76.00	03160 CARDI OPULMONARY	C				0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	C	2,838	157	0	6, 113	76.97
90.00	OUTPATI ENT SERVICE COST CENTERS	C	8, 223	427	56, 734	0	90.00
90.00 91.00	09100 EMERGENCY					0	90.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	00,000	013	01, 377	0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	C	o	0	0	0	
	OTHER REIMBURSABLE COST CENTERS			-	-	-	
101.00	10100 HOME HEALTH AGENCY	C	0 0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	C	491, 727	8, 473	684, 832	32, 591	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0	0	0	0	190.00
	19100 RESEARCH	C	0	0	0		191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	C	2, 599		0	14, 243	192.00
	2 19202 MOB	C	2, 953				192. 02
	19203 ARNETT SURGERY OFFICE	C	786	361	0		192. 03
	19201 OCCUPATIONAL MEDICINE	C	0	0	0		192.04
	19300 NONPAI D WORKERS	C	0	0	0	0	193.00
200.00	5	-		_		0	200.00
201.00 202.00			498,065	10 557	0 684, 832	0 113, 749	201.00
202.00	I TOTAL (SUM TIMES TTO LIN OUGH 201)		470,000	10, 557	004, 032	113, 749	1202.00

Heal th	Financial Systems	IU HEALTH WHI	TE HOSPITAL		Inlie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		eriod:	Worksheet B	2002 10
					rom 01/01/2021 o 12/31/2021	Part II Date/Time Pre	pared:
						5/26/2022 3:4	5 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - TLMOB						1.02
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00700 OPERATION OF PLANT						7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL						7.00
7.02	00702 OPERATION OF PLANT - TLMOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	29, 025					8.00
9.00	00900 HOUSEKEEPI NG	0	99, 761				9.00
10.00	01000 DI ETARY	0	2, 988				10.00
11.00		0	926	0	26,007		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	439 978	0	2, 478	88, 902 0	•
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	1, 225	0	1,069	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0		0	1,007	0	
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	29, 025	18, 874	84, 212	5, 529	49, 727	30.00
	ANCILLARY SERVICE COST CENTERS	I	1		1		
50.00	O5000 OPERATING ROOM	0		0	1, 240	7,357	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0	1,045	0	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	507 746	0	157 378	0	
57.00	05700 CT SCAN	0	1, 017		1, 419	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 436	0	566	0	•
60.00	06000 LABORATORY	0	2, 661	0	2, 304	0	60.00
66.00	06600 PHYSI CAL THERAPY	0	2, 917	0	1, 269	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	231	0	470	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	108	0	235	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	1, 556	0	470	0	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	0	0	0	
73.00	07301 ONCOLOGY DRUGS	0	0	0	0	0	
76.00	03160 CARDI OPULMONARY	0	-	0	1, 727	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0		0		0	
	OUTPATIENT SERVICE COST CENTERS		1		· · · · · · · · · · · · · · · · · · ·		
90.00	09000 CLI NI C	0				4, 725	•
91.00	09100 EMERGENCY	0	17, 850	0	4, 008	27, 093	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0		0	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	92.01
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
101.00	SPECIAL PURPOSE COST CENTERS			0	<u> </u>	Ŭ	
118.00		29, 025	82, 126	84, 212	25, 579	88, 902	118.00
	NONREIMBURSABLE COST CENTERS	r	1				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19100 RESEARCH	0	0	0			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	3, 958	0	428		192. 00 192. 02
	19202 MOB 19203 ARNETT SURGERY OFFICE	0	9, 587 4, 090	0	0		192.02
	19201 OCCUPATI ONAL MEDI CI NE	0	4,090	0	0		192.03
	19300 NONPALD WORKERS	0	0	0	0	0	193.00
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	29, 025	99, 761	84, 212	26, 007	88, 902	202.00

Heal th	Financial Systems	IU HEALTH WHIT	E HOSPITAL		In Lie	eu of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/26/2022 3:4	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00 1.01 1.02 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 1.01 1.02 4.00
7.00 7.01 7.02	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - TLMOB						5.00 7.00 7.01 7.02
8.00 9.00 10.00 11.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA						8.00 9.00 10.00 11.00
13.00 14.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	251, 240 6, 070	137, 327				13.00 14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0		16.00
30.00	03000 ADULTS & PEDI ATRI CS	29, 289	401		0 801, 695	0	30. 00
50, 00	ANCI LLARY SERVI CE COST CENTERS	49, 636	171		0 532, 567	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	984	8		0 183, 049	0	
55.00	05500 RADI OLOGY-THERAPEUTI C	16	5		0 37, 727	0	
56.00	05600 RADI OI SOTOPE	4,677	92		0 33, 100	0	
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 484 551	170 67		0 46, 569 0 56, 438	0	
60.00	06000 LABORATORY	559	0		0 188, 876	0	60.00
66.00	06600 PHYSI CAL THERAPY	1, 779	0		0 164, 729	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 16, 318	0	67.00
68.00	06800 SPEECH PATHOLOGY	2	0		0 8, 051	0	68.00
69.00	06900 ELECTROCARDI OLOGY	6, 114	0		0 46, 599	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	59, 371	0		0 60, 774	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 940	0		0 9, 151	0	
	07300 DRUGS CHARGED TO PATIENTS	0	32, 349		0 51, 929	0	
73.01 76.00	07301 ONCOLOGY DRUGS 03160 CARDI OPULMONARY	0 22, 885	102, 358 0		0 164, 325 0 112, 981	0	
	07697 CARDI OF CEMONART	22, 885	1		0 112, 981 0 29, 718	-	
70.77	OUTPATIENT SERVICE COST CENTERS	55			27,710	0	/0. //
90.00	09000 CLI NI C	13, 232	242		0 259, 967	0	90.00
91.00	09100 EMERGENCY	45, 517	1, 463		0 482, 596	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	121.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0	92.01
404 00	OTHER REIMBURSABLE COST CENTERS						101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
118.00		251, 161	137, 327		0 3, 287, 159	0	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	79	0		0 65, 467		192.00
		0	0		0 229, 248		192.02
	19203 ARNETT SURGERY OFFICE	0	0		0 62, 554		192. 03 192. 04
	19201 OCCUPATIONAL MEDICINE 19300 NONPAID WORKERS	0	0				192.04
200.00		0	0		0		200.00
200.00	5	0	0		0 0		200.00
201.00		251, 240	137, 327		0 3, 644, 428		202.00
						,	

	nancial Systems	IU HEALTH WHITE			u of Form CMS-25	352
ALLOCATIO	ON OF CAPITAL RELATED COSTS		Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Prepa 5/26/2022 3:45	
	Cost Center Description	Total			372072022 3.43	
		26.00		· · · · · · · · · · · · · · · · · · ·		
	NERAL SERVICE COST CENTERS					1
	101 CAP REL COSTS-BLDG & FIXT - HOSPITAL					1
	102 CAP REL COSTS-BLDG & FIXT - TLMOB					1
	0400 EMPLOYEE BENEFITS DEPARTMENT					4
	0500 ADMINISTRATIVE & GENERAL					5
	0700 OPERATION OF PLANT					7
	0701 OPERATION OF PLANT - HOSPITAL					7
02 00	0702 OPERATION OF PLANT - TLMOB					7
00 00	0800 LAUNDRY & LINEN SERVICE					8
00 00	900 HOUSEKEEPI NG					9
D. 00 01	000 DI ETARY				· · · · · · · · · · · · · · · · · · ·	10
1.00 01	100 CAFETERI A					11
3.00 01	300 NURSING ADMINISTRATION					13
4.00 01	400 CENTRAL SERVICES & SUPPLY					14
5.00 01	500 PHARMACY					15
6. 00 01	600 MEDICAL RECORDS & LIBRARY					16
IN	IPATIENT ROUTINE SERVICE COST CENTERS	· · ·				
0. 00 03	3000 ADULTS & PEDIATRICS	801, 695				30
AN	ICI LLARY SERVI CE COST CENTERS	· · · · · ·				
0.00 05	000 OPERATI NG ROOM	532, 567				50
4.00 05	400 RADI OLOGY-DI AGNOSTI C	183, 049				54
5.00 05	500 RADI OLOGY-THERAPEUTI C	37, 727				55
5. 00 05	600 RADI OI SOTOPE	33, 100				56
7.00 05	700 CT SCAN	46, 569				57
	800 MAGNETIC RESONANCE IMAGING (MRI)	56, 438				58
	000 LABORATORY	188, 876				60
	600 PHYSI CAL THERAPY	164, 729				66
	700 OCCUPATI ONAL THERAPY	16, 318				67
1	800 SPEECH PATHOLOGY	8, 051				68
	900 ELECTROCARDI OLOGY	46, 599				69
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	60, 774				71
	200 I MPL. DEV. CHARGED TO PATIENTS	9, 151				72
	300 DRUGS CHARGED TO PATIENTS	51, 929				73
	301 ONCOLOGY DRUGS	164, 325				73
	160 CARDI OPULMONARY	112, 981				76
	7697 CARDI OF OLIMONARY	29, 718				76
-	TPATIENT SERVICE COST CENTERS	29,710				/0
	2000 CLINIC	259, 967				90
						90 91
	100 EMERGENCY	482, 596				
	2200 OBSERVATION BEDS (NON-DISTINCT PART)					92
	2201 OBSERVATION BEDS (DISTINCT PART)	0				92
	100 HOME HEALTH AGENCY	0			1	101
	ECIAL PURPOSE COST CENTERS	0			1	01
18. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 287, 159			1	118
	INREIMBURSABLE COST CENTERS	5,207,159			1	10
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			1	190
	100 RESEARCH	0				190
	2200 PHYSI CLANS' PRI VATE OFFI CES	65, 467				191
	202 MOB	229, 248				192
	2203 ARNETT SURGERY OFFICE	62, 554				192
	2201 OCCUPATIONAL MEDICINE	0				192
	2300 NONPAID WORKERS	0				193
00.00	Cross Foot Adjustments	0				200
01.00	Negative Cost Centers	0				201
202.00	TOTAL (sum lines 118 through 201)	3, 644, 428			2	202

