This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0173 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 Time: 11:29 am use only] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Initial Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH ARNETT HOSPITAL (15-0173) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Todo	d Williams	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Todd Williams			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	278, 535	17, 581	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	278, 535	17, 581	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0173 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 11:29 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 6165 MCCARTY LANE 1.00 PO Box: 1.00 State: IN County: TI PPECANOE 2.00 City: LAFAYETTE Zip Code: 47905 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N)
V XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH ARNETT 150173 29200 11/10/2008 Ν 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Υ N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Υ 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22.03 N Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, yes or "N" for no. 23 00 Which method is used to determine Medicaid days on lines 24 and/or 25 23 00 3 N below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

		Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	Stat Medica eligil unpa	aid ole	HMO da	ys M	ledi cai d days	
		1. 00	2. 00	3. 00	4. 00		5. 00		6. 00	
24. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3,	1, 500	527	13		48	9,	430	37	24. 00
25. 00	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	0	0	O		0		0		25. 00
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
	inimo para ana errgrore but unpara days in cordini 3.				Urk				of Geogr	
26. 00	Enter your standard geographic classification (not wa		at the beg	inning of t	the	1. 0	2		2. 00	26. 00
27. 00	reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,								27. 00	
35. 00	effect in the cost reporting period.								35. 00	
	Beginning: 1.00								di ng: 2. 00	-
36. 00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb	per	1.0			00	36. 00
37. 00										37. 00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)								37. 01	
38. 00	100 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.									38. 00
	Y/N									
	.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)								39. 00	
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobno in column 2, for discharges on or after October 1.	oer 1. Ente	"Y" for y			N		1,00	N	40. 00
							1. 00	2. 0		
45 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for disn	conorti onat	e share in	accord	ance	N	Y	N	45. 00
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wksi	eption for	· extraordi na	nry circumst	tances		N	N N	N	46. 00
47. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS (Ü	N	N	N	47. 00
48. 00	Is the facility electing full federal capital payment Teaching Hospitals	t? Enter "	/" for yes	or "N" for	no.		N	N	N	48. 00
56. 00							56. 00			
57. 00	"Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFW which month(s) of the cost report the residents were	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e) on duty, i	n approved If column ng period? E-4. If co For cost O(1)(iv) and the respo	I GME progra 1 is "Y", o 2 Enter "Y" Dlumn 2 is " reporting p nd (v), rega onse to line	ams tra did 'for y 'N", periods ardless e 56 is	ined es or of "Y"	Y			57.00
58. 00	for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement f	or physicia			4.	N			58. 00

Health Financial Systems IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0173 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 11: 29 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 3.00 1.00 2.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 instructions) 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 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61 04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year' primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents 0.00 0.00 61.10 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 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.

		1. 00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
	Enter the number of FTE residents that your hospital trained in this cost reporting period for which	0.00	62.00
	your hospital received HRSA PCRE funding (see instructions)		l
62. 01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC program. (see instructions)		l
	Teaching Hospitals that Claim Residents in Nonprovider Settings		l
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter	Y	63. 00
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		

Health Financial Systems	IU HEA	LTH ARNETT HOSPITAL		<u>I</u> n Lie	u of Form CMS-2	<u> 2552</u> -10
HOSPITAL AND HOSPITAL HEALTH CARE COM	PLEX IDENTIFICATION D	ATA Provider C		eri od:	Worksheet S-2	
			T	rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/29/2024 11:	pared: 29 am
			Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2.00	3.00	-
Section 5504 of the ACA Base Ye	ear FTE Residents in 1	Nonprovider Settings		•		
64.00 period that begins on or after Enter in column 1, if line 63 i in the base year period, the nu resident FTEs attributable to r	s yes, or your facili mber of unweighted no	ty trained residents on-primary care	0.00	0.00	0. 000000	64. 00
settings. Enter in column 2 th	ne number of unweighte	ed non-primary care				
of (column 1 divided by (column						
	Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	7//	
	1.00	2.00	3. 00	4.00	5. 00	
65.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65. 00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unwei ghted	Ratio (col. 1/	33. 33
			Nonprovi der	Hospi tal	(COI. I + COI.	
			Si te	nospi tai	2))	
			1. 00	2.00	3.00	-
Section 5504 of the ACA Current		in Nonprovider Setting	sEffective f	or cost reporti	ng peri ods	
beginning on or after July 1, 2 66.00 Enter in column 1 the number of		any aona maoi dont	0.00	0.00	0. 000000	
FTEs attributable to rotations			0.00	0.00	0.00000	00.00
Enter in column 2 the number of						
FTEs that trained in your hospi						
(column 1 divided by (column 1					D 11 (1 0)	
	Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te	·		
	1.00	2.00	3. 00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter ir 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)	FAMILY MEDICINE	1350	3. 27			67.00

0.00

Ν

0.00

0.00

Ν

0.00

95.00

96.00

97.00

applicable column.

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

95.00

96.00

"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.	0115 00
115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no	N	0 115. 00
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.		111.00
116.00 Is this facility classified as a referral center? Enter "Y" for yes or	Y	116. 00
"N" for no.		117.00
117.00 s this facility legally-required to carry malpractice insurance? Enter	N	117. 00
"Y" for yes or "N" for no.		140.00
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
	·	
MCRI F32 - 22, 2, 178, 2		
MONT 52 22.2.176.2		

yes, enter the approval date (mm/dd/yyyy) in column 2.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA				Fr	Peri od: From 01/01/2023 To 12/31/2023		Worksheet S- Part I Date/Time Pr 5/29/2024 11	epared:
								1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	for ves	or "N" for	no.				1.00 N	147. 00
148.00 Was there a change in the order of								N	148. 0
149.00 Was there a change to the simplifi	ed cost finding method	d? Enter	r "Y" for ye	s or "N"	for n			N	149. 0
			Part A	Part			tle V	Title XIX	
			1.00	2. 00			3. 00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '									
155. 00 Hospi tal	N TOT NO TOT Each con	IIIponent	N Part A	and Part	В. (3	see 42	N 9413	N N	155. 00
156. 00 Subprovi der - TPF			N	N			N	N N	156. 0
157. 00 Subprovi der – IRF			N I	N			N	N N	157. 0
158. 00 SUBPROVI DER									158. 0
159. 00 SNF			N	N		1	N	N	159. 0
160.00 HOME HEALTH AGENCY			N	N			N	N	160. 0
161.00 CMHC				N			N	N	161. 0
								1.00	\perp
Mul ti campus									
165.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or	r more campu	ses in di	ffere	nt CBS	SAs?	N	165. 0
·	Name	(County	State	Zip	Code	CBSA	FTE/Campus	
	0		1. 00	2. 00	3.	00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0 166. 0
								1.00	+
Health Information Technology (HI	() incentive in the Ame	eri can	Recovery and	l Reinves	tment	Act		1.00	
167.00 s this provider a meaningful user						7.10 t		Υ	167. 0
168.00 f this provider is a CAH (line 10	05 is "Y") and ís a mea	ani ngful	l user (line	167 is '	'Y"),	enter	the		168. 0
reasonable cost incurred for the H									
168.01 If this provider is a CAH and is r						hards	shi p		168. 0
exception under §413.70(a)(6)(ii)?									0140
169.00 If this provider is a meaningful u		and is	not a CAH (line 105	IS "N	ı"), er	iter the	9. 9	9169. 00
transition factor. (see instruction	ons)					Rea	i nni ng	Endi ng	
							1. 00	2.00	1
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and endi	ing date	e for the re	porting		'	1. 00	2.00	170. 00
112-11-104 - 100poot - 101 J (day 3333)						-	1 00	2.00	
171.00 fline 167 is "Y", does this prov	vider have any days for	r indivi	iduals enrol	led in			1. 00 Y		1171.0
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	reported on Wkst. S-3, umn 1. If column 1 is y	Pt. I,	line 2, col	. 6? Ente			ı	1, 73	1771.00

Heal th	Financial Systems IU HEALTH ARN	FTT HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0173	Peri od: From 01/01/2023	Worksheet S-2	
				To 12/31/2023	Date/Time Pre	
				Y/N	5/29/2024 11: Date	29 am
	DART LL. HOCKLIAL AND HOCKLIAL HEATHCARE COMPLEY RELABILISES	MENT OUECTLONG	IALDE	1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in t	the	
1.00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			N		1. 00
	reporting period? If yes, enter the date of the change in c	column 2. (see	Y/N	Date	V/I	
0.00			1.00	2. 00	3.00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N			2. 00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)					3.00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4. 00
5.00	Are the cost report total expenses and total revenues differenthese on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differenthese total expenses and total expenses are total expenses and total expenses and total expenses are total expenses are total expenses and total expenses are t		N			5. 00
	Y/N 1.00	Legal Oper. 2.00				
	Approved Educational Activities			1.00	2.00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	the provider	- N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	Y N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	•	al education	Y		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		he current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 00
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or coinsuratinstructions.	ance amounts wa	ived? If yes,	see	N	14. 00
15. 00	Bed Complement Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	t A Date	Y/N	t B Date	
	PS&R Data	1. 00	2. 00	3. 00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2024	Υ	04/01/2024	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

	Heal th	Financial Systems IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CM	S-2552-10
1.00	HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			From 01/01/2023 To 12/31/2023	Part II Date/Time P 5/29/2024 1	repared:
20.00 If I I I Ine 16 or 17 Is yes, were adjustments adde to PSAR N N 20.00							
Report data for Other? Describe the other adjustments: Y/N Date	20.00	If line 14 or 17 is yes were adjustments made to DCOD		U			20.00
1.00	20.00				N	IN IN	20.00
21.00 Was the cost report prepared only using the provider's N 1.00 Procords? If yes, see instructions. 22.00 Procords? If yes, see instructions. 23.00 Procords? If yes, see instructions. 24.00 Procords on the Neutron of the Nedicare purposes? If yes, see instructions 25.00 Procord on the Neutron of the Nedicare purposes? If yes, see instructions 26.00 Procord on the Neutron of the Nedicare depreciation expense due to appraisals made during the cost reporting period? N 24.00 Procord on the Nedicare depreciation expense due to appraisals made during the cost reporting period? N 24.00 Procord on the Nedicare depreciation expense due to appraisals made during the cost reporting period? N 24.00 Procord on the Nedicare depreciation of Nedicare depreciation of the Nedicare depreciation of Nedicare depreciation of Nedicare depreciation of Nedicare			Y/N	Date		Date	
records? If yes, see instructions. 1.00				2.00		4. 00	
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Name 12.00 Name		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS I	HOSPI TALS)		1.00	
23.00 lave changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 reporting period? If yes, see instructions N 24.00 Nor new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 Nor new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see N 25.00 Nor assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Nor assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit N 27.00 Nor the total one N 27.0		Capital Related Cost					
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Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes enstructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 41.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00							
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37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectivel y. 42.00 Enter the employer/company name of the cost report UTTER 42.00 Enter the telephone number and email address of the cost 377-556-3910 RUTTER®I UHEALTH. ORG	26 00				V		24 00
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the employer/company name of the cost report IU HEALTH UTTER		·	renared by the	home office?			
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If ye	37.00		epared by the	nome office?	, i		37.00
the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If yes, yes, did the provider services to other chain components? If	38. 00		fice different	from that of	N		38. 00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report IU HEALTH Value Valu							
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report IU HEALTH 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00	39. 00	If line 36 is yes, did the provider render services to other			, Y		39. 00
instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report IU HEALTH 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00							
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report IU HEALTH	40. 00		home office?	If yes, see	N		40. 00
Cost Report Preparer Contact Information 41.00 Enter the first name, I ast 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 IU HEALTH UTTER 42.00		i nstructi ons.					
Cost Report Preparer Contact Information 41.00 Enter the first name, I ast 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 IU HEALTH UTTER 42.00			1	00	2	00	
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost preparer. 43.00 Enter the telephone number and email address of the cost preparer. 43.00 Enter the telephone number and email address of the cost preparer.		Cost Report Preparer Contact Information	1.	. 00	Ζ.	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 preparer. 43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00	41 00		RHONDA		UTTER		41 00
respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00					J		11.00
42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00							
43.00 Enter the telephone number and email address of the cost 317-556-3910 RUTTER@IUHEALTH.ORG 43.00	42.00		IU HEALTH			42.00	
		1					
report preparer in columns 1 and 2, respectively.	43.00		317-556-3910		RUTTER@I UHEALTI	H. ORG	43.00
		report preparer in columns I and 2, respectively.	I		I		

Heal th	Financial Systems IU HEALTH ARM	IETT HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0173	Peri od: From 01/01/2023	Worksheet S-2 Part II	
			To 12/31/2023	Date/Time Pre 5/29/2024 11:	pared: 29 am
		3.00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	DIRECTOR, GOVT PROGRAMS			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				
1	1p pp	1	T .		'

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/2

					0 12/31/2023	5/29/2024 11:	
						I/P Days / 0/P	27 alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Title V	
	Compensite	Li ne No.	No. or beas	Avai I abl e	Oran Ren Hours	11 110 1	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	161	58, 764	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		161	58, 764	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	14	5, 110	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00	0	(0.00	0	10. 00
10. 01	BURN INTENSIVE CARE UNIT	33. 01	0	(0.00	0	10. 01
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00	17	6, 205	0.00	0	12.00
13.00	NURSERY	43. 00				0	13. 00
14.00	Total (see instructions)		192	70, 079	0.00	0	14. 00
15. 00	CAH visits					0	15. 00
15. 10	REH hours and visits				0.00	0	15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						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
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		192			_	27. 00
28. 00	Observation Bed Days					0	
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF		_				31. 00
32.00	Labor & delivery days (see instructions)		7	2, 555			32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges	20.00		1 046		_	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	4	1, 349	' I	0	34. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 | 11: 29 am

Component Title XVIII Title XIX Total All Total Interns Employees On Patients & Residents Payroll							5/29/2024 11:	29 am
Part I - STATISTICAL DATA 6.00 7.00 8.00 9.00 10.00			I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
Part I - STATISTICAL DATA 6.00 7.00 8.00 9.00 10.00		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
PART I - STATISTICAL DATA		Component	THE AVIII	TI CI O XIX				
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) 2.00 HMO and other (see instructions) 1.00 HMO IPF Subprovider 4.00 HMO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 1.00 And Adults & Peds. (exclude observation beds) (see instructions)			6.00	7. 00	8. 00	9. 00	10.00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 10,981 8,724 2.00 3.00 HM0 IPF Subprovider 0 0 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8,724 2.00 3.00 0 0 3.00 4.00 5.00 7.00 Joda Adults and Peds. (exclude observation beds) (see instructions)								
Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 10,981 8,724 2.00 10,981 8,724 2.00 10,981 8,724 3.00 10,	1. 00		13, 169	960	37, 107			1. 00
for the portion of LDP room available beds) 2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 10, 981 8, 724 0 0 0 0 3.00 4.00 0 0 5.00 6.00 7.00		9 '						
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 10, 981								
3.00	2 00		10 001	0 724				2 00
4.00 HM0 IRF Subprovider 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			10, 901					
5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					
6.00 Hospital Adults & Peds. Swing Bed NF		•			0			
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 13,169 960 37,107 7.00								•
beds) (see instructions)			13 169		-			1
0.00 INTENSIVE CARE UNIT 000 IUZ 3,789 8.00	8.00	INTENSIVE CARE UNIT	850	102	3, 789			8. 00
9.00 CORONARY CARE UNIT								9. 00
10.00 BURN INTENSIVE CARE UNIT 0 0 0 10.00	10.00	BURN INTENSIVE CARE UNIT	o	0	0			10.00
10. 01 BURN INTENSIVE CARE UNIT 0 0 0 1.0.01	10. 01	BURN INTENSIVE CARE UNIT	0	0	0			10. 01
11.00 SURGICAL INTENSIVE CARE UNIT	11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00 NEONATAL NTENSIVE CARE UNIT 0 252 3,091 12.00	12.00		0	252	3, 091			12. 00
13. 00 NURSERY 1, 480 2, 442 13. 00		y and the second						1
14. 00 Total (see instructions) 14, 019 2, 794 46, 429 14. 59 1, 009. 51 14. 00			14, 019		46, 429	14. 59	1, 009. 51	
15.00 CAH visits 0 0 0 15.00		1	0					•
15. 10 REH hours and visits 0 0 0 1 15. 10		1	0	0	0			1
16. 00 SUBPROVI DER - I PF 16. 00								
17. 00 SUBPROVI DER - RF 17. 00								
18. 00 SUBPROVI DER 18. 00		1						
19.00 SKILLED NURSING FACILITY 19.00 20.00 NURSING FACILITY 20.00		1						
20. 00 NORSTNG FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00								
22. 00 HOME HEALTH AGENCY								1
23. 00 AMBULATORY SURGI CAL CENTER (D. P.)								
24. 00 HOSPI CE 24. 00								
24. 10 HOSPICE (non-distinct part) 336 24. 10					336			•
25. 00 CMHC - CMHC 25. 00								
26. 00 RURAL HEALTH CLINIC 26. 00								26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26. 25	26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00 Total (sum of lines 14-26) 14.59 1,009.51 27.00	27.00	Total (sum of lines 14-26)				14. 59	1, 009. 51	27. 00
28.00 Observation Bed Days 122 5,328 28.00	28. 00	Observation Bed Days		122	5, 328			28. 00
29. 00 Ambul ance Tri ps 0 29. 00	29. 00	Ambul ance Tri ps	0					29. 00
30.00 Employee discount days (see instruction) 0 30.00	30.00	Employee discount days (see instruction)			0			30. 00
31.00 Employee discount days - IRF 0 31.00					-			1
32.00 Labor & delivery days (see instructions) 0 37 911 32.00			0	37				
32.01 Total ancillary labor & delivery room 0 32.01	32. 01				0			32. 01
outpatient days (see instructions)	22.00							22.00
33. 00 LTCH non-covered days 0 33. 00		1						ł
33.01 LTCH site neutral days and discharges 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 0 34.00				0	_			
34.00	54.00	Tromporary Expansion Covid-17 File Acute Care	ı V	O _I	0	l	I	1 34.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared:

					J 12/31/2023	5/29/2024 11:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
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)		(3, 239	238	11, 792	1. 00
2.00	HMO and other (see instructions)			2, 200	1, 865		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
10. 01	BURN INTENSIVE CARE UNIT						10. 01
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	NEONATAL INTENSIVE CARE UNIT						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0. 00	(3, 239	238	11, 792	14.00
15.00	CAH visits						15.00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care						34. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 |

					'	o 12/31/2023	Date/lime Pre 5/29/2024 11:	
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							-
1. 00	Total salaries (see	200. 00	77, 820, 600	423, 809	78, 244, 409	2, 099, 788. 06	37. 26	1.00
2.00	instructions) Non-physician anesthetist Part		0	0	(0.00	0. 00	2. 00
3.00	A Non-physician anesthetist Part		0	0	C	0.00	0. 00	3. 00
4.00	B Physician-Part A -		470, 210	0	470, 210	2, 272. 68	206. 90	4. 00
4. 01 5. 00	Administrative Physicians - Part A - Teaching Physician and Non		0 685, 574	0	1	0. 00 6, 529. 72		1
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	C	0.00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	C	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		1, 199, 824	0	1, 199, 824	31, 200. 00	38. 46	7. 01
8.00	programs) Home office and/or related		0	0	C	0.00	0. 00	8. 00
9. 00 10. 00	organization personnel SNF Excluded area salaries (see	44. 00	0 180, 047	0 2, 768, 329	2, 948, 376	0. 00 49. 286. 90		
10.00	instructions) OTHER WAGES & RELATED COSTS		160, 047	2, 700, 329	2, 940, 370	49, 200. 90	39. 62	10.00
11. 00	Contract labor: Direct Patient Care		9, 281, 006	0	9, 281, 006	75, 331. 95	123. 20	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	C	0.00	0. 00	12. 00
13. 00	services Contract Labor: Physician-Part A - Administrative		34, 655	0	34, 655	215. 31	160. 95	13. 00
14. 00	Home office and/or related organization salaries and		0	О	C	0.00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A - Administrative		28, 923, 638 0 0	0 0	C	682, 289. 00 0. 00 0. 00	0.00	14. 01 14. 02 15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A - Teaching		0	0	C	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	C	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see instructions)		19, 622, 970	0	19, 622, 970			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		601, 645 0	0	601, 645			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	C			21. 00
22. 00	B Physician Part A -		47, 105	0	47, 105			22. 00
	Administrative Physician Part A - Teaching Physician Part B		0 101, 421	Ō	101, 421			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0	0	1			24. 00 25. 00
25. 50	Home office wage-related (core)		6, 408, 613	0	6, 408, 613			25. 50
25. 51	Related organization wage-related (core)		0	0	C			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	C			25. 52

					To	12/31/2023	Date/Time Prep 5/29/2024 11:	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARIE					0, ,0	470 55	
26. 00	Employee Benefits Department	4. 00	4, 540		4, 540			
27. 00	Administrative & General	5. 00	5, 816, 103	-1, 292, 288		84, 628. 08		
28. 00	Administrative & General under		176, 419	0	176, 419	1, 211. 79	145. 59	28. 00
00.00	contract (see inst.)	, 00				0.00	0.00	00.00
29. 00	Maintenance & Repairs	6. 00	1 (01 (50	04 000	4 500 5/4	0.00		29. 00
30.00	Operation of Plant	7. 00	1, 681, 659	-91, 098	1, 590, 561	57, 057. 06		
31.00	Laundry & Linen Service	8. 00	0	0	0	0.00		
32.00	Housekeepi ng	9. 00	1, 738, 251	-10, 487		89, 916. 32		
33. 00	Housekeeping under contract		356, 734	0	356, 734	5, 813. 00	61. 37	33. 00
24.00	(see instructions)	10.00	1 470 711	/10 205	055 407	10 100 07	24 22	24.00
34. 00	Dietary	10. 00	1, 473, 711	-618, 285	· ·	40, 100. 26		
35. 00	Di etary under contract (see		223, 118	0	223, 118	5, 440. 00	41. 01	35. 00
24 00	instructions)	11 00	0	400 204	400 204	32, 177. 03	10.04	27.00
36. 00 37. 00	Cafeteria Maintenance of Personnel	11. 00 12. 00	0	609, 386	609, 386			36. 00 37. 00
		12.00	4 200 070	222 224	2 077 (44	0.00		
38. 00	Nursing Administration		4, 300, 878			85, 987. 02		
39. 00	Central Services and Supply	14. 00	503, 770		· ·	18, 550. 62		
40.00	Pharmacy	15. 00	5, 099, 804	-754, 660	4, 345, 144	94, 183. 53		
41. 00	Medical Records & Medical	16. 00	0	0	0	0. 00	0.00	41. 00
42.00	Records Library	17 00	/ 07 / 100	0	407 400	21 200 00	22 14	42.00
42. 00	Social Service	17. 00	687, 480		687, 480	,		42. 00
43.00	Other General Service	18. 00	651, 108	-676	650, 432	33, 163. 31	19.61	43.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared:

					''	0 12/31/2023	5/29/2024 11:	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		76, 691, 473	423, 809	77, 115, 282	2, 074, 523. 13	37. 17	1.00
	instructions)							
2.00	Excluded area salaries (see		180, 047	2, 768, 329	2, 948, 376	49, 286. 90	59. 82	2.00
	instructions)							
3.00	Subtotal salaries (line 1		76, 511, 426	-2, 344, 520	74, 166, 906	2, 025, 236. 23	36. 62	3.00
	minus line 2)							
4.00	Subtotal other wages & related		38, 239, 299	0	38, 239, 299	757, 836. 26	50. 46	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 078, 688	0	26, 078, 688	0.00	35. 16	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		140, 829, 413	-2, 344, 520	138, 484, 893	2, 783, 072. 49	49. 76	6.00
7.00	Total overhead cost (see		22, 713, 575	-2, 538, 957	20, 174, 618	569, 644. 63	35. 42	7. 00
	instructions)							

Health Financial Systems	IU HEALTH ARNETT HOSPITAL		In Lieu of Form CMS-2552-1
HOSPITAL WAGE RELATED COSTS	Provi der	CCN: 15-0173 Peri od:	Worksheet S-3
			1/01/2023 Part IV
			1/01/2023 Part IV

	To 12/31/2023	Date/Time Prep 5/29/2024 11:2	pared: 29 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	2, 900, 500	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	o	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6. 00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	10, 314, 276	8. 02
8. 03	Health Insurance (Purchased)	0	1
9.00	Prescription Drug Plan	o	9. 00
10.00	Dental, Hearing and Vision Plan	232, 513	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	0	11. 00
	Accident Insurance (If employee is owner or beneficiary)	o	12.00
	Disability Insurance (If employee is owner or beneficiary)	419, 180	13.00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		795, 199	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		1
	TAXES		1
17.00	FICA-Employers Portion Only	5, 711, 473	17. 00
18. 00	Medicare Taxes - Employers Portion Only	O	18. 00
19. 00	Unemployment Insurance	o	19. 00
20.00	State or Federal Unemployment Taxes	o	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	o	22. 00
23.00	Tuition Reimbursement	ol	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	20, 373, 141	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00
	·	·	

Health Financial Systems	IU HEALTH ARNETT HOSPITAL		In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN	N: 15-0173 P F T	rom 01/01/2023	Worksheet S-3 Part V Date/Time Prepared:

		0 12/31/2023	5/29/2024 11: 2	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	9, 281, 006	21, 123, 312	1. 00
2.00	Hospi tal	9, 281, 006	20, 373, 141	2. 00
3.00	SUBPROVI DER - I PF			3.00
4.00	SUBPROVI DER - I RF			4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	7. 00
8.00	SKILLED NURSING FACILITY			8. 00
9.00	NURSING FACILITY			9. 00
10.00	OTHER LONG TERM CARE I			10.00
11.00	Hospi tal -Based HHA			11.00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I			12.00
13.00	Hospi tal -Based Hospi ce			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17. 00	RENAL DIALYSIS I	0	0	17.00
18. 00	Other	0	750, 171	18. 00

	Financial Systems	IU HEALTH ARNETT				eu of Form CMS-2	
10SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC	N: 15-0173	Peri od: From 01/01/2023 To 12/31/2023		pared:
						1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DAT						4
	Uncompensated and Indigent Care Cost-to-Ch	arge Ratio				0.4(7040	4
1.00	Cost to charge ratio (see instructions) Medicaid (see instructions for each line)					0. 167949	1.00
2. 00	Net revenue from Medicaid					61, 766, 823	2.00
2. 00 3. 00	Did you receive DSH or supplemental paymen	ats from Modicaid?				N N	3.00
4. 00	If line 3 is yes, does line 2 include all		tal navment	s from Madic:	ai d2	N N	4.00
5. 00	If line 4 is no, then enter DSH and/or sup				ii u :	, n	1
5. 00	Medicaid charges	premerrar paymerras i	Tom moureur	a .		283, 212, 464	
7. 00	Medicaid cost (line 1 times line 6)					47, 565, 250	
3. 00	Difference between net revenue and costs f	or Medicaid program	(see instru	ctions)		0	
	Children's Health Insurance Program (CHIP)						1
9. 00	Net revenue from stand-alone CHIP	•				0	9.00
10.00	Stand-alone CHIP charges					0	10.00
	Stand-alone CHIP cost (line 1 times line 1					0	1
12.00	2.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)						12.00
	Other state or local government indigent c						4
	Net revenue from state or local indigent c					11	
14. 00	Charges for patients covered under state o 10)	or Local indigent car	re program (Not included	in lines 6 or	77	14.00
	State or local indigent care program cost	•	,			13	
16. 00	Difference between net revenue and costs f					2	16.00
	Grants, donations and total unreimbursed c	ost for Medicaid, Ch	IIP and state	e∕local indiç	jent care program	ns (see	
17 00	instructions for each line) Private grants, donations, or endowment in	some restricted to	fundi na shar	i tu cara		0	17. 00
	Government grants, appropriations or trans						
	Total unreimbursed cost for Medicaid, CHI	• • •			s (sum of lines	2	19.00
7. 00	8, 12 and 16)	T did State and rock	ii indigent	care programs	, (Sum of Titles	[17.00
				Uni nsured	Insured	Total (col. 1	
				pati ents	pati ents	+ col . 2)	
				1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions						4
	Charity care charges and uninsured discoun			27, 711, 70			
21. 00	Cost of patients approved for charity care instructions)	e and uninsured disco	ounts (see	4, 654, 10	1, 104, 100	5, 758, 264	21.00
22. 00	Payments received from patients for amount	s previously writter	off as	33, 7	75 669	34, 444	22. 00
	charity care						
23. 00	Cost of charity care (see instructions)			4, 620, 38	89 1, 103, 431	5, 723, 820	23.00
						1.00	

imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 \mid Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Medicare allowable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

0 25.00

25.01

26.00

27.00

27.01

28.00

29.00

30.00

1, 392, 075

18, 153, 712

17, 644, 718

3, 141, 561

8, 865, 381

8, 865, 383 31.00

330, 846

508, 994

25.00

25. 01

27.01

stay limit

Heal th	Financial Systems IU	HEALTH ARNETT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 15-0173	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II	0 pared:
					1.00	
	PART II - HOSPITAL DATA					
	Uncompensated and Indigent Care Cost-to-Charge R	atio				
1. 00	Cost to charge ratio (see instructions)				0. 167949	1. 00
	Medicaid (see instructions for each line)				ı	
2.00	Net revenue from Medicaid					2.00
3.00	Did you receive DSH or supplemental payments fro					3. 00
4.00	If line 3 is yes, does line 2 include all DSH ar			ai d'?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemen	itai payments from Medica	ıa			5. 00
6.00	Medicaid charges					6. 00 7. 00
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Med	licald program (coo inctr	uctions)			8.00
6.00	Children's Health Insurance Program (CHIP) (see					0.00
9. 00	Net revenue from stand-alone CHIP	This tructions for each fr	ne)			9.00
10.00	Stand-alone CHIP charges					10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11.00
12.00 Difference between net revenue and costs for stand-alone CHIP (see instructions)						12. 00
.2.00	Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care pr					13.00
14. 00						14. 00
15.00	State or local indigent care program cost (line	1 times line 14)				15. 00
16. 00	Difference between net revenue and costs for sta					16. 00
	Grants, donations and total unreimbursed cost fo instructions for each line)			gent care progran	ms (see	
17. 00	Private grants, donations, or endowment income r					17. 00
18. 00	Government grants, appropriations or transfers f		•			18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and 8, 12 and 16)	state and local indigent	care program	s (sum of lines		19. 00
	0, 12 dild 10)		Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
			1.00	2.00	3. 00	
	Uncompensated care cost (see instructions for ea	ch line)				
20.00	Charity care charges and uninsured discounts (se	ee instructions)	27, 711, 7	68 2, 262, 377	29, 974, 145	20. 00
21. 00	Cost of patients approved for charity care and uinstructions)	uni nsured di scounts (see	4, 654, 1	1, 104, 100	5, 758, 264	21. 00
22. 00	Payments received from patients for amounts previously care	riously written off as	33, 7	75 669	34, 444	22. 00
23.00						
24.02	D the	6		E -4 -14	1.00	24.00
24. 00	Does the amount on line 20 col. 2, include chargingosed on patients covered by Medicaid or other		na a rength o	r stay limit	N	24. 00
25. 00	If line 24 is yes, enter the charges for patient		t care progra	m's length of	0	25. 00

1, 392, 075

330, 846

508, 994

18, 153, 712

17, 644, 718

3, 141, 561

8, 865, 381

8, 865, 381 31.00

25.01

26.00

27. 00

27. 01

28.00

29.00

30.00

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 | Medicare allowable bad debts (see instructions)

28.00 Non-Medicare bad debt amount (see instructions)

Charges for insured patients' liability (see instructions)