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH WHI	TE HOSPITAL Provider C	CN: 15-1312 P	eri od:	u of Form CMS-: Worksheet B-1	
				FI Te	rom 01/01/2021 5 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		CAP	ITAL RELATED CO	DSTS		072072022 3.4	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT - HOSPITAL (SQUARE FEET)	TLMOB	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	
		1.00	1.01	1. 02	4.00	5A	
	GENERAL SERVICE COST CENTERS	94, 810					1 1 00
1.01 1.02 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL	94, 810 C C 8, 717 C 13, 105	57, 501 0 0 2, 353 0 0	0	9, 687, 765 346, 342 455, 641 0	-8, 522, 891 0 0	
	00702 OPERATION OF PLANT - TLMOB	7, 129	0	7, 129	0	0	7.02
9.00 10.00 11.00 13.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	422 1, 407 3, 630 1, 127 1, 364 3, 730	1, 293 0 0 0 691	3, 630 1, 127 673	0 348, 729 385, 497 60, 681 1, 029, 615 0	0 0 0 0 0 0 0	
	01500 PHARMACY	1, 593			450, 977	0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	C	0	0	0	0	16.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8,036	8, 036	0	2, 028, 645	0	30.00
	ANCILLARY SERVICE COST CENTERS	1					
54.00 55.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	6, 747 2, 555 525	2, 555 525	0	406, 908 277, 305 65, 614	0 0 0	50.00 54.00 55.00
	05600 RADI OI SOTOPE	362		0	138, 289	0	56.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	494		0	426, 350 181, 132	0	57.00 58.00
	06000 LABORATORY	2, 319			0	0	60.00
	06600 PHYSI CAL THERAPY	2, 247		0	446, 134	0	66.00
	06700 OCCUPATI ONAL THERAPY	179			165, 273	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	84 534		0	94, 256 132, 580	0	68.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	034		0	132, 580	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	C	0	0	0	0	
	07301 ONCOLOGY DRUGS	1 054	° °	0	0	0	
	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	1,056			601, 513 101, 674	0	
	OUTPATIENT SERVICE COST CENTERS	1,200	, U	1,200	101, 074	0	/0. //
	09000 CLI NI C	3, 483				-	90.00
	09100 EMERGENCY	4, 996	4, 996	0	1, 267, 071	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	C	o	0	0	0	92.00 92.01
	OTHER REIMBURSABLE COST CENTERS		,		0	0	/2.01
	10100 HOME HEALTH AGENCY	C	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS	77 010	E7 E01	20.217	0 610 906	0 500 001	110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	77, 818	57, 501	20, 317	9, 619, 806	-8, 522, 891	110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0 0	0	0	0	190.00
	19100 RESEARCH	C		-	0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 982		2, 982	67, 959		192.00
	19202 MOB 19203 ARNETT SURGERY OFFICE	11, 065 2, 945		11, 065 2, 945	0		192. 02 192. 03
	19201 OCCUPATI ONAL MEDI CI NE	2, 743		2, 743	0		192.03
	19300 NONPALD WORKERS	C	0	0	0		193.00
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	58, 198	2, 771, 460	525, 023	1, 764, 948		201. 00 202. 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0. 613838	48. 198466	14. 072288	0. 182183 0		203. 00 204. 00
205.00	Unit cost multiplier (Wkst. B, Part				0.000000		205. 00
206.00	<pre>II) NAHE adjustment amount to be allocated (per Wkst. B-2)</pre>						206. 00
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						l

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH WHI	TE HOSPITAL Provider CO		eri od:	u of Form CMS-: Worksheet B-1	2552-10
				rom 01/01/2021 b 12/31/2021	Date/Time Pre 5/26/2022 3:4	
Cost Center Description	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATI ON OF PLANT - HOSPI TAL (SQUARE FEET)	OPERATION OF PLANT - TLMOB (SQUARE FEET)	LAUNDRY & LINEN SERVICE	
	5.00	7.00	7.01	7.02	8.00	
GENERAL SERVICE COST CENTERS	1	F	1			1 1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.02 00102 CAP REL COSTS-BLDG & FIXT - TLMOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 7.01 00701 OPERATI ON OF PLANT - HOSPITAL 7.02 00702 OPERATI ON OF PLANT - TLMOB 8.00 00800 LAUNDRY & LINEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 OHA00 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY 16.00 MEDI CAL RECORDS & LI BRARY INPATI ENT ROUTI NE SERVI CE COST CENTERS	27, 410, 779 581, 006 2, 396, 174 450, 100 82, 576 726, 140 557, 647 165, 591 1, 526, 412 384, 064 1, 379, 296	86, 093 13, 105 7, 129 422 1, 407 3, 630 1, 127 1, 364 3, 730 1, 593 0	42, 043 0 422 1, 293 0 0 691 3, 730 1, 593	23, 816 0 114 3, 630 1, 127 673 0 0 0 0	3, 328 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 1. \ 02\\ 4. \ 00\\ 5. \ 00\\ 7. \ 01\\ 7. \ 02\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
30. 00 03000 ADULTS & PEDI ATRI CS	3, 329, 675	8, 036	8, 036	0	3, 328	30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	1, 114, 648	6, 747	6, 747	0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 56.00 05600 RADI OL SOTOPE 57.00 05700 CT SCAN 58.00 05800 MAGNETI C 60.00 06000 LABORATORY 66.00 06600 PHYSI CAL	500, 787 154, 127 197, 891 564, 564 459, 996 1, 766, 606 671, 773	2, 555 525 362 494 697 2, 319 2, 247	525 362 494 697 2, 319		0 0 0 0 0 0 0 0 0 0	54.00 55.00 56.00 57.00 58.00 60.00 66.00
 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 07301 ONCOLOGY DRUGS 76. 00 03160 CARDI AC REHABI LI TATI ON 	216, 881 122, 559 199, 758 77, 206 11, 626 1, 077, 598 3, 409, 704 982, 323 156, 176	179 84 534 0 0 0 0 1, 056 1, 280	84 534 0 0 0 0 1, 056	0 0 0 0 0 0 0 0 0 1,280	0 0 0 0 0 0 0 0 0 0 0	67.00 68.00 69.00 71.00 72.00 73.00 73.01 76.00 76.97
OUTPATIENT SERVICE COST CENTERS	130, 170	1,200		1, 200	0	/0. //
90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0THER REI MBURSABLE COST CENTERS	452, 583 3, 346, 516 0	3, 483 4, 996 0	4, 996	0 0 0	0 0 0	90. 00 91. 00 92. 00 92. 01
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONDEL MPUIDSARD E COST CENTEDS	27, 062, 003	69, 101	42, 043	6, 824	3, 328	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192.02 19202 MOB 192.03 19203 ARNETT SURGERY OFFICE 192.04 19201 OCCUPATI ONAL MEDICINE 193.00 19300 NONPAID WORKERS 200.00 Cross Foot Adj ustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	0 143, 023 162, 502 43, 251 0 0 8, 522, 891	0 2, 982 11, 065 2, 945 0 0		0 2, 982 11, 065 2, 945 0 0 653, 120	0 0 0 0	191.00 192.00 192.02 192.03 192.04 193.00 200.00 201.00
202.00 Port I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 310932	761, 659 8. 846933		27. 423581	43. 472957	
204.00 Cost to be allocated (per Wkst. B, Part II)	498, 065	10, 557	684, 832	113, 749	29, 025	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 018170	0. 122623	16. 288847	4. 776159	8. 721454	
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	Financial Systems	IU HEALTH WHI		N 45 4040		u of Form CMS-	
CUST A	LLOCATION - STATISTICAL BASIS		Provider CC	F	Period: From 01/01/2021	Worksheet B-1	
					To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Cost Center Description	HOUSEKEEPING	DI ETARY (PATI ENT DAYS)	CAFETERI A (FTE' S)	NURSI NG	CENTRAL SERVI CES &	
		(TIME SPENT)	(PATTENT DAYS)	(FIE S)	ADMI NI STRATI ON	SUPPLY	
					(DI RECT	(COSTED	
		9.00	10.00	11.00	NURSING HOURS) 13.00	REQUIS.) 14.00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	13.00	14.00	-
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02 4.00	00102 CAP REL COSTS-BLDG & FIXT - TLMOB 00400 EMPLOYEE BENEFITS DEPARTMENT						1.02
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01 7.02	00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - TLMOB						7.01
7.02 8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	25, 004					9.00
10.00	01000 DI ETARY	749					10.00
11. 00 13. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	232		11, 071 1, 055			11.00 13.00
	01400 CENTRAL SERVICES & SUPPLY	245		1, 035		326, 722	
15.00	01500 PHARMACY	307	0	455	5 0	7, 894	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	(0 0	0	16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	4, 731	3, 328	2, 354	41, 758	38, 088	30.00
50.00	ANCI LLARY SERVICE COST CENTERS	4,751	5, 520	2, 33-	f	30,000	30.00
50.00	05000 OPERATI NG ROOM	3, 470		528		64, 548	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 320		445		1, 280	
55.00 56.00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	127 187		67 161		21 6, 082	1
57.00	05700 CT SCAN	255		604		1, 930	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	360		241		717	58.00
60.00		667	0	981		727	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	731		540 200		2, 314 0	1
68.00	06800 SPEECH PATHOLOGY	27		100		3	
69.00	06900 ELECTROCARDI OLOGY	390		200		7, 951	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(77, 206 11, 626	
72.00	07200 TMPL. DEV. CHARGED TO PATTENTS		0	(-	0	1
73.01	07301 ONCOLOGY DRUGS	0	0	(0 0	0	
76.00	03160 CARDI OPULMONARY	412		735		29, 761	1
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	342	0	166	0	71	76.97
90.00	09000 CLINIC	1, 390	0	351	3, 968	17, 208	90.00
91.00	09100 EMERGENCY	4, 474		1, 706			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_				_	92.00
92.01	09201 OBSERVATION BEDS (DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0	(0 0	0	92.01
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00		20, 584	3, 328	10, 889	74,655	326, 619	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	190.00
191.00	19100 RESEARCH	0	0	(191.00
	19200 PHYSICIANS' PRIVATE OFFICES	992		182			192.00
	19202 MOB 19203 ARNETT SURGERY OFFICE	2,403		(0		192.02 192.03
	19201 OCCUPATIONAL MEDICINE	1,025	0	ĺ			192.03
	19300 NONPAI D WORKERS	0	0	(0		193.00
200.00							200.00
201.00		1 0/7 ///	004 (01			025 040	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 067, 666	894, 681	267, 861	2, 115, 301	835, 913	202.00
203.00	-	42. 699808	268. 834435	24. 194833	28. 334351	2. 558484	203.00
204.00	Cost to be allocated (per Wkst. B,	99, 761		26, 007		251, 240	
205 00	Part II) Unit cost multiplier (Wkst. B, Part	3. 989802	25. 304087	2 240114	1. 190838	0. 768972	205 00
205.00	II)	3. 989802	25. 304087	2.349110	1. 190838	0. /089/2	205.00
206.00	NAHE adjustment amount to be allocated						206.00
207 00	(per Wkst. B-2)						207 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
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DDST. AI DOATI 09 - STATISTICAL RASIS Provider CR: 16-137 Provid:	Health Financial Systems	IU HEALTH WHIT	E HOSPI TAL	In Lieu of Form CM	IS-2552-10
To 12/31/202 Date/Time Preparent. (COSTED REQUES.) 100 Cost Conter Description PUNAMAY (COSTED REQUES.) RELICAL LIDBOWS (LIDBOWS				2 Period: Worksheet B	
Cost Feature Description PARAMATY (0):571 (0):00055 (0):00055 PARAMATY (0):551 (0):00055 PARAMATY (0):551 (0):00055 100 0010000000000000000000000000000000000				To 12/31/2021 Date/Time F	
Image: Constraint of the second sec	Cost Center Description	PHARMACY	MEDICAL	5/26/2022 3	3:45 pm
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200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 1,989,984 0 203.00 Unit cost multiplier (Wkst. B, Part I) 0.435008 0.000000 204.00 Cost to be allocated (per Wkst. B, Part I) 0.435008 0.000000 205.00 Unit cost multiplier (Wkst. B, Part I) 0.30020 0.000000 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part I) 0.030020 0.000000 207.00 NAHE unit cost multiplier (Wkst. D, I) 207.00 207.00		0	0		
201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, Part I) 1,989,984 0 203.00 Unit cost multiplier (Wkst. B, Part I) 0.435008 0.000000 204.00 Cost to be allocated (per Wkst. B, 137,327 0 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. D, 206.00 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00					200.00
Part I) Part I) 0.435008 0.000000 203.00 Unit cost multiplier (Wkst. B, Part I) 0.435008 0.000000 204.00 Cost to be allocated (per Wkst. B, Part I) 0.435008 0.000000 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 Unit cost multiplier (Wkst. B, Part II) 0.030020 0.000000 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 207.00					
203.00 Unit cost multiplier (Wkst. B, Part I) 0.435008 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, Part I) 137,327 0 204.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part I) 0.030020 0.000000 205.00 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00		1, 989, 984	0		202.00
Part II) Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.030020 0.000000 205.00 10 11) 205.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 0.040000 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00		0. 435008	0. 000000		203.00
205.00 Unit cost multiplier (Wkst. B, Part 0.030020 0.000000 205.00 205.00 11) NAHE adjustment amount to be allocated (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 207.00	204.00 Cost to be allocated (per Wkst. B,	1 1	O		204.00
206.00II) NAHE adjustment amount to be allocated (per Wkst. B-2)206.00207.00NAHE unit cost multiplier (Wkst. D,207.00		0. 030020	0, 000000		205.00
207.00(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,207.00	11)				
207.00 NAHE unit cost multiplier (Wkst. D, 207.00					206.00
Parts III and IV)					207.00
	Parts III and IV)				I

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	COSTS TO CHARGES		CN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:4	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	B RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 643, 407		7, 643, 4	07 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 547, 242		2, 547, 2	42 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	947, 571		947, 5		0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	254, 543		254, 5		0	55.00
56. 00 05600 RADI OI SOTOPE	319, 450		319, 4	50 0	0	56.00
57.00 05700 CT SCAN	815, 644		815, 6	44 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	687, 195		687, 1	95 0	0	58.00
60. 00 06000 LABORATORY	2, 570, 150		2, 570, 1	50 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	1, 124, 807	0	1, 124, 8	07 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	307,084	0	307, 0	84 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	171, 498	0	171, 4	98 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	349, 798		349, 7		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	298, 740		298, 7	40 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	44, 986		44, 9	86 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 881, 422		1, 881, 4	22 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	5, 953, 140		5, 953, 1	40 0	0	73.01
76. 00 03160 CARDI OPULMONARY	1, 490, 430		1, 490, 4	30 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	269, 975		269, 9	75 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	1, 121, 766		1, 121, 7	66 0	0	90.00
91.00 09100 EMERGENCY	5, 867, 892		5, 867, 8	92 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 210, 414		1, 210, 4	14	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	35, 877, 154	0	35, 877, 1	54 0	0	200. 00
201.00 Less Observation Beds	1, 210, 414		1, 210, 4		0	201.00
202.00 Total (see instructions)	34, 666, 740	0	34, 666, 7	40 0	0	202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL			In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C			iod: m 01/01/2021 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:4	epared: 5 pm
			XVIII		Hospi tal	Cost	
		Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 C	ost or Other	TEFRA	
			+ col. 7)		Ratio	Inpati ent	
						Ratio	
	6.00	7.00	8.00		9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	6, 843, 424		6, 843, 4	24			30.00
ANCI LLARY SERVI CE COST CENTERS							
50.00 05000 OPERATING ROOM	0	8, 136, 058	8, 136, 0	58	0. 313081	0.00000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	122, 297	6, 291, 651	6, 413, 9	48	0. 147736	0.00000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	17, 266	441, 939	459, 2	05	0. 554312	0.00000	55.00
56. 00 05600 RADI OI SOTOPE	260, 982	2, 583, 021	2, 844, 0	03	0. 112324	0.00000	56.00
57.00 05700 CT SCAN	498, 679	7, 359, 717	7, 858, 3	96	0. 103793	0.000000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	102, 077	1, 778, 498	1, 880, 5	75	0.365417	0.00000	58.00
60. 00 06000 LABORATORY	1, 421, 744	6, 777, 967	8, 199, 7	11	0. 313444	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY	648, 109	1, 613, 422		31	0. 497365	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	559, 798	210, 542		40	0. 398634	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	68, 548	237, 455	306, 0	03	0. 560445	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	0	1, 340, 505	1, 340, 5	05	0. 260945	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 903	402, 969	427, 8	72	0. 698199	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	109, 606	109, 6	06	0. 410434	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 719, 866	3, 579, 433	7, 299, 2	99	0. 257754	0.00000	73.00
73.01 07301 ONCOLOGY DRUGS	0	21, 476, 719	21, 476, 7	19	0. 277190	0.00000	73.01
76.00 03160 CARDI OPULMONARY	1, 507, 693	3, 190, 822	4, 698, 5	15	0. 317213	0.00000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1,607,599	1, 607, 5	99	0. 167937	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS							1
90. 00 09000 CLINIC	0	6, 157, 767	6, 157, 7	67	0. 182171	0. 000000	90.00
91.00 09100 EMERGENCY	967, 164	29, 483, 540	30, 450, 7	04	0. 192701	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 680	2, 519, 331	2, 527, 0	11	0. 478990	0.000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	0.000000	0.000000	
OTHER REIMBURSABLE COST CENTERS							
101.00 10100 HOME HEALTH AGENCY	0	0		0			1101.00
200.00 Subtotal (see instructions)	16, 770, 230	105, 298, 561	122, 068, 7	91			200.00
201.00 Less Observation Beds	,, 200	,,,					201.00
202.00 Total (see instructions)	16, 770, 230	105, 298, 561	122, 068, 7	91			202.00
· · · · · · · · · · · · · · · · · · ·			-				