31.00 \mid Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

25. 01

	Financial Systems	IU HEALTH ARNETT		011 45 0470		u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-0173	Period: From 01/01/2023	Worksheet A	
				-	To 12/31/2023	Date/Time Pre	
	Cook Cooker Doorsinties	C-1:	0+1	T-+-1 (1 1	D1: 6:+:	5/29/2024 11:	29 am
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				1 (01. 2)	013 (300 / 0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			\	5, 153, 286	5, 153, 286	1.00
1.00	00100 CAP REL COSTS-BLDG & FIXT - NONHOSP		0		699, 489	699, 489	1.00
1. 02	00102 CAP REL COSTS INTEREST EXPENSE		0			0	1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0) (5, 614, 572	5, 614, 572	2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP		0		860, 819	860, 819	2. 01
3. 00 4. 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	4, 540	1, 195, 915) 1, 200, 45!	0 5 13, 932, 931	0 15, 133, 386	3. 00 4. 00
5. 01	00570 ADMITTING	397, 615	1, 193, 913	1		415, 736	5. 01
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL	5, 418, 488	72, 307, 240			74, 738, 036	5. 06
7.00	00700 OPERATION OF PLANT	1, 681, 659	15, 625, 427	17, 307, 086	-5, 627, 536	11, 679, 550	7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	0	1, 146, 470	1, 146, 470	-360, 331	786, 139	7. 01
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1, 738, 251	2, 199, 934) 3, 938, 18!	0 5 -421, 714	0 3, 516, 471	8. 00 9. 00
10. 00	01000 DI ETARY	1, 473, 711	1, 008, 216			1, 193, 569	10.00
11. 00	01100 CAFETERI A	0	0	1	903, 464	903, 464	11. 00
13. 00	01300 NURSING ADMINISTRATION	4, 300, 878	1, 850, 175			4, 676, 823	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	503, 770	1, 922, 274	1 ' '		12, 717, 556	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5, 099, 804	7, 707, 897	12, 807, 70	-6, 841, 778	5, 965, 923 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	687, 480	214, 717	902, 19	7 -142, 391	759, 806	17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES	651, 108	161, 824	1		712, 261	18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		1, 199, 824	1, 199, 824	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	68, 373	2, 298, 478	1			22. 00
23. 00	02300 PARAMED ED PRGM - PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	107, 521	34, 879	142, 400	135, 342	277, 742	23. 00
30. 00	03000 ADULTS & PEDIATRICS	17, 286, 364	27, 303, 207	44, 589, 57	1 -6, 181, 352	38, 408, 219	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 291, 922	3, 094, 763	1		4, 939, 224	31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0 150 (70	1 (02 722) 2 051 414	0 (33, 430	2 217 000	33. 01
35. 00 43. 00	02060 NEONATAL INTENSIVE CARE UNIT 04300 NURSERY	2, 158, 678	1, 692, 732		-633, 420 918, 876	3, 217, 990 918, 876	35. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>			7,0,0,0	7.107.07.0	10.00
50. 00	05000 OPERATING ROOM	4, 858, 732	23, 304, 132			9, 769, 999	50. 00
51.00	05100 RECOVERY ROOM	845, 089	537, 213				51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	2, 776, 987 229, 422	1, 287, 854 8, 096, 685			3, 076, 627 7, 888, 638	52. 00 53. 00
53. 01	05301 ASC ANESTHESI OLOGY	0	174, 358	1 ' '		13, 236	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 425, 217	7, 735, 741	1		6, 405, 281	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0	55. 00
56. 00 59. 00	05600 RADI OI SOTOPE 05900 CARDI AC CATHETERI ZATI ON	137, 516 1, 200, 847	1, 923, 300 8, 409, 415	1		829, 857 3, 159, 251	56. 00 59. 00
60.00		-18, 110	12, 435, 647	1			1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	914, 749			914, 749	
65. 00	06500 RESPI RATORY THERAPY	1, 980, 278	1, 348, 787	1		2, 489, 675	65. 00
66.00	06600 PHYSI CAL THERAPY	660, 613	432, 947			961, 124	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	416, 249 288, 388	549, 144 155, 562	1		909, 222 391, 566	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 260, 105	1, 422, 882	1		2, 000, 297	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	88, 542	41, 420			94, 115	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		9, 375, 757	9, 375, 757	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		12, 232, 144	12, 232, 144	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 RETAIL PHARMACY	782, 865	10, 273, 924	11, 056, 78	40, 555, 860 -116, 213	40, 555, 860 10, 940, 576	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS	782,803	971, 527	1 ' '		917, 195	•
75. 00	07500 ASC (NON-DISTINCT PART)	o	0)		0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	4, 047, 180	7, 138, 658	11, 185, 838	-5, 832, 606	5, 353, 232	75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0	1 200 045	1 (02 4)	0 0	1 05/ 517	76.00
76. 01 76. 97	03951 OUTPATIENT WOUND CARE CENTER 07697 CARDIAC REHABILITATION	301, 619	1, 380, 845	1, 682, 464	4 -625, 947 0	1, 056, 517 0	76. 01 76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0	ól		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS				ما ما		
90. 00 90. 01	09000	0 425, 401	447, 870		0 1 -296, 619	0 576, 652	90. 00 90. 01
90. 01	09001 COMP MED REV CLINIC	694, 439	204, 383	1		766, 030	90.01
90. 03	09002 ARNETT CANCER CARE CENTER	1, 291, 104	32, 292, 608	1		1, 510, 464	
90. 04	09003 OUTPATIENT INFUSION CENTER	50, 418	15, 706	1		53, 486	90. 04
91.00	09100 EMERGENCY	6, 058, 755	10, 234, 368	16, 293, 123	-2, 405, 666	13, 887, 457	91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	76, 256	72, 801	149, 05	-21, 743	127, 314	92. 00 92. 01
93. 00	04951 OTHER OUTPATIENT SERVICES	70, 230	72,001		0 -21, 743	127, 314	
				•	· '		·

Health Financial Systems	IU HEALTH ARNET	T HOSPITAL		In Lie	eu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CC		Peri od:	Worksheet A
				From 01/01/2023 Fo 12/31/2023	Date/Time Prepared: 5/29/2024 11:29 am
Cost Center Description	Sal ari es	0ther		Reclassi fi cati	
			+ col. 2)	ons (See A-6)	Trial Balance
					(col. 3 +-
					col . 4)
	1.00	2. 00	3. 00	4. 00	5. 00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	(0	0 102. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	77, 748, 074	271, 709, 573	349, 457, 647	-4, 082, 122	345, 375, 525 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	43, 069	92, 958	136, 027	-10, 600	
191. 00 19100 RESEARCH	0	0	(0	0 191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	29, 457	25, 745	55, 202	-6, 006	49, 196 192. 00
193.00 19300 NONPALD WORKERS	0	0	(0	0 193.00
193.01 19301 RETAIL PHARMACY	0	0	(0	0 193. 01
193. 02 19302 WHI TE HOSPI TAL	0	0	(2, 326, 487	2, 326, 487 193. 02
193. 03 19303 HOSPI CE	0	733	733	3 0	733 193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	0	(1, 772, 241	1, 772, 241 193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	(0	0 194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	77, 820, 600	271, 829, 009	349, 649, 609	9 0	349, 649, 609 200. 00

Peri od: Worksheet A From 01/01/2023 Date/Time Prepared: 5/20/2024 11:29 am

				5/29/2024 11:	
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation	1	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	600, 150	5, 753, 436	5	1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP	0			1. 01
1.02	00102 CAP REL COSTS INTEREST EXPENSE	9, 698, 685	9, 698, 685	5	1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 173, 095	6, 787, 667	7	2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP	0			2. 01
3. 00	00300 OTHER CAP REL COSTS	0	0		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-361, 810		l .	4. 00
5. 01 5. 06	OO570 ADMITTING OO590 OTHER ADMINISTRATIVE & GENERAL	0 -20, 551, 151			5. 01 5. 06
7. 00	00700 OPERATION OF PLANT	-20, 551, 151		l .	7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	0		l .	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0			8. 00
9.00	00900 HOUSEKEEPI NG	0			9. 00
10.00	01000 DI ETARY	-47	1, 193, 522	2	10.00
11. 00	01100 CAFETERI A	0	903, 464	1	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-270, 366		•	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-625			14.00
15. 00		-84, 634			15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0		1	16. 00 17. 00
17. 00 18. 00	01850 PATIENT TRANSPORT SERVICES	0			18.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0		•	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	., ,	•	22. 00
23. 00		Ö		1	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-7, 647, 766	30, 760, 453	3	30.00
31. 00	03100 INTENSIVE CARE UNIT	-1, 200	4, 938, 024	1	31. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0	1		33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	-701, 085		l .	35. 00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	918, 876	D	43. 00
50. 00	05000 OPERATING ROOM	-419	9, 769, 580		50.00
51.00	05100 RECOVERY ROOM	0			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	-115			52. 00
53.00	05300 ANESTHESI OLOGY	-7, 533, 695			53. 00
53. 01	05301 ASC ANESTHESI OLOGY	0	13, 236		53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	-854	6, 404, 427	7	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	1	1	55. 00
56. 00	05600 RADI OI SOTOPE	0		l .	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		•	59.00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0		•	60.00
65. 00	06500 RESPIRATORY THERAPY	-648		•	65. 00
66. 00	06600 PHYSI CAL THERAPY	0			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	•	67. 00
68. 00		0		•	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	2, 000, 297	7	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	94, 115		70. 00
71. 00		0	9, 375, 757	l .	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	11 070	40, 555, 860	1	73.00
73. 01 74. 00	07301 RETAI L PHARMACY 07400 RENAL DI ALYSI S	-11, 070 0		1	73. 01 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	917, 193		75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0	5, 353, 232		75. 01
76. 00		l o	0,000,202		76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	0	1, 056, 517	7	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0)	78. 00
a -	OUTPATIENT SERVICE COST CENTERS			J	
90.00	09000 CLINIC	0			90.00
90. 01 90. 02	04950 SLEEP CLINIC 09001 COMP MED REV CLINIC	-38		l .	90. 01 90. 02
90. 02		0	766, 030 1, 510, 464	l .	90. 02
90. 03	09002 ARNETT CANCER CARE CENTER		53, 486		90. 03
91. 00	1 I	-2, 251, 790		•	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_,,,,			92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	127, 314	4	92. 01
93. 00		0	0		93. 00
	OTHER REIMBURSABLE COST CENTERS				1
102.00	0 10200 OPI OI D TREATMENT PROGRAM	0	0)	102. 00

Health Financial Systems IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 15-0173 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

			10 12/31/2023 Date/lime Pro 5/29/2024 11	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-27, 954, 854	317, 420, 671		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	125, 427		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	49, 196		192. 00
193.00 19300 NONPALD WORKERS	0	0		193. 00
193. 01 19301 RETAIL PHARMACY	0	0		193. 01
193. 02 19302 WHI TE HOSPI TAL	0	2, 326, 487		193. 02
193. 03 19303 HOSPI CE	0	733		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	1, 772, 241		193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-27, 954, 854	321, 694, 755		200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023 Provider CCN: 15-0173

KLULAS.	STITCATIONS			Trovider c	CN. 15-0173	From 01/01/2023 To 12/31/2023	Date/Time	Prepared:
		Increases					5/29/2024	11: 29 am
	Cost Center 2.00	Li ne # 3. 00	Sal ary 4.00	0ther 5.00				
	A - NONBILLABLE SUPPLIES	3.00	4.00	5.00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	EMPLOYEE BENEFITS DEPARTMENT ADMITTING DIETARY CENTRAL SERVICES & SUPPLY PATIENT TRANSPORT SERVICES RADIOISOTOPE LABORATORY ELECTROCARDIOLOGY RETAIL PHARMACY OUTPATIENT WOUND CARE CENTER GIFT, FLOWER, COFFEE SHOP &	4. 00 5. 01 10. 00 14. 00 18. 00 56. 00 60. 00 69. 00 73. 01 76. 01 190. 00	0 0 0 0 0 0	3 241 10, 787, 624 1, 246 18, 398 99 67, 502 128 35, 183 138				1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	CANTEEN	0. 00 0. 00		0 0 0 0 0 0 0 0 0 0 0 0 0 0				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 27. 00 28. 00
	B - BILLABLE SUPPLIES		J					
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00		9, 375, 757				1. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	0			9, 375, 757				2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
1. 00	C - IMPLANTS IMPL. DEV. CHARGED TO	72.00		12, 232, 144				1. 00
2. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00		159				2. 00
3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00		0.00 0.00 0.00 0.00 0.00 0.00 0.00	0 0 0 0 0 0	0 0 0 0 0 0				3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am Provider CCN: 15-0173

					5/29/2024	
		Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
11. 00	2. 00	0.00	4.00	5.00		11. 00
12. 00		0.00	ō	O		12. 00
13.00	L	0.00	0	0		13. 00
	0		0	12, 232, 303		
1. 00	D - DRUGS DRUGS CHARGED TO PATIENTS	73. 00	0	40, 555, 860		1 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	11, 579		1. 00 2. 00
3.00	RETAIL PHARMACY	73. 01	o	7, 098		3. 00
4.00		0.00	o	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		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	Ö	Ö		10. 00
11.00		0.00	О	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		14. 00 15. 00
16. 00		0.00	Ö	0		16. 00
17. 00		0.00	Ö	O		17. 00
18.00		0.00	О	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00 21. 00
21. 00 22. 00		0. 00 0. 00	0	0		21.00
23. 00		0.00	Ö	0		23. 00
	0 — — — — —			40, 574, 537		
	E - BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	13, 899, 933		1.00
2. 00 3. 00	LABORATORY	60. 00 0. 00	0	794 0		2. 00
4. 00		0.00	0	0		3. 00 4. 00
5. 00		0.00	o	Ö		5. 00
6.00		0.00	O	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10. 00
11. 00		0.00	o	Ö		11. 00
12.00		0.00	О	0		12. 00
13.00		0. 00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00 16. 00	•	0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	o	Ö		17. 00
18.00		0.00	O	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	Ö	0		23. 00
24.00		0.00	O	0		24. 00
25. 00		0.00	0	0		25. 00
26.00		0.00	0	0		26. 00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
28. 00 29. 00		0.00	0	0		29.00
30.00		0.00	Ö	0		30.00
31.00		0.00	О	0		31. 00
32.00		0.00	0	0		32.00
33.00		0. 00 0. 00	0	0		33.00
34. 00 35. 00		0.00	0	0		34. 00 35. 00
36. 00		0.00	0	0		36. 00
37. 00		0.00	Ö	0		37. 00
38. 00		0.00	0	0		38. 00
39. 00		0.00	0	0		39. 00
	O F - CAFETERIA		0	13, 900, 727		
1. 00	CAFETERI A	11. 00	609, 386	294, 078		1.00
55	0	<u> </u>	609, 386	294, 078		55
		. !		1		•

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 11: 29 am Provider CCN: 15-0173

Cost Center Line # Salary Other						5/29/2	2024 11: 29 am
C			Increases		2.1		
C							
1.00 OP PEL COSIS=LEC & FIXT 1.00 1.184 2.00			3.00	4.00	5.00		
Defermation of PLANT	1 00		1 00		1 184		1.00
DOM/OSE TALE DOM/OSE TAL							2. 00
PROPERTY INSURANCE 100 CAP FILE COSTS BILDS & FIXT 1.00 0 767,718 2.00 0 1.4,854 0 1.00 0 1.0	2.00		,,,,,		2,		2.00
1.00 GAP RET COSTS-BLIGS A FIXT 1.00 0 767,718 1.00 0 597,338 2.2 2.00		0			3, 333		
CAP REL COSTS-BLOG & FIXT 1.01 0 59, 238 2.0							
3.00				- 1			1. 00
CAP REL COSTS-AWRILE EQUIP 2.00	2. 00		1. 01	O	59, 238		2. 00
Care	2 00		2 00		14 554		2 00
Color Co	3.00	CAP REL COSTS-MVBLE EQUIP					3.00
1.00		U _ LEASE EXPENSE		U _I	341,010		
2.00 CAP REL COSTS-BLOG & FIXT - NOMBORD - 2.01	1 00		1 00	0	455 624		1.00
NOMOSP CAP REL COSTS-INVBLE EQUIP 2.01			•	- 1			2.00
A - 00		NONHOSP					
NONHOSP NONH	3.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	160, 313		3. 00
5.00	4.00		2. 01	0	104, 930		4. 00
1.00				_			
1.	5.00	NURSING ADMINISTRATION	13.00	•			5. 00
1.00		U LATEREST EXPENSE		U	808, 108		
NONHOSP	1 00		2 01	٥	617		1 00
2 0 0 0 0 0 0 0 0 17 1.00	1.00		2.01	٩	017		1.00
No. HOUSEKEEPING SUPPLIES	2.00	Nothingsi	0.00	0	0		2. 00
NOTE					— — <u> </u>		
2.00		K - HOUSEKEEPING SUPPLIES		<u>'</u>	-		
3.00	1.00	HOUSEKEEPI NG	9. 00	0	59, 794		1. 00
4. 0. 0			•				2. 00
5.00				- 1			3. 00
6.00 0.00 0.00 0 0 0 0 0			•	-1			4. 00
7.00 8.00 9.00 9.00 9.00 9.00 10.00 10.00 10.00 10.00 11.00				- 1			5. 00
8.00 0.00 0.00 0 0 0 0 0				-			6.00
9.00 10.00 11.00 11.00 10.00 0.00 0.00 0				-1			7. 00
10. 00 10. 00 0 0 0 0 10. 10. 11. 10. 12. 00 0. 00 0 0 0 0 11. 10. 12. 00 13. 00 0. 00 0 0 0 0 0 13. 01. 13. 01. 14. 00 0. 00 0 0 0 0 0 13. 01. 14. 15. 16. 00 0. 00 0 0 0 0 0 15. 01. 15. 00 0. 00 0 0 0 0 15. 01. 15. 00 0. 00 0 0 0 0 15. 01. 15. 00 0. 00 0 0 0 0 15. 01. 15. 00 0. 00 0 0 0 0 0 0 15. 01. 15. 00 0. 00 0 0 0 0 0 0 0							
11.00 0.00 0 0 11.0 12.2 13.00 0.00 0 0 0 12.2 13.00 14.00 15.00 0.00 0 0 0 0 13.1 14.00 15.00 0.00 0 0 0 0 15.00 15.00 15.00 16.00 17.00 0.00 0 0 0 0 17.00 18.00 0.00 0 0 0 0 0 18.00 19.00 0 0 0 19.0				- 1			
12.00 13.00 14.00 15.00 0.00 0.00 0.00 0.00 0.00 0.00							11. 00
13.00				-1			12. 00
15.00				o			13. 00
16.00	14.00		0.00	O	0		14. 00
17.00	15.00		0.00	O	0		15. 00
18. 0	16.00		0.00	0	0		16. 00
19.00 0.00			•	0	0		17. 00
20.00 0.00 0 0 0 0 22.0 23.00 23.00 0.00 0 0 0 0 0 24.00 25.00 0.00 0 0 0 0 25.00 25.00 0.00 0 0 0 0 25.00 26.00 27.00 0.00 0 0 0 0 27.00 28.00 29.00 0.00 0 0 0 0 0 0 29.00 0.00 0 0 0 0 0 0 0				- 1			18. 00
21. 00 22. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 0							19. 00
22. 00 23. 00 23. 00 24. 00 0. 00 0. 00 0. 00 0. 00 0. 00 24. (0) 25. 00 26. 00 27. 00 28. 00 29. 00 0				-			20.00
23. 00				- 1			
24. 00				0	0		
25. 00				0	0		24. 00
26. 00				- 1			25. 00
27. 00 28. 00 29. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							26. 00
29.00 0				o	0		27. 00
1.00				0	0		28. 00
L - DEPRECIATION EXPENSE 1.00	29. 00		0.00	+			29. 00
1. 00		0		0	59, 794		
2. 00			1				
NONHOSP 3.00 CAP REL COSTS-MVBLE EQUI P 2.00 0 5, 439, 705 4.00 CAP REL COSTS-MVBLE EQUI P 2.01 0 755, 272 4.00 755, 272 6.00 6.00 0 0 0 0 0 0 0 0 0							1.00
3. 00 CAP REL COSTS-MVBLE EQUI P - 2. 00 0 5, 439, 705 4. 00 CAP REL COSTS-MVBLE EQUI P - NONHOSP 2. 01 0 755, 272 4. 00 6. 00 6. 00 7. 00 0 0 0 6. 00 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00		1. 01	O	555, 184		2. 00
4. 00 CAP REL COSTS-MVBLE EQUI P - NONHOSP	2 00		2 00	0	5 420 705		2 00
5. 00 0. 00 0 0 5. 00 6. 00 0. 00 0 0 6. 0 7. 00 0. 00 0 0 7. 0 8. 00 0. 00 0 0 0 9. 00 0. 00 0 0 9. 0 10. 00 0. 00 0 0 10. 0 11. 00 0. 00 0 0 11. 0 12. 00 0. 00 0 0 12. 0 13. 00 0. 00 0 0 13. 0 14. 00 0. 00 0 0 0							4. 00
5.00 0.00 0 0 5.0 6.00 0.00 0 0 0 6.0 7.00 0.00 0 0 0 7.0 8.00 0.00 0 0 0 8.0 9.00 0.00 0 0 9.0 10.00 0.00 0 0 10.0 11.00 0.00 0 0 11.0 12.00 0.00 0 0 13.0 14.00 0.00 0 0 0	7.00		2.01	٩	133, 212		4.00
6.00 7.00 8.00 9.00 10.00 0.00 0.00 0.00 0.00 0.00	5.00		0.00	o	o		5. 00
7.00 0.00 0 0 8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 0.00 0 0 13.00 0.00 0 0 14.00 0.00 0 0							6. 00
8.00 0.00 0 0 9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 0.00 0 0 13.00 0.00 0 0 14.00 0.00 0 0							7. 00
9.00 0.00 0 0 10.00 0.00 0 0 11.00 0.00 0 0 12.00 0.00 0 0 13.00 0.00 0 0 14.00 0.00 0 0				o			8. 00
10.00 0.00 0 0 11.00 0.00 0 0 12.00 0.00 0 0 13.00 0.00 0 0 14.00 0.00 0 0			0.00	o			9. 00
12. 00 0. 00 0 0 13. 00 0. 00 0 0 14. 00 0. 00 0 0				o	О		10.00
13. 00 14. 00 0. 00 0 0 13. 0 14. 0				o			11. 00
14.00				- 1			12. 00
							13. 00
15.00 0.00 0 0 15.0				•			14. 00
	15. 00	1	0. 00	0	0		15. 00

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 11:29 am

					5/29/202	4 11: 29 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00	<u> </u>	
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20. 00
21. 00		0.00	0	0		21.00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23.00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26.00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00			9	0		30. 00
	M FMLA DECLASS		0	11, 179, 421		
1 00	M - FMLA RECLASS ADMITTING	5. 01	0	O E 47		1. 00
1. 00 2. 00	1		0	8, 547		2.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5. 06	U	26, 681		2.00
3.00	HOUSEKEEPI NG	9. 00	0	10. 487		3. 00
4.00	DI ETARY	10.00	0	8, 899		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	71, 570		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 568		6. 00
7. 00	PHARMACY	15. 00	0	37, 332		7. 00
8. 00	PATIENT TRANSPORT SERVICES	18. 00	0	676		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	73, 613		9. 00
10. 00	INTENSIVE CARE UNIT	31.00	0	27, 120		10.00
11. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	10, 164		11. 00
12. 00	OPERATING ROOM	50.00	0	19, 950		12. 00
13. 00	RECOVERY ROOM	51.00	0	7, 563		13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	15, 851		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	15, 692		15. 00
16. 00	RADI OI SOTOPE	56.00	0	7, 202		16. 00
17. 00	CARDIAC CATHETERIZATION	59.00	ő	703		17. 00
18. 00	RESPIRATORY THERAPY	65. 00	Ö	4, 789		18. 00
19. 00	SPEECH PATHOLOGY	68.00	0	671		19. 00
20. 00	ELECTROCARDI OLOGY	69. 00	Ö	7, 060		20.00
21. 00	ASC (NON-DISTINCT PART)	75. 01	Ö	29, 854		21. 00
22. 00	COMP MED REV CLINIC	90. 02	Ö	1, 493		22. 00
23. 00	ARNETT CANCER CARE CENTER	90. 03	0	612		23. 00
24. 00	EMERGENCY	91.00	0	31, 084		24. 00
21100	0			419, 181		200
	N - NURSERY		<u> </u>	1177 101		
1.00	NURSERY	43.00	802, 761	116, 115		1.00
2.00		0.00	0	0		2. 00
			802, 761	116, 115		
	O - ARNETT TO WHITE ALLOCATION	N	·			
1.00	WHITE HOSPITAL	193. 02	1, 557, 400	769, 087		1.00
2.00		0.00	0	0		2. 00
3.00		0.00	O	0		3. 00
4.00		0.00	O	0		4. 00
5.00		0.00	o	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
	0 — — — — —		1, 557, 400	769, 087		
	P - ARNETT TO FRANKFORT ALLOC	CATI ON				
1.00	FRANKFORT HOSPITAL	193. 04	1, 080, 195	692, 046		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	O	0		7. 00
8.00		0.00	O	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00	<u>L</u>	0.00	•	0		12. 00
	0		1, 080, 195	692, 046		

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provider CCN: 15-0173	Period: Worksheet A-6 From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

					10 12/3	/29/2024 11	
		Increases		·			
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5.00			
	Q - INTERNS AND RESIDENTS						
1. 00	I &R SERVICES-SALARY & FRINGES APPRVD	21. 00	0	1, 199, 824			1. 00
	0	- $ -$		1, 199, 824			
	R - PARAMEDICAL EDUCATION						
1.00	PARAMED ED PRGM - PHARMACY	23. 00	130, 734	10, 001			1. 00
	0		130, 734	10, 001		 	
	X - RESIDENCY STAFF						
1.00	I&R SERVICES-OTHER PRGM.	22. 00	824, 880	0			1. 00
	COSTS APPRVD						
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0_	3 <u>2, 9</u> 95			2. 00
	0		824, 880	32, 995		 	
	AE - LABORATRY SALARIES						
1.00	LABORATORY	6000	1 <u>8, 1</u> 10	0			1. 00
	TOTALS		18, 110	0			
500.00	Grand Total: Increases		5, 023, 466	102, 919, 523			500.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2023 To 12/31/2023 Provider CCN: 15-0173

Date/Time Prepared: 5/29/2024 11:29 am

						5/29/2024 11:	29 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - NONBILLABLE SUPPLIES						
1.00	OTHER ADMINISTRATIVE &	5. 06	0	3, 906	0		1. 00
	GENERAL		_		_		
2.00	OPERATION OF PLANT	7. 00	0	119, 976	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	438	0		3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	2, 776	0		4. 00
5.00	PHARMACY	15. 00	0	59, 679			5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	972, 910	0		6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	318, 282	0		7. 00
8.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	76, 920	0		8. 00
9.00	OPERATING ROOM	50.00	o	5, 047, 453	0		9. 00
10.00	RECOVERY ROOM	51.00	ol	76, 074	0		10.00
11. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	111, 824	0		11.00
12.00	ANESTHESI OLOGY	53.00	0	240, 673	0		12. 00
13. 00	ASC ANESTHESI OLOGY	53. 01	0	95, 943	0		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	1, 242, 316	0		14. 00
15. 00	CARDI AC CATHETERI ZATI ON	59.00	ő	405, 605	0		15. 00
16. 00	RESPIRATORY THERAPY	65. 00	0	348, 482	0		16. 00
17. 00	PHYSICAL THERAPY	66.00	0		0		17. 00
	l .		0	1, 469	0		1
18.00	OCCUPATIONAL THERAPY	67.00	U	1, 201			18.00
19.00	SPEECH PATHOLOGY	68.00	U	2, 187	0		19. 00
20.00	RENAL DI ALYSI S	74.00	0	5, 485	0		20.00
21. 00	ASC (NON-DISTINCT PART)	75. 01	0	1, 311, 809	0		21. 00
22. 00	SLEEP CLINIC	90. 01	0	23, 454	0		22. 00
23. 00	COMP MED REV CLINIC	90. 02	0	903	0		23. 00
24. 00	ARNETT CANCER CARE CENTER	90. 03	0	37, 999	0		24. 00
25.00	OUTPATIENT INFUSION CENTER	90. 04	0	280	0		25. 00
26.00	EMERGENCY	91.00	0	398, 963	0		26. 00
27.00	OBSERVATION BEDS (DISTINCT	92. 01	0	3, 385	0		27. 00
	PART)						
28.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	197	0		28. 00
			₀	10, 910, 589			
	B - BILLABLE SUPPLIES						1
1.00	OPERATION OF PLANT	7. 00		18	0		1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00		29, 756	0		2. 00
3. 00	PHARMACY	15. 00	İ	145	0		3. 00
4. 00	ADULTS & PEDIATRICS	30.00		260, 342	0		4. 00
5. 00	INTENSIVE CARE UNIT	31.00		66, 060	0		5. 00
6. 00	NEONATAL INTENSIVE CARE UNIT	35.00		4, 093	0		6. 00
7. 00	OPERATING ROOM	50.00		3, 738, 805	0		7. 00
8. 00	RECOVERY ROOM	51. 00			0		8.00
9. 00				7, 203	0		9. 00
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52. 00 53. 00		164, 980	0		1
10.00	l .			9, 502			10.00
11.00	ASC ANESTHESI OLOGY	53. 01		6, 317	0		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00		2, 347, 186	0		12.00
13. 00	RADI OI SOTOPE	56.00		704	0		13. 00
14. 00	CARDI AC CATHETERI ZATI ON	59. 00		1, 704, 795	0		14. 00
15. 00	RESPI RATORY THERAPY	65. 00		14, 233	0		15. 00
16. 00	PHYSI CAL THERAPY	66. 00		565	0		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00		800	0		17. 00
18.00	RETAIL PHARMACY	73. 01		301	0		18. 00
19.00	RENAL DIALYSIS	74.00		38, 578	0		19. 00
20.00	ASC (NON-DISTINCT PART)	75. 01		519, 304	0		20. 00
21.00	OUTPATIENT WOUND CARE CENTER	76. 01		402, 627	0		21. 00
22.00	SLEEP CLINIC	90. 01		712	0		22. 00
23.00	COMP MED REV CLINIC	90. 02		189	0		23. 00
24.00	ARNETT CANCER CARE CENTER	90. 03		1, 168	0		24. 00
25. 00	OUTPATIENT INFUSION CENTER	90. 04		304	0		25. 00
26. 00	EMERGENCY	91.00		56, 451	0		26. 00
27. 00	OBSERVATION BEDS (DISTINCT	92. 01		619	0		27. 00
27.00	PART)	72.01		017	J		27.00
				9, 375, 757			
	C - IMPLANTS		<u> </u>	7, 373, 737			1
1.00	CENTRAL SERVICES & SUPPLY	14.00		2, 548	0		1.00
2.00	ADULTS & PEDIATRICS	30.00		2, 546	0		2. 00
3.00	OPERATING ROOM				0		1
		50. 00		6, 519, 001			3.00
4.00	DELIVERY ROOM & LABOR ROOM	52.00		24, 213	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00		54, 153	0		5. 00
6.00	CARDI AC CATHETERI ZATI ON	59.00		3, 321, 544	0		6. 00
7. 00	ASC (NON-DISTINCT PART)	75. 01		2, 241, 599	0		7. 00
8.00	OUTPATIENT WOUND CARE CENTER	76. 01		68, 745	0		8. 00
9.00	ARNETT CANCER CARE CENTER	90. 03		227	0		9. 00
10.00	CARDIAC CATHETERIZATION				0		10. 00
11. 00	ASC (NON-DISTINCT PART)				0		11. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 11: 29 am

						5/29/2024 11	: 29 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
12. 00	6.00 OUTPATIENT WOUND CARE CENTER	7. 00	8. 00	9. 00	10.00		12. 00
13. 00	ARNETT CANCER CARE CENTER				0		13. 00
13.00	0	+		12, 232, 303			13.00
	D - DRUGS		<u> </u>	12, 232, 303			
1.00	NURSI NG ADMI NI STRATI ON	13. 00	0	83	0		1. 00
2.00	ADULTS & PEDIATRICS	30.00	0	468, 913			2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	325, 719	1		3. 00
4.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	19, 851	0		4. 00
5.00	OPERATING ROOM	50.00	O	474, 295	O		5. 00
6.00	RECOVERY ROOM	51.00	0	4, 123	0		6. 00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	56, 512	0		7. 00
8.00	ANESTHESI OLOGY	53.00	0	71, 340	0		8. 00
9.00	ASC ANESTHESIOLOGY	53. 01	0	12, 332	0		9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	566, 133	0		10.00
11. 00	RADI OI SOTOPE	56.00	0	991, 055			11. 00
12.00	CARDIAC CATHETERIZATION	59. 00	0	208, 407	0		12. 00
13.00	RESPI RATORY THERAPY	65.00	0	16, 831	0		13. 00
14. 00	ELECTROCARDI OLOGY	69. 00	0	192, 369			14. 00
15. 00	PHARMACY	15. 00	0	4, 810, 404			15. 00
16. 00	RENAL DIALYSIS	74. 00	0	9, 510			16. 00
17. 00	ASC (NON-DISTINCT PART)	75. 01	0	176, 572	0		17. 00
18. 00	OUTPATIENT WOUND CARE CENTER	76. 01	0	292	I I		18. 00
19. 00	ARNETT CANCER CARE CENTER	90. 03	0	31, 709, 751	0		19.00
20. 00	OUTPATIENT INFUSION CENTER	90.04	0	3, 048			20.00
21. 00	EMERGENCY	91.00	0	454, 046			21. 00
22. 00	OBSERVATION BEDS (DISTINCT PART)	92. 01	U	2, 674	0		22. 00
23. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	277	o		23. 00
23.00	n Trans-rans-rans-rans-rans-rans-rans-rans-		— — — ў	40, 574, 537			23.00
	E - BENEFITS		<u> </u>	40, 374, 337			
1.00	ADMI TTI NG	5. 01	0	76, 889	0		1.00
2.00	OTHER ADMINISTRATIVE &	5. 06	o	735, 428			2. 00
	GENERAL						
3.00	OPERATION OF PLANT	7. 00	0	249, 652	o		3.00
4.00	HOUSEKEEPI NG	9.00	0	448, 556	1		4. 00
5.00	DI ETARY	10.00	0	357, 289	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	767, 034	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14. 00	0	94, 769	0		7. 00
8.00	PHARMACY	15. 00	0	693, 858	0		8. 00
9.00	SOCI AL SERVI CE	17. 00	0	142, 391	0		9. 00
10.00	PATIENT TRANSPORT SERVICES	18. 00	0	101, 917			10.00
11. 00	I&R SERVICES-OTHER PRGM.	22. 00	0	13, 175	0		11. 00
	COSTS APPRVD						
12. 00	PARAMED ED PRGM - PHARMACY	23. 00	0	5, 393	1		12. 00
13.00	ADULTS & PEDIATRICS	30.00	0	3, 156, 954			13.00
14.00	INTENSIVE CARE UNIT	31.00	0	564, 165	1		14.00
15. 00	NEONATAL INTENSIVE CARE UNIT	35.00	0	404, 646			15. 00
16.00	OPERATING ROOM	50.00	0	889, 332	1		16.00
17. 00	RECOVERY ROOM	51.00	0	140, 185			17. 00
18. 00 19. 00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52. 00 53. 00	0	572, 571 33, 636			18.00
20. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	736, 396			19. 00 20. 00
21. 00	RADI OLOGI - DI AGNOSTI C	56.00	0	26, 615			21.00
22. 00	CARDI AC CATHETERI ZATI ON	59.00	0	174, 513			22. 00
23. 00	RESPIRATORY THERAPY	65.00	0	268, 667			23. 00
24. 00	PHYSI CAL THERAPY	66.00	0	130, 397			24. 00
25. 00	OCCUPATI ONAL THERAPY	67. 00	0	54, 970			25. 00
26. 00	SPEECH PATHOLOGY	68. 00	0	28, 209			26. 00
27. 00	ELECTROCARDI OLOGY	69. 00	0	313, 354			27. 00
28. 00	ELECTROENCEPHALOGRAPHY	70. 00	o	30, 642			28. 00
29. 00	RETAIL PHARMACY	73. 01	o	121, 992			29. 00
30. 00	ASC (NON-DISTINCT PART)	75. 01	o	809, 710			30.00
31. 00	OUTPATIENT WOUND CARE CENTER	76. 01	0	49, 624			31.00
32. 00	SLEEP CLINIC	90. 01	ol	115, 560			32. 00
33. 00	COMP MED REV CLINIC	90. 02	0	131, 610			33. 00
34.00	ARNETT CANCER CARE CENTER	90. 03	0	315, 807			34.00
35.00	OUTPATIENT INFUSION CENTER	90. 04	0	9, 006	1		35. 00
36.00	EMERGENCY	91. 00	0	1, 104, 506	0		36. 00
37.00	OBSERVATION BEDS (DISTINCT	92. 01	0	14, 994	O		37. 00
	PART)						
38. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	10, 897	0		38. 00
20.00	CANTEEN	400 4-	_		_		20.00
39. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	5, 418			39. 00
	0		O	13, 900, 727	<u> </u>		1