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1312 Period: Tom 01/01/2021 Worksheet C Part I Period: Data Worksheet C Part I Cost Center Description PPS Inpatient Ratio Title XVIII Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS Interview Title XVIII Hospital Cost ANCILLARY SERVICE COST CENTERS Interview Interview Social Social ANCILLARY SERVICE COST CENTERS Interview Social Social Social Social Control Contro Contro Contro Control Control Control Control Control Control C	Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description PPS Inpatient Ratio Net of 11.00	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	epared: 15 pm
Ratio Ratio 10.00 30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 30.00 50.00 05000 OPERATING ROOM 0.000000 50.00 05500 RAD IOLGY-DI AGNOSTIC 0.000000 50.00 05500 RAD IOLGY-DI AGNOSTIC 0.000000 55.00 05500 RAD IOLGY-DI AGNOSTIC 0.000000 56.00 05500 RAD IOLGY-DI AGNOSTIC 0.000000 57.00 05700 CT SCAN 0.000000 56.00 05600 RAD IOLGOY-THERAPEUTI C 0.000000 57.00 05700 CT SCAN 0.000000 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MR1) 0.000000 60.00 06000 LABORATORY 0.000000 60.00 06600 PEECH PATHOLOGY 0.000000 61.00 06000 LABORATORY 0.000000 71.00 71.00 71.00 72.00 07200 [NPL, DEV, CHARGED TO PATI ENTS 0.000000 73.00 7300 [NULS CARGED TO PATI ENTS 0.000000 73.00 7300 [NULS CARGED TO PATI ENTS 0.000000 <tr< td=""><td></td><td></td><td>Title XVIII</td><td>Hospi tal</td><td>Cost</td><td></td></tr<>			Title XVIII	Hospi tal	Cost	
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000[ADULTS & PEDIATRICS 30.00 ANCI LLARY SERVICE COST CENTERS 50.00 50.00 COSOOO] OPERATI NG ROM 0.000000 54.00 05000] OPERATI NG ROM 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 56.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 56.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 58.00 05600 RADI OLOGY-THERAPEUTI C 0.000000 58.00 05600 RADI OLOGY-THERAPEUTI C 0.000000 58.00 05600 RADI TORY 0.000000 50.00 05600 RADI TORY 0.000000 60.00 66000 PHYSI CAL THERAPY 0.000000 61.00 06700 0CUPATI ONAL THERAPY 0.000000 62.00 06700 DECERARDI OLOGY 0.000000 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72.00 07300 DRUCLAS CHARGED TO PATI ENTS 0.000000	Cost Center Description					
INPATLENT ROUTI NE SERVI CE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS		11.00				
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 0PERATING ROM 0.000000 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 0.000000 56.00 57.00 CT SCAN 0.000000 56.00 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0.000000 58.00 60.00 06000 LABORATORY 0.000000 66.00 61.00 06000 LABORATORY 0.000000 66.00 62.00 06400 DABORATORY 0.000000 67.00 63.00 06400 PHYSI CAL THERAPY 0.000000 67.00 64.00 06400 PHYSI CAL THERAPY 0.000000 67.00 69.00 65000 ELCTROCARDI OLOGY 0.000000 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 73.00 73.00 73.00 73.00 73.00 73.00 73.01 07300 DRUGS CHARGED TO PATIE						30.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 57.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 56.00 57.00 05700 CT SCAN 0.000000 56.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 60.00 60.00 LABRATORY 0.000000 60.00 66.00 61.00 06000 LABRATORY 0.000000 66.00 62.00 O6500 PHYSI CAL THERAPY 0.000000 66.00 63.00 06600 PHYSI CAL THERAPY 0.000000 67.00 64.00 06700 OCCUPATI ONAL THERAPY 0.000000 68.00 65.00 06600 ELECTROCARDI OLOGY 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 73.01 07301 ONCLOGY DRUGS 0.000000 73.01 74.00 07000<		0.000000				50.00
55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05500 RADI OL SOTOPE 0.000000 56.00 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0.000000 58.00 60.00 06000 LABORATORY 0.000000 60.00 64.00 06600 PHYSI CAL THERAPY 0.000000 60.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 066300 SPECH PATHOLOGY 0.000000 68.00 69.00 06000 LECTROCARDI OLOGY 0.000000 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.01 73.01 07301 DRUGS CHARGED TO PATI ENTS 0.000000 73.01 74.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.01 75.00 07300 DRUGS CHARGED TO PATI ENTS 0.0000000 73.01 <						
56.00 05600 RADIOLSOTOPE 0.000000 56.00 57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 60.00 LABORATORY 0.000000 60.00 60.00 66.00 06600 PHYSI CAL THERAPY 0.000000 60.00 67.00 0C000 CCUPATIONAL THERAPY 0.000000 67.00 68.00 06600 SPEECH PATHOLOGY 0.000000 68.00 69.00 06600 PLLECTROCARDIOLOGY 0.000000 69.00 71.00 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 71.00 OT300 DRUGS CHARGED TO PATIENTS 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.01 73.01 OT301 ONCLOGY DRUGS 0.000000 73.01 73.01 74.01 NOLGY CREARGENCY 0.000000 73.01 75.90 07697 CARDIA C REHABILITATION 0.000000 73.01						
57.00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0.000000 58.00 60.00 06000 LABORATORY 0.000000 66.00 61.00 06000 CCUPATI ONAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPECH PATHOLOGY 0.000000 69.00 69.00 O46900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 73.00 73.01 07301 DRUCB CARGED TO PATI ENTS 0.000000 73.00 74.00 07100 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 73.01 07301 DRUCBCY COST CENTERS 0.000000 73.00 90.00 O9000 CLI NI C 0.000000 91.00 91.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 60.00 68.00 68.00 68.00 68.00 69.00 ELECTROCARDIOLOGY 0.000000 71.00 71.00 71.00 71.00 71.00 72.00 72.00 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>1</td></td<>						1
60.00 06000 LABORATORY 0.00000 60.00 66.00 06600 PHYSICAL THERAPY 0.00000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.01 07301 INCOLOGY DRUGS 0.000000 73.00 74.00 CABDI AC REHABILITATION 0.000000 73.01 76.07 7697 CARDI AC REHABILITATION 0.000000 76.00 70.00 OP0000 CLINIC 0.000000 90.00 91.00 90.00 09000 CLINIC 0.000000 92.01 92.01 92.01 92.00 <						
66.00 06600 PHYSI CAL THERAPY 0.00000 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 69.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07301 ONCOLOGY DRUGS 0.000000 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 73.00 76.07 07697 CARDI AC REHABILI TATI ON 0.000000 76.00 76.97 07697 CARDI AC REHABILI TATI ON 0.000000 76.97 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMEGENCY 0.000000 91.00 92.00 09200 DSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 91.00 92.01 07201 DSERVATI ON BEDS (DI STINCT PART) 0.0000000 92.01 0710						
67.00 06700 0CCUPATIONAL THERAPY 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.01 07301 ONCOGY DRUGS 0.000000 73.00 76.00 03160 CARDIOPULMONARY 0.000000 76.00 76.97 07697 CARDI AC REHABILITATION 0.000000 76.97 001704 PO100 MERGENCY 0.000000 76.97 90.00 09000 CLINIC 0.000000 91.00 92.00 92.01 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92.01 92.01 01000 MERGENCY 0.000000 92.01 92.01 92.01 92.01 01000 BSERVATION BEDS (DISTINCT PART) 0.						
68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 73.00 76.00 03160 CARDI OPULMONARY 0.000000 73.01 76.07 OAPTOT CARDIA C. REHABILITATION 0.000000 76.00 70.00 09000 CLINIC 0.000000 76.97 00.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 92.01 92.01 07201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 92.01 92.01 OTHER REI MBURSABLE COST CENTERS 101.00 000000 92.01 011.000 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
69.00 06900 ELECTROCARDIOLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.01 73.01 07301 ONCOLOGY DRUGS 0.000000 73.01 76.00 03160 CARDI OPULMONARY 0.000000 76.00 76.97 07697 CARDI AC REHABILITATION 0.000000 76.97 00000 CLINIC 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 91.00 91.00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0.000000 91.00 92.01 09201 OBSERVATION BEDS (DI STINCT PART) 0.000000 92.01 92.01 01000 HEALTH AGENCY 0.000000 92.01 92.01 01000 HEALTH AGENCY 0.000000 92.01 01000 IOBSERVATI ON B						
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.000000 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 73.01 76.00 03160 CARDI OPULMONARY 0.000000 76.00 76.97 OTAPT ENT SERVICE COST CENTERS 0.000000 76.97 00100 EMERGENCY 0.000000 90.00 90.00 09000 CLINIC 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92.00 92.01 09210 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92.01 92.01 09210 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92.01 92.01 09210 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92.01 92.01 001100 HOME HEALTH AGENCY 0.000000 92.01 92.01 010100 HOME HEALTH AGENCY 0.000000 201.00						
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.01 07301 ONCOLOGY DRUGS 0.000000 73.01 76.00 03160 CARDI OPULMONARY 0.000000 76.00 76.97 CARDI AC REHABILITATION 0.000000 76.97 0UTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 09000 CLINIC 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.01 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 92.00 92.01 09201 OBSERVATI ON BEDS (DI STINCT PART) 0.000000 92.01 0THER REIMBURSABLE COST CENTERS 101.00 0.000000 92.01 011.00 IOMBER REIMBURSABLE COST CENTERS 101.00 101.00 01000 Subtotal (see instructions) 200.00 201.00 201.00 Less Observation Beds 201.00 201.00						
73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.01 73.01 07301 ONCOLOGY DRUGS 0.000000 73.01 76.00 03160 CARDI AC REHABI LI TATI ON 0.000000 76.00 76.97 OAG97 CARDI AC REHABI LI TATI ON 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 0.000000 92.00 92.01 02010 DBER (DI STINCT PART) 0.000000 92.01 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 200.000 201.00 Subtotal (see instructions) 200.00 201.00 201.00						
73.01 07301 0NC0LOGY DRUGS 0.000000 73.01 76.00 03160 CARDI OPULMONARY 0.000000 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 76.97 0UTPATI ENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 91.00 92.01 09200 0BSERVATI ON BEDS (DI STI NCT PART) 0.000000 92.00 92.01 0THER REI MBURSABLE COST CENTERS 92.01 0THER REI MBURSABLE COST CENTERS 101.00 101.00 HOME HEALTH AGENCY 200.000 200.00 Subtotal (see instructions) 200.00 201.00 Less Observati on Beds 201.00						
76.00 03160 CARDI OPULMONARY 0.00000 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 0.000000 76.97 OUTPATI ENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.000000 92.00 92.01 OBSERVATI ON BEDS (DI STI NCT PART) 0.000000 92.01 011.00 IDISER REI MBURSABLE COST CENTERS 92.01 101.00 IDIME HEALTH AGENCY 0.000000 92.01 200.00 Subtotal (see instructions) 101.00 200.00 201.00						
76.97 O7697 CARDIAC REHABILITATION 0.00000 76.97 OUTPATIENT SERVICE COST CENTERS 00000 00000 01010 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 90.00 91.00 92.0						1
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 9000 CLINIC 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 91.00 91.00 92.00						
90.00 09000 CLINIC 0.00000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0THER REIMBURSABLE COST CENTERS 01.000 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00		0. 000000				76.97
91.00 09100 EMERGENCY 0.000000 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.01		1 1				
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92.01 92.01 0BSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0THER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 201.00						
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART) 0. 000000 92. 01 0THER REI MBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 101. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 201. 00						
OTHER REI MBURSABLE COST CENTERS101.0010100HOME HEALTH AGENCY101.00200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00		0. 000000				92.00
101.00 HOME HEALTH AGENCY 101.00 200.00 Subtotal (see instructions) 200.00 200.00 201.00 Less Observation Beds 201.00		0. 000000				92.01
200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00						
201.00 Less Observation Beds 201.00						
202.00 Total (see instructions) 202.00						
	202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:4	
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	7, 643, 407		7, 643, 40	07 0	7, 643, 407	30.00
50. 00 05000 OPERATING ROOM	2, 547, 242		2, 547, 24	2 0	2, 547, 242	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	947, 571		947, 57		947, 571	•
55. 00 05500 RADI OLOGY-THERAPEUTI C	254, 543		254, 54		254, 543	
56. 00 05600 RADI OI SOTOPE	319, 450		319, 45		319, 450	
57. 00 05700 CT SCAN	815, 644		815, 64		815, 644	•
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	687, 195		687, 19		687, 195	
60. 00 06000 LABORATORY	2, 570, 150		2, 570, 15		2, 570, 150	
66. 00 06600 PHYSI CAL THERAPY	1, 124, 807		1, 124, 80		1, 124, 807	
67.00 06700 OCCUPATI ONAL THERAPY	307,084		307, 08		307, 084	•
68.00 06800 SPEECH PATHOLOGY	171, 498		171, 49		171, 498	•
69. 00 06900 ELECTROCARDI OLOGY	349, 798		349, 79		349, 798	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	298, 740		298, 74	0 0	298, 740	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	44, 986		44, 98	6 0	44, 986	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 881, 422		1, 881, 42		1, 881, 422	73.00
73.01 07301 ONCOLOGY DRUGS	5, 953, 140		5, 953, 14	0 0	5, 953, 140	73.01
76.00 03160 CARDI OPULMONARY	1, 490, 430		1, 490, 43	0 0	1, 490, 430	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	269, 975		269, 97	5 0	269, 975	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	1, 121, 766		1, 121, 76	0 0	1, 121, 766	90.00
91.00 09100 EMERGENCY	5, 867, 892		5, 867, 89	02 0	5, 867, 892	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 210, 414		1, 210, 41	4	1, 210, 414	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0			0 0	0	92.01
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	35, 877, 154		35, 877, 15			
201.00 Less Observation Beds	1, 210, 414		1, 210, 41	4	1, 210, 414	
202.00 Total (see instructions)	34, 666, 740	0	34, 666, 74	0 0	34, 666, 740	202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPI TAL			In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C				Worksheet C Part I Date/Time Pre 5/26/2022 3:4	
i			e XIX	L	Hospi tal	Cost	
		Charges					
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00		9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	I		•				
30. 00 03000 ADULTS & PEDIATRICS	6, 843, 424		6, 843, 4	24			30.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM	0	8, 136, 058	8, 136, 0	58	0.313081	0.00000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	122, 297	6, 291, 651	6, 413, 9	48	0. 147736	0.00000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	17, 266	441, 939	459, 2	05	0.554312	0. 000000	55.00
56. 00 05600 RADI OI SOTOPE	260, 982	2, 583, 021	2, 844, 0	03	0. 112324	0.00000	56.00
57.00 05700 CT SCAN	498, 679	7, 359, 717	7, 858, 3	96	0. 103793	0.00000	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	102, 077	1, 778, 498	1, 880, 5	75	0.365417	0.00000	58.00
60. 00 06000 LABORATORY	1, 421, 744	6, 777, 967	8, 199, 7	11	0.313444	0.00000	60.00
66. 00 06600 PHYSI CAL THERAPY	648, 109	1, 613, 422			0.497365	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	559, 798	210, 542	770, 3	40	0.398634	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	68, 548	237, 455	306, 0	03	0.560445	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 340, 505	1, 340, 5	05	0.260945	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 903	402, 969	427, 8	72	0. 698199	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	109, 606	109, 6	06	0. 410434	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 719, 866	3, 579, 433	7, 299, 2	99	0. 257754	0.00000	73.00
73.01 07301 ONCOLOGY DRUGS	0	21, 476, 719	21, 476, 7	19	0.277190	0.00000	73.01
76.00 03160 CARDI OPULMONARY	1, 507, 693	3, 190, 822	4, 698, 5	15	0.317213	0.00000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1,607,599	1, 607, 5	99	0. 167937	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	6, 157, 767	6, 157, 7	67	0. 182171	0.00000	90.00
91.00 09100 EMERGENCY	967, 164	29, 483, 540	30, 450, 7	04	0. 192701	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 680	2, 519, 331	2, 527, 0	11	0.478990	0.00000	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	0.00000	0.00000	92.01
OTHER REIMBURSABLE COST CENTERS			•				
101.00 10100 HOME HEALTH AGENCY	0	0		0			101.00
200.00 Subtotal (see instructions)	16, 770, 230	105, 298, 561	122, 068, 7	91			200.00
201.00 Less Observation Beds							201.00
202.00 Total (see instructions)	16, 770, 230	105, 298, 561	122, 068, 7	91			202.00

Health Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 3:4	pared: 5 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
56. 00 05600 RADI OI SOTOPE	0.000000				56.00
57.00 05700 CT SCAN	0.000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
60. 00 06000 LABORATORY	0.000000				60.00
66.00 06600 PHYSI CAL THERAPY	0.000000				66, 00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0,000000				69,00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0,000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0, 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73. 01 07301 ONCOLOGY DRUGS	0. 000000				73.01
76. 00 03160 CARDI OPULMONARY	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS					
90, 00 09000 CLINIC	0.000000				90, 00
91. 00 09100 EMERGENCY	0. 000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000				92.01
OTHER REIMBURSABLE COST CENTERS	0.000000				72.01
101.00 10100 HOME HEALTH AGENCY					101.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	i I				202.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/26/2022 3:4	pared: 5 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	T	1	1			
50. 00 05000 OPERATI NG ROOM	532, 567				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	183, 049				1, 230	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	37, 727				0	55.00
56. 00 05600 RADI OI SOTOPE	33, 100				987	56.00
57.00 05700 CT SCAN	46, 569					57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	56, 438					
60. 00 06000 LABORATORY	188, 876				11, 379	60.00
66. 00 06600 PHYSI CAL THERAPY	164, 729				11, 583	66.00
67.00 06700 OCCUPATI ONAL THERAPY	16, 318					67.00
68.00 06800 SPEECH PATHOLOGY	8, 051	306, 003	0. 02631	0 32, 110	845	68.00
69. 00 06900 ELECTROCARDI OLOGY	46, 599	1, 340, 505	0. 03476	2 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	60, 774	427, 872	0. 14203	8 11, 789	1, 674	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 151	109, 606	0. 08349	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	51, 929	7, 299, 299	0. 00711	4 1, 057, 912	7, 526	73.00
73.01 07301 ONCOLOGY DRUGS	164, 325	21, 476, 719	0. 00765	1 0	0	73.01
76. 00 03160 CARDI OPULMONARY	112, 981	4, 698, 515	0. 02404	6 638, 106	15, 344	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	29, 718	1, 607, 599	0. 01848	6 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	259, 967	6, 157, 767	0. 04221	8 0	0	90.00
91.00 09100 EMERGENCY	482, 596			8 53, 132	842	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	126, 957	2, 527, 011	0. 05024	0 190	10	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0.00000	0 0	0	92.01
200.00 Total (lines 50 through 199)	2, 612, 421	115, 225, 367		2, 853, 167	55, 733	200. 00