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am Provider CCN: 15-0173

					'	5/29/2024 1	
		Decreases		·			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	F - CAFETERIA	10.00	, , , , , , , ,	204 270			
1. 00	DI ETARY	1000	609, 386	294, 078			1. 00
	0 DRODERTY TAY		609, 386	294, 078			_
1 00	G - PROPERTY TAX	F 0/		1 104	1.0		1.00
1. 00	OTHER ADMINISTRATIVE & GENERAL	5. 06		1, 184	13		1. 00
2. 00	CAP REL COSTS-BLDG & FIXT -	1. 01		2, 149	13		2. 00
2.00	NONHOSP	1.01		2, 147	13		2.00
	0	+	— — — d	3, 333			
	H - PROPERTY INSURANCE		<u> </u>	0,000			
1.00	OTHER ADMINISTRATIVE &	5. 06	0	341, 010	12		1.00
1.00	GENERAL	0.00	J	011,010	12		1.00
2.00		0.00	0	0	12		2. 00
3.00		0.00	0	0	12		3. 00
			— — - -	341, 010			
	I - LEASE EXPENSE	·	-1		'		
1.00	OPERATION OF PLANT	7.00	0	455, 649	10		1.00
2.00	OPERATING ROOM	50.00	0	160, 313	10		2. 00
3.00	ASC (NON-DISTINCT PART)	75. 01	0	104, 930	10		3. 00
4.00	SLEEP CLINIC	90. 01	0	87, 216	10		4. 00
5.00		0. 00	0	0	0		5. 00
	0 = = = = = =		0	808, 108			
	J - INTEREST EXPENSE						
1.00	OTHER ADMINISTRATIVE &	5. 06	0	149	11		1. 00
	GENERAL						
2.00	OUTPATIENT WOUND CARE CENTER	76. 01	0	468	0		2. 00
	0		0	617			
	K - HOUSEKEEPING SUPPLIES						
1.00	ADMITTING	5. 01		3, 000	0		1. 00
2.00	OTHER ADMINISTRATIVE &	5. 06		795	0		2. 00
	GENERAL				_		
3.00	OPERATION OF PLANT	7. 00		1, 758	0		3. 00
4.00	DI ETARY	10.00		2	0		4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00		10	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00		15, 159	0		6. 00
7.00	PHARMACY	15.00		4, 587	0		7. 00
8.00	ADULTS & PEDIATRICS	30.00		18, 532	0		8. 00
9.00	INTENSIVE CARE UNIT	31.00		1, 086	0		9.00
10.00	NEONATAL INTENSIVE CARE UNIT	35.00		957	0		10.00
11.00	OPERATING ROOM	50.00		1, 291	0		11.00
12.00	RECOVERY ROOM	51.00		214	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	52.00		682	0		13. 00
14.00	RADI OLOGY - DI AGNOSTI C	53. 00 54. 00		21	0		14. 00
15. 00 16. 00				4, 421	0		15. 00
17. 00	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	56. 00 59. 00		67	0		16. 00 17. 00
18. 00	PHYSICAL THERAPY	66.00		1, 163	0		18. 00
19. 00	SPEECH PATHOLOGY	68.00		1, 029			19. 00
20. 00	ELECTROCARDI OLOGY	69. 00		1, 029	l		20.00
21. 00	RENAL DIALYSIS	74. 00		624	l .		21. 00
22. 00	ASC (NON-DISTINCT PART)	75. 01		636	0		22. 00
23. 00	OUTPATIENT WOUND CARE CENTER	76. 01		219	1		23. 00
24. 00	SLEEP CLINIC	90. 01		359	l .		24. 00
25. 00	COMP MED REV CLINIC	90. 02		90			25. 00
26. 00	ARNETT CANCER CARE CENTER	90. 03		1, 801			26. 00
27. 00	EMERGENCY	91.00		1, 057			27. 00
28. 00	OBSERVATION BEDS (DISTINCT	92. 01		71	o		28. 00
00	PART)	72. 31		, ,			_5. 55
29. 00	PHYSÍCIANS' PRIVATE OFFICES	192. 00		114	o		29. 00
	0	 	₀	59, 794			
	L - DEPRECIATION EXPENSE		-1				
1.00	OTHER ADMINISTRATIVE &	5. 06	0	52, 965	9		1. 00
	GENERAL						
2.00	OPERATION OF PLANT	7. 00	0	4, 683, 157	9		2. 00
3.00	OPERATION OF PLANT -	7. 01	0	362, 480	9		3. 00
	NONHOSPI TAL						
4.00	HOUSEKEEPI NG	9. 00	0	32, 514	9		4. 00
5.00	DI ETARY	10. 00	0	27, 844	l 1		5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	271, 873	l 1		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	161, 278	l 1		7. 00
8.00	PHARMACY	15. 00	0	372, 262	l 1		8. 00
9.00	ADULTS & PEDIATRICS	30. 00	0	288, 114	0		9. 00
10. 00	INTENSIVE CARE UNIT	31.00	0	172, 149	l 1		10. 00
11. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	126, 953	0		11. 00

Health Financial Systems RECLASSIFICATIONS Period: From 01/01/2023 Provider CCN: 15-0173 Worksheet A-6

						From 01/01/2023 To 12/31/2023	Date/Time Prepar	
		Decreases					5/29/2024 11: 29	_am
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	.]		
	6. 00	7. 00	8. 00	9. 00	10. 00			
12. 00 13. 00	OPERATING ROOM RECOVERY ROOM	50. 00 51. 00	0	1, 386, 051 63, 347		0	1	12. 00 13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	31, 908		0	1	14. 00
15. 00	ANESTHESI OLOGY	53.00	o	82, 297		0	1	15. 00
16.00	ASC ANESTHESIOLOGY	53. 01	О	46, 530		0	1	16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	709, 202		0		17. 00
18. 00	RADI OI SOTOPE	56.00	0	230, 916		0	1	18.00
19. 00 20. 00	CARDI AC CATHETERI ZATI ON RESPIRATORY THERAPY	59. 00 65. 00	0	634, 984 191, 177		0	1	19. 00 20. 00
21. 00	SPEECH PATHOLOGY	68.00	o	20, 959		0	1	21. 00
22.00	ELECTROCARDI OLOGY	69.00	o	122, 801	(0	2	22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70.00	0	5, 205		0	1	23. 00
24. 00	RETAIL PHARMACY	73. 01	0	1, 146		0		24. 00 25. 00
25. 00 26. 00	RENAL DIALYSIS ASC (NON-DISTINCT PART)	74. 00 75. 01	0	135 615, 710		0	1	25. 00 26. 00
27. 00	OUTPATIENT WOUND CARE CENTER	76. 01	o	139, 155		0	1	27. 00
28. 00	SLEEP CLINIC	90. 01	O	69, 318		0	2	28. 00
29. 00	ARNETT CANCER CARE CENTER	90. 03	0	6, 495		0	1	29. 00
30. 00	EMERGENCY	91.00	0	270, 496	<u> </u>	0	3	30. 00
	M - FMLA RECLASS		UU	11, 179, 421				
1.00	ADMITTING	5. 01	8, 547	0	(0		1. 00
2.00	OTHER ADMINISTRATIVE &	5. 06	26, 681	0	(0		2.00
	GENERAL	0.00	10 10-					
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	10, 487 8, 899	0		0	1	3. 00 4. 00
5. 00	NURSING ADMINISTRATION	13. 00	71, 570	0		0	1	5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	1, 568	0		0	i	6. 00
7.00	PHARMACY	15. 00	37, 332	0	(0		7. 00
8.00	PATIENT TRANSPORT SERVICES	18. 00	676	0		0	1	8. 00
9.00	ADULTS & PEDIATRICS	30.00	73, 613	0		0	1	9. 00
10. 00 11. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	31. 00 35. 00	27, 120 10, 164	0		0	1	10. 00 11. 00
12. 00	OPERATING ROOM	50.00	19, 950	0		0	1	12.00
13.00	RECOVERY ROOM	51.00	7, 563	0	(0	1	13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52.00	15, 851	0		0	1	14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	15, 692	0		0	1	15. 00
16. 00 17. 00	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	56. 00 59. 00	7, 202 703	0		0	1	16. 00 17. 00
18. 00	RESPIRATORY THERAPY	65.00	4, 789	0		0	1	18. 00
19. 00	SPEECH PATHOLOGY	68.00	671	0		0	1	19. 00
20.00	ELECTROCARDI OLOGY	69. 00	7, 060	0		0	1	20. 00
21. 00	ASC (NON-DISTINCT PART)	75. 01	29, 854	0		0	1	21. 00
22. 00 23. 00	COMP MED REV CLINIC ARNETT CANCER CARE CENTER	90. 02 90. 03	1, 493 612	0		0	1	22. 00 23. 00
24. 00	EMERGENCY	91.00	31, 084	0		0	1	24. 00
	0		419, 181			1		
	N - NURSERY							
1.00	ADULTS & PEDIATRICS	30.00	779, 935	113, 417		0	1	1.00
2.00	DELIVERY ROOM & LABOR ROOM	5200	22, 826 802, 761	<u>2, 6</u> 9 <u>8</u> 116, 115		0		2. 00
	O - ARNETT TO WHITE ALLOCATIO	N	002/701	110, 110	<u>I</u>			
1.00	ADMI TTI NG	5. 01	16, 613	5, 845		0		1.00
2.00	OTHER ADMINISTRATIVE &	5. 06	732, 117	368, 305	(0		2. 00
3.00	GENERAL OPERATION OF PLANT	7. 00	45, 549	13, 114	,	0		3. 00
4. 00	NURSING ADMINISTRATION	13. 00	147, 516	112, 548		0	1	4. 00
5. 00	PHARMACY	15. 00	366, 498	106, 459		0	1	5. 00
6.00	ADULTS & PEDIATRICS	30.00	37, 593	55, 942		0		6. 00
7.00	OPERATING ROOM	50.00	86, 755	28, 366		0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C ELECTROCARDI OLOGY	54.00	34, 887	13, 048		0	1	8. 00
9. 00 10. 00	EMERGENCY	69. 00 91. 00	56, 187 33, 685	20, 701 44, 759		0	1	9. 00 10. 00
	0		1, 557, 400	769, 087		7		
_	P - ARNETT TO FRANKFORT ALLOC					-1		
1.00	ADMITTING	5. 01	16, 613	5, 845		0	1	1.00
2.00	OTHER ADMINISTRATIVE & GENERAL	5. 06	491, 717	260, 116	1	0		2. 00
3. 00	OPERATION OF PLANT	7. 00	45, 549	13, 114		0		3. 00
4. 00	NURSI NG ADMI NI STRATI ON	13. 00	104, 148	68, 267	(0	1	4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14.00	56, 047	148, 134		0	1	5. 00
6.00	PHARMACY	15. 00	220, 096	67, 055		0	1	6. 00
7. 00 8. 00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	2, 554 46, 122	25, 873 15, 081		0		7. 00 8. 00
0.00	O ENTITIO ROOM	30.00	40, 122	13, 001	<u>'</u>	~I		

Health Financial Systems RECLASSIFICATIONS IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0173

Period: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am

						5/29/2024 11:	<u> 29 am</u>
	Decreases						
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
9.00	RADI OLOGY-DI AGNOSTI C	54.00	34, 887	13, 048	0		9.00
10.00	ELECTROCARDI OLOGY	69.00	32, 107	11, 829	0		10.00
11. 00	ASC (NON-DISTINCT PART)	75. 01	12, 447	39, 889	0		11.00
12.00	EMERGENCY	91.00	17, 908	23, 795	0		12.00
	0		1, 080, 195	692, 046			
	Q - INTERNS AND RESIDENTS						
1.00	I&R SERVICES-OTHER PRGM.	22. 00	0	1, 199, 824	0		1.00
	COSTS APPRVD						
	0		0	1, 199, 824			
	R - PARAMEDICAL EDUCATION						
1.00	PHARMACY	1500	130, 734	10, 001	0		1.00
	0		130, 734	10, 001			
	X - RESIDENCY STAFF						
1.00	I&R SERVICES-OTHER PRGM.	22. 00	0	824, 880	0		1.00
	COSTS APPRVD						
2.00	I&R SERVICES-OTHER PRGM.	22.00	0	32, 995	0		2.00
	COSTS APPRVD						
	0		0	857, 875			
	AE - LABORATRY SALARIES						
1. 00	LABORATORY	6000	0_	1 <u>8, 1</u> 10			1. 00
	TOTALS		0	18, 110			
500.00	Grand Total: Decreases		4, 599, 657	103, 343, 332			500.00

					To 12/31/2023	Date/Time Prep 5/29/2024 11:	pared:
				Acqui si ti ons		3/24/2024 11.	27 аш
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	3, 297, 223	0	(0	1, 076, 003	1.00
2.00	Land Improvements	590, 336	0	(0	0	2. 00
3.00	Buildings and Fixtures	170, 662, 483	0	(0	0	3. 00
4.00	Building Improvements	15, 745, 996	616, 865	(616, 865	0	4. 00
5.00	Fixed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	80, 003, 288	7, 543, 441	(7, 543, 441	298, 546	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	270, 299, 326	8, 160, 306	(8, 160, 306	1, 374, 549	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	270, 299, 326	8, 160, 306	(8, 160, 306	1, 374, 549	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	2, 221, 220	2, 221, 221				1. 00
2.00	Land Improvements	590, 336	0				2. 00
3.00	Buildings and Fixtures	170, 662, 483	0				3. 00
4.00	Building Improvements	16, 362, 861	2, 058, 263				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	87, 248, 183	48, 298, 471				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	277, 085, 083	52, 577, 955				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	277, 085, 083	52, 577, 955				10. 00

				Т	o 12/31/2023	Date/Time Prep 5/29/2024 11:	pared: 29 am
			SL	IMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11.00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	0	0	0	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT - NONHOSP	0	0	0	0	0	1. 01
1. 02	CAP REL COSTS INTEREST EXPENSE	0	0	0	0	0	1. 02
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
2. 01	CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	0	0	0	0	2. 01
3.00	Total (sum of lines 1-2)	CLIMMADY OF	E CADITAL	U	U	0	3. 00
SUMMARY OF CAPITAL							
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
1.01	CAP REL COSTS - BLDG & FIXT - NONHOSP	0	0				1. 01
1. 02 2. 00	CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP	0	0				1. 02 2. 00
2.00	CAP REL COSTS-MVBLE EQUIP - NONHOSP	0	0				2.00
3.00	Total (sum of lines 1-2)		0				3.00
3.00	Total (Sum of Tries 1-2)	١	0	I		l	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0173 Period: From 01/01/2023 Period: From 01/2023 Period: From 01/01/2023 Period: From 01/2023 P
COMPUTATION OF RATIOS
Cost Center Description
Cost Center Description
Leases for Ratio
Leases for Ratio
Col. 1 - col. 2) 1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
Note
1.00 CAP REL COSTS-BLDG & FIXT 189,836,900 0 189,836,900 0.685121 0 1.00 1.01 CAP REL COSTS-BLDG & FIXT - NONHOSP 0 0 0 0.000000 0 1.01 1.02 CAP REL COSTS INTEREST EXPENSE 0 0 0 0.000000 0 1.02 2.00 CAP REL COSTS-MVBLE EQUIP 87,248,183 0 87,248,183 0.314879 0 2.00 2.01 CAP REL COSTS-MVBLE EQUIP - NONHOSP 0 0 0.000000 0 2.01 3.00 Total (sum of lines 1-2) 277,085,083 0 277,085,083 1.000000 0 3.00
1. 01 CAP REL COSTS-BLDG & FIXT - NONHOSP 0 0 0 0 0 0 0 0 0
1. 02 CAP REL COSTS INTEREST EXPENSE 0 0 0 0 0 0 0 0 0
2. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 87, 248, 183 0. 314879 0 2. 00 0 0. 000000 0 2. 01 3. 00 Total (sum of lines 1-2) 277, 085, 083 0 277, 085, 083 1. 000000 0 3. 00 3. 00
2. 01 CAP REL COSTS-MVBLE EQUIP - NONHOSP 0 0 0 0.000000 0 2. 01 3. 00 Total (sum of lines 1-2) 277, 085, 083 0 277, 085, 083 1.000000 0 3. 00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes 0ther capital -Relate d Costs through 7) 6. 00 7. 00 8. 00 9. 00 10. 00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1. 00 CAP REL COSTS-BLDG & FIXT 0 0 0 5, 029, 410 455, 624 1. 00
3.00 Total (sum of lines 1-2) 277,085,083 0 277,085,083 1.000000 0 3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL
Cost Center Description
Capital -Relate Col s. 5
d Costs through 7)
CAP REL COSTS-BLDG & FIXT 0 0 5, 029, 410 455, 624 1. 00
PART - RECONCILIATION OF CAPITAL COSTS CENTERS
1. 00 CAP REL COSTS-BLDG & FIXT 0 0 5, 029, 410 455, 624 1. 00
1. 01 CAP REL COSTS-BLDG & FIXT - NONHOSP 0 0 555, 184 87, 216 1. 01
1. 02 CAP REL COSTS INTEREST EXPENSE 0 0 0 0 1. 02
2. 00 CAP REL COSTS - NVBLE EQUIP 0 0 6, 612, 800 160, 313 2. 00
2.01 CAP REL COSTS-MVBLE EQUI P - NONHOSP 0 0 755.272 104.930 2.01
3.00 Total (sum of lines 1-2) 0 0 12, 952, 666 808, 083 3.00
SUMMARY OF CAPITAL
Cost Center Description
Cost Center Description Interest Insurance (see Taxes (see Other Total (2) (sum instructions) Capital - Relate of cols. 9
d Costs (see through 14)
instructions)
11.00 12.00 13.00 14.00 15.00

0

0 617

9, 698, 685

9, 699, 302

267, 218

59, 238

14, 554

341, 010

1, 184

0

0

-965

-2, 149

1.00

1.01

1.02

2. 00 2. 01

5, 753, 436

9, 698, 685

6, 787, 667 860, 819

23, 800, 096

699, 489

1.00

1.01

1.02

2. 00

3.00

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT

CAP REL COSTS-BLDG & FIXT - NONHOSP

CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - NONHOSP

CAP REL COSTS INTEREST EXPENSE

Total (sum of lines 1-2)

Peri od: Worksheet A-8 From 01/01/2023 Date/Time Prepared: 5/20/2024 11:29 am

				To	12/31/2023	Date/Time Prep 5/29/2024 11:2	
				Expense Classification on		7 2 77 202 1 111	27 (411)
				To/From Which the Amount is t	to be Adjusted		
	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	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1. 01	0	1. 01
1.01	COSTS-BLDG & FLXT - NONHOSP		O	NONHOSP	1.01		1.01
1. 02	(chapter 2) Investment income - CAP REL	В	-14 201 416	CAP REL COSTS INTEREST	1. 02	11	1. 02
1.02	COSTS INTEREST EXPENSE	5	14, 201, 410	EXPENSE	1.02		1. 02
2. 00	(chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
2. 01	Investment income - CAP REL COSTS-MVBLE EQUIP - NONHOSP		0	CAP REL COSTS-MVBLE EQUIP - NONHOSP	2. 01	0	2. 01
	(chapter 2)						
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	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
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	О	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-18, 800, 579			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	46, 647, 900			0	12. 00
	transactions (chapter 10)	A 0 1	40, 047, 700			Ĭ	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	
15. 00	Rental of quarters to employee		0		0. 00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than						
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
18.00	abstracts		0		0.00		16.00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty				3. 30	Ĭ	50
22. 00	charges (chapter 21) Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to	,					
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1. 01	0	26. 01
	COSTS-BLDG & FLXT - NONHOSP			NONHOSP			
26. 02	Depreciation - CAP REL COSTS INTEREST EXPENSE			CAP REL COSTS INTEREST EXPENSE	1. 02	0	26. 02
27. 00	Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP	1			l	l	

From 01/01/2023 | Date/Time Prepared:

					3 12/31/2023	5/29/2024 11:	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
27. 01	Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP -	2. 01	0	27. 01
27.0.	COSTS-MVBLE EQUIP - NONHOSP		ŭ	NONHOSP	2.0.	Ĭ	
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	l e	1
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	ł	30.00
00.00	therapy costs in excess of		ŭ		07.00		00.00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
	instructions)		_				
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	-13, 900, 114	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 00
33. 01	HAF OFFSET	A		OTHER ADMINISTRATIVE &	5. 06	l e	•
				GENERAL		_	
33. 02	MI SCELLANEOUS I NCOME	В	-588, 372	OTHER ADMINISTRATIVE &	5. 06	0	33. 02
		_	,	GENERAL		_	
33. 03	MI SCELLANEOUS I NCOME	В	-9, 471	OPERATION OF PLANT	7. 00	0	33. 03
33. 04	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	l e	•
33. 05	MI SCELLANEOUS I NCOME	В	·	CENTRAL SERVICES & SUPPLY	14. 00	l e	
33. 06	MI SCELLANEOUS I NCOME	В		PHARMACY	15. 00	l e	•
33. 07	MI SCELLANEOUS I NCOME	В	·	ADULTS & PEDIATRICS	30.00	ł	
33. 08	MI SCELLANEOUS I NCOME	В		DELIVERY ROOM & LABOR ROOM	52.00	l e	
33. 09	MI SCELLANEOUS I NCOME	В		RETAIL PHARMACY	73. 01	Ö	
33. 10	MI SCELLANEOUS I NCOME	В	·	SLEEP CLINIC	90. 01	Ö	ı
33. 11	NON-ALLOWABLE MARKETING	A		OTHER ADMINISTRATIVE &	5. 06		1
55. 11	NON ALLOWABLE WARKETING	^	303, 321	GENERAL	3.00		33. 11
33. 12	NON-ALLOWABLE MARKETING	A	_47	DI ETARY	10.00	0	33. 12
33. 13	NON-ALLOWABLE MARKETING	A		OPERATING ROOM	50.00	l e	
33. 14	NON-ALLOWABLE MARKETING	A		RADI OLOGY-DI AGNOSTI C	54.00	l e	•
33. 15	NON-ALLOWABLE MARKETING	A		RESPIRATORY THERAPY	65.00	l e	
33. 16	NON-ALLOWABLE MARKETING	A		EMERGENCY	91.00	l e	1
33. 17	CONTRI BUTI ON EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	l e	1
33. 17	CONTRIBUTION EXPENSE	Ä		OTHER ADMINISTRATIVE &	5.06	l .	
55. 10	CONTAIDUTION EXPENSE	_ ^	-320, 107	GENERAL	5.00	l	33. 10
33. 19	CONTRI BUTI ON EXPENSE	A	180	NURSING ADMINISTRATION	13.00	0	33. 19
33. 20	CONTRIBUTION EXPENSE	A		ADULTS & PEDIATRICS	30.00	l e	
33. 21	CONTRIBUTION EXPENSE	A		RETAIL PHARMACY	73. 01	Ö	1
33. 22	RECRUI TMENT	A	·	OTHER ADMINISTRATIVE &	5. 06		1
00. 22	The street time to	, ,	2017720	GENERAL	0.00	Ĭ	00.22
33. 23	OTHER ADJUSTMENTS (SPECIFY)		Λ		0.00	0	33. 23
00. 20	(3)		Ü		0.00	Ĭ	00.20
33. 24	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 24
55. £ f	(3)		O		3.00		55. 2
33. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 25
3	(3)		· ·		2.00]	
33. 26	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 26
	(3)		· ·		2.00]	
33. 27	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 27
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-27, 954, 854				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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.

Worksheet A-8-1

From 01/01/2023

Line No. Cost Center Expense I tems Amount of Al I owable Cost Menum Included in Wks. A, column 5. 1.00 2.00 3.00 4.00 5.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 2.00 1.02 CAP REL COSTS-BLDG & FIXT HOME OFFICE ALLOCATION 23, 900, 101 0.2.00 3.00 2.00 CAP REL COSTS-MUBLE EQUIP HOME OFFICE ALLOCATION 1, 173, 095 0.3.00 4.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE ALLOCATION 13, 582, 845 17, 424 4, 00 4.01 5.06 OTHER ADMINISTRATIVE & GENER HOME OFFICE ALLOCATION 46, 841, 909 39, 432, 776 4.01 4.02 4.00 EMPLOYEE BENEFITS DEPARTMENT RELATED PARTY 24, 394 24, 394 4.02 4.03 5.06 OTHER ADMINISTRATIVE & GENER RELATED PARTY 1, 103, 035 1, 103, 035 4.03 4.04 13.00 NURSING ADMINISTRATION RELATED PARTY 1, 103, 035 1, 103, 035 4.03 4.05 2.00 [AB SERVICES-OTHER PROM. COS RELATED PARTY 916, 130 916, 130 916, 130 4.05 4.06 30.00 ADULTS & PEDIATRICS RELATED PARTY 7, 630, 305 7, 630, 305 4.06 4.07 35.00 NEONATAL INTENSIVE CARE UNIT RELATED PARTY 7, 630, 305 7, 630, 305 4.06 4.08 5.00 ONEONATAL INTENSIVE CARE UNIT RELATED PARTY 7, 630, 305 7, 630, 305 4.06 4.09 53.00 ANGSTHESIOLOGY RELATED PARTY 7, 630, 305 7, 630, 305 4.06 4.09 53.00 ANGSTHESIOLOGY RELATED PARTY 7, 637, 697, 758, 793 75					To 12/31/2023	Date/Time Pre 5/29/2024 11:	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED		line No	Cost Center	Expense Items	Amount of		27 alli
1.00 2.00 3.00 4.00 5.00		Errie No.	Sost senter	Expense i tems			
1.00							
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED 1. 00 1. 00 CAP REL COSTS-BLDG & FIXT 1. 00 CAP REL COSTS-BLDG & FIXT 2. 00 3. 00 2. 00 CAP REL COSTS-WABLE EQUIP 4. 00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 5. 06 OTHER ADMINISTRATIVE & GENER 4. 01 4. 02 4. 00 EMPLOYEE BENEFITS DEPARTMENT 5. 06 OTHER ADMINISTRATIVE & GENER 6. 03 6. 05 OF OTHER ADMINISTRATIVE & GENER 6. 05 OF OTHER ADMINISTR							
HOME OFFICE COSTS: 1.00 CAP REL COSTS-BLDG & FIXT HOME OFFICE ALLOCATION 1,055,799 455,649 1.00 2.00 3.00 2.00 CAP REL COSTS INTEREST EXPEN HOME OFFICE ALLOCATION 1,173,095 0.3.00 3.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE ALLOCATION 1,173,095 0.3.00 4.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE ALLOCATION 13,582,845 17,424 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE ALLOCATION 13,582,845 17,424 4.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE ALLOCATION 46,841,909 39,432,776 4.01 4.00 EMPLOYEE BENEFITS DEPARTMENT RELATED PARTY 24,394 24,394 4.02 4.00 4.03 13.00 NURSI NG ADMINI STRATI ON RELATED PARTY 1,103,035 1,103,035 4.03 4.04 4.05		1. 00	2.00	3. 00	4. 00	5. 00	
1.00 CAP REL COSTS-BLDG & FIXT HOME OFFICE ALLOCATION 1, 055, 799 455, 649 1.00 2.00 1.02 CAP REL COSTS INTEREST EXPEN HOME OFFICE ALLOCATION 23, 900, 101 0 2.00 CAP REL COSTS-MYBLE EQUIP HOME OFFICE ALLOCATION 1, 173, 095 0 3.00 4.00 A.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE ALLOCATION 13, 582, 845 17, 424 4.00 4.01 5.06 OTHER ADMINISTRATIVE & GENER HOME OFFICE ALLOCATION 46, 841, 909 39, 432, 776 4.01 4.00 EMPLOYEE BENEFITS DEPARTMENT RELATED PARTY 24, 394 24, 394 24, 394 4.02 4.03 5.06 OTHER ADMINISTRATIVE & GENER RELATED PARTY 1, 103, 035 1, 103, 035 4.03 13.00 NURSING ADMINISTRATION RELATED PARTY 31, 541 31, 541 4.04 4.05 4.06 30.00 ADULTS & PEDIATRICS RELATED PARTY 916, 130 916, 130 916, 130 4.05 4.06 30.00 ADULTS & PEDIATRICS RELATED PARTY 7, 630, 305 7		A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
2.00		HOME OFFICE COSTS:					
3.00	1.00		l .		1, 055, 799	455, 649	1.00
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4. 00 EMPLOYEE BENEFITS DEPARTMENT RELATED PARTY 24, 394 4. 02 4. 03 5. 06 OTHER ADMINISTRATIVE & GENER RELATED PARTY 1, 103, 035 1, 103, 035 4. 03 4. 04 13. 00 NURSI NG ADMINISTRATION RELATED PARTY 31, 541 31, 541 4. 04 4. 05 22. 00 &R SERVI CES-OTHER PRGM. COS RELATED PARTY 916, 130 916							
4. 03							
4. 04			l .			· ·	
4. 05			l .				
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4. 07 4. 08 4. 09 4. 09 4. 10 5. 00 PERATI NG ROOM RELATED PARTY RELATED PARTY A03, 301 A03, 301 A09, 301 A			N.				
4.08							
4. 09			l l				
4. 10 54. 00 RADI OLOGY-DI AGNOSTI C RELATED PARTY 17,657 17,657 4. 10 4. 11 60. 00 LABORATORY RELATED PARTY 12,126,738 12,126,738 4. 11 4. 12 63. 00 BLOOD STORING, PROCESSING & RELATED PARTY 1,781 1,781 1,781 4. 12 4. 13 70. 00 ELECTROENCEPHALOGRAPHY RELATED PARTY 12,000 12,000 4. 13 4. 14 90. 01 SLEEP CLINIC RELATED PARTY 1,505 1,505 4. 14 4. 15 91. 00 EMERGENCY RELATED PARTY 2,251,740 2,251,740 4. 15 5. 00 0 119,366,364 72,718,464 5. 00							
4. 11 60. 00 LABORATORY RELATED PARTY 12, 126, 738 12, 126, 738 4. 11 4. 12 63. 00 BLOOD STORING, PROCESSING & 1, 781 1, 781 1, 781 1, 781 4. 12 4. 13 70. 00 ELECTROENCEPHALOGRAPHY RELATED PARTY 12, 000 12, 000 4. 13 4. 14 90. 01 SLEEP CLINIC RELATED PARTY 1, 505 1, 505 4. 14 4. 15 91. 00 EMERGENCY RELATED PARTY 2, 251, 740 2, 251, 740 4. 15 5. 00 0 119, 366, 364 72, 718, 464 5. 00			l l				
4. 12 63. 00 BLOOD STORING, PROCESSING & RELATED PARTY 1, 781 1,781 4. 12 4. 13 70. 00 ELECTROENCEPHALOGRAPHY RELATED PARTY 12,000 12,000 4. 13 4. 14 90. 01 SLEEP CLINIC RELATED PARTY 1,505 1,505 4. 14 4. 15 91. 00 EMERGENCY RELATED PARTY 2,251,740 2,251,740 4. 15 5. 00 0 119,366,364 72,718,464 5. 00							
4. 13 70. 00 ELECTROENCEPHALOGRAPHY RELATED PARTY 12,000 12,000 4. 13 4. 14 90. 01 SLEEP CLINIC RELATED PARTY 1,505 1,505 4. 14 4. 15 91. 00 EMERGENCY RELATED PARTY 2,251,740 2,251,740 4. 15 5. 00 0 119,366,364 72,718,464 5. 00							
4. 14 90. 01 SLEEP CLINIC RELATED PARTY 1, 505 1, 505 4. 14 4. 15 91. 00 EMERGENCY RELATED PARTY 2, 251, 740 2, 251, 740 4. 15 5. 00 0 119, 366, 364 72, 718, 464 5. 00							
4. 15 91. 00 EMERGENCY RELATED PARTY 2, 251, 740 2, 251, 740 4. 15 5. 00 0 119, 366, 364 72, 718, 464 5. 00							
5.00 0 119,366,364 72,718,464 5.00							
		91. 00	EMERGENCY	RELATED PARTY		· · · · · ·	
	5. 00	0		0	119, 366, 364	72, 718, 464	5. 00

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

 or book poored to not horizon /if	001 411110 1 41147 01 27 1110 4111041	it air onabi o on	our a po riiai ou tou rii oor aiiir i	or time parti	
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	IU HEALTH	100.00	IU HEALTH	100. 00	6. 00
7.00			0.00		0.00	7. 00
8.00			0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					l

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

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5.00 46, 647, 900 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A. columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

1103 110 0	been posted to worksheet A,	cordinas i anazor 2, the amount arrowable should be rhareated in cordina 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.00
7.00		6.00
8.00		8. 00 9. 00
9.00		9.00
10.00		10.00
7. 00 8. 00 9. 00 10. 00 100. 00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

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| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0173