Health Financial Systems	IU HEALTH WHI	TE HOSPI TAL		In Li	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 01/01/202 To 12/31/202	1 Date/Time Pre 5/26/2022 3:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdowr	1	
	Cost	Post-Stepdown	-	Adj ustments		
		Adjustments				
	1.00	2A	2.00	ЗA	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0		0	0 0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0 0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0	0 0	56.00
57.00 05700 CT SCAN	0	0		0	0 0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	o o	58.00
60. 00 06000 LABORATORY	0	0		0	o o	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	o o	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	o o	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	o o	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	o o	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	o o	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	o o	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	o l	73.00
73.01 07301 ONCOLOGY DRUGS	0	0		0	o o	73.01
76.00 03160 CARDI OPULMONARY	0	0		0	o o	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	o o	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0		0	0 0	90.00
91.00 09100 EMERGENCY	0	0		0	o o	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0	0 0	92.01
200.00 Total (lines 50 through 199)	0	0		0	0 0	200.00

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2021		
				To 12/31/2021	Date/Time Prep 5/26/2022 3:45	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 8, 136, 058		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 6, 413, 948		
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 459, 205		
56. 00 05600 RADI OI SOTOPE	0	0		0 2, 844, 003		
57.00 05700 CT SCAN	0	0		0 7, 858, 396		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 1, 880, 575	0. 000000	58.00
60. 00 06000 LABORATORY	0	0		0 8, 199, 711	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 261, 531		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 770, 340	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 306, 003	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 1, 340, 505	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 427, 872	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 109, 606	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 7, 299, 299	0.000000	
73.01 07301 ONCOLOGY DRUGS	0	0		0 21, 476, 719	0.000000	73.01
76.00 03160 CARDI OPULMONARY	0	0		0 4, 698, 515	0. 000000	76.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 1, 607, 599	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 6, 157, 767	0. 000000	90.00
91.00 09100 EMERGENCY	0	0		0 30, 450, 704	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 527, 011	0. 000000	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0		0 0	0. 000000	92.01
200.00 Total (lines 50 through 199)	0	0		0 115, 225, 367		200. 00

Health Financial Systems	IU HEALTH WHIT	E HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 3:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	43, 114		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0. 000000	84, 804		0 0	0	56.00
57.00 05700 CT SCAN	0. 000000	129, 458		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	42, 846		0 0	0	58.00
60. 00 06000 LABORATORY	0. 000000	494, 013		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	159, 017		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	106, 676		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	32, 110		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	11, 789		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1,057,912		0 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 000000	0		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	638, 106		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			1		. · · ·	
90, 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 000000	53, 132		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000	190		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)		2, 853, 167		0 0	0	200.00
					•	

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 3:4	
		Title	XVIII	Hospi tal	Cost	
			Charges	noopritar	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 313081	0			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 147736		.,,		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 554312		146, 94		0	55.00
56. 00 05600 RADI OI SOTOPE	0. 112324		00110		0	56.00
57.00 05700 CT SCAN	0. 103793	0	_/		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 365417	0	533, 79	98 0	0	58.00
60. 00 06000 LABORATORY	0. 313444		1, 877, 13	37 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 497365	0	451, 68	30 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 398634	0	46, 6	35 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 560445	0	34, 63	20 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 260945	0	325, 0	14 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 698199	0	160, 20	57 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 410434	0	36, 3	51 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 257754	0	744, 53	27 1, 840	0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 277190	0	10, 115, 0	28 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0. 317213	0	1, 016, 2	29 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 167937	0	664, 8	15 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 182171	0	2, 021, 5		0	
91. 00 09100 EMERGENCY	0. 192701	0	6, 165, 78	32 131, 307	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 478990		671, 7	95 0	0	
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0 0	0	
200.00 Subtotal (see instructions)		0	31, 534, 93	33 133, 147	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0 0		201.00
202.00 Net Charges (line 200 - line 201)		0	31, 534, 93	133, 147	0	202.00

Health Financial Systems	IU HEALTH WHITE HOSPITAL			In Lie	u of Form CMS.	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Peri od: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pro 5/26/2022 3:	epared: 45 pm
		Title	XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	705, 559	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	194, 037					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	81, 456					55.00
56. 00 05600 RADI OI SOTOPE	94,072					56.00
57.00 05700 CT SCAN	219, 858	0				57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	195,059					58.00
60. 00 06000 LABORATORY	588, 377	0				60.00
66. 00 06600 PHYSI CAL THERAPY	224, 650	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	18, 590	0				67.00
68.00 06800 SPEECH PATHOLOGY	19, 403	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	84, 811					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	111, 898					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	14, 920					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	191, 905					73.00
73.01 07301 ONCOLOGY DRUGS	2, 803, 785					73.01
76.00 03160 CARDI OPULMONARY	322, 361					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	111, 647	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	368, 271					90.00
91.00 09100 EMERGENCY	1, 188, 152					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.01 09201 OBSERVATION BEDS (DISTINCT PART)	321, 783					92.00 92.01
	-	-				200.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program	7, 860, 594					200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	7, 860, 594	25, 777				202.00

	Financial Systems IU HEALTH WHITE ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1312	Period: From 01/01/2021	Worksheet D-1	
			To 12/31/2021	Date/Time Prep 5/26/2022 3:49	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 889 3, 121	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	5, 121	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	and dave)		2, 560	
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	380	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	and dave) after December	21 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	Join days) arter December	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	- 31 of the cost	388	7
00	reporting period Total swing-bed NF type inpatient days (including private roc	om days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	to the Dreamon (avaluding	, owing had and	1 1/0	Ģ
50	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excruding	j swing-beu anu	1, 160	
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct		room days)	380	10
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		5 1	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14
00	Total nursery days (title V or XIX only)			0	15 16
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	
00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	of the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	231.10	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	15)		7, 643, 407	21
00	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	0	22
00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportir	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 21 of the cost reporti	ng pariod (lina	89, 667	2
	7 x line 19)			87,007	
00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			909, 551	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		6, 733, 856	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	nue line 22) (cco instrum	stions)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0. 00 0. 00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	36
00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 733, 856	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
0.0	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			0.155.55	
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		2, 157. 59 2, 502, 804	
. 00	Medically necessary private room cost applicable to the Progr			2, 502, 804	40
	Total Program general inpatient routine service cost (line 39			2, 502, 804	

				From 01/01/2021			
				To 12/31/2021	Date/Time Pre 5/26/2022 3:4		
			e XVIII	Hospi tal	Cost		
Cost Center Description	Total Inpatient C	Total ostInpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
00 NURSERY (title V & XIX only)						42.	
Intensive Care Type Inpatient H	ospital Units		1		l	1 42	
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT						43	
00 BURN INTENSIVE CARE UNIT						45	
00 SURGICAL INTENSIVE CARE UNIT						46	
00 OTHER SPECIAL CARE (SPECIFY)						47	
Cost Center Description					1.00	-	
00 Program inpatient ancillary ser	vice cost (Wkst D_3 col	3 line 200)	-		<u> </u>	2 48	
00 Total Program inpatient costs (ons)		3, 335, 906		
PASS THROUGH COST ADJUSTMENTS							
00 Pass through costs applicable t	o Program inpatient routi	ne services (from	m Wkst. D, sun	n of Parts I and	0	50	
<pre>111) 00 Pass through costs applicable t</pre>	o Program inpationt ancil	Lary corvicos (fi	rom Wkst D a	um of Parts II	0	51	
and IV)	o nogram inpatrent dicit	iary services (II	IOM WRSt. D, S				
00 Total Program excludable cost (0		
00 Total Program inpatient operati		related, non-phy	ysician anesth	netist, and	0	53	
medical education costs (line 4 TARGET AMOUNT AND LIMIT COMPUTA	· · · · · · · · · · · · · · · · · · ·					-	
00 Program discharges					0	54	
00 Target amount per discharge					0.00		
00 Target amount (line 54 x line 5					0		
00 Difference between adjusted inp	0						
00 Bonus payment (see instructions 00 Lesser of lines 53/54 or 55 fro							
market basket	in the cost reporting peri	ou enuring 1990, t		inpounded by the	0.00	59	
00 Lesser of lines 53/54 or 55 fro					0.00		
00 If line 53/54 is less than the					0	61	
which operating costs (line 53) amount (line 56), otherwise ent			60), or 1% of	the target			
00 Relief payment (see instruction		,			o	62	
00 Allowable Inpatient cost plus i		structions)			0	63	
PROGRAM INPATIENT ROUTINE SWING)	++!		010 004		
00 Medicare swing-bed SNF inpatier instructions)(title XVIII only)	t routine costs through L	December 31 01 the	e cost reporti	ng period (see	819, 884	64	
00 Medicare swing-bed SNF inpatier	t routine costs after Dec	cember 31 of the d	cost reporting	period (See	o	65	
instructions)(title XVIII only)							
00 Total Medicare swing-bed SNF in	patient routine costs (li	ne 64 plus line (65)(title XVII	l only). For	819, 884	66	
CAH (see instructions) OO Title V or XIX swing-bed NF inp	atient routine costs thro	ough December 31 (of the cost re	porting period	0	67	
(line 12 x line 19)		0					
00 Title V or XIX swing-bed NF inp	atient routine costs afte	er December 31 of	the cost repo	orting period	0	68 (
(line 13 x line 20) 00 Total title V or XIX swing-bed	NE inpationt routing cost	c (line 67 , line	o 49)		0	69	
PART III - SKILLED NURSING FACI	•		,		0	1 09	
00 Skilled nursing facility/other						70	
00 Adjusted general inpatient rout		n (line 70 ÷ line	2)			71	
00 Program routine service cost (I			25)			72	
00 Medically necessary private roc 00 Total Program general inpatient						73	
00 Capital -related cost allocated	-			Part II. column		75	
26, line 45)	,			,			
00 Per diem capital-related costs						76	
00 Program capital-related costs (00 Inpatient routine service cost						77	
00 Aggregate charges to beneficiar	. ,	m provider record	ds)			79	
00 Total Program routine service of		•		nus line 79)		80	
00 Inpatient routine service cost	per diem limitation			-		81	
00 Inpatient routine service cost	•					82	
00 Reasonable inpatient routine se		ions)				83	
00 Program inpatient ancillary ser 00 Utilization review - physician		tions)				84	
00 Total Program inpatient operati						86	
PART IV - COMPUTATION OF OBSERV	ATION BED PASS THROUGH CC						
00 Total observation bed days (see	instructions)				561	87	
00 Adjusted general inpatient rout					2, 157. 60	88	

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	801, 695	7, 643, 407	0. 10488	7 1, 210, 414	126, 957	90.00
91.00 Nursing Program cost	0	7,643,407	0.00000	0 1, 210, 414	0	91.00
92.00 Allied health cost	0	7, 643, 407	0.00000	0 1, 210, 414	0	92.00
93.00 All other Medical Education	0	7, 643, 407	0. 00000	0 1, 210, 414	0	93.00

	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1312	Peri od: From 01/01/2021 To 12/31/2021	Worksheet D-1 Date/Time Prep 5/26/2022 3:45	pared:
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
. 00 . 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			3, 889 3, 121	1.0 2.0
. 00 . 00	Private room days (excluding swing-bed and observation bed day		rivate room days,	3, 121	3.0
00	do not complete this line.	od dave)	-	2 540	4.0
. 00 . 00	Semi-private room days (excluding swing-bed and observation by Total swing-bed SNF type inpatient days (including private roo		er 31 of the cost	2, 560 380	
00	reporting period		21 -6 +6+		
. 00	Total swing-bed SNF type inpatient days (including private row reporting period (if calendar year, enter 0 on this line)	om days) arter December	31 of the cost	0	6.0
. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	r 31 of the cost	388	7.0
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m davs) after December (31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)	5.			
0.00	Total inpatient days including private room days applicable to newborn days) (see instructions)	o the Program (excluding	g swing-bed and	37	9. C
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	0	10.0
1.00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11. C
	December 31 of the cost reporting period (if calendar year, e	nter 0 on this line)	5 .		
2.00	Swing-bed NF type inpatient days applicable to titles V or XL through December 31 of the cost reporting period	X only (including priva	te room days)	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.0
4.00	after December 31 of the cost reporting period (if calendar yo Medically necessary private room days applicable to the Progra			0	14.0
5.00	Total nursery days (title V or XIX only)	am (exer during swring bed	uuys)	0	
6.00	Nursery days (title V or XIX only)			0	16.0
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost		17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	as after December 31 of	the cost		18. (
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	f the cost	231.10	19. (
0. 00	Medicaid rate for swing-bed NF services applicable to service: reporting period	s after December 31 of	the cost	0.00	20. (
1. 00	Total general inpatient routine service cost (see instructions	s)		7, 643, 407	21. (
2.00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	er 31 of the cost repor	ting period (line	0	22. (
3. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23. (
4 00	x line 18) Swing had aget applicable to NE type carviage through December	n 21 of the east report	ng partial (Line	89, 667	24.0
	Swing-bed cost applicable to NF type services through December 7×1 ine 19)		0	89,007	24.0
5. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.0
. 00	x line 20) Total swing-bed cost (see instructions)			909, 551	26.0
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 733, 856	27.(
8. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bed c	narges)	0	28. (
9.00	Private room charges (excluding swing-bed charges)			0	29. (
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	· lino 20)		0 0. 000000	30. 31.
	Average private room per diem charge (line 29 ÷ line 3)	÷ 111e 20)		0.00000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
3.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
4.00	Drivets reem east differential adjustment (line 2 v line 2F)			0 6, 733, 856	36.
4.00 5.00 6.00	Private room cost differential adjustment (line 3 x line 35)				37.
4.00 5.00 6.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	0, 755, 656	
4.00 5.00 6.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	•	fferential (line	0, 733, 830	
4.00 5.00 6.00 7.00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	USTMENTS			
4. 00 5. 00 6. 00 7. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	USTMENTS instructions)	TTerential (line	2, 157. 59 79, 831	

COMPUTATION OF INPATIENT OPERATING COST	P	<u>SPITAL</u> rovider CC	N: 15-1312	Peri od:	u of Form CMS- Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		Title	e XIX	Hospi tal	Cost	
Cost Center Description	Total Inpatient CostInpat	Total ient Days[Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only)						42. (
Intensive Care Type Inpatient Hospita 3.00 INTENSIVE CARE UNIT	al Units					43.
4. 00 CORONARY CARE UNIT						43.
5. 00 BURN INTENSIVE CARE UNIT						45.
6.00 SURGICAL INTENSIVE CARE UNIT						46.
7.00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	<u> </u>
8.00 Program inpatient ancillary service	cost (Wkst. D-3, col. 3, lir	ie 200)			44, 452	48.
9.00 Total Program inpatient costs (sum o	f lines 41 through 48)(see i	nstructior	ıs)		124, 283	49. (
PASS THROUGH COST ADJUSTMENTS 0.00 Pass through costs applicable to Pro	rom inpotiont routing convi	coc (from	What D au	of Dorte L and	0	50.
(111)	gram inpatrent routine servi	Ces (1101	WKSL. D, SUN	I UI PAILS I ANU	0	50.1
1.00 Pass through costs applicable to Pro	gram inpatient ancillary ser	vices (fro	om Wkst. D, s	um of Parts II	0	51.0
and IV)						50
2.00 Total Program excludable cost (sum o 3.00 Total Program inpatient operating co		l non-nhvs	sician anesth	etist and	0	
medical education costs (line 49 min		i, non phys			0	33.
TARGET AMOUNT AND LIMIT COMPUTATION	·					
4.00 Program discharges					0	54. 55.
5.00 Target amount per discharge 6.00 Target amount (line 54 x line 55)					0.00	
7.00 Difference between adjusted inpatien	t operating cost and target	amount (li	ne 56 minus	line 53)	0	
8.00 Bonus payment (see instructions)					0	
9.00 Lesser of lines 53/54 or 55 from the	cost reporting period endir	ig 1996, up	odated and co	mpounded by the	0.00	59.
market basket 0.00 Lesser of lines 53/54 or 55 from pri	or year cost report, updated	l by the ma	arket basket		0.00	60.
1.00 If line 53/54 is less than the lower				the amount by	0	
which operating costs (line 53) are		nes 54 x 6	50), or 1% of	the target		
amount (line 56), otherwise enter ze 2.00 Relief payment (see instructions)	ro (see instructions)				0	62.
3.00 Allowable Inpatient cost plus incent	ve payment (see instruction	is)			0	
PROGRAM INPATIENT ROUTINE SWING BED						
4.00 Medicare swing-bed SNF inpatient rou instructions)(title XVIII only)	tine costs through December	31 of the	cost reporti	ng period (See	0	64. (
5.00 Medicare swing-bed SNF inpatient rou	tine costs after December 31	of the co	ost reporting	period (See	0	65.
instructions)(title XVIII only)						
6.00 Total Medicare swing-bed SNF inpatie	nt routine costs (line 64 pl	us line 65	5)(title XVII	l only). For	0	66.
CAH (see instructions) 07.00 Title V or XIX swing-bed NF inpatien	t routine costs through Dece	mber 31 of	f the cost re	porting period	0	67.0
(line 12 x line 19)	5					
8.00 Title V or XIX swing-bed NF inpatien	t routine costs after Decemb	er 31 of t	the cost repo	orting period	0	68.
9.00 Total title V or XIX swing-bed NF in	patient routine costs (line	67 + line	68)		0	69.
PART III - SKILLED NURSING FACILITY,	· · · · · · · · · · · · · · · · · · ·		,			
0.00 Skilled nursing facility/other nursi	5					70.
1.00 Adjusted general inpatient routine s 2.00 Program routine service cost (line 9		0 ÷ line 2	2)			71.
3.00 Medically necessary private room cos		ne 14 x lir	ne 35)			73.
4.00 Total Program general inpatient rout			,			74.
5.00 Capital-related cost allocated to in	patient routine service cost	s (from Wo	orksheet B, F	Part II, column		75.
26, line 45) 6.00 Per diem capital-related costs (line	75 ÷ line 2)					76.
7.00 Program capital -related costs (line	•					77.
3.00 Inpatient routine service cost (line	74 minus line 77)					78.
9.00 Aggregate charges to beneficiaries f			· .			79.
0.00 Total Program routine service costs 1.00 Inpatient routine service cost per d	•	imitation	(iine /8 mir	ius i i ne 79)		80. 81.
2.00 Inpatient routine service cost per d						82.
3.00 Reasonable inpatient routine service						83.
4.00 Program inpatient ancillary services						84.
5.00 Utilization review - physician compe 6.00 Total Program inpatient operating co		85)				85. 86.
PART IV - COMPUTATION OF OBSERVATION		,				00.
7.00 Total observation bed days (see inst	ructions)				561	
88.00 Adjusted general inpatient routine c 39.00 Observation bed cost (line 87 x line		2)			2, 157. 60	
	SST LCOO LDCTPUCTLODCI				1, 210, 414	1 89

Health Financial Systems	IU HEALTH WHI	TE HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	801, 695	7, 643, 407	0. 10488	7 1, 210, 414	126, 957	90.00
91.00 Nursing Program cost	0	7, 643, 407	0.00000	0 1, 210, 414	0	91.00
92.00 Allied health cost	0	7, 643, 407	0.00000	0 1, 210, 414	0	92.00
93.00 All other Medical Education	0	7, 643, 407	0.00000	0 1, 210, 414	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT				u of Form CMS-2	2002 10
TWEATTENT ANGLEART SERVICE COST ATTORTONIENT	Provider C	CN: 15-1312	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Data (Tima Dra	norod.
			To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	0.500.057		
30. 00 03000 ADULTS & PEDIATRICS			2, 598, 957		30.00
ANCI LLARY SERVI CE COST CENTERS		0.0100	01	0	
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 3130		0	50.00
55. 00 05500 RADI OLOGY-DI AGNOSTI C		0. 1477		6, 369 0	54.00 55.00
56. 00 05600 RADI 0L0GY - THERAPEOTIC		0. 5543			56.00
57. 00 05700 CT SCAN		0. 1123			57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 1037			58.00
60. 00 06000 LABORATORY		0. 3134			60.00
66. 00 06600 PHYSI CAL THERAPY		0. 4973			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 3986			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 5604			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2609		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6981			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4104		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2577	54 1, 057, 912	272, 681	73.00
73.01 07301 ONCOLOGY DRUGS		0. 2771	90 0	0	73.01
76. 00 03160 CARDI OPULMONARY		0. 3172	13 638, 106	202, 416	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1679	37 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 1821		0	90.00
91. 00 09100 EMERGENCY		0. 1927		10, 239	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4789		91	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.0000		0	92.01
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 853, 167	833, 102	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			2, 853, 167		202.00

Health Financial Systems IU HE	ALTH WHITE HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	· CCN: 15-1312	Peri od:	Worksheet D-3	
	0		From 01/01/2021		
	Componer	t CCN: 15-Z312	To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
	Ti	tle XVIII	Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		-	1		
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		0.0100	1	0	
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI 0L0GY-DI AGNOSTI C		0. 31308			50.00 54.00
54. 00 05500 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1477.			54.00
56. 00 05600 RADI OLOGY - THERAPEOTIC		0. 5543		, o	
57. 00 05700 CT_SCAN		0. 1123			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 1037			58.00
60. 00 06000 LABORATORY		0. 3034		-	60.00
66. 00 06600 PHYSI CAL THERAPY		0. 49736			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 39863			67.00
68. 00 06800 SPEECH PATHOLOGY		0. 56044			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 26094			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0, 69819			71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 41043			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2577		26, 673	73.00
73.01 07301 ONCOLOGY DRUGS		0. 2771	0 0		73.01
76.00 03160 CARDI OPULMONARY		0. 3172	13 75, 278	23, 879	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 16793	37 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 1821	/1 0	0	90.00
91.00 09100 EMERGENCY		0. 19270	01 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4789	90 0	0	92.00
92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART)		0.0000	00 0	-	92.01
200.00 Total (sum of lines 50 through 94 and 96 thro			595, 114		
201.00 Less PBP Clinic Laboratory Services-Program o	nly charges (line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)			595, 114		202.00