West: A Line # Cost Center/Physician Identifier Resourceration Provider Component Component Provider Component RCE Amount Physician (April 1997) Component RCE Amount Physician (April 1997) RCE Amoun						1	To 12/31/2023	B Date/Time Pre 5/29/2024 11:	epared: 29 am
1.00		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		27 (3.11)
1.00				Remuneration	Component	Component		ider Component	
1.00									
CENERAL CONTRESING ADMINISTRATION 2.63, 204 2.63, 204 0 211, 500 0 2.00									
2.00	1. 00			424, 831	424, 831	0	211, 500	0	1. 00
3. 00 30. 00 ADULTS & PEDI ATRICS 7, 624, 474 7, 624, 474 0 211, 500 0 3. 00 5. 00 33. 00 INTENSIVE CARE UNIT 1, 200 1, 200 0 211, 500 0 4. 00 5. 00 35. 00 OPERATIN RE ROWN 350 350 0 246, 500 0 6. 00 7. 00 53. 00 AMESTHESI OLOGY 7, 533, 695 7, 533, 695 0 229, 400 0 7, 00 8. 00 91. 00 EMRGENCY 2, 251, 740 0 211, 500 0 8. 00 9. 00 0. 00 0 0 0 0 0 0 10. 00 0. 00 0 0 0 0 0 0 10. 00 0. 00 0 0 0 0 0 10. 00 0. 00 0 0 0 0 0 10. 00 0. 00 0 0 0 0 10. 00 0. 00 0 0 0 10. 00 0. 00 0 0 0 10. 00 0. 00 0 0 0 10. 00 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0 10. 00 0 0 0 0						_		_	
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18,800,579 18,000,579 18,000				0	_	_	, and the second	·	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cost of Cost		0.00		10 000 570	ľ		Ĭ	1	
Identifier	200.00	Wkst Alino#	Cost Contor/Physician						200.00
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1.00		1. 00	2.00	8. 00	9. 00			14. 00	
2. 00	1.00	5. 06	OTHER ADMINISTRATIVE &	0	0	0	0	0	1. 00
3. 00									
4. 00	2.00			0	0	0	0	0	2. 00
S. 00				0	0	0	0	0	
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7. 00				0	0	0	0	1	
8. 00 91. 00 EMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0	1	
9.00				0	0	0	0		
10.00			EMERGENCY	0	0	0	0	_	
Number Cost Center/Physician Cost Center/Physician Component Share of col. Li mi t Share of col. Share of col. Share of col. Li mi t Share of col. Share of				0	0	0	0	1	
Wkst. A Line # Cost Center/Physician Identifier Component Share of col. 14		0.00		0	0	0	0	_	
Identifier Component Share of col. Li mi t Di sal I owance	200.00	WI+ A I : //	Cook Cooks (Dharis si sa	0	0 Adi:td DCE	U DOE	0	0	200.00
Share of col 14 14 15 15 16 17 18 17 18 18 18 18 18		WKSt. A LINE #			, ,		Adjustment		
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1.00		1. 00	2.00		16, 00	17. 00	18. 00		
CANOR CANO	1.00								1. 00
3.00 30.00 ADULTS & PEDIATRICS 0 0 0 7,624,474 3.00 4.00 31.00 INTENSI VE CARE UNI T 0 0 0 1,200 4.00 5.00 35.00 INTENSI VE CARE UNI T 0 0 0 0 701,085 5.00 6.00 50.00 OPERATI NG ROOM 0 0 0 0 350 6.00 7.00 53.00 ANESTHESI OLOGY 0 0 0 0 7,533,695 7.00 8.00 91.00 EMERGENCY 0 0 0 0 0 0 2,251,740 8.00 9.00 0 0 0 0 9.00 9.00									
4. 00 31. 00 INTENSI VE CARE UNI T 0 0 1, 200 4. 00 5. 00 35. 00 NEONATAL INTENSI VE CARE UNI T 0 0 0 701, 085 5. 00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 350 6. 00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 7, 533, 695 7. 00 8. 00 91. 00 EMERGENCY 0 0 0 2, 251, 740 8. 00 9. 00 0 0 0 0 9. 00	2.00	13. 00	NURSING ADMINISTRATION	0	0	0	263, 204		2. 00
5. 00 35. 00 NEONATAL INTENSIVE CARE UNIT 0 0 0 701,085 5.00 6. 00 50. 00 OPERATI NG ROOM 0 0 0 350 6.00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 7, 533, 695 7.00 8. 00 91. 00 EMERGENCY 0 0 0 2, 251, 740 8.00 9. 00 0 0 0 0 0 9.00	3.00			0	0	0	7, 624, 474		3. 00
6. 00 50. 00 OPERATI NG ROOM 0 0 350 6. 00 7. 00 53. 00 ANESTHESI OLOGY 0 0 0 7, 533, 695 7. 00 8. 00 91. 00 EMERGENCY 0 0 0 2, 251, 740 8. 00 9. 00 0 0 0 0 9. 00	4.00	31.00 INTENSIVE CARE UNIT		0	0	0	1, 200		4. 00
7. 00 53. 00 ANESTHESI OLOGY 0 0 7, 533, 695 7. 00 8. 00 91. 00 EMERGENCY 0 0 0 0 2, 251, 740 8. 00 9. 00 0 0 9. 00	5.00	35.00 NEONATAL INTENSIVE CARE UNIT		0	0	0	701, 085		5. 00
8. 00 91. 00 EMERGENCY 0 0 0 2, 251, 740 8. 00 9. 00 0 0 9. 00	6.00	50. 00	OPERATING ROOM	0	0	0	350		6. 00
9.00 0.00 0 0 9.00				0	0	0			
			EMERGENCY	0	0	0	2, 251, 740		
10.00 l 0.00l l 0l 0l 0l 10.00				0	0	0	0		
	10.00	0. 00		0	0	0	0		10. 00
200. 00 0 0 18, 800, 579 200. 00	200.00			0	0	0	18, 800, 579		200. 00

| Period: | Worksheet B | From 01/01/2023 | Part | | Date/Time Prepared: | 5/29/2024 | 11: 29 am

							5/29/2024 11:	
					CAPITAL REI	LATED COSTS		
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	BLDG & FIXT - NONHOSP	CAP REL COSTS INTEREST EXPENSE	MVBLE EQUIP	
			0	1.00	1. 01	1. 02	2. 00	
		AL SERVICE COST CENTERS						
1. 00 1. 01 1. 02 2. 00 2. 01	00101 00102 00200	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - NONHOSP CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP - NONHOSP	5, 753, 436 699, 489 9, 698, 685 6, 787, 667 860, 819	5, 753, 436 0 0	699, 489	9, 698, 685	6, 787, 667 0	1. 00 1. 01 1. 02 2. 00 2. 01
4. 00 5. 01 5. 06 7. 00 7. 01	00570 00590 00700 00701	EMPLOYEE BENEFITS DEPARTMENT ADMITTING OTHER ADMINISTRATIVE & GENERAL OPERATION OF PLANT OPERATION OF PLANT - NONHOSPITAL	14, 771, 576 415, 736 54, 186, 885 11, 670, 079 786, 139	0 16, 933 181, 725 1, 042, 429 0	179, 340 0 10, 419	0 28, 544 306, 337 1, 757, 244 0	0 19, 977 214, 391 1, 229, 815 0	4. 00 5. 01 5. 06 7. 00 7. 01
8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00	00900 01000 01100 01300 01400	LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY	3, 516, 471 1, 193, 522 903, 464 4, 406, 457 12, 716, 931 5, 881, 289	0 73, 115 101, 351 101, 569 58, 727 287, 978 72, 780	1, 300 0 0 0 662	0 123, 251 170, 849 171, 217 98, 998 485, 450 122, 687	0 86, 258 119, 570 119, 827 69, 284 339, 745 85, 863	8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
16. 00 17. 00 18. 00 21. 00 22. 00 23. 00	01700 01850 02100 02200 02300	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE PATIENT TRANSPORT SERVICES I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD PARAMED ED PRGM. PHARMACY	0 759, 806 712, 261 1, 199, 824 1, 120, 857 277, 742	0 0 19, 857 0 4, 291 2, 415	0 16, 132	0 0 33, 473 0 7, 234 4, 071	0 0 23, 427 0 5, 063 2, 849	16. 00 17. 00 18. 00 21. 00 22. 00 23. 00
30. 00 31. 00 33. 00 33. 01	03000 03100 03300	IENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	30, 760, 453 4, 938, 024 0	1, 651, 332 172, 225 0 0	0	2, 783, 692 290, 324 0 0	1, 948, 178 203, 184 0 0	30. 00 31. 00 33. 00 33. 01
35. 00 43. 00	02060	NEONATAL INTENSIVE CARE UNIT NURSERY	2, 516, 905 918, 876	130, 053 46, 828		219, 233 78, 938	153, 431 55, 245	35. 00 43. 00
43.00		LARY SERVICE COST CENTERS	710,070	40, 020		70, 750	33, 243	43.00
50. 00 51. 00 52. 00 53. 00 53. 01 54. 00 55. 00	05000 05100 05200 05300 05301 05400	OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY ASC ANESTHESI OLOGY RADI OLOGY-I AGNOSTI C RADI OLOGY-THERAPEUTI C	9, 769, 580 1, 091, 156 3, 076, 512 354, 943 13, 236 6, 404, 427	441, 321 65, 885 208, 768 19, 741 0 229, 862	0 0 1, 149 917 0	743, 944 111, 063 351, 925 33, 277 0 387, 482	520, 652 77, 728 246, 296 23, 289 0 271, 181	50. 00 51. 00 52. 00 53. 00 53. 01 54. 00 55. 00
56. 00 59. 00 60. 00 63. 00 65. 00 66. 00	05600 05900 06000 06300 06500	RADI OI SOTOPE CARDI AC CATHETERI ZATI ON LABORATORY BLOOD STORI NG, PROCESSI NG & TRANS. RESPI RATORY THERAPY PHYSI CAL THERAPY	829, 857 3, 159, 251 12, 418, 430 914, 749 2, 489, 027 961, 124	30, 055 90, 906 135, 741 8, 990 18, 330 10, 838	000000000000000000000000000000000000000	50, 664 153, 242 228, 821 15, 155 30, 899 18, 269	35, 457 107, 247 160, 141 10, 606 21, 624 12, 786	56. 00 59. 00 60. 00 63. 00 65. 00 66. 00
67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 73. 01	06800 06900 07000 07100 07200 07300	OCCUPATIONAL THERAPY SPEECH PATHOLOGY ELECTROCARDIOLOGY ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS RETAIL PHARMACY	909, 222 391, 566 2, 000, 297 94, 115 9, 375, 757 12, 232, 144 40, 555, 860 10, 929, 506	7, 943 4, 684 34, 986 0 0 0 16, 206	0 0 0	13, 389 7, 896 58, 977 0 0 0 27, 318	9, 371 5, 526 41, 275 0 0 0 0 19, 119	67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 73. 01
74. 00 75. 00 75. 01 76. 00 76. 01 76. 97 77. 00 78. 00	07400 07500 07501 03950 03951 07697	RENAL DIALYSIS ASC (NON-DISTINCT PART) ASC (NON-DISTINCT PART) CARDIAC CATHERIZATION OUTPATIENT WOUND CARE CENTER CARDIAC REHABILITATION ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY	917, 195 917, 195 0 5, 353, 232 0 1, 056, 517 0 0	22, 912 0 0 0 0 0 0	0 0 265, 034 0 0 0	38, 623 0 0 0 0 0 0	27, 031 0 0 0 0 0 0	74. 00 75. 00 75. 01 76. 00 76. 01 76. 97 77. 00 78. 00
90. 00 90. 01 90. 02 90. 03 90. 04 91. 00 92. 00	0UTPA 09000 04950 09001 09002 09003	TIENT SERVICE COST CENTERS CLINIC SLEEP CLINIC COMP MED REV CLINIC ARNETT CANCER CARE CENTER OUTPATIENT INFUSION CENTER EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	0 576, 614 766, 030 1, 510, 464 53, 486 11, 635, 667	0 0 0 0 844 294, 626	0 29, 591 9, 127 115, 563 0	0 0 0 0 1, 422 496, 657	0 0 0 0 995 347, 588	90. 00 90. 01 90. 02 90. 03 90. 04

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0173	Peri od:	Worksheet B

				rom 01/01/2023 o 12/31/2023	Part I Date/Time Pre 5/29/2024 11:	pared: 29 am
		·	CAPITAL RE	LATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - NONHOSP	CAP REL COSTS I NTEREST EXPENSE	MVBLE EQUIP	
	0	1.00	1. 01	1. 02	2. 00	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	127, 314	10, 605	C	17, 877	12, 511	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	C	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	C	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	317, 420, 671	5, 616, 851	633, 399	9, 468, 442	6, 626, 530	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	125, 427	32, 935	0	55, 519		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	49, 196	26, 185	45, 930	44, 141		192. 00
193.00 19300 NONPALD WORKERS	0	0	C	0		193. 00
193. 01 19301 RETAIL PHARMACY	0	0	C	0		193. 01
193. 02 19302 WHI TE HOSPI TAL	2, 326, 487	41, 911	9, 757	70, 650		193. 02
193. 03 19303 HOSPI CE	733	0	C	0		193. 03
193. 04 19304 FRANKFORT HOSPITAL	1, 772, 241	35, 554	10, 403	59, 933		193. 04
194.00 07950 MARKETI NG/PUBLI C RELATIONS	0	0	C	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	321, 694, 755	5, 753, 436	699, 489	9, 698, 685	6, 787, 667	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0173

				To	12/31/2023	Date/Time Prep 5/29/2024 11:	
	Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - NONHOSP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	Subtotal	OTHER ADMINISTRATIVE & GENERAL	- 7 dili
	ACTUAL OFFICE OF ACCUMENTS OF A	2. 01	4. 00	5. 01	5A. 01	5. 06	
1. 00 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	860, 819 0 4, 605 220, 703	14, 771, 576 67, 183 786, 909 300, 296	556, 720 0 0	56, 076, 290 15, 999, 863		1. 00 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00
7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	12, 823 0 1, 600 0 0 815 520	0 0 326, 200 161, 504 115, 051 750, 975 84, 234 820, 359 0	0 0 0 0 0 0	809, 381 0 4, 128, 195 1, 746, 796 1, 411, 128 5, 384, 441 13, 915, 815 6, 983, 921	170, 873 0 871, 528 368, 777 297, 912 1, 136, 742 2, 937, 851 1, 474, 417	7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 21. 00 22. 00 23. 00	01850 PATIENT TRANSPORT SERVICES 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	0 0 0 19, 852 0	129, 796 122, 801 0 168, 645 44, 982	0 0 0 0	889, 602 911, 819 1, 199, 824 1, 342, 074 332, 059	192, 500 253, 302 283, 333	17. 00 18. 00 21. 00 22. 00 23. 00
30. 00 31. 00 33. 00 33. 01 35. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03301 BURN INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 0 0 0 0 0	3, 094, 887 616, 391 0 0 405, 637 151, 560	49, 682 8, 919 0 0 5, 160 1, 176	40, 288, 224 6, 229, 067 0 0 3, 430, 419 1, 252, 623	1, 315, 056 0 0 724, 216	30. 00 31. 00 33. 00 33. 01 35. 00 43. 00
50. 00 51. 00 52. 00 53. 00 53. 01 54. 00 55. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0 0 0 1, 414 1, 129 0	888, 470 158, 124 516, 990 43, 315 0 819, 341	6, 689 8, 944 3, 087 1, 643 39, 790 0	12, 415, 666 1, 510, 645 4, 409, 435 480, 215 16, 925 8, 152, 083	318, 921 930, 902 101, 381 3, 573 1, 721, 035	55. 00
56. 00 59. 00 60. 00 63. 00 65. 00 67. 00 68. 00 69. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0 0 0 0 0 0 0	24, 603 226, 586 0 372, 970 124, 723 78, 587 54, 321 219, 904 16, 717	1, 386 1, 015 599 13, 764 236	976, 844 3, 761, 018 12, 972, 232 951, 151 2, 938, 256 1, 129, 126 1, 019, 527 464, 592 2, 369, 203 111, 068	794, 011 2, 738, 646 200, 803 620, 313 238, 377 215, 238 98, 083 500, 177 23, 448	63. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00
71. 00 72. 00 73. 00 73. 01 74. 00 75. 00 75. 01 76. 00 76. 01	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07301 RETAIL PHARMACY 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07501 ASC (NON-DISTINCT PART) 03950 CARDIAC CATHERIZATION	0 0 0 0 0 0 326, 160	0 0 147, 804 0 756, 117 0 56, 945	21, 570 47, 473 79, 766 3, 423 1, 004 50, 199 0 4, 819	9, 397, 327 12, 279, 617 40, 635, 626 11, 143, 376 1, 006, 765 0 6, 750, 742 0 1, 118, 281	2, 592, 424 8, 578, 813 2, 352, 545 212, 544 0 1, 425, 190	71. 00 72. 00 73. 00 73. 01 74. 00 75. 00 75. 01 76. 00 76. 01
76. 97 77. 00 78. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0 0 0	0 0 0	0 0 0	000000000000000000000000000000000000000	0 0	76. 97 77. 00 78. 00
90. 00 90. 01 90. 02 90. 03 90. 04 91. 00 92. 00 92. 01 93. 00	04950 SLEEP CLINIC 09001 COMP MED REV CLINIC 09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY	0 36, 416 11, 232 142, 216 0 0	0 80, 315 130, 828 243, 644 9, 519 1, 128, 278 14, 397 0	151 10, 980 300 74, 965	0 724, 980 917, 368 2, 022, 867 66, 566 13, 977, 781 0 182, 791	193, 671 427, 060 14, 053 2, 950, 933 38, 590	90. 03 90. 04 91. 00 92. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0173	Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

				rom 01/01/2023 o 12/31/2023		
	CAPITAL RELATED COSTS	END 07.22				
Cost Center Description	NONHOSP	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	Subtotal	OTHER ADMI NI STRATI VE & GENERAL	
	2. 01	4. 00	5. 01	5A. 01	5. 06	
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	(0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	779, 485	14, 259, 908	556, 720	316, 233, 614	54, 923, 356	118. 00
NONREI MBURSABLE COST CENTERS	T. T.					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 131	(260, 867		
191. 00 19100 RESEARCH	0	0	(0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	56, 523	5, 561	(258, 428		1
193. 00 19300 NONPALD WORKERS	0	0	(0		193. 00
193. 01 19301 RETAIL PHARMACY	0	0	(0		193. 01
193. 02 19302 WHI TE HOSPI TAL	12, 008	294, 036	(2, 804, 294		
193. 03 19303 HOSPI CE	0	0	(733		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	12, 803	203, 940	(2, 136, 819	451, 117	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	(0	0	194. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	0	0	(0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	860, 819	14, 771, 576	556, 720	321, 694, 755	56, 076, 290	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0173

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/29/2024 11: 29 am Cost Center Description OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY **PLANT** PLANT -LINEN SERVICE NONHOSPI TAL 7.00 8.00 9. 00 10.00 7.01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 1.01 1.01 1.02 00102 CAP REL COSTS INTEREST EXPENSE 1.02 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5 01 5.06 00590 OTHER ADMINISTRATIVE & GENERAL 5.06 7.00 00700 OPERATION OF PLANT 19, 377, 690 7 00 00701 OPERATION OF PLANT - NONHOSPITAL 7.01 980, 254 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 313, 981 2, 519 5, 316, 223 9.00 10.00 01000 DI ETARY 435, 238 100, 533 2, 651, 344 10.00 01100 CAFETERIA 0 100.749 11.00 11.00 436, 175 C 0 01300 NURSING ADMINISTRATION 0 13.00 252, 197 r 58, 253 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 236, 684 286, 851 14.00 1, 283 0 15.00 01500 PHARMACY 312, 544 819 0 72, 957 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16,00 0 Λ 16,00 17.00 01700 SOCIAL SERVICE 0 C 0 17.00 01850 PATIENT TRANSPORT SERVICES 0 18.00 85, 273 19, 697 0 18.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 21.00 0 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 0 22.00 18.429 31, 252 33, 434 0 22.00 23.00 02300 PARAMED ED PRGM - PHARMACY 10, 370 0 2, 395 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 7 091 442 n 2, 353, 277 30.00 1 638 008 03100 INTENSIVE CARE UNIT 0 31.00 739, 599 0 170, 835 240, 293 31.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 33.00 0 0 33.01 03301 BURN INTENSIVE CARE UNIT 0 0 0 0 33.01 02060 NEONATAL INTENSIVE CARE UNIT 0 129,003 35.00 558, 494 C 0 35, 00 43.00 04300 NURSERY 201, 095 0 46, 450 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 1, 895, 195 n O 437 759 0 50 00 05100 RECOVERY ROOM 0 51.00 282, 933 0 65, 353 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 896, 527 0 207, 083 57, 774 52.00 52.00 C 53.00 05300 ANESTHESI OLOGY 84,774 2, 226 0 21, 659 0 53.00 05301 ASC ANESTHESI OLOGY 0 1, 659 53 01 0 53 01 0 1.777 228, 006 54.00 05400 RADI OLOGY-DI AGNOSTI C 987, 111 C 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 129,066 0 0 29, 812 0 56, 00 05900 CARDIAC CATHETERIZATION 0 90.172 59 00 59 00 390, 384 Ω 0 60.00 06000 LABORATORY 582, 921 134, 645 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 38, 607 0 8, 918 0 63.00 06500 RESPIRATORY THERAPY 78, 714 0 18, 182 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 46.541 10, 750 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 34, 109 0 7,879 0 67.00 68 00 06800 SPEECH PATHOLOGY 20, 116 4,646 68.00 06900 ELECTROCARDI OLOGY 34, 704 0 69.00 150, 244 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 0 73.00 73.01 07301 RETAIL PHARMACY 69.593 C 16, 075 0 73.01 74.00 07400 RENAL DIALYSIS 98, 392 22, 727 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 0 0 07501 ASC (NON-DISTINCT PART) 75.01 0 513, 449 0 479, 360 0 75.01 03950 CARDIAC CATHERIZATION 0 76.00 0 0 76.00 03951 OUTPATIENT WOUND CARE CENTER 0 0 0 0 76.01 76.01 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0 0 90.01 04950 SLEEP CLINIC 0 57, 327 53, 520 0 90.01 09001 COMP MED REV CLINIC 90.02 0 17, 682 0 16, 508 0 90.02 90.03 09002 ARNETT CANCER CARE CENTER 0 223.881 0 209, 017 0 90.03 09003 OUTPATIENT INFUSION CENTER 0 90.04 90.04 3,623 C 837 0 91.00 09100 EMERGENCY 1, 265, 233 0 292, 248 0 91.00 C 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) O 92 01 92 01 45.542 r 10.519 0 04951 OTHER OUTPATIENT SERVICES 0 93.00 0 0 93.00 0 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 0

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lieu of	f Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provider CCN: 15-0173	Peri od: Wo	rksheet B

				From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/29/2024 11:	
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT	PLANT -	LINEN SERVICE			
		NONHOSPI TAL				
	7. 00	7. 01	8. 00	9. 00	10. 00	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	18, 791, 146	852, 215	(5, 061, 203	2, 651, 344	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	141, 435	0	(32, 669	0	190. 00
191. 00 19100 RESEARCH	0	0	(0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	112, 449	88, 981	(109, 047	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	(0	0	193. 00
193. 01 19301 RETAIL PHARMACY	0	0	(0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	179, 980	18, 903		59, 235	0	193. 02
193. 03 19303 HOSPI CE	0	0	(0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	152, 680	20, 155		54, 069	0	193. 04
194. 00 07950 MARKETI NG/PUBLI C RELATIONS	0	0	(0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	(o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	19, 377, 690	980, 254	(5, 316, 223	2, 651, 344	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am

			10) 12/31/2023	5/29/2024 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON			RECORDS &	
	11.00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FLXT - NONHOSP						1. 01
1.02 00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00570 ADMI TTI NG						5. 01
5.06 00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00 O0700 OPERATION OF PLANT						7. 00
7.01 OO701 OPERATION OF PLANT - NONHOSPITAL						7. 01
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	2 245 074					10.00
11. 00 01100 CAFETERI A	2, 245, 964	1				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	109, 286		19 400 724			13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	23, 581 119, 702	7, 661 0	18, 409, 726 37, 594	9, 001, 954		14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	119,702		37, 374	9,001,934	0	16.00
17. 00 01700 SOCIAL SERVICE	27, 176		0	0	0	17. 00
18. 00 01850 PATIENT TRANSPORT SERVICES	42, 139		16	0	0	18. 00
21. 00 02100 &R SERVI CES-SALARY & FRINGES APPRVD	38, 570		0	Ö	0	21.00
22. 00 02200 L&R SERVI CES-OTHER PRGM. COSTS APPRVD	12, 636	1	0	ol	0	22. 00
23. 00 02300 PARAMED ED PRGM - PHARMACY	7, 746	1	0	ol	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	7,7,10		3	<u> </u>		20.00
30. 00 03000 ADULTS & PEDIATRICS	620, 182	2, 902, 779	573, 060	50, 508	0	30.00
31.00 03100 INTENSIVE CARE UNIT	111, 956		178, 276	21, 839	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	0	o	0	33.00
33.01 03301 BURN INTENSIVE CARE UNIT	0	0	0	o	0	33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT	65, 349	376, 067	43, 817	3, 211	0	35. 00
43. 00 04300 NURSERY	25, 696	118, 583	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	149, 204		2, 948, 805	13, 681	0	50.00
51.00 05100 RECOVERY ROOM	26, 119		42, 768	381	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	86, 604	406, 545	63, 705	6, 621	0	52. 00
53. 00 05300 ANESTHESI OLOGY	9, 755	26, 315	136, 019	11, 773	0	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	0	0	53, 061	1, 472	0	53. 01
54. 00 05400 RADI OLOGY - DI AGNOSTI C	133, 713	155, 390	784, 309	20, 425	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 05600 RADI OI SOTOPE	3, 490	1	1, 686	2, 303	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	37, 539	185, 535	419, 104	11, 541	0	59.00
60.00 06000 LABORATORY 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	102, 122	0	5	U O	0	60. 00 63. 00
65. 00 06500 RESPIRATORY THERAPY	61, 833	0	195, 729	2	0	65.00
66. 00 06600 PHYSI CAL THERAPY	21, 466	0	1, 105	3	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	12, 636	0	726	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	7, 984		1, 296	ol	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	50, 704		2, 228	1, 477	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2,776	0	0	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	5, 140, 371	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	6, 706, 430	o	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	7, 006, 980	0	73. 00
73. 01 07301 RETAIL PHARMACY	21, 651	0	238	1, 730, 346	0	73. 01
74. 00 07400 RENAL DI ALYSI S	0	0	3, 025	173	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	0	585, 252	764, 567	17, 463	0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0	0	O	0	76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER	0	64, 621	8, 299	0	0	76. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	U	O ₁	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			0	ما	0	00.00
90. 00 09000 CLI NI C 90. 01 04950 SLEEP CLI NI C			13, 652	U A	0	90. 00 90. 01
90. 01 04950 SLEEP CLINIC 90. 02 09001 COMP MED REV CLINIC			13, 652 578	ol N	0	90.01
90. 03 09002 ARNETT CANCER CARE CENTER	42, 403	152, 725	63, 614	34, 281	0	90.02
90. 04 09003 OUTPATIENT INFUSION CENTER	1, 533	1	154	34, 261	0	90.03
91. 00 09100 EMERGENCY	214, 157	686, 014	223, 494	66, 744	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	214, 137	330, 014	220, 474	50, 744	O	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	3, 172	14, 656	1, 856	334	0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0,172	0	., 550	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS			-1	-1		1
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
- <u>- </u>		. '		'		

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared:

			10) 12/31/2023	Date/IIme Pre	
					5/29/2024 11:	29 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 192, 880	6, 940, 919	18, 409, 587	9, 001, 954	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 644	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	139	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETALL PHARMACY	0	0	0	0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	28, 207	0	0	0	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	22, 233	0	0	0	0	193. 04
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 245, 964	6, 940, 919	18, 409, 726	9, 001, 954	0	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0173

					0 12/31/2023	5/29/2024 11:	
			OTHER GENERAL	INTERNS &	RESI DENTS		
	Cost Center Description	SOCIAL SERVICE	SERVI CE PATI ENT	SERVICES-SALAR	SERVI CES-OTHER	PARAMED ED	
	Cost Genter Bescription	SOUTHE SERVICE	TRANSPORT	Y & FRI NGES	PRGM. COSTS	PRGM -	
			SERVI CES			PHARMACY	
	CENEDAL CEDIUSE COCT CENTERS	17. 00	18. 00	21. 00	22. 00	23. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.00	00100 CAP REL COSTS-BLDG & FIXT - NONHOSP						1. 00
1. 02	00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMITTING						5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL						7. 01
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	1, 104, 587					17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES	0	1, 251, 777	1			18. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	1	1		21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD	0	0	1	1, 721, 158	400 (70	22. 00
23. 00	02300 PARAMED ED PRGM - PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	0	0)		422, 673	23. 00
30. 00	03000 ADULTS & PEDIATRICS	865, 821	111, 578	1, 236, 233	1, 426, 397	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	88, 409	l ·			0	31. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	20,000	1	I	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0	o c	o c	o	0	33. 01
35.00	02060 NEONATAL INTENSIVE CARE UNIT	72, 122	11, 589	58, 943	68, 010	0	35. 00
43.00	04300 NURSERY	56, 979	2, 641	C	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	116, 109			0	50.00
51. 00	05100 RECOVERY ROOM	0	15, 023		1	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	21, 256	20, 087 6, 934		102, 394	0	52. 00 53. 00
53. 00	05300 ANESTHESI OLOGY	0	3, 689			0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	1		ا ۱	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	Ö	o	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	13, 941	C	0	0	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	53, 421	0	0	0	59. 00
60.00	06000 LABORATORY	0	65, 353	1	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	3, 707	1	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	12, 140		0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0				0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	2, 279 1, 344	1		0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	30, 912			0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	530	1		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	48, 443	•	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	106, 616		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	180, 616	o	o	422, 673	73.00
73. 01	07301 RETAIL PHARMACY	0	7, 687	' C	0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0	2, 255	[C	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0	112, 739		0	0	75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0	10 022		0	0	76.00
76. 01 76. 97	03951 OUTPATIENT WOUND CARE CENTER 07697 CARDIAC REHABILITATION	0	10, 822			0	76. 01 76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0				0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0				0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS			·1	91		70.00
90.00	09000 CLINI C	0	O) C	0	0	90. 00
90. 01	04950 SLEEP CLINIC	0	4, 590) c	O	0	90. 01
90. 02	09001 COMP MED REV CLINIC	0	338			0	90. 02
90. 03	09002 ARNETT CANCER CARE CENTER	0	24, 659			0	90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	0	673	1	0	0	90. 04
91.00	09100 EMERGENCY	0	168, 361	27, 174	31, 354	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		104			^	92. 00 92. 01
92. 01 93. 00	O9201 OBSERVATION BEDS (DISTINCT PART) O4951 OTHER OUTPATIENT SERVICES	0	194 	1	-	0	92. 01 93. 00
73.00	10 170 110 MILK OUT ATTEM SERVICES	1 0	1	1	·ı	0	/3.00

Heal the Financial Customs	III UEALTU ADAU	TT HOODITAL		مال ما	u of Form CMC 1	DEE2 10
Heal th Financial Systems	IU HEALTH ARNE		ON 15 0170 5		u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2023	Worksheet B Part I	
				To 12/31/2023		pared:
					5/29/2024 11:	29 am
		OTHER GENERAL	INTERNS &	RESI DENTS		
		SERVI CE		_		
Cost Center Description	SOCI AL SERVI CE			RSERVI CES-OTHER	PARAMED ED	
		TRANSPORT	Y & FRINGES	PRGM. COSTS	PRGM -	
		SERVI CES			PHARMACY	
OTHER RELABILITION OF SENTERS	17. 00	18. 00	21. 00	22. 00	23. 00	
OTHER REIMBURSABLE COST CENTERS						
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	C) (0	0	102. 00
SPECIAL PURPOSE COST CENTERS	1 404 507	4 054 777	1 404 (0)	4 704 450	400 (70	440.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 104, 587	1, 251, 777	1, 491, 696	1, 721, 158	422, 673	1118.00
NONREI MBURSABLE COST CENTERS			\		0	1 190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0				-	190.00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0					191.00
193. 00 19300 NONPALD WORKERS	0					193. 00
193. 01 19301 RETAIL PHARMACY	0					193. 00
193. 02 19302 WHI TE HOSPI TAL	0					193. 01
193. 03 19303 HOSPI CE	0					193. 02
193. 04 19304 FRANKFORT HOSPITAL	0					193. 03
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	0				-	194. 00
200.00 Cross Foot Adjustments			1			200.00
201.00 Negative Cost Centers	_	ر ا				201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 104, 587	1, 251, 777	1, 491, 696	1, 721, 158		
202.00 TOTAL (Sum Titles Tio thi ough 201)	1, 104, 307	1,231,777	1, 471, 070	1, 721, 130	422, 073	1202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/2 Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0173