Health Financial Systems IU HEALTH WHITE	HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1312	Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre	narad
			10 12/31/2021	5/26/2022 3:4	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	81, 516		30, 00
ANCI LLARY SERVICE COST CENTERS			01, 510		30.00
50. 00 05000 OPERATI NG ROOM		0. 3130	81 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1477		516	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 5543		0	55.00
56. 00 05600 RADI 0I SOTOPE		0. 1123	24 3, 204	360	56.00
57. 00 05700 CT SCAN		0. 1037			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 3654	17 1, 615	590	58.00
60. 00 06000 LABORATORY		0. 3134	44 28, 669	8, 986	60.00
66. 00 06600 PHYSI CAL THERAPY		0. 4973	65 2, 701	1, 343	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 3986	34 799	319	67.00
68.00 06800 SPEECH PATHOLOGY		0. 5604	45 821	460	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2609		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 6981		102	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 4104		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2577			
73. 01 07301 ONCOLOGY DRUGS		0. 2771		0	73.01
76.00 O3160 CARDI OPULMONARY		0. 3172			76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 1679	37 0	0	76.97
		0.4004	74		
90. 00 09000 CLINIC		0. 1821		0	90.00
91.00 09100 EMERGENCY		0. 1927			91.00 92.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 92. 01 09201 OBSERVATI ON BEDS (DI STINCT PART)		0. 4789		0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0000	173,090	-	
200.00 Less PBP Clinic Laboratory Services-Program only charges	s (ling 61)		173,090	44, 452	200.00
202.00 Net charges (line 200 minus line 201)	3 (1116 01)		173, 090		201.00
		1	175,070	I	1202.00

			From 01/01/2021	Part B	
			To 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
1	PART B - MEDICAL AND OTHER HEALTH SERVICES			7.00(.071	
00 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		7, 886, 371 0	1
00	OPPS payments			0	
00 01	Outlier payment (see instructions)			0	4.0 4.0
00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
	Line 2 times line 5	,		0	
00 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
. 00	Organ acquisitions			0	10.0
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			7, 886, 371	11.0
	Reasonable charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	Line (0)			12.0
	Total reasonable charges (from wkst. D-4, Pt. 111, col. 4, 1 Total reasonable charges (sum of lines 12 and 13)	TThe 69)		0	
	Customary charges				
	Aggregate amount actually collected from patients liable for			0	
. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13	1 3	ni a chargebasis	0	10.0
	Ratio of line 15 to line 16 (not to exceed 1.000000)	. ,		0. 000000	
	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	nlvifline 18 exceeds li	ne 11) (see	0	
. 00	instructions)	The to exceeds the	lie 11) (366		17.0
. 00	Excess of reasonable cost over customary charges (complete or	nlyifline 11 exceeds li	ne 18) (see	0	20.0
. 00	instructions) Lesser of cost or charges (see instructions)			7, 965, 235	21. (
. 00	Interns and residents (see instructions)			0	22.
	Cost of physicians' services in a teaching hospital (see ins [.] Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0	
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.0
	Deductibles and coinsurance amounts (for CAH, see instruction	-		62, 190	
	Deductibles and Coinsurance amounts relating to amount on lin Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			5, 668, 039 2, 235, 006	
. 00	instructions)			2, 233, 000	27.0
	Direct graduate medical education payments (from Wkst. E-4,	-		0	
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29))		0 2, 235, 006	
	Primary payer payments			2, 555	
	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI			2, 232, 451	32.
	Composite rate ESRD (from Wkst. I-5, line 11)	I CES)		0	33. (
	Allowable bad debts (see instructions)			624, 466	
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		405, 903 262, 014	
	Subtotal (see instructions)			2, 638, 354	
	MSP-LCC reconciliation amount from PS&R			0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	nc)		0	39. 39.
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for repla		ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
1	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 638, 354 0	
	Demonstration payment adjustment amount after sequestration			0	
1	Sequestration adjustment-PARHM pass-throughs			1 000 00/	40.0
1	Interim payments Interim payments-PARHM			4, 083, 896	41.0
	Tentative settlement (for contractors use only)			0	
. 01	Tentative settlement-PARHM (for contractor use only)				42.
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-1, 445, 542	43.0
	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	382, 361	
	§115. 2				1
	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. (
	Outlier reconciliation adjustment amount (see instructions)			0	
. 00	The rate used to calculate the Time Value of Money			0.00	92. (
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93. (94. (

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2021 Fo 12/31/2021	Worksheet E-1 Part I Date/Time Prep 5/26/2022 3:45	
		Title	XVIII	Hospi tal	Cost	
		I npati ent	t Part A	Par	t 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		3, 223, 94	7	4, 083, 896	1.00
2.00	Interim payments payable on individual bills, either		(C	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	· ·				
3.01	ADJUSTMENTS TO PROVIDER		(D	0	3. 01
3. 02				C	0	3. 02
3.03				C	0	3.03
3.04				D	0	3.04
3.05					0	3.05
0 50	Provider to Program	I				0 5
3.50 3.51	ADJUSTMENTS TO PROGRAM				0	3.50 3.51
3.51					0	3.5
3.52 3.53					0	3.52
3.54					0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			5	0	3.99
	3. 50-3. 98)			-		
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 223, 94	7	4, 083, 896	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					E O
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	II				
5.01	TENTATI VE TO PROVI DER			D	0	5.01
5.02			(D	0	5.02
5.03				2	0	5.03
	Provider to Program	I I		-	-	
5.50	TENTATI VE TO PROGRAM			D	0	5.50
5.51					0	5.51
5.52 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines				0	5.52 5.99
J. 77	5. 50-5. 98)		,		0	0.95
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					5. 50
6.01	SETTLEMENT TO PROVIDER		(D	0	6. O´
6.02	SETTLEMENT TO PROGRAM		142, 76	9	1, 445, 542	6. 02
7.00	Total Medicare program liability (see instructions)		3, 081, 17		2, 638, 354	7.00
				Contractor	NPR Date	
		0		Number 1.00	(Mo/Day/Yr) 2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C		Period: From 01/01/202		
		Component	CCN: 15-Z312	To 12/31/202	1 Date/Time Pre 5/26/2022 3:4	
		Title	e XVIII	Swing Beds - SN		
		Inpatier	nt Part A	Pa	nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		1, 112, 2	39	C) 1.
00	Interim payments payable on individual bills, either			0	0) 2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					1
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
01	ADJUSTMENTS TO PROVIDER			0	0	3 3
)2				0	0	
)3				0	0) 3
)4				0	0) 3
)5				0	0) 3
	Provider to Program		1		_	_
50	ADJUSTMENTS TO PROGRAM			0	0	-
51				0	0	-
52				0	0	
53				0	0	
54				0		
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0) 3
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 112, 2	30	0	4
50	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 112, 2	57	Ĭ	ή ⁻
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
0	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		1	0		
)1)2	TENTATI VE TO PROVI DER			0		
)2)3				0		
55	Provider to Program		1	0		4 3
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0) 5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0) 5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
11	the cost report. (1)			0		
)1	SETTLEMENT TO PROVIDER		(2.2.5)	0	0	
)2	SETTLEMENT TO PROGRAM		63, 0			
00	Total Medicare program liability (see instructions)		1, 049, 2	Contractor	NPR Date) 7
				Number	(Mo/Day/Yr)	
			0	1, 00	2.00	
00	Name of Contractor			1.00	2.00	8

Heal th	Financial Systems IU HEAL	TH WHITE HOSPITAL	In Lie	u of Form CMS-	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1312	Peri od:	Worksheet E-1	
			From 01/01/2021 To 12/31/2021	Part II	norod.
			10 12/31/2021	Date/Time Pre 5/26/2022 3:4	
		Title XVIII	Hospi tal	Cost	
	<u></u>			1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST RE				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CAL				-
1.00	Total hospital discharges as defined in AARA §4102 fr				1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines		for cost		2.00
	reporting periods beginning on or after 10/01/2013, I				
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line				3.00
4.00	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum c		d plus for cost		4.00
	reporting periods beginning on or after 10/01/2013, I				
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 lir				5.00
6.00	Total hospital charity care charges from Wkst. S-10,				6.00
7.00	CAH only - The reasonable cost incurred for the purch line 168	nase of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruc	ctions)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after seques	stration (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructi	ons)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line	30 and line 31) (see instructio	ns)		32.00

	nancial Systems IU HEALTH WHITE HOS ION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1312	Peri od:	u of Form CMS-2 Worksheet E-2	-002
	Cor	nponent CCN: 15-Z312	From 01/01/2021 To 12/31/2021	Date/Time Prep 5/26/2022 3:45	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A 1.00	Part B 2.00	
CC	MPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		828, 083	0	1.0
.00 Ir	npatient routine services - swing bed-NF (see instructions)				2.0
	ncillary services (from Wkst. D-3, col. 3, line 200, for Part A,		231, 512	0	3.0
	art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b	ed pass-through, see			
	nstructions) ursing and allied health payment-PARHM (see instructions)				3. (
1	er diem cost for interns and residents not in approved teaching	orogram (see		0.00	4. (
	nstructions)	5			
	rogram days		380	0	5.0
	nterns and residents not in approved teaching program (see instr		0	0	6.0
	tilization review - physician compensation - SNF optional method ubtotal (sum of lines 1 through 3 plus lines 6 and 7)	oniy	0 1, 059, 595	0	7.0 8.0
	rimary payer payments (see instructions)		1,037,373	0	9.0
	ubtotal (line 8 minus line 9)		1, 059, 595	Ő	10.0
	eductibles billed to program patients (exclude amounts applicabl	e to physician	0	0	11. (
1.1	rofessional services)			_	
	ubtotal (line 10 minus line 11)		1, 059, 595	0	12.0
	pinsurance billed to program patients (from provider records) (e pr physician professional services)	xci ude coi nsurance	10, 388	0	13.0
	D% of Part B costs (line 12 x 80%)			0	14. (
	ubtotal (see instructions)		1, 049, 207	0	15. (
1	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. (
1	oneer ACO demonstration payment adjustment (see instructions)	`			16.
	ural community hospital demonstration project (§410A Demonstrati djustment (see instructions)	on) payment	0		16. 5
	emonstration payment adjustment amount before sequestration		0	0	16. 9
	lowable bad debts (see instructions)		0	0	17. (
7.01 Ac	djusted reimbursable bad debts (see instructions)		0	0	17. (
	lowable bad debts for dual eligible beneficiaries (see instruct	i ons)	0	0	18.0
	otal (see instructions) equestration adjustment (see instructions)		1, 049, 207 0	0	19. (19. (
	emonstration payment adjustment amount after sequestration)		0	0	19.0
	equestration adjustment-PARHM pass-throughs		0	0	19. (
9.25 Se	equestration for non-claims based amounts (see instructions)		0	0	19.2
1	nterim payments		1, 112, 239	0	20.0
	nterim payments-PARHM		0	0	20.0
	entative settlement (for contractor use only) entative settlement-PARHM (for contractor use only)		0	0	21. (21. (
1	alance due provider/program (line 19 minus lines 19.01, 19.02, 1	9.25.20. and 21)	-63, 032	0	22.0
	al ance due provider/program-PARHM (see instructions)				22.0
	rotested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	50, 290	0	23.0
	napter 1, §115.2 ural Community Hernital Demonstration Draiget (\$4104 Demonstrati	an) Adjuctment			
	iral Community Hospital Demonstration Project (§410A Demonstrations the first year of the current 5-year demonstration period				200. 0
	entury Cures Act? Enter "Y" for yes or "N" for no.				200.0
	ost Reimbursement				
	edicare swing-bed SNF inpatient routine service costs (from Wkst	. D-1, Pt. II, line			201. (
1	6 (title XVIII hospital)) edicare swing-bed SNF inpatient ancillary service costs (from Wk	st D-3 col 3 lin	۹		202. 0
	DO (title XVIII swing-bed SNF))		0		202. (
03. 00 Ta	otal (sum of lines 201 and 202)				203. (
	edicare swing-bed SNF discharges (see instructions)				204. (
	<pre>mputation of Demonstration Target Amount Limitation (N/A in fir eriod)</pre>	st year of the curre	nt 5-year demonst	ration	
	edicare swing-bed SNF target amount				205. (
	edicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206. 0
Ad	ljustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme	nt			
1	rogram reimbursement under the §410A Demonstration (see instruct	-			207. (
	edicare swing-bed SNF inpatient service costs (from Wkst. E-2, c	ol. 1, sum of lines	1		208. (
	nd 3) djustment to Medicare swing-bed SNF PPS payments (see instructio	ns)			209. (
	eserved for future use	13)			209. C 210. C
	mparision of PPS versus Cost Reimbursement				
	otal adjustment to Medicare swing-bed SNF PPS payment (line 209	olus line 210) (see			215. (