				To	Date/Time Pr 5/29/2024 11	
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost & Post			
			Stepdown			
		04.00	Adjustments	07.00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP					1. 01
1. 02 2. 00	00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP					1. 02 2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 01	00570 ADMITTING					5. 01
5. 06 7. 00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT					5. 06 7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL					7. 01
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11.00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES					18. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD					21. 00
22. 00 23. 00	02200 1 &R SERVICES-OTHER PRGM. COSTS APPRVD 02300 PARAMED ED PRGM - PHARMACY					22. 00 23. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS					25.00
30. 00	03000 ADULTS & PEDIATRICS	67, 662, 998		65, 000, 368		30. 00
31. 00 33. 00	03100 INTENSIVE CARE UNIT	9, 832, 551 0	-147, 594 0	9, 684, 957 0		31. 00 33. 00
33. 00	03301 BURN INTENSIVE CARE UNIT	0	0	0		33. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 541, 240	-126, 953	5, 414, 287		35. 00
43. 00	04300 NURSERY	1, 968, 516	0	1, 968, 516		43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	21, 099, 573	-26, 012	21, 073, 561		50.00
51. 00	05100 RECOVERY ROOM	2, 426, 527	0	2, 426, 527		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	7, 297, 676	-191, 137	7, 106, 539		52. 00
53. 00 53. 01	05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY	881, 051	0	881, 051		53. 00 53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	82, 156 12, 271, 435	0	82, 156 12, 271, 435		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0		55. 00
56.00	05600 RADI OI SOTOPE	1, 363, 369	0	1, 363, 369		56.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	5, 742, 725 16, 595, 924	0	5, 742, 725 16, 595, 924		59. 00 60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 203, 186	o	1, 203, 186		63.00
65. 00	06500 RESPIRATORY THERAPY	3, 925, 170	O	3, 925, 170		65. 00
66.00	1 1	1, 450, 479		1, 450, 479		66.00
67. 00 68. 00	+ I	1, 292, 394 598, 061	0	1, 292, 394 598, 061		67. 00 68. 00
69. 00		3, 184, 784		3, 184, 784		69. 00
70. 00	+ +	137, 822	i i	137, 822		70. 00
71. 00 72. 00		16, 570, 067 21, 685, 087	0	16, 570, 067 21, 685, 087		71. 00 72. 00
73. 00	· · · · · · · · · · · · · · · · · · ·	56, 824, 708	0	56, 824, 708		73.00
73. 01	07301 RETAIL PHARMACY	15, 341, 511	O	15, 341, 511		73. 01
74.00	· · · · · · · · · · · · · · · · · · ·	1, 345, 881	0	1, 345, 881		74.00
75. 00 75. 01		0 10, 648, 762	0	0 10, 648, 762		75. 00 75. 01
76. 00		0	o	0		76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	1, 438, 110	0	1, 438, 110		76. 01
76. 97 77. 00		0	0	0		76. 97 77. 00
77. 00 78. 00	I I		0	0		78.00
	OUTPATIENT SERVICE COST CENTERS		9	51		
	09000 CLINIC	0	0	0		90.00
90. 01 90. 02		1, 007, 124 1, 146, 145		1, 007, 124 1, 146, 145		90. 01 90. 02
90. 02	1	3, 200, 507	0	3, 200, 507		90. 02
90. 04	09003 OUTPATIENT INFUSION CENTER	91, 168		91, 168		90. 04
91.00		19, 903, 493	-58, 528	19, 844, 965		91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	297, 654	0	297, 654		92. 00 92. 01
	04951 OTHER OUTPATIENT SERVICES	0		0		93. 00

Health Financial Systems	IU HEALTH ARNE				u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN	N: 15-0173	Peri od:	Worksheet B
				From 01/01/2023 To 12/31/2023	Part I Date/Time Prepared:
				10 12/31/2023	5/29/2024 11: 29 am
Cost Center Description	Subtotal	Intern &	Total		
	F	Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	24.00	25.00	26. 00		
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OID TREATMENT PROGRAM	0	0		0	102. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	314, 057, 854	-3, 212, 854	310, 845, 00	00	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	492, 688	0	492, 68	38	190. 00
191. 00 19100 RESEARCH	0	0		0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	623, 602	0	623, 60	02	192. 00
193.00 19300 NONPALD WORKERS	0	0		0	193. 00
193.01 19301 RETAIL PHARMACY	0	0		0	193. 01
193. 02 19302 WHI TE HOSPI TAL	3, 682, 650	0	3, 682, 6	50	193. 02
193. 03 19303 HOSPI CE	888	0	88	38	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	2, 837, 073	0	2, 837, 0	73	193. 04
194. 00 07950 MARKETING/PUBLIC RELATIONS	o	О		0	194. 00
200.00 Cross Foot Adjustments	0	0		0	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	321, 694, 755	-3, 212, 854	318, 481, 90	01	202. 00
				•	•

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 | 11: 29 am

						5/29/2024 11:	29 am
				CAPITAL RE	LATED COSTS		
				I			
	Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -		MVBLE EQUIP	
		Assigned New		NONHOSP	INTEREST		
		Capi tal			EXPENSE		
		Related Costs	1.00	1.01	1.00	2.00	
	GENERAL SERVICE COST CENTERS	0	1.00	1. 01	1. 02	2. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00	00100 CAP REL COSTS-BLDG & FIXT - NONHOSP						1. 00
1. 01	00102 CAP REL COSTS INTEREST EXPENSE						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP			•			2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	4. 00
5. 01	00570 ADMITTING	0	16, 933	3, 742	28, 544	19, 977	5. 01
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL	0	181, 725	1		214, 391	
7. 00	00700 OPERATION OF PLANT	0	1, 042, 429			1, 229, 815	1
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL	0	0			0	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	O	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	73, 115	1, 300	123, 251	86, 258	1
10.00	01000 DI ETARY	0	101, 351	0	170, 849	119, 570	10.00
11.00	01100 CAFETERI A	0	101, 569	0	171, 217	119, 827	11. 00
13.00	01300 NURSING ADMINISTRATION	0	58, 727	0	98, 998	69, 284	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	287, 978	662	485, 450	339, 745	14. 00
15. 00	01500 PHARMACY	0	72, 780	423	122, 687	85, 863	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES	0	19, 857	0	33, 473	23, 427	18. 00
21. 00		0	0	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD	0	4, 291	16, 132	7, 234	5, 063	
23. 00	02300 PARAMED ED PRGM - PHARMACY	0	2, 415	0	4, 071	2, 849	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00		0	1, 651, 332			1, 948, 178	1
31. 00		0	172, 225		· ·	203, 184	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	_	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0	100.050	0	-	0	33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	0	130, 053			153, 431	1
43. 00	04300 NURSERY	0	46, 828	0	78, 938	55, 245	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	441, 321	0	743, 944	520, 652	50.00
51. 00	05100 RECOVERY ROOM	0	65, 885	1		520, 652 77, 728	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	208, 768	1		246, 296	1
53. 00	05300 ANESTHESI OLOGY	0	19, 741	1		23, 289	
53. 00	05301 ASC ANESTHESI OLOGY	0	19,741	917		23, 209	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	229, 862	1		271, 181	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	227, 002	Ö		271, 101	55. 00
56. 00	05600 RADI OI SOTOPE	0	30, 055		_	35, 457	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	90, 906			107, 247	
60. 00	06000 LABORATORY	0	135, 741	1		160, 141	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8, 990	1		10, 606	
65.00	06500 RESPIRATORY THERAPY	0	18, 330	1			65.00
	06600 PHYSI CAL THERAPY	0	10, 838		18, 269		66. 00
	06700 OCCUPATI ONAL THERAPY	0	7, 943				67. 00
68.00	06800 SPEECH PATHOLOGY	0	4, 684	0	7, 896	5, 526	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	34, 986	0	58, 977	41, 275	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00		0	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01	07301 RETAIL PHARMACY	0	16, 206		27, 318	19, 119	
	07400 RENAL DIALYSIS	0	22, 912	0	38, 623		74. 00
75. 00		0	0	0	0	0	
	07501 ASC (NON-DISTINCT PART)	0	0	265, 034	0	0	
	03950 CARDI AC CATHERI ZATI ON	0	0	0	0	0	
76. 01	03951 OUTPATIENT WOUND CARE CENTER	0	0	0	0	0	76. 01
76. 97	1	0	0	0	0	0	76. 97
77. 00	1	0		0	-	0	
78. UU	07800 CAR T-CELL IMMUNOTHERAPY	0		0	0	0	78. 00
90.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	^		_		0	90.00
90.00	04950 SLEEP CLINIC			29, 591		0	
	09001 COMP MED REV CLINIC			9, 127		0	1
90. 02		0	1	115, 563		0	1
90. 03	1		844			995	
91. 00	1	0	294, 626	1		347, 588	
92. 00	1 1		27.,320			3,300	92. 00
	09201 OBSERVATION BEDS (DISTINCT PART)	0	10, 605	О	17, 877	12, 511	92. 01
							<u> </u>

Health Financial Systems	IU HEALTH ARNETT HOSPITAL	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0173	Peri od: From 01/01/2023	Worksheet B

			Fi	rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre 5/29/2024 11:	
		CAPITAL RELATED COSTS				
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT - NONHOSP	CAP REL COSTS I NTEREST EXPENSE	MVBLE EQUIP	
	0	1. 00	1. 01	1. 02	2. 00	
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS	,					
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	5, 616, 851	633, 399	9, 468, 442	6, 626, 530	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 935	0	55, 519		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	26, 185	45, 930	44, 141		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 RETAIL PHARMACY	0	0	0	0		193. 01
193. 02 19302 WHI TE HOSPI TAL	0	41, 911	9, 757	70, 650		1
193. 03 19303 HOSPI CE	0	0	0	0		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	35, 554	10, 403	59, 933		
194.00 07950 MARKETI NG/PUBLI C RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	5, 753, 436	699, 489	9, 698, 685	6, 787, 667	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0173

		To 12/31/2023 Date/Time Prep 5/29/2024 11:2					
	Cost Center Description	CAPI TAL RELATED COSTS MVBLE EQUI P - NONHOSP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT		OTHER ADMI NI STRATI VE & GENERAL	
	GENERAL SERVICE COST CENTERS	2.01	2A	4. 00	5. 01	5. 06	
1. 00 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 21. 00 22. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS INTEREST EXPENSE 00201 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 PATIENT TRANSPORT SERVICES	0 4, 605 220, 703 0 12, 823 0 1, 600 0 0 815 520 0 0 0	0 73, 801 1, 102, 496 4, 029, 488 23, 242 0 285, 524 391, 770 392, 613 227, 009 1, 114, 650 282, 273 0 76, 757			1, 102, 496 66, 415 3, 360 0 17, 136 7, 251 5, 858 22, 351 57, 765 28, 990 0 3, 693 3, 785 4, 980 5, 571	1. 00 1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 21. 00 22. 00
23. 00		0	9, 335	C	0	1, 378	23. 00
30. 00 31. 00 33. 00 33. 01 35. 00 43. 00	03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03301 BURN INTENSIVE CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT	0 0 0 0 0	6, 383, 202 665, 733 0 0 502, 717 181, 011	c	1, 185 0 0 0 686	167, 236 25, 857 0 0 14, 240 5, 200	30. 00 31. 00 33. 00 33. 01 35. 00 43. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 59. 00 60. 00 63. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 01 74. 00 75. 00 76. 01 76. 01 76. 97 77. 00 78. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM & LABOR ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OL OSTOPE 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07301 RETAI L PHARMACY 07400 RENAL DI ALYSI S 07501 ASC (NON-DI STI NCT PART) 07501 ASC (NON-DI STI NCT PART) 03951 OUTPATI ENT WOUND CARE CENTER 07697 CARDI AC REHABI LI TATI ON	0 0 0 1,414 1,129 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 705, 917 254, 676 806, 989 78, 870 2, 046 888, 525 0 116, 176 351, 395 524, 703 34, 751 70, 853 41, 893 30, 703 18, 106 135, 238 0 0 0 62, 643 88, 566 591, 194 0 0 0 0 0		889 1, 189 410 218 5, 288 6 825 3, 161 3, 867 219 718 184 135 80 1, 829 31 2, 866 6, 309 10, 420 455 133 0 6, 671 0 640 0 0	51, 537 6, 271 18, 304 1, 993 70 33, 839 0 4, 055 15, 612 53, 848 3, 948 12, 197 4, 687 4, 232 1, 929 9, 835 461 39, 008 50, 973 168, 591 46, 256 4, 179 0 0 28, 022 0 4, 642 0	66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 73. 00 73. 01 74. 00 75. 00 75. 01 76. 00
90. 00 90. 01 90. 02 90. 03 90. 04 91. 00 92. 00 92. 01 93. 00	09000 CLINIC 04950 SLEEP CLINIC 09001 COMP MED REV CLINIC 09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 36, 416 11, 232 142, 216 0 0	0 66, 007 20, 359 257, 779 3, 261 1, 138, 871 0 40, 993	C C	272 20 1, 459 40 9, 962	0 3, 009 3, 808 8, 397 276 58, 022 759 0	90. 00 90. 01 90. 02 90. 03 90. 04 91. 00 92. 00 92. 01 93. 00

Health Financial Systems	IU HEALTH ARNET	u of Form CMS-	2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-0173	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/29/2024 11:	
	CAPI TAL					

			T	o 12/31/2023	Date/Time Pre 5/29/2024 11:	
	CAPI TAL					
	RELATED COSTS					
Cost Center Description	MVBLE EQUIP -	Subtotal	EMPLOYEE	ADMI TTI NG	OTHER	
	NONHOSP		BENEFITS		ADMI NI STRATI VE	
	2. 01	2A	DEPARTMENT	5. 01	& GENERAL	
OTHER REIMBURSABLE COST CENTERS	2.01	ZA	4. 00	5. 01	5. 06	
102. 00 10200 OPI OI D TREATMENT PROGRAM		٥	0	0		102. 00
SPECIAL PURPOSE COST CENTERS	l ol	<u> </u>	0	U		102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	779, 485	23, 124, 707	0	73, 801	1, 079, 826	110 00
NONREI MBURSABLE COST CENTERS	777,403	23, 124, 707	0	73,001	1,077,020	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		127, 309	0	0	1 083	190. 00
191. 00 19100 RESEARCH		127, 307	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	56, 523	203, 671	0	0		192. 00
193. 00 19300 NONPALD WORKERS	00,020	200, 07 1	0	0		193. 00
193. 01 19301 RETAIL PHARMACY		0	0	0		193. 01
193. 02 19302 WHI TE HOSPI TAL	12, 008	183, 771	0	0	11, 641	
193. 03 19303 HOSPI CE	12,000	0	0	0		193. 03
193. 04 19304 FRANKFORT HOSPI TAL	12, 803	160, 638	0	0		193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0		194. 00
200.00 Cross Foot Adjustments		o	_			200. 00
201.00 Negative Cost Centers	0	o o	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	860, 819	23, 800, 096	0	73, 801		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0173

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/29/2024 11:29 am Cost Center Description OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY **PLANT** PLANT -LINEN SERVICE NONHOSPI TAL 7.00 8.00 9. 00 10.00 7.01 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 1.01 1.01 1.02 00102 CAP REL COSTS INTEREST EXPENSE 1.02 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00570 ADMITTING 5.01 5 01 5.06 00590 OTHER ADMINISTRATIVE & GENERAL 5.06 7.00 00700 OPERATION OF PLANT 4, 095, 903 7 00 00701 OPERATION OF PLANT - NONHOSPITAL 26, 602 7.01 7.01 0 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 66, 367 68 369, 095 9.00 10.00 01000 DI ETARY 91, 997 6, 980 497, 998 10.00 0 6, 995 92, 195 01100 CAFETERIA 0 11.00 11.00 0 0 01300 NURSING ADMINISTRATION 0 13.00 53, 307 C 4,044 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 261, 400 19, 916 14.00 35 0 15.00 01500 PHARMACY 66,063 22 0 5,065 15.00 0 01600 MEDICAL RECORDS & LIBRARY 0 16,00 C 0 Λ 16,00 17.00 01700 SOCIAL SERVICE 0 C 0 0 17.00 01850 PATIENT TRANSPORT SERVICES 0 18.00 18,024 0 1, 368 0 18.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 21.00 C 0 0 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 3.895 848 2, 321 0 22.00 23.00 02300 PARAMED ED PRGM - PHARMACY 2, 192 0 166 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 1 498 935 n 113 725 442, 012 30 00 03100 INTENSIVE CARE UNIT 0 31.00 156, 331 0 11,861 45, 134 31.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0 0 0 33.01 03301 BURN INTENSIVE CARE UNIT 0 0 ol 0 33.01 02060 NEONATAL INTENSIVE CARE UNIT 0 8, 956 35.00 118,050 C 0 35, 00 43.00 04300 NURSERY 42,506 0 3, 225 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 400 591 n O 30 393 0 50 00 0 05100 RECOVERY ROOM 51.00 59,804 0 4, 537 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 189, 501 0 0 14, 377 10, 852 52.00 52.00 1, 504 53.00 05300 ANESTHESI OLOGY 17, 919 60 0 0 53.00 05301 ASC ANESTHESI OLOGY 0 53 01 48 0 53 01 115 15, 830 54.00 05400 RADI OLOGY-DI AGNOSTI C 208, 648 C 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 0 56.00 05600 RADI OI SOTOPE 27, 281 0 0 2,070 0 56, 00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 82, 516 0 6.260 0 60.00 06000 LABORATORY 123, 213 9, 348 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 8, 161 0 619 0 63.00 06500 RESPIRATORY THERAPY 0 65.00 16.638 0 1, 262 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 9.838 0 746 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 7, 210 0 547 0 67.00 68 00 06800 SPEECH PATHOLOGY 4, 252 323 68.00 06900 ELECTROCARDI OLOGY 31, 757 0 2, 409 69.00 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 C 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 C 0 0 73.00 73.01 07301 RETAIL PHARMACY 14,710 C 1, 116 0 73.01 74.00 07400 RENAL DIALYSIS 20. 797 0 1,578 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 0 0 07501 ASC (NON-DISTINCT PART) 75.01 0 13, 934 0 33, 281 0 75.01 03950 CARDIAC CATHERIZATION 0 0 76.00 C 0 0 76.00 03951 OUTPATIENT WOUND CARE CENTER 0 0 0 0 76.01 76.01 0 0 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0 0 0 90.01 04950 SLEEP CLINIC 0 1,556 3, 716 0 90.01 09001 COMP MED REV CLINIC 90.02 0 480 0 1, 146 0 90.02 90.03 09002 ARNETT CANCER CARE CENTER 0 6.076 0 14, 512 0 90.03 09003 OUTPATIENT INFUSION CENTER 0 90.04 90.04 766 58 0 91.00 09100 EMERGENCY 267, 435 0 20, 290 0 91.00 C 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) O 92 01 92 01 9.626 r 730 0 04951 OTHER OUTPATIENT SERVICES 93.00 C 0 0 93.00 0 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102. 00 0

						5/29/2024 11:	29 am
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT	PLANT -	LINEN SERVICE			
			NONHOSPI TAL				
		7. 00	7. 01	8. 00	9. 00	10. 00	
SPECI	AL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 971, 925	23, 127	0	351, 389	497, 998	118. 00
NONRE	IMBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 895	0	0	2, 268	0	190. 00
191. 00 19100	RESEARCH	0	0	0	0	0	191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	23, 768	2, 415	0	7, 571	0	192. 00
193. 00 19300	NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301	RETAIL PHARMACY	0	0	0	0	0	193. 01
193. 02 19302	WHITE HOSPITAL	38, 043	513	0	4, 113	0	193. 02
193. 03 19303	HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304	FRANKFORT HOSPITAL	32, 272	547	0	3, 754	0	193. 04
194. 00 07950	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	4, 095, 903	26, 602	0	369, 095	497, 998	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am

				12/31/2023	5/29/2024 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON			RECORDS &	
	11.00	13.00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FLXT - NONHOSP						1. 01
1.02 00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00570 ADMI TTI NG						5. 01
5.06 00590 OTHER ADMINISTRATIVE & GENERAL						5. 06
7.00 O0700 OPERATION OF PLANT						7. 00
7.01 00701 OPERATION OF PLANT - NONHOSPITAL						7. 01
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	407 ((1					10.00
11. 00 01100 CAFETERI A	497, 661	220 027				11.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY	24, 216		1 450 254			13. 00 14. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	5, 225 26, 523	1	1, 459, 356 2, 980	411, 916		15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	20, 523	0	2, 960	411, 910	0	16.00
17. 00 01700 SOCIAL SERVICE	6, 022	0	0	0	0	17. 00
18. 00 01850 PATIENT TRANSPORT SERVICES	9, 337	16	1	0	0	18. 00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRVD	8, 546	0	0	0	0	21.00
22. 00 02200 L&R SERVI CES-OTHER PRGM. COSTS APPRVD	2, 800	Ö	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM - PHARMACY	1, 716		0	o	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1,710	<u> </u>	<u> </u>	<u> </u>		20.00
30. 00 03000 ADULTS & PEDIATRICS	137, 422	138, 397	45, 427	2, 311	0	30.00
31.00 03100 INTENSIVE CARE UNIT	24, 807	27, 157	14, 132	999	0	31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
33.01 03301 BURN INTENSIVE CARE UNIT	0	О	0	0	0	33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT	14, 480	17, 930	3, 473	147	0	35. 00
43. 00 04300 NURSERY	5, 694	5, 654	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	33, 061	22, 694	233, 753	626	0	50.00
51.00 05100 RECOVERY ROOM	5, 787	7, 837	3, 390	17	0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	19, 190		5, 050	303	0	52. 00
53. 00 05300 ANESTHESI OLOGY	2, 161	1, 255	10, 782	539	0	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	0	0	4, 206	67	0	53. 01
54. 00 05400 RADI OLOGY - DI AGNOSTI C	29, 628	7, 409	62, 173	935	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	773	0 04/	134	105	0	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	8, 318	1	33, 223 0	528	0	59. 00 60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	22, 628	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	13, 701	0	15, 516	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	4, 756	0	13, 310	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 800	Ö	58	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	1, 769	1	103	o	0	
69. 00 06900 ELECTROCARDI OLOGY	11, 235		177	68	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	615		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o	407, 480	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	531, 628	O	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	320, 628	0	73. 00
73. 01 07301 RETAIL PHARMACY	4, 797	0	19	79, 180	0	73. 01
74. 00 07400 RENAL DI ALYSI S	0	0	240	8	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	0	27, 903	60, 608	799	0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0	0	0	0	76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER	0	3, 081	658	O	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	<u>U</u>	0	0	0	78. 00
90. 00 09000 CLINIC	0	٥	0	ام	0	90.00
90. 01 04950 SLEEP CLINIC	0	ا	1, 082	0	0	90.00
90. 02 09001 COMP MED REV CLINIC			46	0	0	90.02
90. 03 09002 ARNETT CANCER CARE CENTER	9, 396	7, 282	5, 043	1, 569	0	90. 02
90. 04 09003 OUTPATIENT INFUSION CENTER	340	1	12	18	0	90. 04
91. 00 09100 EMERGENCY	47, 453	1	17, 716	3, 054	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1		, , ,	.,		92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	703	699	147	15	0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	1	0	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS						1
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00

			10) 12/31/2023	5/29/2024 11:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	485, 899	330, 927	1, 459, 345	411, 916	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	586	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	11	0	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 RETAIL PHARMACY	0	0	0	0	0	193. 01
193. 02 19302 WHI TE HOSPI TAL	6, 250	0	0	0	0	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	4, 926	0	0	0	0	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	497, 661	330, 927	1, 459, 356	411, 916	0	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0173

						1	0 12/31/2023	Date/lime Pre 5/29/2024 11:	
				OTHER GENER	AL	INTERNS &	RESI DENTS		
		6001.41	CED\	SERVI CE		CEDULOEC CALAB	CEDVI OFC. OTHER	DADAMED ED	
	Cost Center Description	SOCI AL	SERVI CE	PATI ENT TRANSPORT		SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM -	
				SERVI CES		I & IKINGES	TROW. COSTS	PHARMACY	
		17	7. 00	18. 00		21.00	22.00	23. 00	
	GENERAL SERVICE COST CENTERS	T					1		
1.00	00100 CAP REL COSTS-BLDG & FIXT								1.00
1. 01 1. 02	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE								1. 01 1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUIP								2.00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP								2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT								4. 00
5. 01	00570 ADMI TTI NG								5. 01
5.06	00590 OTHER ADMINISTRATIVE & GENERAL								5.06
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL								7. 00 7. 01
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 CAFETERI A								11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON								13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY								14.00
15. 00 16. 00	01600 MEDI CAL RECORDS & LI BRARY								15. 00 16. 00
17. 00	01700 SOCIAL SERVICE		9, 715						17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES		C	109, 2	288				18. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD		C		0	13, 526			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM. COSTS APPRVD		C		0		68, 007		22. 00
23. 00	02300 PARAMED ED PRGM - PHARMACY		C		0			14, 787	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	1	7, 615	l o -	738				30.00
31. 00	03100 NTENSI VE CARE UNI T		7,013		748				31.00
33. 00	03300 BURN INTENSIVE CARE UNIT		C		0				33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT		C		0				33. 01
35.00	02060 NEONATAL INTENSIVE CARE UNIT		634		012				35. 00
43. 00	04300 NURSERY		501		231				43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		C	10,	134				50.00
51. 00	05100 RECOVERY ROOM		C		311				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		187		753				52. 00
53.00	05300 ANESTHESI OLOGY		C		505				53. 00
53. 01	05301 ASC ANESTHESI OLOGY		C		322				53. 01
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C			/,	799 0				54. 00 55. 00
56. 00	05600 RADI OI SOTOPE		C	1. :	217				56.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		C		662				59. 00
60.00	06000 LABORATORY		C	5, 1	704				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		C		324				63. 00
65.00	06500 RESPIRATORY THERAPY		C		060				65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		(272 199				66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		0		117				68.00
69. 00	06900 ELECTROCARDI OLOGY		C		<i>,</i>				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		C		46				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		C		228				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		C		305				72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 RETAIL PHARMACY			15,	/9/ 571				73. 00 73. 01
74. 00	07400 RENAL DI ALYSI S		0		ว/ เ 197				74.00
75. 00	07500 ASC (NON-DISTINCT PART)		C		0				75. 00
75. 01	07501 ASC (NON-DISTINCT PART)		C	9, 8	340				75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON		C		0				76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER		C		945				76. 01
76. 97 77. 00	07697 CARDI AC REHABI LI TATI ON				0				76. 97 77. 00
78.00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY		0		0				78.00
. 0. 00	OUTPATIENT SERVICE COST CENTERS			'	J				7 3. 50
90.00	09000 CLI NI C		C		0				90. 00
	04950 SLEEP CLINIC		C		401				90. 01
	09001 COMP MED REV CLINIC		C		30				90. 02
90. 03 90. 04	O9002 ARNETT CANCER CARE CENTER O9003 OUTPATIENT INFUSION CENTER		0	2,	152 59				90. 03 90. 04
90.04	09100 EMERGENCY		0	14, (90.04
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)								92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		C		17				92. 01
93. 00	04951 OTHER OUTPATIENT SERVICES		C		0				93. 00

Health Financial Systems	IU HEALTH ARNE	ETT HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Pre 5/29/2024 11:	
		OTHER GENERAL SERVI CE		RESIDENTS		
Cost Center Description	SOCIAL SERVICE	PATI ENT TRANSPORT SERVI CES	Y & FRINGES	RSERVICES-OTHER PRGM. COSTS	PARAMED ED PRGM - PHARMACY	
	17. 00	18. 00	21.00	22. 00	23. 00	
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0)			102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	9, 715	109, 288	3	0 0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0)			190. 00
191. 00 19100 RESEARCH	0	0)			191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0)			192. 00
193.00 19300 NONPALD WORKERS	0	0)			193. 00
193. 01 19301 RETAIL PHARMACY	0	0)			193. 01
193. 02 19302 WHI TE HOSPI TAL	0	0)			193. 02
193. 03 19303 HOSPI CE	0	0)			193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	0)			193. 04
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0				194. 00

9, 715

109, 288

13, 526

13, 526

68, 007

68, 007

194. 00 14, 787 200. 00

0 201. 00 14, 787 202. 00

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

200.00

201.00

202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0173

					5/29/2024	
	Cost Center Description	Subtotal	Intern &	Total		
			Residents Cost			
			& Post			
			Stepdown Adjustments			
		24.00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP					1. 01
1. 02	00102 CAP REL COSTS INTEREST EXPENSE					1. 02
2.00	00200 CAP REL COSTS-MVBLE EQUI P					2.00
2. 01 4. 00	00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 01 4. 00
5. 01	00570 ADMITTING					5. 01
5. 06	00590 OTHER ADMINISTRATIVE & GENERAL					5. 06
7.00	00700 OPERATION OF PLANT					7. 00
7. 01	00701 OPERATION OF PLANT - NONHOSPITAL					7. 01
8.00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18. 00	01850 PATIENT TRANSPORT SERVICES					18. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD					21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM. COSTS APPRVD					22. 00
23. 00	O2300 PARAMED ED PRGM - PHARMACY					23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	8, 952, 622	0	8, 952, 622		30.00
31. 00	03100 INTENSIVE CARE UNIT	975, 722	0			31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0			33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0	0	0		33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	682, 325	0	682, 325		35. 00
43. 00	04300 NURSERY	244, 178	0	244, 178		43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	2 405 57/	0	2 405 57/		F0.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	2, 495, 576 344, 519	0			50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 087, 078	0	1, 087, 078		52.00
53. 00	05300 ANESTHESI OLOGY	116, 098	0	116, 098		53. 00
53. 01	05301 ASC ANESTHESI OLOGY	7, 092	0			53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 260, 074	0	1, 260, 074		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0		55. 00
56. 00	05600 RADI OI SOTOPE	152, 636	0			56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	514, 521	0	514, 521		59. 00
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	743, 311 48, 022	0	743, 311 48, 022		60. 00 63. 00
65. 00	06500 RESPIRATORY THERAPY	131, 945	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	62, 464	0			66. 00
67. 00		45, 884	0			67. 00
68. 00	06800 SPEECH PATHOLOGY	26, 679	0	,		68. 00
69. 00	06900 ELECTROCARDI OLOGY	197, 398	0	197, 398		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 153	0	1, 153		70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	453, 582	0	453, 582		71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	598, 215 515, 436	0	598, 215 515, 436		73.00
73. 00	07300 DROGS CHARGES TO FATTENTS	209, 847	0	209, 847		73. 01
74. 00	07400 RENAL DI ALYSI S	115, 698	0	115, 698		74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0		75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	772, 252	0	772, 252		75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0	0	. 0		76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	9, 966	0	9, 966		76. 01
76. 97 77. 00	07697 CARDIAC REHABILITATION 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0		76. 97 77. 00
78.00		0	0			78.00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	. 0	U	. 0		75.00
90.00	09000 CLINIC	0	0	0		90. 00
90. 01	04950 SLEEP CLINIC	76, 043	0	76, 043		90. 01
90. 02		25, 889	0	25, 889		90. 02
90. 03	09002 ARNETT CANCER CARE CENTER	313, 665	0	313, 665		90. 03
90.04		4, 989	0	4, 989		90. 04
91.00	09100 EMERGENCY	1, 610, 205	0	1, 610, 205		91.00
92. 00 92. 01	09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)	53, 701	0	53, 701		92. 00 92. 01
	04951 OTHER OUTPATIENT SERVICES	0 33, 701	0			93.00
	1 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1 2 1	١ ٧	<u> </u>	·	I	

Health Financial Systems	IU HEALTH ARN	ETT HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od:	Worksheet B
				From 01/01/2023 To 12/31/2023	Part II Date/Time Prepared:
					5/29/2024 11:29 am
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown Adjustments			
	24. 00	25. 00	26. 00		
OTHER REIMBURSABLE COST CENTERS	200	20.00	20.00		
102.00 10200 OPIOID TREATMENT PROGRAM	0	0		0	102. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	22, 848, 785	0	22, 848, 78	85	118. 00
NONREI MBURSABLE COST CENTERS	·				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	161, 141	0	161, 14	1	190. 00
191. 00 19100 RESEARCH	0	0		0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	238, 509	0	238, 50	19	192. 00
193. 00 19300 NONPALD WORKERS	0	0		0	193. 00
193.01 19301 RETAIL PHARMACY	0	0		0	193. 01
193. 02 19302 WHI TE HOSPI TAL	244, 331	0	244, 33	31	193. 02
193. 03 19303 H0SPI CE	3	0		3	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	211, 007	0	211, 00	07	193. 04
194.00 07950 MARKETI NG/PUBLI C RELATI ONS	0	0		0	194. 00
200.00 Cross Foot Adjustments	96, 320	0	96, 32	20	200. 00
201.00 Negative Cost Centers	0	0		0	201. 00
202.00 TOTAL (sum lines 118 through 201)	23, 800, 096	0	23, 800, 09	96	202.00

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/29/2024 11: 29 am

				CAP	ITAL RELATED CO	OSTS	5/29/2024 11:	29 am
			DI DO A FLYT				IN IDLE FOLLID	
		Cost Center Description	BLDG & FIXT (SQUARE FEET)	NONHOSP	CAP REL COSTS INTEREST	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - NONHOSP	
			(520	(SQUARE FEET)	EXPENSE	(======================================	(SQUARE FEET)	
			1.00	1. 01	(SQUARE FEET) 1.02	2. 00	2. 01	
	GENER	AL SERVICE COST CENTERS	1.00	1.01	1.02	2.00	2.01	
1.00	00100	CAP REL COSTS-BLDG & FIXT	395, 499					1. 00
1.01		CAP REL COSTS BLDG & FIXT - NONHOSP	0					1. 01
1. 02 2. 00		CAP REL COSTS INTEREST EXPENSE CAP REL COSTS-MVBLE EQUIP	0	0	395, 499	395, 499		1. 02 2. 00
2. 01		CAP REL COSTS-MVBLE EQUIP - NONHOSP				0	87, 676	2. 01
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	· -	0	0	4. 00
5. 01		ADMITTING OTHER ADMINISTRATIVE & GENERAL	1, 164			1, 164	l	5. 01
5. 06 7. 00		OPERATION OF PLANT	12, 492 71, 658		· .			5. 06 7. 00
7. 01		OPERATION OF PLANT - NONHOSPITAL	0	1, 306		0	1, 306	7. 01
8.00		LAUNDRY & LINEN SERVICE	0	0		0	0	8. 00
9. 00 10. 00		HOUSEKEEPI NG DI ETARY	5, 026 6, 967	163		5, 026 6, 967	163	9. 00 10. 00
11. 00	1	CAFETERIA	6, 982			· ·	Ö	11. 00
13.00	01300	NURSING ADMINISTRATION	4, 037	0	4, 037	4, 037	0	13. 00
14.00		CENTRAL SERVICES & SUPPLY	19, 796			19, 796	l e	14. 00
15. 00 16. 00		PHARMACY MEDI CAL RECORDS & LI BRARY	5,003	53 0		5, 003 0	53 0	15. 00 16. 00
17. 00		SOCIAL SERVICE	Ö	Ö		0	Ö	17. 00
18. 00		PATIENT TRANSPORT SERVICES	1, 365	0	1, 365	1, 365	0	18. 00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM. COSTS APPRVD	0 295	0 2, 022	0 295	0 295	0 2, 022	21. 00 22. 00
23. 00		PARAMED ED PRGM - PHARMACY	166	1		166		23. 00
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	113, 515			113, 515	l	
31. 00 33. 00		INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	11, 839	0		11, 839 0	0	31. 00 33. 00
33. 01		BURN INTENSIVE CARE UNIT	o o	Ö	·	0	ő	33. 01
35. 00		NEONATAL INTENSIVE CARE UNIT	8, 940			8, 940	0	35. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	3, 219	0	3, 219	3, 219	0	43. 00
50.00	05000	OPERATING ROOM	30, 337	0	30, 337	30, 337	0	50. 00
51.00	05100	RECOVERY ROOM	4, 529				l	
52.00		DELIVERY ROOM & LABOR ROOM	14, 351	0		14, 351	0	52.00
53. 00 53. 01		ANESTHESI OLOGY ASC ANESTHESI OLOGY	1, 357 0	144 115		1, 357 0	144 115	•
54. 00		RADI OLOGY-DI AGNOSTI C	15, 801	0		15, 801	0	54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56. 00 59. 00		RADI OI SOTOPE CARDI AC CATHETERI ZATI ON	2, 066 6, 249		,	2, 066 6, 249	l e	56. 00 59. 00
60.00		LABORATORY	9, 331		1	9, 331	0	60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	618			618	l e	63. 00
65. 00 66. 00		RESPI RATORY THERAPY	1, 260 745	0			0	65. 00 66. 00
67.00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	546		745 546	745 546	l .	67.00
68. 00		SPEECH PATHOLOGY	322	0	322	322	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	2, 405	0	2, 405	2, 405	i e	69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	Ö	72.00
73. 00		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01 74. 00		RETALL PHARMACY RENAL DIALYSIS	1, 114	0	1, 114	1, 114	l	73. 01 74. 00
75.00	1	ASC (NON-DISTINCT PART)	1, 575 0		1, 575 0	1, 575 0	0	75.00
75. 01		ASC (NON-DISTINCT PART)	Ö	33, 220	Ö	0	33, 220	
76.00		CARDI AC CATHERI ZATI ON	0	0	0	0	0	76.00
76. 01 76. 97		OUTPATIENT WOUND CARE CENTER CARDIAC REHABILITATION	0	0	0	0	0	76. 01 76. 97
77. 00		ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78. 00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
90. 00		TIENT SERVICE COST CENTERS CLINIC	1	l 0	Ο	0	0	90. 00
90. 00		SLEEP CLINIC		3, 709		0	3, 709	90.00
90. 02	09001	COMP MED REV CLINIC	0	1, 144	0	o o	1, 144	90. 02
90. 03		ARNETT CANCER CARE CENTER	0	14, 485		0	14, 485	•
90. 04 91. 00		OUTPATIENT INFUSION CENTER EMERGENCY	58 20, 253	ł .		58 20, 253	0	90. 04 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	20, 255	Ĭ	20, 255	20, 233		92.00
92. 01	09201	OBSERVATION BEDS (DISTINCT PART)	729	0	729	729	0	92. 01
							<u> </u>	