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1312	Period: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Pre 5/26/2022 3:4	pare
		Title XVIII	Hospi tal	Cost	0 p
		· ·			
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC	CARE PART A SERVICES - COST	REI MBURSEMENT		
. 00	Inpatient services			3, 335, 906	
. 00	Nursing and Allied Health Managed Care payment (see instru	uctions)		0	2.
. 00	Organ acquisition			0	3.
. 00	Subtotal (sum of lines 1 through 3)			3, 335, 906	
. 00	Primary payer payments	- >			5.
. 00	Total cost (line 4 less line 5). For CAH (see instructions	S)		3, 369, 265	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				-
. 00	Reasonable charges Routine service charges			0	7.
. 00	Ancillary service charges			0	8.
. 00	Organ acquisition charges, net of revenue			0	
0.00	Total reasonable charges			0	
0.00	Customary charges				1
1.00	Aggregate amount actually collected from patients liable f	for payment for services on	a charge basis	0	1 11.
2.00	Amounts that would have been realized from patients liable			0	12.
	had such payment been made in accordance with 42 CFR 413.1	13(e)	0		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
4.00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complete	e only if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
6.00	Excess of reasonable cost over customary charges (complete	e only if line 6 exceeds lir	ne 14) (see	0	16
7 00	instructions)	notructions)		0	17
7.00	Cost of physicians' services in a teaching hospital (see i COMPUTATION OF REIMBURSEMENT SETTLEMENT	Instructions)		0	17.
8.00	Direct graduate medical education payments (from Worksheet	t F-4 line 49)		0	18.
9.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 369, 265	
D. 00	Deductibles (exclude professional component)			318, 756	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			3, 050, 509	22
3.00	Coinsurance			0	23
4.00	Subtotal (line 22 minus line 23)			3, 050, 509	24
5.00	Allowable bad debts (exclude bad debts for professional se	ervices) (see instructions)		47, 183	
5.00	Adjusted reimbursable bad debts (see instructions)			30, 669	
7.00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		14, 764	
8.00	Subtotal (sum of lines 24 and 25, or line 26)			3, 081, 178	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruct	tions)		0	29
9.98	Recovery of accel erated depreciation.			0	29
9.99	Demonstration payment adjustment amount before sequestrati	UII		0 2 001 170	
). 00). 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 081, 178 0	30
). 01). 02	Demonstration payment adjustment amount after sequestration	ac		0	
). 02). 03				0	30
1.00	Interim payments			3, 223, 947	
1.01	Interim payments-PARHM			0,220,747	31
2.00	Tentative settlement (for contractor use only)			0	
2. 01	Tentative settlement-PARHM (for contractor use only)			Ū	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 3	30.02, 31, and 32)		-142, 769	
	Balance due provider/program-PARHM (lines 2, 3, 18, and 26		and 32 01)	, , , , ,	33
3.01	Dalance une provider/program-PARTM (TITLES Z. S. To. and Z.				

	E SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 01/01/2021	Worksheet G	
nd-ty Iy)	ype accounting records, complete the General Fund column			rom 01/01/2021 o 12/31/2021	Date/Time Pre	par
57		General Fund	Speci fi c	Endowment Fund	5/26/2022 3:4 Plant Fund	5 p
		1.00	Purpose Fund 2.00	3.00	4.00	<u> </u>
	CURRENT ASSETS					
	Cash on hand in banks	38, 894, 549		-	0	
00	Temporary investments	0	0	-	0	
	Notes recei vabl e Accounts recei vabl e	4, 857, 476		0	0	
	Other receivable	4, 857, 478			0	
	Allowances for uncollectible notes and accounts receivable	043		o o	0	
	Inventory	586, 764	0	0	0	
00	Prepai d'expenses	167, 309	0	0 0	0	:
	Other current assets	0	0	0	0	
	Due from other funds	0		-	0	
	Total current assets (sum of lines 1-10)	44, 847, 141	(0 0	0	11
	Land	972, 779		ol	0	11:
	Land improvements	122, 178		-	0	
00	Accumulated depreciation	-115, 181	(c	0 0	0	14
	Bui I di ngs	30, 277, 094	C	0 0	0	
	Accumulated depreciation	-8, 355, 900		0	0	
	Leasehold improvements Accumulated depreciation			0	0	
	Fixed equipment				0	
	Accumulated depreciation	0			0	1
	Automobiles and trucks	0		0	0	
. 00	Accumulated depreciation	C	c c	0	0	2
	Major movable equipment	12, 481, 024	C	0	0	1 -
	Accumulated depreciation	-7, 127, 493		0	0	
	Minor equipment depreciable				0	
	Accumulated depreciation HIT designated Assets				0	
	Accumul ated depreciation	C C		o o	0	
	Mi nor equi pment-nondepreci abl e	0		0	0	
. 00	Total fixed assets (sum of lines 12-29)	28, 254, 501	c	0	0	30
	OTHER ASSETS					
	Investments	188, 509		-	0	
	Deposits on leases Due from owners/officers				0	
	Other assets	141, 200			0	
	Total other assets (sum of lines 31-34)	329, 709		0	0	
	Total assets (sum of lines 11, 30, and 35)	73, 431, 351	0	0	0	
	CURRENT LIABILITIES					
	Accounts payable	2, 505, 086		-	0	
	Salaries, wages, and fees payable	618, 808		-	0	
	Payroll taxes payable	47, 142	0		0	
	Notes and Loans payable (short term) Deferred income	650, 000			0	
	Accelerated payments	2, 304, 555		, 0	0	4
	Due to other funds	4, 979, 055		0 0	0	
. 00	Other current liabilities	11, 042		0	0	44
. 00	Total current liabilities (sum of lines 37 thru 44)	11, 115, 688	0	0 0	0	4!
	LONG TERM LI ABI LI TI ES					١.
	Mortgage payable Notes payable	18, 335, 000		0	0	
	Unsecured Loans	18, 335, 000			0	
	Other long term liabilities	29, 965		0	0	
	Total long term liabilities (sum of lines 46 thru 49)	18, 364, 965		0	0	
00	Total liabilities (sum of lines 45 and 50)	29, 480, 653	C	0	0	5
	CAPITAL ACCOUNTS	10	1			١.
	General fund balance	43, 950, 698				5
	Specific purpose fund Donor created - endowment fund balance - restricted		0	0		5
	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		5
	Governing body created - endowment fund balance			0		5
	Plant fund balance - invested in plant			Ŭ	0	
	Plant fund balance - reserve for plant improvement,	1			0	
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	43, 950, 698		0	0	
. 00	Total liabilities and fund balances (sum of lines 51 and	73, 431, 351	(ין 0	0	60

Health Financial Systems		IU HEALTH WHITE HOSPITAL			In Lieu of Form CMS-2552-10			
STATEMENT OF CHANGES IN FUND BALANCES			Provider CCN: 15-1312		Peri od: From 01/01/2021 To 12/31/2021		Worksheet G-1 Date/Time Pre 5/26/2022 3:4	pared:
		General	Fund	Speci al	Purpos	se Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET INTERCOMPANY TRANSACTIONS ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	47, 363 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	34, 185, 297 9, 718, 037 43, 903, 334 47, 364 43, 950, 698 0			0 0 0 0		$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		43, 950, 698			0		19.00
		Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET INTERCOMPANY TRANSACTIONS ROUNDING Total additions (sum of line 4-9)	0	0 0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0	0 0 0 0 0 0		0 0 0			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CO	CN: 15-1312	Period: From 01/01	/2021	Worksheet G-2 Parts I & II	
					/2021	Date/Time Pre 5/26/2022 3:4	
	Cost Center Description		I npati ent	Outpati	ent	Total	
			1.00	2.00)	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services			[
1.00	Hospi tal		6, 166, 7	38		6, 166, 738	•
2.00	SUBPROVIDER - IPF						2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVIDER						4.00
5.00	Swing bed - SNF		676, 6	86		676, 686	
6.00	Swing bed - NF			0		0	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		6, 843, 4	24		6, 843, 424	10.00
11 00	Intensive Care Type Inpatient Hospital Services						1 4 4 4 4 4
11.00	I NTENSI VE CARE UNI T						11.00
12.00	CORONARY CARE UNIT						12.00
	BURN INTENSIVE CARE UNIT						13.00
	SURGI CAL I NTENSI VE CARE UNI T						14.00
	OTHER SPECIAL CARE (SPECIFY)	C 1 .					15.00
16.00	Total intensive care type inpatient hospital services (sum o	r iines		0		0	16.00
17 00	11-15)		(042 4	24		(040 404	17 00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 1) Ancillary services	0)	6, 843, 4 8, 951, 9		37, 923	6, 843, 424 76, 089, 885	
18.00 19.00	Outpatient services		8, 951, 9 974, 8		57, 923 50, 638		•
19.00 20.00	RURAL HEALTH CLINIC		974, 8				•
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0		20.00
21.00	HOME HEALTH AGENCY			0	0	0	
22.00	AMBULANCE SERVICES				0	0	22.00
	CMHC						23.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)						24.00
26.00	HOSPICE						26.00
20.00	OTHER (SPECIFY)			0	0	0	27.00
	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst	16, 770, 2	30 105, 29	•		28.00
20.00	G-3. Line 1)	5 10 WK31.	10, 770, 2	100,21	/0, 301	122,000,771	20.00
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			34, 73	30, 470		29.00
30.00	ADD (SPECIFY)			0			30,00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		34, 73	30, 470		43.00
	to Wkst. G-3, line 4)						

Heal th	Financial Systems	IU HEALTH WHITE	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-1312	Peri od:	Worksheet G-3		
From 01/01/2021 To 12/31/2021						oared:	
					1.00		
1.00	Total patient revenues (from Wkst. G-2, Par	122, 068, 791	1.00				
2.00	Less contractual allowances and discounts of	82, 952, 687	2.00				
3.00	Net patient revenues (line 1 minus line 2)				39, 116, 104	3.00	
4.00	Less total operating expenses (from Wkst. 0		3)		34, 730, 470		
5.00	Net income from service to patients (line 3	3 minus line 4)			4, 385, 634	5.00	
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc				0	6.00	
7.00	Income from investments				0	7.00	
8.00	Revenues from telephone and other miscellar	neous communication	services		0	8.00	
9.00	Revenue from television and radio service	0					
10.00	Purchase di scounts	0	10.00				
11.00					0	11.00	
12.00	5				0	12.00	
13.00					0	13.00	
14.00	1 5 5	Jests			0	14.00	
15.00					0	15.00	
16.00			0	16.00			
17.00			0	17.00			
18.00	Revenue from sale of medical records and at		0	18.00			
19.00					0	19.00	
20.00	5	0	20.00				
21.00					0	21.00	
22.00					0	22.00	
23.00		0	23.00				
24.00					751, 302		
24.50					4, 581, 101		
25.00					5, 332, 403		
26.00					9, 718, 037		
27.00		0	27.00				
28.00		0 710 027	28. 00 29. 00				
29.00	Net income (or loss) for the period (line 2	20 III IIUS II IIE 28)			9, 718, 037	∠9. UU	