			To		Date/Time Pre 5/29/2024 11:	
	CAPITAL RELATED COSTS					
Cost Center Description	BLDG & FIXT	BLDG & FIXT -	CAP REL COSTS	MVBLE EQUIP	MVBLE EQUIP -	
	(SQUARE FEET)	NONHOSP	INTEREST	(SQUARE FEET)	NONHOSP	
		(SQUARE FEET)			(SQUARE FEET)	
	1.00		(SQUARE FEET)		0.01	
OO OO OAOEA OTHER OHTRATIENT OFRIVIORS	1.00	1. 01	1. 02	2. 00	2. 01	00.00
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	0	0	0	93. 00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	0	0	U	U	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	386, 110	79, 392	386, 110	386, 110	70 202	118. 00
NONREI MBURSABLE COST CENTERS	360, 110	17, 372	300, 110	300, 110	17, 372	1110.00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	2, 264	0	2, 264	2, 264	0	190. 00
191. 00 19100 RESEARCH	2,201	0	2,201	2, 201		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 800	5, 757	1, 800	1, 800	-	192. 00
193. 00 19300 NONPALD WORKERS	0	0,707	0	0		193. 00
193. 01 19301 RETAI L PHARMACY	0	0	Ō	0		193. 01
193. 02 19302 WHI TE HOSPI TAL	2, 881	1, 223	2, 881	2, 881	1, 223	193. 02
193. 03 19303 HOSPI CE	0	0	0	0	0	193. 03
193. 04 19304 FRANKFORT HOSPI TAL	2, 444	1, 304	2, 444	2, 444	1, 304	193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	5, 753, 436	699, 489	9, 698, 685	6, 787, 667	860, 819	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	14. 547283	7. 978113	24. 522654	17. 162286	9. 818183	203. 00
204.00 Cost to be allocated (per Wkst. B,						204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part						205. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
rai tS III allu IV)	1					I

Canal Cention Description PREFORE CONTROL CONTROL		i Financiai Systems	TU HEALTH ARNE				u of form CMS	
Country Coun	COST /	ALLOCATION - STATISTICAL BASIS		Provi der CC	F	rom 01/01/2023		pared:
ERBERGEL SERVICE COST CENT SINS 1. 00 001001 CAP REL COSTS-ELLOS & FEXT - NOMOSP 1. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.		Cost Center Description	BENEFITS DEPARTMENT (GROSS	(PATI ENT		ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	27 4111
1.00		In		5. 01	5A. 06	5. 06	7. 00	
1 00 100 CAP REL COSTS - LIDES & FIRTY - NOMENOSP 1 0 0 0000 CAP REL COSTS - INTEREST EXPENSES 2 0 0 0000 CAP REL COSTS - INTEREST EXPENSES 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 00							1 1 00
16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 889,602 0.17.0	1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 00102 CAP REL COSTS INTEREST EXPENSE 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING 00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - NONHOSPITAL 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 011000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	355, 842 4, 167, 973 1, 590, 561 0 1, 727, 764 855, 426 609, 386 3, 977, 644 446, 155	0 0 0 0 0 0 0	0 0 0 0 0	15, 999, 863 809, 381 0 4, 128, 195 1, 746, 796 1, 411, 128 5, 384, 441 13, 915, 815	0 0 5, 026 6, 967 6, 982 4, 037 19, 796	1. 01 1. 02 2. 00 2. 01 4. 00 5. 01 5. 06 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
18. 00 01850 PATIENT TRANSPORT SERVICES 650, 432 0 0 11, 199, 624 021 020 02000 LAR SERVICES-SALARY & RINGES APPRVD 893, 253 0 0 13,42,074 295, 220 02000 LAR SERVICES-OTHER PROM. COSTS APPRVD 893, 253 0 0 332,059 166 230, 00 03000 03000 040UTS & PEDEQUE - PHARMACE DIST CENTERS 0 0 332,059 166 230, 00 03000 04UITS & PEDQUE - PHARMACE DIST CENTERS 0 0 0 0 0 0 0 0 0			4, 343, 144	0	0	0, 703, 721		1
30. 00 303000 ADULTS & PEDIATRICS 16, 392, 669 165, 056, 435 0 40, 288, 224 113, 515 30. 00 31. 00 3300 WIFENSI VE CARE UNIT 0 0 0 0 0 33. 00 33. 00 3300 BURN INTENSI VE CARE UNIT 0 0 0 0 0 33. 00 33. 00 3300 BURN INTENSI VE CARE UNIT 0 0 0 0 0 0 33. 00 33. 00 3300 WIFENSI VE CARE UNIT 2, 148, 514 17, 144, 208 0 3, 430, 419 8, 940 35. 00 4300 WIFENSI VE CARE UNIT 2, 148, 514 17, 144, 208 0 1, 252, 623 3, 219 43. 00 4300 WIFENSI VE CARE UNIT 2, 148, 514 17, 144, 208 0 1, 252, 623 3, 219 43. 00 4300 WIFENSI VE CARE UNIT 2, 148, 514 2, 148	18. 00 21. 00 22. 00	01850 PATIENT TRANSPORT SERVICES 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD	650, 432 0 893, 253	0 0 0 0	0	911, 819 1, 199, 824 1, 342, 074	1, 365 0 295	18. 00 21. 00 22. 00
13.1 00 03100 INTERSIVE CARE UNIT					_			
ABOOD OBSOD OBSON OBSO	31. 00 33. 00	03100 INTENSIVE CARE UNIT 03300 BURN INTENSIVE CARE UNIT	3, 264, 802		0	6, 229, 067 0	11, 839 0	31. 00 33. 00
SOLO			1					1
51.00 05100 RECOVERY ROOM 1.510.0645 4.529 51.00 52.00 52.00 ELIVERY ROOM 1.520 4.509 4.551 4.515 52.00 52.00 ELIVERY ROOM 4.500 4.551 4.351 52.00 52.00 ELIVERY ROOM 4.500 4.551 4.351 52.00 53.00 08.511 51.357 53.00 53.01 08.511 52.00 53.00 6.600 50.00 50.00 5.457, 0.38 0 0 6.955 0 53.01 53.00 55.00								
90. 02 09001 COMP MED REV CLINIC 692, 946 500, 247 0 917, 368 0 90. 03 09002 ARNETT CANCER CARE CENTER 1, 290, 492 36, 478, 451 0 2, 022, 867 0 90. 03 09003 0UTPATI ENT I NFUSI ON CENTER 50, 418 995, 833 0 66, 566 58 90. 04 09100 EMERGENCY 5, 976, 078 249, 054, 692 0 13, 977, 781 20, 253 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 76, 256 287, 695 0 182, 791 729 92. 00 09200 OBSERVATI ON BEDS (DI STINCT PART) 76, 256 287, 695 0 182, 791 729 92. 00 09200	51. 00 52. 00 53. 01 54. 00 55. 00 56. 00 59. 00 60. 00 65. 00 67. 00 68. 00 67. 00 71. 00 72. 00 73. 01 74. 00 75. 00 75. 00 76. 01 76. 01 76. 07 77. 00 78. 00 90. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07301 RETAIL PHARMACY 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 07501 ASC (NON-DI STINCT PART) 03950 CARDI AC CATHERI ZATI ON 03951 OUTPATIENT WOUND CARE CENTER 07697 CARDI AC REHABI LI TATI ON 07700 ALLOGENEI C HSCT ACQUI SI TI ON 07800 CAR T-CELL I IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	837, 526 2, 738, 310 229, 422 0 4, 339, 751 0 130, 314 1, 200, 144 0 0 1, 975, 489 660, 613 416, 249 287, 717 1, 164, 751 88, 542 0 0 782, 865 0 4, 004, 879 0 301, 619 0 0 0	22, 222, 781 29, 714, 255 10, 256, 970 5, 457, 038 132, 193, 690 20, 623, 158 79, 024, 553 96, 675, 518 5, 483, 632 17, 959, 302 4, 605, 885 3, 371, 738 1, 988, 512 45, 727, 197 784, 204 71, 660, 714 157, 716, 684 266, 272, 258 11, 371, 038 3, 336, 091 0166, 773, 281 0 16, 008, 731 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 510, 645 4, 409, 435 480, 215 16, 925 8, 152, 083 0 976, 844 3, 761, 018 12, 972, 232 951, 151 2, 938, 256 1, 129, 126 1, 019, 527 464, 592 2, 369, 203 111, 068 9, 397, 327 12, 279, 617 40, 635, 626 11, 143, 376 1, 006, 765 0 6, 750, 742 0 1, 118, 281 0 0 0	4, 529 14, 351 1, 357 0 15, 801 0 2, 066 6, 249 9, 331 618 1, 260 745 546 322 2, 405 0 0 0 1, 114 1, 575 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 01 54. 00 55. 00 56. 00 59. 00 60. 00 63. 00 66. 00 67. 00 68. 00 67. 00 71. 00 72. 00 73. 01 74. 00 75. 01 76. 01 76. 97 77. 00 78. 00
	90. 01 90. 02 90. 03 90. 04 91. 00 92. 00	04950 SLEEP CLINIC 09001 COMP MED REV CLINIC 09002 ARNETT CANCER CARE CENTER 09003 OUTPATIENT INFUSION CENTER 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	425, 401 692, 946 1, 290, 492 50, 418 5, 976, 078	6, 789, 235 500, 247 36, 478, 451 995, 833 249, 054, 692	0 0 0 0 0	724, 980 917, 368 2, 022, 867 66, 566 13, 977, 781	0 0 0 58 20, 253	90. 01 90. 02 90. 03 90. 04 91. 00 92. 00
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	cial Systems TON - STATISTICAL BASIS	IU HEALTH ARNE	Provider C	CN: 15_0173 D	eriod:	u of Form CMS Worksheet B-1	
COST ALLOCAT	TON STATISTICAL BASIS		Trovider of		rom 01/01/2023		
				Т	o 12/31/2023	Date/Time Pre	
	Cost Center Description	EMPLOYEE	ADMI TTI NG	Reconciliation	OTHER	5/29/2024 11: OPERATION OF	29 am
	cost center bescription	BENEFITS	(PATI ENT		ADMI NI STRATI VE	PLANT	
		DEPARTMENT	CHARGES)		& GENERAL	(SQUARE FEET)	
		(GROSS	ŕ		(ACCUM. COST)	,	
		SALARI ES)					
		4.00	5. 01	5A. 06	5. 06	7. 00	
	REI MBURSABLE COST CENTERS						
	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	AL PURPOSE COST CENTERS	75 500 740	1 050 000 040	F (07 (200	2/0 157 224	200 707	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	75, 529, 748	1, 850, 829, 840	-56, 076, 290	260, 157, 324	300, 796]118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	43, 069	0		260, 867	2 264	190. 00
191. 00 19100		43,009	0		200, 807		191. 00
	PHYSICIANS' PRIVATE OFFICES	29, 457	0		258, 428		192. 00
	NONPALD WORKERS	27, 107	0	ol o	200, 120		193. 00
	RETALL PHARMACY	o	0	ol o	0		193. 01
193. 02 19302	WHITE HOSPITAL	1, 557, 400	0	0	2, 804, 294	2, 881	193. 02
193. 03 19303	HOSPI CE	o	0	0	733	0	193. 03
193. 04 19304	FRANKFORT HOSPITAL	1, 080, 195	0	0	2, 136, 819	2, 444	193. 04
	MARKETING/PUBLIC RELATIONS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	14, 771, 576	556, 720)	56, 076, 290	19, 377, 690	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 188799	0. 000301		0, 211116	62, 471396	203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	73, 801		1, 102, 496	4, 095, 903	
	Part II)		•				
205. 00	Unit cost multiplier (Wkst. B, Part II)	0. 000000	0. 000040		0. 004151	13. 204710	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	l l		I			l

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0173

			Т	o 12/31/2023	Date/Time Pre 5/29/2024 11:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, G.III
	PLANT -	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(FTES)	
	NONHOSPITAL (SQUARE FEET)	(PATIENT DAYS)				
	7. 01	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 1.02 00102 CAP REL COSTS INTEREST EXPENSE						1. 01 1. 02
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUI P - NONHOSP						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01 00570 ADMI TTI NG						5. 01
5.06 O0590 OTHER ADMINISTRATIVE & GENERAL 7.00 O0700 OPERATION OF PLANT						5. 06 7. 00
7. 01 00700 OPERATION OF PLANT - NONHOSPITAL	63, 422					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE		1				8. 00
9. 00 00900 HOUSEKEEPI NG	163	1	368, 418			9. 00
10. 00 01000 DI ETARY		1	6, 967		04.050	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON			6, 982 4, 037	1	84, 959 4, 134	11. 00 13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	83		19, 879		892	14. 00
15. 00 01500 PHARMACY	53	1	5, 056		4, 528	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	(0	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE		0	0	0	1, 028	17.00
18.00 01850 PATIENT TRANSPORT SERVICES 21.00 02100 &R SERVICES-SALARY & FRINGES APPRVD			1, 365		1, 594 1, 459	18. 00 21. 00
22. 00 02200 &R SERVI CES-OTHER PRGM. COSTS APPRV			2, 317	0	478	22. 00
23.00 02300 PARAMED ED PRGM - PHARMACY		1	166	1	293	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS					23, 460	30.00
31.00 03100 INTENSIVE CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT			1		4, 235 0	31. 00 33. 00
33. 01 03301 BURN INTENSIVE CARE UNIT				Ö	0	33. 01
35.00 02060 NEONATAL INTENSIVE CARE UNIT		3, 091	8, 940	0	2, 472	35. 00
43. 00 04300 NURSERY	(2, 442	3, 219	0	972	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 OPERATING ROOM) 0	30, 337	O	5, 644	50.00
51. 00 05100 RECOVERY ROOM		l .			988	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM				1	3, 276	52. 00
53. 00 05300 ANESTHESI OLOGY	144	1	1, 501	0	369	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	115	l .	115		0	53. 01
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C			15, 801	l	5, 058 0	54. 00 55. 00
56. 00 05600 RADI OI SOTOPE		ol ö	2, 066	-	132	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	6, 249		1, 420	59. 00
60. 00 06000 LABORATORY	(0	9, 331		3, 863	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0	618	1	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY			1, 260 745		2, 339 812	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		o o	546		478	
68.00 06800 SPEECH PATHOLOGY		0	322	. 0	302	68. 00
69. 00 06900 ELECTROCARDI OLOGY	(0	2, 405	0	1, 918	69. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	105 0	70. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73. 00
73. 01 07301 RETAIL PHARMACY		0	1, 114		819	73. 01
74. 00 07400 RENAL DI ALYSI S		0	1, 575	1	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 75. 01 07501 ASC (NON-DISTINCT PART)	33, 220) C 33, 220	-	0	75. 00 75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	33, 220	ol ö) 33, 220	Ö	0	76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER		0) c	0	0	76. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	(0	0	0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY		0		0	0	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		<u>) </u>	ή	ıl Ol		78. 00
90. 00 09000 CLI NI C		0) C	O	0	90.00
90. 01 04950 SLEEP CLINIC	3, 709		3, 709	1	0	90. 01
90. 02 09001 COMP MED REV CLINIC	1, 144	1	1, 144		0	90. 02
90. 03 09002 ARNETT CANCER CARE CENTER 90. 04 09003 OUTPATIENT INFUSION CENTER	14, 485		14, 485 58		1, 604 58	90. 03 90. 04
91. 00 09100 EMERGENCY) o	20, 253	1	8, 101	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			25,250		3, .01	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)		0	729	1	120	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	() 0) C	0	0	93. 00

Health Financial Systems IU		ETT HOSPITAL		III LI E	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		Peri od:	Worksheet B-1	
			1	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 11:	
	ERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(FTES)	
	NHOSPITAL UARE FEET)	(PATIENT DAYS)				
	7. 01	8. 00	9, 00	10, 00	11. 00	
OTHER REIMBURSABLE COST CENTERS	7.0.	0.00	71.00	10.00		
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	55, 138	47, 340	350, 745	41, 807	82, 951	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	2, 264	0		190. 00
191. 00 19100 RESEARCH	0	0	(0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	5, 757	0	7, 557	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	(0		193. 00
193. 01 19301 RETAI L PHARMACY	0	0	(0	-	193. 01
193. 02 19302 WHI TE HOSPI TAL	1, 223	0	4, 105	0		193. 02
193. 03 19303 HOSPI CE	0	0	(0		193. 03
193. 04 19304 FRANKFORT HOSPITAL	1, 304	0	3, 747	0		193. 04
194. 00 07950 MARKETI NG/PUBLI C RELATI ONS	U	Ü	(194. 00
200. 00 Cross Foot Adjustments						200. 00 201. 00
201.00 Negative Cost Centers	000 254	0	E 21/ 22	2 (51 244		
202.00 Cost to be allocated (per Wkst. B, Part I)	980, 254	U	5, 316, 223	2, 651, 344	2, 245, 964	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	15. 456056	0. 000000	14, 429868	63, 418662	26. 435857	203. 00
204.00 Cost to be allocated (per Wkst. B,	26, 602	0	369, 095	497, 998	497, 661	204. 00
Part II)	.,				,	
205.00 Unit cost multiplier (Wkst. B, Part	0. 419444	0. 000000	1. 001838	11. 911833	5. 857661	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						207.00

COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC		eriod: rom 01/01/2023	Worksheet B-1	
				T			
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	5/29/2024 11: SOCI AL SERVI CE	29 am
	2001 201121 20001 Pt. 011	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
		(FTES)	SUPPLY (COSTED	REQUIS.)	LI BRARY (PATI ENT	(PATIENT DAYS)	
		(FIES)	REQUIS.)		CHARGES)		
		13.00	14.00	15. 00	16. 00	17. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 00	00100 CAP REL COSTS-BLDG & FLXT - NONHOSP						1. 00
1.02	00102 CAP REL COSTS INTEREST EXPENSE						1. 02
2. 00 2. 01	00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP						2. 00 2. 01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 01	00570 ADMI TTI NG						5. 01
5. 06 7. 00	00590 OTHER ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 06 7. 00
7. 00 7. 01	00700 OPERATION OF PLANT - NONHOSPITAL						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION	41, 675					13. 00
14.00	1	46	33, 578, 318				14.00
15. 00 16. 00	1	0	68, 570 0	52, 102, 664 0	1, 850, 829, 840		15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	O	O	Ō	0	47, 340	
	01850 PATIENT TRANSPORT SERVICES	2	29	0	0	0	18. 00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM. COSTS APPRVD	0	0		0	0	21. 00 22. 00
	02300 PARAMED ED PRGM - PHARMACY	0	0	0	0	0	23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	17, 429	1 045 221	202 240	1/5 05/ /25	27 107	20.00
30. 00 31. 00	1 1	3, 420	1, 045, 231 325, 165			37, 107 3, 789	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
33. 01 35. 00	03301 BURN INTENSIVE CARE UNIT	0	70, 020	10.504	17 144 200	0	33. 01 35. 00
43. 00	+ I	2, 258 712	79, 920 0	18, 586 0	17, 144, 208 3, 907, 168		
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	1	2, 858 987	5, 378, 460 78, 007	79, 187 2, 204		0	
52. 00	1	2, 441	116, 195			911	
53.00	05300 ANESTHESI OLOGY	158	248, 091	68, 143	10, 256, 970	0	53. 00
53. 01 54. 00	05301 ASC ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	933	96, 780			0	53. 01 54. 00
55. 00		933	1, 430, 536 0	118, 218 0	132, 193, 690	0	55. 00
56. 00		0	3, 075			0	56. 00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 114	764, 422 10	66, 797 0		0	59. 00 60. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		5, 483, 632	-	
65. 00	06500 RESPI RATORY THERAPY	О	356, 999		17, 959, 302	0	65. 00
66. 00 67. 00		0	2, 015 1, 325		4, 605, 885 3, 371, 738	0	66. 00 67. 00
68. 00	1 I	0	2, 364		1, 988, 512	0	68.00
	06900 ELECTROCARDI OLOGY	271	4, 063	8, 548		0	69. 00
70. 00 71. 00		0	0 9, 375, 757	0	784, 204 71, 660, 714	0	70. 00 71. 00
72. 00		o	12, 232, 144	0	157, 716, 684	0	72.00
73. 00		0	0	40, 555, 860		0	73. 00
73. 01 74. 00	07301 RETAI L PHARMACY 07400 RENAL DI ALYSI S	0	434 5, 518			0	73. 01 74. 00
	07500 ASC (NON-DISTINCT PART)	o	0, 310	0	0, 330, 071	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	3, 514	1, 394, 529	101, 075	166, 773, 281	0	75. 01
76. 00 76. 01	03950 CARDI AC CATHERI ZATI ON 03951 OUTPATI ENT WOUND CARE CENTER	388	0 15, 137	0	0 16, 008, 731	0	76. 00 76. 01
76. 97		0	15, 157	0	0,000,731	0	76. 97
77. 00	1 1	0	0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0]	0	0	0	78. 00
90. 00		0	0	0	0	0	90.00
90. 01	04950 SLEEP CLINIC	0	24, 901	0	6, 789, 235	0	
90. 02 90. 03	O9001 COMP MED REV CLINIC O9002 ARNETT CANCER CARE CENTER	917	1, 054		500, 247	0	
90.03	09003 OUTPATIENT INFUSION CENTER	20	116, 028 280			0	90. 03 90. 04
91. 00	09100 EMERGENCY	4, 119	407, 641			0	91. 00
92. 00 92. 01	O9200 OBSERVATION BEDS (NON-DISTINCT PART) O9201 OBSERVATION BEDS (DISTINCT PART)	88	3, 385	1, 933	287, 695	0	92. 00 92. 01
	04951 OTHER OUTPATIENT SERVICES	0	3, 365 0		· ·		93. 00
		•					

Health Financial Systems	IU HEALTH ARNE				u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1
				From 01/01/2023 To 12/31/2023	Data /Time Dranamada
				To 12/31/2023	Date/Time Prepared: 5/29/2024 11: 29 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE
555 C 5511 C 5555 1 P C 1 511	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	0001712 021171 02
	7.5 11. 6 1 1 4 1 1 1	SUPPLY	REQUIS.)		(PATIENT DAYS)
	(FTES)	(COSTED		(PATLENT	(
		REQUIS.)		CHARGES)	
	13.00	14.00	15. 00	16.00	17. 00
OTHER REIMBURSABLE COST CENTERS	1		•		
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		0 0	0 102. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	41, 675	33, 578, 065	52, 102, 66	4 1, 850, 829, 840	47, 340 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0 190. 00
191. 00 19100 RESEARCH	0	0		0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	253		0	0 192. 00
193.00 19300 NONPALD WORKERS	0	0		0	0 193. 00
193.01 19301 RETAIL PHARMACY	0	0		0	0 193. 01
193. 02 19302 WHI TE HOSPI TAL	0	0		0	0 193. 02
193. 03 19303 HOSPI CE	0	0		0	0 193. 03
193. 04 19304 FRANKFORT HOSPI TAL	0	0		0	0 193. 04
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0		0 0	0 194. 00
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	6, 940, 919	18, 409, 726	9, 001, 95	4 0	1, 104, 587 202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	166. 548746	0. 548262			23. 333059 203. 00
204.00 Cost to be allocated (per Wkst. B,	330, 927	1, 459, 356	411, 91	6 0	9, 715 204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	7. 940660	0. 043461	0. 00790	6 0. 000000	0. 205218 205. 00
NAHE adjustment amount to be allocated					206. 00
(per Wkst. B-2)					207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)					207. 00
raitS iii and IV)	1	l	I		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0173 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am OTHER GENERAL INTERNS & RESIDENTS SERVI CE Cost Center Description PATI ENT SERVI CES-SALAR SERVI CES-OTHER PARAMED ED TRANSPORT Y & FRINGES PRGM. COSTS PRGM (ASSI GNED (ASSI GNED PHARMACY SERVI CES (PATI ENT TIME) TIME) (ASSI GNED CHARGES) TIME) 21.00 22.00 18.00 23.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00101 CAP REL COSTS-BLDG & FIXT - NONHOSP 1.01 1.01 1.02 00102 CAP REL COSTS INTEREST EXPENSE 1.02 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 00201 CAP REL COSTS-MVBLE EQUIP - NONHOSP 2.01 2.01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.01 00570 ADMITTING 5.01 00590 OTHER ADMINISTRATIVE & GENERAL 5 06 5 06 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT - NONHOSPITAL 7.01 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 15.00 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01850 PATIENT TRANSPORT SERVICES 18.00 1, 850, 829, 840 18.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 11, 363 21.00 02200 I&R SERVICES-OTHER PRGM. COSTS APPRVD 22.00 0 22.00 11.363 23.00 02300 PARAMED ED PRGM - PHARMACY 100 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 165, 056, 435 9, 417 9. 417 30.00 0 31.00 03100 INTENSIVE CARE UNIT 29, 630, 373 522 522 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 33.00 C 03301 BURN INTENSIVE CARE UNIT 0 33.01 0 33.01 0 35.00 02060 NEONATAL INTENSIVE CARE UNIT 17, 144, 208 449 449 35.00 04300 NURSERY 3, 907, 168 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 171, 758, 273 92 92 0 50.00 05100 RECOVERY ROOM 22, 222, 781 0 51.00 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 29, 714, 255 52.00 676 676 52.00 0 53.00 05300 ANESTHESI OLOGY 10, 256, 970 C 0 53.00 53.01 05301 ASC ANESTHESI OLOGY 5, 457, 038 0 0 0 0 0 53.01 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 132, 193, 690 54 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 C 55.00 56.00 05600 RADI OI SOTOPE 20, 623, 158 0 56.00 05900 CARDIAC CATHETERIZATION 59.00 79, 024, 553 0 0 0 0 59.00 0 06000 LABORATORY 96 675 518 60 00 Ω 60 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 5, 483, 632 0 63.00 06500 RESPIRATORY THERAPY 17, 959, 302 0 0 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 4, 605, 885 0 0 66, 00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 3, 371, 738 0 68.00 06800 SPEECH PATHOLOGY 1, 988, 512 0 0 0 68.00 06900 ELECTROCARDI OLOGY 45, 727, 197 0 69.00 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 784.204 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 71, 660, 714 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 157, 716, 684 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 266, 272, 258 100 73 00 07301 RETAIL PHARMACY 73 01 11, 371, 038 0 0 0 73 01 74.00 07400 RENAL DIALYSIS 3, 336, 091 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.00 0 07501 ASC (NON-DISTINCT PART) 0 75. 01 166, 773, 281 0 75.01 0 03950 CARDI AC CATHERI ZATI ON 0 76.00 76.00 03951 OUTPATIENT WOUND CARE CENTER 16,008,731 0 0 0 76.01 76.01 07697 CARDIAC REHABILITATION 0 0 76 97 0 76.97 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 0 0 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C n 0 0 90.00 04950 SLEEP CLINIC 6, 789, 235 90.01 C 0 0 90.01 09001 COMP MED REV CLINIC 0 90.02 500, 247 C 0 90.02 36, 478, 451 90.03 09002 ARNETT CANCER CARE CENTER 0 0 0 90.03 09003 OUTPATIENT INFUSION CENTER 995, 833 0 90.04 90.04 0 09100 EMERGENCY 249, 054, 692 0 91.00 91 00 207 207 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

Health Financ	ial Systems	IU HEALTH ARNE	TT HOSDITAL		Inlie	u of Form CMS-2552-10
	ON - STATISTICAL BASIS	TO TILALITY ARM	Provi der CO	CN: 15-0173	Peri od:	Worksheet B-1
					From 01/01/2023 To 12/31/2023	Date/Time Prepared: 5/29/2024 11:29 am
		OTHER GENERAL	INTERNS &	RESI DENTS		
	Need Control Brownistics	SERVI CE	SERVI CES-SALAR	CEDVI CEC OTHE	R PARAMED ED	
C	Cost Center Description	PATI ENT TRANSPORT	Y & FRINGES	PRGM. COSTS	PARAMED ED PRGM -	
		SERVI CES	(ASSI GNED	(ASSI GNED	PHARMACY	
		(PATI ENT	TIME)	TIME)	(ASSI GNED	
		CHARGES)	1111112)	l IIWL)	TIME)	
		18. 00	21. 00	22.00	23. 00	
92. 01 09201 0	DBSERVATION BEDS (DISTINCT PART)	287, 695	0		0 0	92. 01
93.00 04951 0	OTHER OUTPATIENT SERVICES	0	0		0	93. 00
OTHER F	REIMBURSABLE COST CENTERS					
	OPIOID TREATMENT PROGRAM	0	0		0	102. 00
	PURPOSE COST CENTERS					
	SUBTOTALS (SUM OF LINES 1 through 117)	1, 850, 829, 840	11, 363	11, 36	3 100	118. 00
	MBURSABLE COST CENTERS					
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	•	0	190. 00
191. 00 19100 F		0	0		0	191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0		0	192. 00
	NONPALD WORKERS	0	0		0	193. 00
	RETAIL PHARMACY	0	0		0	193. 01
193. 02 19302 W	WHI TE HOSPI TAL	0	0		0	193. 02 193. 03
	FRANKFORT HOSPITAL	0	0		0	193. 03
	MARKETING/PUBLIC RELATIONS	0	0		0	194. 00
	Cross Foot Adjustments	U	U		U U	200. 00
	Negative Cost Centers					201. 00
	Cost to be allocated (per Wkst. B,	1, 251, 777	1, 491, 696	1, 721, 15	8 422, 673	201.00
	Part I)	1, 231, 777	1, 471, 070	1, 721, 13	422,073	202.00
	Jnit cost multiplier (Wkst. B, Part I)	0. 000676	131. 276599	151. 47038	6 4, 226. 730000	203. 00
	Cost to be allocated (per Wkst. B,	109, 288			•	204. 00
	Part II)	,	,			
205. 00 L	Jnit cost multiplier (Wkst. B, Part	0. 000059	1. 190355	5. 98495	1 147. 870000	205. 00
	1)					
	NAHE adjustment amount to be allocated				0	206. 00
	(per Wkst. B-2)					
	NAHE unit cost multiplier (Wkst. D,				0. 000000	207. 00
	Parts III and IV)			I		1

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am

					10 12/31/2023	5/29/2024 11:	29 am
			Title	XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.	, .a.j .		Broarronanco		
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00	03000 ADULTS & PEDIATRICS	65, 000, 368		65, 000, 36	.8 0	65, 000, 368	30. 00
31. 00	03100 INTENSIVE CARE UNIT						31. 00
		9, 684, 957		9, 684, 9		9, 684, 957	
33.00	03300 BURN INTENSIVE CARE UNIT	0			0 0	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	5 444 007			0 0	0	33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 414, 287		5, 414, 28		5, 414, 287	35. 00
43.00	04300 NURSERY	1, 968, 516		1, 968, 5	6 0	1, 968, 516	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	21, 073, 561		21, 073, 56		21, 073, 561	50. 00
51.00	05100 RECOVERY ROOM	2, 426, 527		2, 426, 52	27 0	2, 426, 527	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 106, 539		7, 106, 53	39 0	7, 106, 539	52.00
53.00	05300 ANESTHESI OLOGY	881, 051		881, 05	51 0	881, 051	53.00
53. 01	05301 ASC ANESTHESI OLOGY	82, 156		82, 15	66 0	82, 156	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 271, 435		12, 271, 43	35 0	12, 271, 435	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0			ol ol	0	55. 00
56. 00	05600 RADI OI SOTOPE	1, 363, 369		1, 363, 36	9 0	1, 363, 369	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 742, 725		5, 742, 72		5, 742, 725	59. 00
60.00	06000 LABORATORY	16, 595, 924		16, 595, 92		16, 595, 924	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 203, 186		1, 203, 18		1, 203, 186	63. 00
65. 00	06500 RESPIRATORY THERAPY	3, 925, 170				3, 925, 170	65. 00
			0				
66.00	06600 PHYSI CAL THERAPY	1, 450, 479	0	.,,		1, 450, 479	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 292, 394	0	1, 292, 39		1, 292, 394	67. 00
68. 00	06800 SPEECH PATHOLOGY	598, 061	0	598, 00		598, 061	68. 00
69. 00	06900 ELECTROCARDI OLOGY	3, 184, 784		3, 184, 78		3, 184, 784	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	137, 822		137, 82		137, 822	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 570, 067		16, 570, 0		16, 570, 067	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	21, 685, 087		21, 685, 08		21, 685, 087	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	56, 824, 708		56, 824, 70	0	56, 824, 708	73. 00
73. 01	07301 RETAIL PHARMACY	15, 341, 511		15, 341, 5°	1 0	15, 341, 511	73. 01
74.00	07400 RENAL DIALYSIS	1, 345, 881		1, 345, 88	31 0	1, 345, 881	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0			0 0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	10, 648, 762		10, 648, 76	0	10, 648, 762	75. 01
76.00	03950 CARDI AC CATHERI ZATI ON	0			ol ol	0	76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	1, 438, 110		1, 438, 1 ⁻	0	1, 438, 110	76. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0		1, 100, 1	o o	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			o o	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o o				0	78. 00
70.00	OUTPATIENT SERVICE COST CENTERS			l	9 9	0	70.00
90. 00	09000 CLINIC	0			0 0	0	90. 00
90. 00	04950 SLEEP CLINIC	1, 007, 124		1, 007, 12		1, 007, 124	90.00
90.01	09001 COMP MED REV CLINIC	1, 146, 145		1, 146, 14		1, 146, 145	90.01
90. 03	09002 ARNETT CANCER CARE CENTER	3, 200, 507		3, 200, 50		3, 200, 507	90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	91, 168		91, 10		91, 168	90. 04
91.00	09100 EMERGENCY	19, 844, 965		19, 844, 90		19, 844, 965	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 161, 217		8, 161, 2		8, 161, 217	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	297, 654		297, 65		297, 654	92. 01
93. 00	04951 OTHER OUTPATIENT SERVICES	0			0 0	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPIOID TREATMENT PROGRAM	0			0	0	102. 00
200.00	Subtotal (see instructions)	319, 006, 217	0	319, 006, 2°	7 0	319, 006, 217	200. 00
201.00	Less Observation Beds	8, 161, 217		8, 161, 2°	7	8, 161, 217	201. 00
202.00	Total (see instructions)	310, 845, 000	0	310, 845, 00	0 0	310, 845, 000	202. 00
		•			•		

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am Provider CCN: 15-0173

				2011.1		3/29/2024 11.	27 4111
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient	
				_		Rati o	
		6. 00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7. 00	10.00	
30. 00	03000 ADULTS & PEDI ATRI CS	133, 776, 288		133, 776, 288			30.00
							•
31.00	03100 I NTENSI VE CARE UNI T	29, 630, 373		29, 630, 373			31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		0			33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0		0			33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	17, 144, 208		17, 144, 208			35. 00
43.00	04300 NURSERY	3, 907, 168		3, 907, 168			43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	62, 799, 626	108, 958, 648	171, 758, 274	0. 122693	0.000000	50.00
51.00	05100 RECOVERY ROOM	4, 768, 663	17, 454, 119	22, 222, 782	0. 109191	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	27, 895, 839	1, 818, 416			0.000000	
53. 00	05300 ANESTHESI OLOGY	4, 003, 054	6, 253, 917		0. 085898	0. 000000	
53. 00	05301 ASC ANESTHESI OLOGY	17, 633	5, 439, 405			0. 000000	
				1			
54.00	05400 RADI OLOGY-DI AGNOSTI C	48, 862, 078		1		0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	· -	0. 000000	0. 000000	
56.00	05600 RADI 0I SOTOPE	2, 247, 507	18, 375, 651			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	34, 912, 516	44, 112, 038	79, 024, 554	0. 072670	0.000000	59. 00
60.00	06000 LABORATORY	36, 265, 851	60, 409, 666	96, 675, 517	0. 171666	0.000000	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	4, 306, 148	1, 177, 483	5, 483, 631	0. 219414	0. 000000	63.00
65.00	06500 RESPIRATORY THERAPY	16, 619, 963	1, 339, 339			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	3, 763, 830	842, 055			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 788, 623	583, 115			0. 000000	
68. 00	06800 SPEECH PATHOLOGY					0.00000	
		1, 745, 756	242, 756				
69. 00	06900 ELECTROCARDI OLOGY	22, 475, 388	23, 251, 809			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	616, 299	167, 905			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 331, 627	43, 329, 087			0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	57, 039, 770	100, 676, 914	157, 716, 684	0. 137494	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	63, 440, 707	202, 831, 551	266, 272, 258	0. 213408	0.000000	73. 00
73. 01	07301 RETAIL PHARMACY	103	11, 370, 935	11, 371, 038	1. 349174	0. 000000	73. 01
74.00	07400 RENAL DIALYSIS	2, 949, 368	386, 723		0. 403431	0.000000	
75. 00	07500 ASC (NON-DISTINCT PART)	_, , 0	0	1	0. 000000	0. 000000	
75. 01	07501 ASC (NON-DISTINCT PART)	355, 808	166, 417, 473	166, 773, 281	0. 063852	0. 000000	
76. 00	03950 CARDI AC CATHERI ZATI ON	333,000	100, 417, 473	100, 773, 201	0. 000000	0. 000000	
		00 501	15 010 120	1/ 000 700			
76. 01	03951 OUTPATIENT WOUND CARE CENTER	98, 591	15, 910, 139			0.000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	1		0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1		0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0.000000	0.000000	90.00
90. 01	04950 SLEEP CLINIC	1, 316	6, 787, 919	6, 789, 235	0. 148341	0.000000	90. 01
90. 02	09001 COMP MED REV CLINIC	1, 072	499, 175	500, 247	2. 291158	0.000000	90. 02
90. 03	09002 ARNETT CANCER CARE CENTER	202, 987	36, 275, 464			0. 000000	
90. 04	09003 OUTPATIENT INFUSION CENTER	5, 314	990, 519			0. 000000	
91. 00	09100 EMERGENCY		196, 316, 085			0. 000000	
		52, 738, 607					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	981, 631	30, 298, 516			0.000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	287, 695	1		0. 000000	
93. 00	04951 OTHER OUTPATIENT SERVICES	0	0	0	0. 000000	0. 000000	93. 00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPI OI D TREATMENT PROGRAM	0	0	0			102. 00
200.00	Subtotal (see instructions)	664, 693, 712	1, 186, 136, 129	1, 850, 829, 841			200. 00
201.00	Less Observation Beds						201. 00
202.00		664, 693, 712	1, 186, 136, 129	1, 850, 829, 841			202. 00
50	1 (,			1	

5/29/2024 11:29 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 33.00 03300 BURN INTENSIVE CARE UNIT 33.00 03301 BURN INTENSIVE CARE UNIT 33. 01 33.01 02060 NEONATAL INTENSIVE CARE UNIT 35.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 122693 50.00 51.00 05100 RECOVERY ROOM 0.109191 51.00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 239163 52 00 53. 00 | 05300 | ANESTHESI OLOGY 0.085898 53.00 53.01 05301 ASC ANESTHESI OLOGY 0.015055 53.01 05400 RADI OLOGY-DI AGNOSTI C 0.092829 54.00 54.00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.066109 56.00 05900 CARDIAC CATHETERIZATION 0.072670 59.00 59.00 06000 LABORATORY 0. 171666 60.00 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 219414 63.00 63 00 65.00 06500 RESPIRATORY THERAPY 0. 218559 65.00 06600 PHYSI CAL THERAPY 66.00 0. 314919 66.00 06700 OCCUPATIONAL THERAPY 0.383302 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.300758 68.00 69.00 06900 ELECTROCARDI OLOGY 0.069647 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0. 175748 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 231229 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.137494 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 213408 73.00 73.00 73. 01 07301 RETAIL PHARMACY 1. 349174 73.01 07400 RENAL DIALYSIS 0.403431 74.00 74.00 75. 00 | 07500 | ASC (NON-DISTINCT PART) 0.000000 75.00 07501 ASC (NON-DISTINCT PART) 75. 01 0.063852 75.01 76. 00 03950 CARDI AC CATHERI ZATI ON 0.000000 76 00 03951 OUTPATIENT WOUND CARE CENTER 0.089833 76.01 76.01 76. 97 07697 CARDIAC REHABILITATION 0.000000 76. 97 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 90 01 04950 SLEEP CLINIC 0. 148341 90 01 09001 COMP MED REV CLINIC 90.02 2. 291158 90.02 90.03 09002 ARNETT CANCER CARE CENTER 0. 087737 90.03 90.04 09003 OUTPATIENT INFUSION CENTER 0.091549 90.04 91 00 09100 EMERGENCY 0.079681 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 260907 92.00 92.01 09201 OBSERVATION BEDS (DISTINCT PART) 1.034617 92.01 04951 OTHER OUTPATIENT SERVICES 0.000000 93.00 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 102.00

200.00

201. 00 202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am

					10 12/31/2023	5/29/2024 11:	29 am
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	5551 5511to. 25551 Pt. 511	(from Wkst. B,	Adj.	10101 00010	Di sal I owance		
		Part I, col.	riaj.		Di Sai i Gwanec		
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INDATIENT DOUTINE CEDVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	/F 000 2/0		/F 000 2/		/F 000 2/0	20.00
30.00	03000 ADULTS & PEDIATRICS	65, 000, 368		65, 000, 36		,,	1
31. 00	03100 INTENSIVE CARE UNIT	9, 684, 957		9, 684, 95		9, 684, 957	31. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
33. 01	03301 BURN INTENSIVE CARE UNIT	0			0	0	33. 01
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	5, 414, 287		5, 414, 28		5, 414, 287	35. 00
43.00	04300 NURSERY	1, 968, 516		1, 968, 51	6 0	1, 968, 516	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 073, 561		21, 073, 56	0	21, 073, 561	50. 00
51.00	05100 RECOVERY ROOM	2, 426, 527		2, 426, 52	.7l ol	2, 426, 527	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 106, 539		7, 106, 53		7, 106, 539	52.00
53. 00	05300 ANESTHESI OLOGY	881, 051		881, 05		881, 051	53.00
53. 01	05301 ASC ANESTHESI OLOGY	82, 156		82, 15		82, 156	53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	12, 271, 435		12, 271, 43		12, 271, 435	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	12, 271, 433		12, 271, 40	0 0	12, 271, 433	55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C			1 242 24			56.00
		1, 363, 369		1, 363, 36		1, 363, 369	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 742, 725		5, 742, 72		5, 742, 725	59. 00
60.00	06000 LABORATORY	16, 595, 924		16, 595, 92		16, 595, 924	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 203, 186		1, 203, 18		1, 203, 186	63. 00
65. 00	06500 RESPI RATORY THERAPY	3, 925, 170	0	3, 925, 17	0 0	3, 925, 170	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 450, 479	0	1, 450, 47	'9 0	1, 450, 479	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1, 292, 394	0	1, 292, 39	0	1, 292, 394	67. 00
68.00	06800 SPEECH PATHOLOGY	598, 061	0	598, 06	0	598, 061	68. 00
69.00	06900 ELECTROCARDI OLOGY	3, 184, 784		3, 184, 78	0	3, 184, 784	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	137, 822		137, 82	2 0	137, 822	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 570, 067		16, 570, 06	o7 o	16, 570, 067	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	21, 685, 087		21, 685, 08		21, 685, 087	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	56, 824, 708		56, 824, 70		56, 824, 708	73. 00
73. 01	07301 RETAIL PHARMACY	15, 341, 511		15, 341, 5		15, 341, 511	73. 01
74. 00	07400 RENAL DI ALYSI S	1, 345, 881		1, 345, 88		1, 345, 881	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	1, 343, 001		1, 343, 00	0	1, 343, 661	75.00
75. 00		10 (40 7(2		10 (40 7)			75. 00
	07501 ASC (NON-DISTINCT PART)	10, 648, 762		10, 648, 76		10, 648, 762	1
76. 00	03950 CARDI AC CATHERI ZATI ON	1 400 410		4 400 44	0	0	76.00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	1, 438, 110		1, 438, 11		1, 438, 110	
76. 97	07697 CARDI AC REHABI LI TATI ON	0			0 0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0			0	0	90. 00
90. 01	04950 SLEEP CLINIC	1, 007, 124		1, 007, 12	24 0	1, 007, 124	90. 01
90. 02	09001 COMP MED REV CLINIC	1, 146, 145		1, 146, 14	5 0	1, 146, 145	90. 02
90. 03	09002 ARNETT CANCER CARE CENTER	3, 200, 507		3, 200, 50	0	3, 200, 507	90. 03
90.04	09003 OUTPATIENT INFUSION CENTER	91, 168		91, 16	ol	91, 168	90. 04
91.00	09100 EMERGENCY	19, 844, 965		19, 844, 96		19, 844, 965	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 161, 217		8, 161, 2		8, 161, 217	92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	297, 654		297, 65			92. 01
93. 00	04951 OTHER OUTPATIENT SERVICES	277,034		277,00	0 0	277,034	93. 00
73.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>	0	73.00
102.00	10200 OPI OI D TREATMENT PROGRAM				0	0	102. 00
200.00		319, 006, 217	0	319, 006, 2	-		1
200.00			١			8, 161, 217	
		8, 161, 217	О	8, 161, 21			
202.00	Total (see instructions)	310, 845, 000	ı	310, 845, 00	vo _l 0	310, 845, 000	2U2. UU

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 11: 29 am | PPS Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES IU HEALTH ARNETT HOSPITAL Provider CCN: 15-0173 Title XIX

				Ti tl	e XIX	Hospi tal	PPS	
				Charges				
		Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
		, , , , , , , , , , , , , , , , , , ,			+ col. 7)	Ratio	Inpati ent	
					,		Ratio	
			6. 00	7. 00	8. 00	9. 00	10.00	
	INPAT	IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	133, 776, 288		133, 776, 288			30. 00
31. 00		INTENSIVE CARE UNIT	29, 630, 373		29, 630, 373			31. 00
33. 00		BURN INTENSIVE CARE UNIT	27, 030, 373		27, 030, 373			33. 00
33. 00		BURN INTENSIVE CARE UNIT	0					33. 00
35. 00			17 144 200		17 144 200			35. 00
		NEONATAL INTENSIVE CARE UNIT	17, 144, 208		17, 144, 208			
43.00		NURSERY	3, 907, 168		3, 907, 168			43. 00
		LARY SERVICE COST CENTERS	40.700.404	100 050 (10	474 750 074	0.400/00		
50. 00		OPERATI NG ROOM	62, 799, 626	108, 958, 648		0. 122693	0. 000000	50.00
51. 00		RECOVERY ROOM	4, 768, 663	17, 454, 119		0. 109191	0. 000000	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	27, 895, 839	1, 818, 416		0. 239163	0. 000000	52.00
53.00		ANESTHESI OLOGY	4, 003, 054	6, 253, 917		0. 085898	0.000000	
53. 01		ASC ANESTHESI OLOGY	17, 633	5, 439, 405	5, 457, 038	0. 015055	0.000000	
54.00	05400	RADI OLOGY-DI AGNOSTI C	48, 862, 078	83, 331, 612	132, 193, 690	0. 092829	0.000000	54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	0.000000	0.000000	55. 00
56.00	05600	RADI OI SOTOPE	2, 247, 507	18, 375, 651	20, 623, 158	0. 066109	0.000000	56. 00
59.00	05900	CARDIAC CATHETERIZATION	34, 912, 516	44, 112, 038	79, 024, 554	0. 072670	0.000000	59. 00
60.00		LABORATORY	36, 265, 851	60, 409, 666		0. 171666	0.000000	60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	4, 306, 148	1, 177, 483		0. 219414	0. 000000	63. 00
65. 00		RESPI RATORY THERAPY	16, 619, 963	1, 339, 339		0. 218559	0. 000000	
66. 00		PHYSI CAL THERAPY	3, 763, 830	842, 055		0. 314919	0. 000000	66.00
67. 00		OCCUPATI ONAL THERAPY	2, 788, 623	583, 115		0. 383302	0. 000000	67. 00
68. 00		SPEECH PATHOLOGY	1, 745, 756	242, 756		0. 300758	0. 000000	68. 00
69. 00		ELECTROCARDI OLOGY	22, 475, 388			0. 069647	0. 000000	
70.00		ELECTROENCEPHALOGRAPHY	616, 299	167, 905		0. 175748	0.000000	
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 331, 627	43, 329, 087		0. 231229	0.000000	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	57, 039, 770	100, 676, 914		0. 137494	0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	63, 440, 707	202, 831, 551		0. 213408	0. 000000	73. 00
73. 01		RETAIL PHARMACY	103	11, 370, 935		1. 349174	0. 000000	
74.00		RENAL DIALYSIS	2, 949, 368	386, 723	3, 336, 091	0. 403431	0. 000000	
75.00		ASC (NON-DISTINCT PART)	0	0	0	0. 000000	0. 000000	
75. 01		ASC (NON-DISTINCT PART)	355, 808	166, 417, 473	166, 773, 281	0. 063852	0.000000	
76.00		CARDIAC CATHERIZATION	0	0	0	0. 000000	0.000000	76. 00
76. 01	03951	OUTPATIENT WOUND CARE CENTER	98, 591	15, 910, 139	16, 008, 730	0. 089833	0.000000	76. 01
76. 97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76. 97
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77. 00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	0	0	0	0. 000000	0.000000	78. 00
	OUTPA	TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	0	0	0.000000	0.000000	90.00
90. 01		SLEEP CLINIC	1, 316	6, 787, 919	6, 789, 235	0. 148341	0.000000	90. 01
90. 02		COMP MED REV CLINIC	1, 072	499, 175		2. 291158	0. 000000	
90. 03		ARNETT CANCER CARE CENTER	202, 987	36, 275, 464		0. 087737	0. 000000	90. 03
90. 04		OUTPATIENT INFUSION CENTER	5, 314	990, 519		0. 091549	0. 000000	
91. 00		EMERGENCY	52, 738, 607	196, 316, 085		0. 079681	0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	981, 631	30, 298, 516		0. 260907	0. 000000	92. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT FART)	981,031	287, 695			0. 000000	92. 00
93. 00		OTHER OUTPATIENT SERVICES	0	207, 093		0. 000000	0. 000000	
73.00		REIMBURSABLE COST CENTERS	U	U		0.000000	0.000000	73.00
100.00		OPLOLD TREATMENT PROGRAM		^	0			102.00
			0	1 104 124 120				102. 00
200.00		Subtotal (see instructions)	004, 093, /12	1, 180, 130, 129	1, 850, 829, 841			200.00
201.00		Less Observation Beds	//4 /00 710	1 10/ 10/ 100	1 050 000 0:1			201. 00
202.00	וי	Total (see instructions)	664, 693, 712	1, 186, 136, 129	1, 850, 829, 841			202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES IU HEALTH ARNETT HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0173

Peri od: Worksheet C
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am

			Title XIX	Hospi tal	PPS	. 7 aiii
	Cost Center Description	PPS Inpatient	THE XIX	1103pi tui	113	
	cost center bescription	Ratio				
		11. 00				
ΙΝΡΔ	TIENT ROUTINE SERVICE COST CENTERS	11.00				
	O ADULTS & PEDIATRICS					30. 00
	O INTENSIVE CARE UNIT					31. 00
	O BURN INTENSIVE CARE UNIT					33. 00
	1 BURN INTENSIVE CARE UNIT					33. 01
	O NEONATAL INTENSIVE CARE UNIT					35. 00
	NURSERY					43. 00
	LLARY SERVICE COST CENTERS					43.00
	O OPERATING ROOM	0. 122693				50. 00
	O RECOVERY ROOM	0. 122093				51. 00
	O DELIVERY ROOM & LABOR ROOM	0. 239163				52. 00 53. 00
	O ANESTHESI OLOGY 1 ASC ANESTHESI OLOGY	0. 085898				53. 00
		0. 015055				
	O RADI OLOGY THE PARELLE C	0. 092829				54. 00
	O RADI OLOGY-THERAPEUTI C	0.000000				55. 00
	O RADI OI SOTOPE	0. 066109				56.00
	O CARDI AC CATHETERI ZATI ON	0. 072670				59. 00
	O LABORATORY	0. 171666				60.00
63. 00 0630	D BLOOD STORING, PROCESSING & TRANS.	0. 219414				63. 00
	O RESPI RATORY THERAPY	0. 218559				65. 00
	O PHYSI CAL THERAPY	0. 314919				66. 00
	O OCCUPATIONAL THERAPY	0. 383302				67. 00
	O SPEECH PATHOLOGY	0. 300758				68. 00
	0 ELECTROCARDI OLOGY	0. 069647				69. 00
	0 ELECTROENCEPHALOGRAPHY	0. 175748				70.00
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 231229				71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0. 137494				72.00
	O DRUGS CHARGED TO PATIENTS	0. 213408				73. 00
	1 RETAIL PHARMACY	1. 349174				73. 01
	O RENAL DIALYSIS	0. 403431				74. 00
	O ASC (NON-DISTINCT PART)	0. 000000				75. 00
	1 ASC (NON-DISTINCT PART)	0. 063852				75. 01
	O CARDI AC CATHERI ZATI ON	0. 000000				76. 00
	1 OUTPATIENT WOUND CARE CENTER	0. 089833				76. 01
	7 CARDIAC REHABILITATION	0. 000000				76. 97
	O ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78. 00 0780	O CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
	ATIENT SERVICE COST CENTERS					
	D CLINIC	0. 000000				90.00
	O SLEEP CLINIC	0. 148341				90. 01
	1 COMP MED REV CLINIC	2. 291158				90. 02
90. 03 0900	2 ARNETT CANCER CARE CENTER	0. 087737				90. 03
90. 04 0900	3 OUTPATIENT INFUSION CENTER	0. 091549				90.04
	O EMERGENCY	0. 079681				91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 260907				92.00
	1 OBSERVATION BEDS (DISTINCT PART)	1. 034617				92. 01
93. 00 0495	1 OTHER OUTPATIENT SERVICES	0. 000000				93.00
OTHER	R REIMBURSABLE COST CENTERS					
102. 00 1020	O OPIOID TREATMENT PROGRAM					102. 00
200. 00	Subtotal (see instructions)				2	200. 00
201. 00	Less Observation Beds				2	201. 00
202.00	Total (see instructions)				2	202. 00
•						

 Heal th Financial Systems
 I U HEALTH ARNETT HOSPITAL

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
 Provider

 REDUCTIONS FOR MEDICALD ONLY
 Provider
 In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 29 am

					12/01/2020	5/29/2024 11:	29 am
			Ti tI	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
		·		col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 073, 561	2, 495, 576	18, 577, 985	0		50.00
51.00	05100 RECOVERY ROOM	2, 426, 527	344, 519	2, 082, 008	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	7, 106, 539	1, 087, 078	6, 019, 461	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	881, 051	116, 098	764, 953	0	0	53. 00
53. 01	05301 ASC ANESTHESI OLOGY	82, 156	7, 092	75, 064	0	0	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 271, 435	1, 260, 074	11, 011, 361	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	1, 363, 369	152, 636	1, 210, 733	0	0	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	5, 742, 725	514, 521	5, 228, 204	0	0	59. 00
60.00	06000 LABORATORY	16, 595, 924	743, 311	15, 852, 613	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 203, 186	1		0	0	63.00
65.00	06500 RESPIRATORY THERAPY	3, 925, 170			0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 450, 479	1		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 292, 394	1		0	o	67.00
68. 00	06800 SPEECH PATHOLOGY	598, 061	26, 679		0	o	1
69. 00	06900 ELECTROCARDI OLOGY	3, 184, 784	1		0	Ō	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	137, 822	1		0	Ō	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 570, 067	453, 582		0	o o	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	21, 685, 087			0	o o	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	56, 824, 708			0	ő	
73. 01	07301 RETAIL PHARMACY	15, 341, 511	209, 847		0	o o	1
74. 00	07400 RENAL DIALYSIS	1, 345, 881	115, 698		0	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	1, 343, 001	113, 070		0	0	
75. 00	07501 ASC (NON-DISTINCT PART)	10, 648, 762	1	1	0	0	
76. 00	03950 CARDI AC CATHERI ZATI ON	10, 040, 702	772,232	7, 070, 310	0	0	76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	1, 438, 110	9, 966	1, 428, 144	0	0	76. 01
76. 97	07697 CARDIAC REHABILITATION	1,430,110	7, 700	1, 420, 144	0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION				0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY				0	0	78.00
70.00	OUTPATIENT SERVICE COST CENTERS	1 0		ή σ		1 0	70.00
90. 00	09000 CLINIC	0		0	0	0	90.00
90. 00	04950 SLEEP CLINIC	1, 007, 124			0	l .	
90. 01	09001 COMP MED REV CLINIC	1, 146, 145			0	0	
90. 02	09002 ARNETT CANCER CARE CENTER	3, 200, 507	313, 665		0	0	90.02
90. 03	09003 OUTPATIENT INFUSION CENTER	91, 168			0	0	90.03
91. 00	09100 EMERGENCY	19, 844, 965			0	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 161, 217			0	0	91.00
92. 00	09201 OBSERVATION BEDS (NON-DISTINCT PART)				0	_	
93. 00	04951 OTHER OUTPATIENT SERVICES	297, 654	1		0	l .	
93.00	OTHER REIMBURSABLE COST CENTERS	1 0		y U	0	<u> </u>	93.00
102.00	10200 OPLOLD TREATMENT PROGRAM	1		ol ol	0		102. 00
200.00	l I	236, 938, 089		_	0		200. 00
					0		200.00
201.00	1	8, 161, 217			0		201.00
202.00	Total (line 200 minus line 201)	228, 776, 872	11, 993, 938	216, 782, 934	0	ıl O	1202. UU

Peri od: Worksheet C From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 29 am REDUCTIONS FOR MEDICALD ONLY

						9 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
·	Capital and	(Worksheet C,	Cost to Charg	e		
	Operating Cost	Part I, column	Ratio (col. 6			
	Reducti on	8)	/ col. 7)			
	6.00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	21, 073, 561	171, 758, 274	0. 12269	3	Ę	50.00
51.00 05100 RECOVERY ROOM	2, 426, 527	22, 222, 782	0. 10919	1		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 106, 539	29, 714, 255	0. 23916	3	5	52. 00
53. 00 05300 ANESTHESI OLOGY	881, 051		0. 08589	8	5	53.00
53. 01 05301 ASC ANESTHESI OLOGY	82, 156	5, 457, 038			5	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 271, 435	1				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1	1			55. 00
56. 00 05600 RADI 0I SOTOPE	1, 363, 369	20, 623, 158	•			56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	5, 742, 725					59. 00
60. 00 06000 LABORATORY	16, 595, 924					60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 203, 186		•			63. 00
65. 00 06500 RESPIRATORY THERAPY	3, 925, 170	1			1	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 450, 479	1				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 292, 394	1				67. 00
68. 00 06800 SPEECH PATHOLOGY	598, 061	1				68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 184, 784	1				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	137, 822					70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 570, 067					71. 00
	21, 685, 087				ı	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	56, 824, 708					73.00
73. 01 07301 RETAI L PHARMACY	15, 341, 511					73. 01
74. 00 07400 RENAL DI ALYSI S	1, 345, 881	ľ				74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	1	0.0000			75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	10, 648, 762	166, 773, 281				75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	1 100 110	0 47 000 700	0.00000			76.00
76. 01 03951 OUTPATIENT WOUND CARE CENTER	1, 438, 110	1				76. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0				76. 97
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0		•			77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0		78. 00
OUTPATIENT SERVICE COST CENTERS			0.0000	ما		00 00
90. 00 09000 CLI NI C	0	-				90.00
90. 01 04950 SLEEP CLINIC	1, 007, 124					90. 01
90. 02 09001 COMP MED REV CLI NI C	1, 146, 145					90. 02
90. 03 09002 ARNETT CANCER CARE CENTER	3, 200, 507		l .			90. 03
90. 04 09003 OUTPATIENT INFUSION CENTER	91, 168					90. 04
91. 00 09100 EMERGENCY	19, 844, 965		•		1	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 161, 217	1				92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	297, 654	1				92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	0.00000	0		93. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0			0		02. 00
200.00 Subtotal (sum of lines 50 thru 199)		1, 666, 371, 804				00.00
201.00 Less Observation Beds	8, 161, 217	l .				01.00
202.00 Total (line 200 minus line 201)	228, 776, 872	1, 666, 371, 804			20	02.00

Health Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0173	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/29/2024 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 952, 622	0	8, 952, 62	2 42, 435	210. 97	30.00
31.00 INTENSIVE CARE UNIT	975, 722		975, 72	2 3, 789	257. 51	31. 00
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	33.00
33. 01 BURN INTENSIVE CARE UNIT	0			0	0.00	33. 01
35.00 NEONATAL INTENSIVE CARE UNIT	682, 325		682, 32	25 3, 091	220. 75	35. 00
43. 00 NURSERY	244, 178		244, 17	'8 2, 442	99. 99	43.00
200.00 Total (lines 30 through 199)	10, 854, 847		10, 854, 84	51, 757		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	13, 169	2, 778, 264				30.00
31.00 INTENSIVE CARE UNIT	850	218, 884				31.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
33. 01 BURN INTENSIVE CARE UNIT	0	0				33. 01
35.00 NEONATAL INTENSIVE CARE UNIT	0	0				35. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	14, 019	2, 997, 148				200. 00

Health Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/29/2024 11:	pared: 29 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T	T .=. === .=.	1			
50. 00 05000 OPERATI NG ROOM	2, 495, 576				304, 570	50.00
51. 00 05100 RECOVERY ROOM	344, 519				24, 548	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 087, 078				4, 615	52.00
53. 00 05300 ANESTHESI OLOGY	116, 098		0. 01131		14, 401	
53. 01 05301 ASC ANESTHESI OLOGY	7, 092				4	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 260, 074				164, 663	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	-	0.00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE	152, 636				6, 890	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	514, 521	79, 024, 554			63, 990	59. 00
60. 00 06000 LABORATORY	743, 311	96, 675, 517	0. 00768	9 11, 126, 005	85, 548	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	48, 022	5, 483, 631	0. 00875	7 1, 483, 111	12, 988	63.00
65. 00 06500 RESPIRATORY THERAPY	131, 945	17, 959, 302	0.00734	7 4, 396, 826	32, 303	65. 00
66. 00 06600 PHYSI CAL THERAPY	62, 464	4, 605, 885	0. 01356	2 1, 521, 368	20, 633	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	45, 884	3, 371, 738	0. 01360	8 1, 122, 460	15, 274	67. 00
68.00 06800 SPEECH PATHOLOGY	26, 679	1, 988, 512	0. 01341	7 723, 359	9, 705	68.00
69. 00 06900 ELECTROCARDI OLOGY	197, 398	45, 727, 197	0. 00431	7 8, 697, 924	37, 549	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 153	784, 204	0. 00147	0 241, 031	354	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	453, 582	71, 660, 714	0.00633	0 7, 988, 632	50, 568	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	598, 215	157, 716, 684	0.00379	3 21, 846, 982	82, 866	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	515, 436	266, 272, 258	0. 00193	6 19, 354, 922	37, 471	73.00
73. 01 07301 RETAIL PHARMACY	209, 847	11, 371, 038	0. 01845		0	73. 01
74. 00 07400 RENAL DIALYSIS	115, 698	3, 336, 091	0. 03468	1 984, 127	34, 131	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	772, 252	166, 773, 281	0. 00463	1 89, 554	415	75. 01
76.00 03950 CARDIAC CATHERIZATION	0	0	0.00000	o o	0	76. 00
76.01 03951 OUTPATIENT WOUND CARE CENTER	9, 966	16, 008, 730	0. 00062	3 56, 685	35	76. 01
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	o o	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	_	1 0.0000	0 0	0	90. 00
90. 01 04950 SLEEP CLI NI C	76, 043	6, 789, 235	0. 01120	1 0	0	90. 01
90. 02 09001 COMP MED REV CLINIC	25, 889	500, 247	0. 05175	2 678	35	90. 02
90. 03 09002 ARNETT CANCER CARE CENTER	313, 665		0. 00859		902	90. 03
90.04 09003 OUTPATIENT INFUSION CENTER	4, 989	995, 833	0. 00501	0 4, 820	24	90. 04
91. 00 09100 EMERGENCY	1, 610, 205	249, 054, 692	0. 00646	5 19, 238, 150	124, 375	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 124, 061	31, 280, 147	0. 03593	5 287, 641	10, 336	92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	53, 701	287, 695	0. 18665	9 0	0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0	0	0. 00000	0 0	0	93. 00
200.00 Total (lines 50 through 199)	13, 117, 999	1, 666, 371, 804		151, 248, 754	1, 139, 193	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PAS	IU HEALTH ARNE SS THROUGH COST			In Lie Period: From 01/01/2023 To 12/31/2023		pared:
		Title	e XVIII	Hospi tal	PPS	<u> </u>
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdowr Adjustments	Allied Health Cost	Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	000000000000000000000000000000000000000	1	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0	31. 00 33. 00 33. 01 35. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	200.00
LAIDATLENT DOUTLAG CEDIA OF COCT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0	0 0 0 0 0	3, 78 3, 09 2, 44	9 0.00 0.00 0.00 1 0.00 2 0.00	850 0 0 0	31. 00 33. 00 33. 01 35. 00
	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 33.01 03301 BURN INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY	0 0 0 0 0					30. 00 31. 00 33. 00 33. 01 35. 00 43. 00

43. 00 200. 00

43. 00 | 04300 | NURSERY | Total (lines 30 through 199)

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | THROUGH COSTS

Non Physician Anesthetist Cost Center Description Non Physician Anesthetist Cost Program Program All I del Heal th All ided Heal th Anesthetist Cost Program P						10 12/31/2023	5/29/2024 11:	
Norsing Program Nursing Program Program Prost-Stepdown Adjustments 2.00 3A 3.00				Ti tl e	× XVIII	Hospi tal		27 diii
ANCILLARY SERVICE COST CENTERS		Cost Center Description	Non Physician					
ANCILLARY SERVICE COST CENTERS		cost conton boodinption					/	
AMCILLARY SERVICE COST CENTERS					l rogram			
ANCILLARY SERVICE COST CENTERS			0031			riaj astiliorits		
ANCILLARY SERVICE COST CENTERS			1.00		2,00	3A	3, 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 52.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 052.00 0 0 0 0 0 0 0 0 0	ANC	CILLARY SERVICE COST CENTERS		·				
52.00 05.0	50. 00 050	OOO OPERATING ROOM	0	C		0 0	0	50.00
52.00 05.0		•	0			0 0	0	•
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 53.00 53.01 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 0 0 0 0 0 53.00 55.00 05500 RADIOLOGY-HERAPEUTIC 0 0 0 0 0 0 0 0 0 0 55.00 55.00 05500 RADIOLOGY-HERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•		ł .	•	0	•	•
53.01 05.301 ASC ANESTHESI OLGY	1	l	0			0	0	
54. 00 05.400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 55. 00 05. 00		•	0			0	•	•
55.00		•	0			0	0	
56, 00 05600 RADI ACCATHETERI ZATI ON O O O O O O O O	1	l	0			0	1	•
59,00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 0 0 59,00	1	•						•
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0		•	0				٥	1
63.00 06300 BLODD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 70.00 07000 ELECTROENCEPHALLOGRAPHY 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 RETAL PHARMACY 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76.01 03951 OUTPATIENT WOUND CARE CENTER 0 0 0 0 0 76.01 03951 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 76.01 03951 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 76.01 07800 CARDI AC CATHERIZATION 0 0 0 0 0 77.00 07000 CARDI AC CATHERIZATION 0 0 0 0 0 78.00 07000 CARDI AC CATHERIZATION 0 0 0 0 0 79.00 07000 CARDI AC CATHERIZATION 0 0 0 0 0 79.01 04950 SLEEP CLINIC 0 0 0 0 0 78.00 07800 CARDI AC REHABILITATION 0 0 0 0 79.01 07900 CARDI AC CATHERIZATION 0 0 0 0 79.02 07000 CARDI AC CATHERIZATION 0 0 0 0 79.03 09002 ARNETT CARGE CARE CENTER 0 0 0 0 79.04 09003 OUTPATIENT INFUSION CENTER 0 0 0 0 79.05 09000 CARDI AC TENTER 0 0 0 0 79.01 09000 09000 0000 0000 0000 79.02 09000 0000 0000 0000 0000 79.03 09000 0000 0000 0000 79.04 09000 0000 0000 0000 0000 79.05 00000 00000 0000 0000 79.07 000000 00000 00000 00000 79.08		l .	0				0	
65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.01 07301 RETAIL PHARMACY 0 0 0 0 0 74.00 07400 RENLA LI HARMACY 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75.01 07501 ASC (NON-DISTINCT PART) 0 0 0 0 0 76.00 03950 CARDIAC CATHERIZATI ON 0 0 0 0 0 76.01 03950 CARDIAC CATHERIZATI ON 0 0 0 0 77.00 07700 ALLOGENEI C HASTER C HOTEL C HARDIAC CONTROL CONTROL C THERES C HARDIAC C		•	0					•
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69.00 70.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 71.00 73.00 07300 PRUSC CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 RUSC CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.01 07301 RETAI L PHARMACY 0 0 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.00 0.3951 OUTPATIENT WOUND CARE CENTER 0 0 0 0 0 0 0 76.01 0.3951 OUTPATIENT WOUND CARE CENTER 0 0 0 0 0 0 76.01 0.7900 CARDIAC REHABILITATION 0 0 0 0 0 0 76.02 0.7900 CARDIAC REHABILITATION 0 0 0 0 0 0 77.00 0.7900 CARDIAC REHABILITATION 0 0 0 0 0 0 78.00 0.7900 CARTIAC RESPICE COST CENTERS 0 0 0 0 0 0 78.00 0.7900 CARTIAC REARBILITATION 0 0 0 0 0 78.00 0.7900 CARTIAC REARBILITATION 0 0 0 0 0 79.01 0.9900 CARTIAC REARBILITATION 0 0 0 0 0 79.02 0.9900 CARTIAC REARBILITATION 0 0 0 0 0 79.02 0.9900 CARTIAC REARBILITATION 0 0 0 0 0 79.03 0.9900 CARTIAC REARBILITATION 0 0 0 0 0 79.04 0.9900 CARTIAC REARBILITATION 0 0 0 0 79.05 0.9900 CARTIAC REARBILITATION 0 0 0 0 79.01 0.9900 CARTIAC REARBILITATION 0 0 0 0 79.02 0.9900 CARTIAC REARBILITATION 0 0 0 0 79.03 0.9900 CARTIAC REARBILITATION 0 0 0 0 79.04 0.9900 CARTIAC REARBILITATION 0 0 0 0 79.05 0.9900 CARTIAC REARBILITATION 0								•
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	200. 00	Total (lines 50 through 199)	0	0)	0 0	422, 673	200. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0173 THROUGH COSTS

Cost Center Description				ΙΤ	o 12/31/2023	Date/Time Prep 5/29/2024 11:	
Medical ducation Cost 1, 2, 3, and 2, 3, and 2, 3, and 2, 3, and 3, an			Title	xVIII	Hospi tal		27 diii
Education Cost 1, 2, 3, and cols 2, 3 and 4)	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
ANCILLARY SERVICE COST CENTERS	· ·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
ANCILLARY SERVICE COST CENTERS		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
ANCILLARY SERVICE COST CENTERS			4)	col s. 2, 3,	8)	7)	
ANCILLARY SERVICE COST CENTERS				and 4)		(see	
ANCILLARY SERVICE COST CENTERS						instructions)	
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60. 00 06000 LABORATORY 0 0 0 96,675,517 0.000000 60. 00 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 5,483,631 0.000000 63. 00 65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 17,959,302 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 4,605,885 0.000000 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 3,371,738 0.000000 66. 00 67. 00 06700 0CCUPATIONAL THERAPY 0 0 0 0 3,371,738 0.000000 67. 00 68. 00 06900 SEECH PATHOLOGY 0 0 0 0 1,988,512 0.000000 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 45,727,197 0.000000 69. 00 69. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 0 734,204 0.000000 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 157,716,684 0.000000 71. 00 72. 00 07200 IMPLE. DEV. CHARGED TO PATIENTS 0 0 0 157,716,684 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 157,716,684 0.000000 72. 00 73. 01 07301 RETAIL PHARMACY 0 0 0 0 1,336,091 0.000000 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0.000000 75. 01 76. 00 03950 CARDIAC CATHERIZATION 0 0 0 0.000000 75. 01 76. 01 03951 0UTPATIENT WOUND CARE CENTER 0 0 0 0 0.000000 77. 00 77. 00 0700 ALLOGENEIC HISCT ACQUISITION 0 0 0 0.000000 77. 00 78. 00 07000 CARDIAC CATHERIZATION 0 0 0 0.000000 77. 00 79. 01 04950 SLEEP CLINIC 0 0 0 0 0.000000 79. 00 90. 01 04950 SLEEP CLINIC COST CENTER 0 0 0 0 0.000000 79. 00 90. 02 09000 COMP ED REV CLINIC 0 0 0 0 0.000000 90. 00 90. 01 04950 SLEEP CLINIC 0 0 0 0 0.000000 90. 00 90. 01 04950 DESERVATION BEDS (INSTINCT PART) 0 0 0 0 0 0.000000 90. 00 90. 01 09200 08SERVATION BEDS (INSTINCT PART) 0 0 0 0 0 0 0.000000 90. 00 90. 01 09201 08SERVATION B	· · · · · · · · · · · · · · · · · · ·	1	0				
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74. 00		1	422, 6/3	1			
75. 00	· · · · · · · · · · · · · · · · · · ·	0	0	1			
75. 01 07501 ASC (NON-DISTINCT PART) 76. 00 03950 CARDI AC CATHERIZATION 76. 01 03951 OUTPATIENT WOUND CARE CENTER 77. 00 07697 CARDI AC REHABILITATION 78. 00 07700 ALLOGENEIC HSCT ACQUISITION 79. 00 07800 CAR T-CELL IMMUNOTHERAPY 79. 00 07800 CAR T-CELL IMMUNOTHERAPY 79. 00 09000 CLINIC 79. 00 09000 CLINIC 79. 00 09000 CLINIC 79. 00 09000 CLINIC 79. 00 09000 ARRETT CANCER CENTER 79. 01 04950 SLEEP CLINIC 79. 02 09001 COMP MED REV CLINIC 79. 03 09002 ARNETT CANCER CARE CENTER 79. 04 09003 OUTPATIENT INFUSION CENTER 79. 05 09000 ARRETT CANCER CARE CENTER 79. 00 09000 OUTPATIENT INFUSION CENTER 79. 00 09000 OUTPATIENT SERVICES 79. 00 09000 OUTPATIENT SERVICES 79. 00 00 00 00 00 00 00 00 00 00 00 00 00	· · · · · · · · · · · · · · · · · · ·	0	0		3, 336, 091		
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76. 01 03951 OUTPATIENT WOUND CARE CENTER 0 0 0 16, 008, 730 0.000000 76. 01 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0.000000 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0.000000 77. 00 78. 00 00000 CLI NI C 0 0 0 0 0 0.000000 90. 00 90. 01 04950 SLEEP CLI NI C 0 0 0 0 0.000000 90. 01 90. 02 09001 COMP MED REV CLI NI C 0 0 0 0 0.000000 90. 02 90. 03 09002 ARNETT CANCER CARE CENTER 0 0 0 0 36, 478, 451 0.000000 90. 02 90. 04 09003 OUTPATIENT INFUSION CENTER 0 0 0 0 36, 478, 451 0.000000 90. 03 90. 04 09003 OUTPATIENT INFUSION CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		١	0	1			
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77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0		0	0		16, 008, 730		
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0		1	0				
OUTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0		1	0		0		
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0		0	0	1	0	0.000000	78.00
90. 01 04950 SLEEP CLINIC 0 0 0 6, 789, 235 0. 000000 90. 01 90. 02 90. 01 000000 90. 02 90. 03 09002 ARNETT CANCER CARE CENTER 0 0 0 36, 478, 451 0. 000000 90. 03 90. 04 09003 OUTPATIENT INFUSION CENTER 0 0 0 36, 478, 451 0. 000000 90. 03 90. 04 91. 00 9100 EMERGENCY 0 0 0 249, 054, 692 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 31, 280, 147 0. 000000 92. 01 93. 00 04951 OTHER OUTPATIENT SERVICES 0 0 0 0 0 0. 000000 93. 00						0.00000	00.00
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93. 00 04951 OTHER OUTPATI ENT SERVICES 0 0 0 0. 000000 93. 00		0	0	1			
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200.00 Total (lines 50 through 199) 0 422,673 422,673 1,666,371,804 200.00	200.00 lotal (lines 50 through 199)	ا ا	422, 6/3	422, 6/3	5 1,666,371,804		200.00

 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 In Lieu of Form CMS-2552-10 IU HEALTH ARNETT HOSPITAL Worksheet D Part IV Date/Time Prepared: 5/29/2024 11: 29 am Peri od: From 01/01/2023 To 12/31/2023 THROUGH COSTS Title XVIII Hospital
Inpatient Inpatient Outpatient PPS Cost Center Description Outpati ent Outpati ent

	'	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	20, 961, 445	0	18, 758, 852	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	1, 583, 411	0	3, 193, 477	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	126, 157	0	3, 996	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	1, 272, 310	0	995, 399	0	53.00
53. 01	05301 ASC ANESTHESI OLOGY	0. 000000	2, 693	0	679, 877	0	53. 01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	17, 274, 708	0	15, 948, 210	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	930, 912	0	4, 995, 168	0	56.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	9, 827, 982	0	10, 548, 133	0	59.00
60.00	06000 LABORATORY	0. 000000	11, 126, 005	0	5, 557, 373	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	1, 483, 111	0	309, 754	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	4, 396, 826	0	99, 788	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 521, 368		32, 999	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	1, 122, 460	0	10, 160	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	723, 359	0	8, 008	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	8, 697, 924	0	7, 181, 072	0	69. 00
70. 00		0. 000000	241, 031		26, 692	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	7, 988, 632		9, 620, 131	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	21, 846, 982		22, 281, 258	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 001587	19, 354, 922		58, 482, 296		73. 00
73. 01	07301 RETAIL PHARMACY	0. 000000	0	0	0	0	73. 01
74. 00		0. 000000	984, 127	O	61, 284	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	o	0	0	75. 00
75. 01	07501 ASC (NON-DISTINCT PART)	0. 000000	89, 554	0	27, 667, 172	0	75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0. 000000	0	0	0	0	76. 00
76. 01	03951 OUTPATIENT WOUND CARE CENTER	0. 000000	56, 685	0	2, 947, 687	0	76. 01
	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	0	0	77. 00
78. 00		0. 000000	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS		-		-		
90. 00	09000 CLI NI C	0. 000000	0	0	0	0	90. 00
90. 01	04950 SLEEP CLINIC	0. 000000	0	o	747, 477	0	90. 01
90. 02	09001 COMP MED REV CLINIC	0. 000000	678	o	185, 476	0	90. 02
90. 03	09002 ARNETT CANCER CARE CENTER	0. 000000	104, 861		9, 782, 458	0	90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	0. 000000	4, 820		222, 704	0	90. 04
91. 00	09100 EMERGENCY	0. 000000	19, 238, 150		21, 110, 834	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	287, 641	1 0	3, 980, 981		92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	207, 011		19, 056	0	92. 01
93. 00		0. 000000	0	١	. , , 000	0	93. 00
200.00		0.000000	151, 248, 754	30, 716	225, 457, 772		
200.00	1.5ta. (11165 55 till bagil 177)	ı	.01, 210, 704	35,710	220, 107, 772	,2,011	

	iici ai - Systellis	TU HEALTH AKIN				u or Form Cws	2332-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2023 Fo 12/31/2023	Date/Time Pre	pared:
			T	V0/11 1 1		5/29/2024 11:	29 am
			IITIE	Changes	Hospi tal	PPS	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Charges Cost	Cost	Costs PPS Services	
	cost center bescription	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9		Subject To	Subject To		
		1 41 1 7 001.		Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 122693			0	2, 301, 580	50. 00
	RECOVERY ROOM	0. 109191			0	348, 699	
	DELIVERY ROOM & LABOR ROOM	0. 239163			0	956	
	ANESTHESI OLOGY	0. 085898		1	0	85, 503	53. 00
53. 01 05301	1 ASC ANESTHESI OLOGY	0. 015055	679, 877		0	10, 236	53. 01
	RADI OLOGY-DI AGNOSTI C	0. 092829	15, 948, 210		0	1, 480, 456	54.00
55. 00 05500	RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
	RADI OI SOTOPE	0. 066109	4, 995, 168		0	330, 226	56. 00
	CARDIAC CATHETERIZATION	0. 072670			0	766, 533	
	LABORATORY	0. 171666		1	0	954, 012	
	BLOOD STORING, PROCESSING & TRANS.	0. 219414	309, 754		0	67, 964	63. 00
	RESPI RATORY THERAPY	0. 218559		l .	0	21, 810	
	PHYSI CAL THERAPY	0. 314919			0	10, 392	
4	OCCUPATIONAL THERAPY	0. 383302		1	0	3, 894	1
	SPEECH PATHOLOGY	0. 300758	1	1	0	2, 408	1
	ELECTROCARDI OLOGY	0. 069647		1	0	500, 140	
	ELECTROENCEPHALOGRAPHY	0. 175748			0	4, 691	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 231229		1	0	2, 224, 453	
	IMPL. DEV. CHARGED TO PATIENTS	0. 137494		1	0	3, 063, 539	
	DRUGS CHARGED TO PATIENTS	0. 213408		1	22, 657	12, 480, 590	1
	1 RETAIL PHARMACY	1. 349174		1	0	0	
	RENAL DIALYSIS	0. 403431		l .	0	24, 724	1
	ASC (NON-DISTINCT PART)	0. 000000	 	1	0	0	75. 00
	1 ASC (NON-DISTINCT PART)	0. 063852		1	0	1, 766, 604	
	CARDI AC CATHERI ZATI ON	0. 000000		1	0	0	
	1 OUTPATIENT WOUND CARE CENTER	0. 089833			0	264, 800	
	7 CARDI AC REHABI LI TATI ON	0. 000000			0	0	
	ALLOGENEIC HSCT ACQUISITION	0. 000000		1	0	0	
	CAR T-CELL IMMUNOTHERAPY	0. 000000) 0	1	0	0	78. 00
	ATIENT SERVICE COST CENTERS CLINIC	0. 000000) 0	ı	0	0	90.00
	SLEEP CLINIC	0. 148341	1	1		110, 881	
	1 COMP MED REV CLINIC	2. 291158		1		424, 955	
	2 ARNETT CANCER CARE CENTER	0. 087737		1		858, 284	
	3 OUTPATIENT INFUSION CENTER	0. 091549		1		20, 388	
	D EMERGENCY	0. 079681		1		1, 682, 132	
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 260907		1			
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 034617		1		1, 038, 666 19, 716	
	OTHER OUTPATIENT SERVICES	0. 000000				19,716	1
200. 00	Subtotal (see instructions)	0.000000	225, 457, 772	l .	22, 657	1	
201. 00	Less PBP Clinic Lab. Services-Program		223, 431, 112	1	22, 657	30, 009, 232	200.00
201.00	Only Charges						201.00
202. 00	Net Charges (line 200 - line 201)		225, 457, 772		22, 657	30, 869, 232	202, 00
: 301	1	Ţ.	1 ===,,	1	22, 307	1, 00,, 202	,

Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Ti me Prepared: 5/39/2024 11:39 am

					5/29/2024 11:	
		Title	XVIII	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	Ö	1			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	Ö	1			52. 00
53. 00 05300 ANESTHESI OLOGY		0	•			53.00
53. 01 05301 ASC ANESTHESI OLOGY			l .			53. 00
	0		1			1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	1			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI OI SOTOPE	0	0	•			56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	0	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		4, 835				73.00
73. 01 07301 RETAIL PHARMACY		4, 833	1			73. 00
	0		•			1
74. 00 07400 RENAL DI ALYSI S	0	0	•			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	•			75. 00
75. 01 07501 ASC (NON-DI STI NCT PART)	0	0				75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0				76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER	0	0				76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	1			76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	1			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90. 00
90. 01 04950 SLEEP CLINIC	0	0				90. 01
90. 02 09001 COMP MED REV CLI NI C	0	0				90. 02
90. 03 09002 ARNETT CANCER CARE CENTER	0	0				90. 03
90.04 09003 OUTPATIENT INFUSION CENTER	0	0				90. 04
91. 00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0	Ö	1			92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)		0				92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES		0				93. 00
		l ~				
		4, 835				200.00
201.00 Less PBP Clinic Lab. Services-Program						201. 00
Only Charges	0	4 025				202 00
202.00 Net Charges (line 200 - line 201)	1	4, 835	I			202. 00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS Provider CCN: 15-0173 Period: From 01/01/202: To 12/31/202: Title XIX Hospital Related Cost (from Wkst. B, Part II, col. 26) 1.00 2.00 3.00 4.00	B Date/Time Prep 5/29/2024 11: 2 PPS PPS Per Diem (col. 3 / col. 4) 5.00	
Cost Center Description Capital Related Cost (from Wkst. B, Part II, col. 26) Capital Swing Bed Capital Capital Reduced Capital Related Cost (col. 1 - col. 2)	Per Diem (col. 3 / col. 4) 5.00	
Related Cost (from Wkst. B, Part II, col. 26) Related Cost (col. 1 - col. 2)	3 / col . 4) 5.00	
(from Wkst. B, Part II, col. (col. 1 - col. 2)	5. 00	
Part II, col. (col. 1 - col. 2)		
26) 2)		
1 00 2 00 4 00		
	_	
INPATIENT ROUTINE SERVICE COST CENTERS		
30. 00 ADULTS & PEDI ATRI CS 8, 952, 622 0 8, 952, 622 42, 43		30. 00
31. 00 INTENSIVE CARE UNIT 975, 722 975, 722 3, 78		
33.00 BURN INTENSIVE CARE UNIT O O O	0.00	33.00
33.01 BURN INTENSIVE CARE UNIT 0 0 0	0.00	33. 01
35.00 NEONATAL INTENSIVE CARE UNIT 682, 325 682, 325 3,09	1 220. 75	35.00
43. 00 NURSERY 244, 178 244, 178 2, 44:	99. 99	43.00
200.00 Total (lines 30 through 199) 10,854,847 10,854,847 51,75	7	200. 00
Cost Center Description Inpatient Inpatient		
Program days Program		
Capital Cost		
(col. 5 x col.		
6)		
6.00 7.00		
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		
30. 00 ADULTS & PEDI ATRI CS 960 202, 531		30. 00
31. 00 I NTENSI VE CARE UNI T 102 26, 266		31. 00
33.00 BURN INTENSIVE CARE UNIT 0 0		33. 00
33.01 BURN INTENSIVE CARE UNIT 0 0		33. 01
35. 00 NEONATAL INTENSIVE CARE UNIT 252 55, 629		35.00
43. 00 NURSERY 1, 480 147, 985		43.00
200.00 Total (lines 30 through 199) 2,794 432,411		200. 00

Health Financial Systems	IU HEALTH ARNI	ETT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-0173	Peri od:	Worksheet D	
				From 01/01/2023	Part II	
				To 12/31/2023	Date/Time Pre	pared:
		T: +1	o VIV	Hooni tol	5/29/2024 11:	29 am_
Cook Cooker Donordinkling	C! +-1		e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges (from Wkst. C,			Capital Costs	
	Related Cost		to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	2, 495, 576	171, 758, 274	0. 01453	374, 740	5, 445	50. 00
51. 00 05100 RECOVERY ROOM		1			443	51.00
· · · · · · · · · · · · · · · · · · ·	344, 519					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 087, 078				13, 492	52.00
53. 00 05300 ANESTHESI OLOGY	116, 098		0. 01131		316	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	7, 092				0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 260, 074	132, 193, 690			7, 185	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55. 00
56. 00 05600 RADI OI SOTOPE	152, 636	20, 623, 158	0.00740	10, 402	77	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	514, 521	79, 024, 554	0. 00651	1 117, 291	764	59. 00
60. 00 06000 LABORATORY	743, 311	96, 675, 517	0. 00768	672, 305	5, 169	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	48, 022	5, 483, 631	0.00875	45, 738	401	63.00
65. 00 06500 RESPIRATORY THERAPY	131, 945		0. 00734	494, 470	3, 633	65. 00
66. 00 06600 PHYSI CAL THERAPY	62, 464	4, 605, 885			659	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	45, 884				483	67. 00
68. 00 06800 SPEECH PATHOLOGY	26, 679				502	68. 00
69. 00 06900 ELECTROCARDI OLOGY	197, 398				1, 144	69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 153				1, 144	70.00
						70.00
· · · · · · · · · · · · · · · · · · ·	453, 582	71, 660, 714	0.00633		1, 951	
	598, 215		l .		298	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	515, 436				2, 467	73. 00
73. 01 07301 RETAI L PHARMACY	209, 847				0	73. 01
74. 00 07400 RENAL DI ALYSI S	115, 698	3, 336, 091	0. 03468		463	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000		0	75. 00
75.01 07501 ASC (NON-DISTINCT PART)	772, 252	166, 773, 281	0. 00463		0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0	0	0. 00000		0	76. 00
76.01 03951 OUTPATIENT WOUND CARE CENTER	9, 966	16, 008, 730	0. 00062	23 0	0	76. 01
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	00	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	00	0	90.00
90. 01 04950 SLEEP CLINIC	76, 043	6, 789, 235	0. 01120	0	0	90. 01
90. 02 09001 COMP MED REV CLINIC	25, 889	500, 247	0. 05175	52 0	0	90. 02
90.03 09002 ARNETT CANCER CARE CENTER	313, 665	36, 478, 451	0.00859	0	0	90. 03
90. 04 09003 OUTPATIENT INFUSION CENTER	4, 989	995, 833			0	90. 04
91. 00 09100 EMERGENCY	1, 610, 205	1			4, 199	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 124, 061	31, 280, 147			694	92.00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	53, 701	287, 695			0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0 0	207,070	0. 00000		0	93. 00
200.00 Total (lines 50 through 199)	_	1, 666, 371, 804		5, 631, 769	_	
200.00 10tal (11163 30 till ough 177)	13, 117, 799	1 1,000,371,004	I	3,031,709	47, 190	1200.00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	IU HEALTH ARNE SS THROUGH COST			In Lie Period: From 01/01/2023 To 12/31/2023		pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Post-Stepdown Adjustments		Medical Education Cost	
INDATIENT POUTINE CERVICE COCT CENTERS	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0	000000000000000000000000000000000000000		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	_	31. 00 33. 00 33. 01 35. 00
200.00 Total (lines 30 through 199)	o	0)	0	0	200. 00
Cost Center Description		Total Costs (sum of cols. 1 through 3, minus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5.00	6. 00	7. 00	8. 00	
INPATI ENT ROUTINE SERVICE COST CENTERS	0	0 0 0 0 0 0	3, 78 3, 78 3, 09 2, 44	9 0.00 0 0.00 0 0.00 1 0.00 2 0.00	102 0 0 252 1, 480	31. 00 33. 00 33. 01 35. 00
	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 31.00 03100 INTENSIVE CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 33.01 03301 BURN INTENSIVE CARE UNIT 35.00 02060 NEONATAL INTENSIVE CARE UNIT 43.00 04300 NURSERY	0 0 0 0 0					30. 00 31. 00 33. 00 33. 01 35. 00 43. 00

43. 00 200. 00

43. 00 | 04300 | NURSERY | Total (lines 30 through 199)

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time | Prepared: THROUGH COSTS

					10 12/31/2023	5/29/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0			0	_	
51. 00	05100 RECOVERY ROOM	0	_	1	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	C		0	0	53. 00
53. 01	05301 ASC ANESTHESI OLOGY	0	C		0	0	53. 01
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	C		0	0	56. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C		0	0	59. 00
60. 00	06000 LABORATORY	0	C	1	0	0	60. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	C	1	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C	1	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	_	1	0	0	
68. 00	06800 SPEECH PATHOLOGY	0	C	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		1	0	0	69. 00
		0	C	1	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	1	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	1	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C		0	422, 673	1
73. 01	07301 RETAIL PHARMACY	0	C		0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0	C	1	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	1	0	0	
75. 01	07501 ASC (NON-DISTINCT PART)	0	C	1	0 0	0	75. 01
76. 00	03950 CARDI AC CATHERI ZATI ON	0	C	1	0	0	
76. 01	03951 OUTPATIENT WOUND CARE CENTER	0	C	1	0	0	76. 01
	07697 CARDI AC REHABI LI TATI ON	0	_	1	0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	_	1	0 0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	<u> </u>)	0 0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS			J.			00.00
90.00	09000 CLINIC	0		1	0 0		
90. 01	04950 SLEEP CLINIC	0	C		0 0	_	70.0.
90. 02	09001 COMP MED REV CLINIC	0			0	0	90. 02
90. 03	09002 ARNETT CANCER CARE CENTER	0			0	0	90. 03
90. 04	09003 OUTPATIENT INFUSION CENTER	0			0	0	90.04
91.00	09100 EMERGENCY	0	C	7	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)]		0		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		C	1		0	1 - 1 - 1
93. 00	04951 OTHER OUTPATIENT SERVICES	0		1	0	_	93. 00
200.00	Total (lines 50 through 199)	0) c	4	0 0	422, 673	J200. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-0173 THROUGH COSTS

				Т	o 12/31/2023	Date/Time Pre 5/29/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	29 alli
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Social Control Code (p.t. on	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col . 5 ÷ col .	
			4)	col s. 2, 3,	8)	7)	
			ŕ	and 4)		(see	
				ŕ		instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0			0. 000000	•
51. 00	05100 RECOVERY ROOM	0	0	1	, , ,	0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C		0. 000000	•
53. 00	05300 ANESTHESI OLOGY	0	0	l ~		0. 000000	•
53. 01	05301 ASC ANESTHESI OLOGY	0	0	C		0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	· ·		0. 000000	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	l ~	_	0. 000000	•
56. 00	05600 RADI OI SOTOPE	0	0			0. 000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	l ~	, ,	0. 000000	1
60.00	06000 LABORATORY	0	0			0. 000000	•
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	~	-,,	0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	0	0			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	0	0	· ·	.,,	0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1		0.000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0	C	,	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	,	0.000000	•
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C		0.000000	•
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	C	, ,	0.000000	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	422 (72	422 (72		0.000000	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	422, 673			0. 001587	1
73. 01	07301 RETAIL PHARMACY	0	0	1		0.000000	ł
74. 00 75. 00	07400 RENAL DIALYSIS	0	0	0	3, 336, 091	0. 000000 0. 000000	
75. 00 75. 01	07500 ASC (NON-DISTINCT PART) 07501 ASC (NON-DISTINCT PART)	0	0	i c	144 772 201	0. 000000	1
76. 00	03950 CARDI AC CATHERI ZATI ON	0	0		166, 773, 281	0.000000	1
76. 00	03951 OUTPATIENT WOUND CARE CENTER	0	0	i c	16, 008, 730	0.000000	1
76. 01	07697 CARDIAC REHABILITATION	0	0		0 10,000,730	0.000000	•
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		_	0.000000	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		_	0. 000000	•
76.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	U		, o	0.000000	76.00
90. 00	09000 CLINIC	0	0		0	0.000000	90.00
90. 01	04950 SLEEP CLINIC	0	0		_	0. 000000	90. 01
90. 02	09001 COMP MED REV CLINIC	0	0		-, ,	0. 000000	
90. 03	09002 ARNETT CANCER CARE CENTER	n	0			0. 000000	•
90. 04	09003 OUTPATIENT INFUSION CENTER		0			0. 000000	1
91. 00	09100 EMERGENCY	l o	0	Ö		0. 000000	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			0. 000000	
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)		0			0. 000000	•
93. 00	04951 OTHER OUTPATIENT SERVICES	l ol	0	1		0. 000000	
200.00	1	0	422, 673	422, 673	1, 666, 371, 804		200. 00
		'				1	•

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0173 THROUGH COSTS

			To	12/31/2023	Date/Time Prep 5/29/2024 11:	
		Ti tl	e XIX	Hospi tal	PPS	27 (
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	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	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	374, 740		0	0	50. 00
51.00 05100 RECOVERY ROOM	0. 000000	28, 560	0	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	368, 804	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	27, 903	0	0	0	53. 00
53. 01 05301 ASC ANESTHESI OLOGY	0. 000000	0	0	0	0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	753, 758	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	10, 402	0	0	0	56. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	117, 291	0	0	0	59. 00
60. 00 06000 LABORATORY	0. 000000	672, 305	0	0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	45, 738	0	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	494, 470	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	48, 604	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	35, 459	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	37, 444	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	264, 983	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	7, 725	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	308, 260	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	78, 644	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 001587	1, 274, 458	2, 023	0	0	73.00
73. 01 07301 RETAIL PHARMACY	0. 000000	0	0	0	0	73. 01
74.00 07400 RENAL DIALYSIS	0. 000000	13, 356	0	o	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	o	0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	0. 000000	0	0	o	0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	0. 000000	0	0	o	0	76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER	0. 000000	0	0	o	0	76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	o	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	0	o	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	o	0	78. 00
OUTPATIENT SERVICE COST CENTERS	•					
90. 00 09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01 04950 SLEEP CLINIC	0. 000000	0	0	o	0	90. 01
90. 02 09001 COMP MED REV CLINIC	0. 000000	0	0	0	0	90. 02
90. 03 09002 ARNETT CANCER CARE CENTER	0. 000000	0	0	0	0	90. 03
90.04 09003 OUTPATIENT INFUSION CENTER	0. 000000	0	0	o	0	90. 04
91. 00 09100 EMERGENCY	0. 000000	649, 548	o	o	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	19, 317	o	o	0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0	o	o	0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	0. 000000	0	o	o	0	93. 00
200.00 Total (lines 50 through 199)		5, 631, 769	2, 023	o	0	200. 00

Cost Center Description		TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		Provi der Co	CN: 15-0173	Period: From 01/01/2023	Worksheet D Part V	
Cost Center Description							To 12/31/2023	Date/lime Pre	pared: 29 am
Cost Center Description					Ti tl	e XIX	Hospi tal		
No.						Charges		Costs	
No. Part 1, col. 9		Cost Center Description	Cost to Charge	PPS	Reimbursed			PPS Services	
Part I				Sei				(see inst.)	
Ded. & Col ns. Cole Inst. See Inst.					inst.)				
See Inst. See			Part I, col. 9	'					
NOTE LARY SERVICE COST CENTERS									
MOCILLARY SERVICE COST CENTERS			1 00		2.00			E 00	
50.00 GSG000 OFERATI NG ROOM 0.122693 0 772,719 0 0 50.00		ANCILLARY SERVICE COST CENTERS	1.00		2.00	3.00	4.00	5.00	
51.00 05100 RECOVERY ROOM & LABOR ROOM 0.109191 0 129, 360 0 0 51.00 052.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0520.00 0530.01	50 00		0 122693	3	0	772 71	9 0	0	50 00
52.00 05200 DELLVERY ROOM & LABOR ROOM 0.299163 0.64,972 0 0.52.00 0.53.00 0.55.00 0.5			l .						
53.00 05300 ANSTHESI OLOGY 0.085898 0 42,005 0 0.53.00 53.01 05301 ASC AMESTHESI OLOGY 0.015055 0 51.098 0 0.53.00 54.00 05400 RADI OLOGY-DI ACNOSTI C 0.0902829 0 935.796 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55.00 56.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 71.230 0 0 56.00 57.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 71.230 0 0 56.00 58.00 05500 RADI OLOGY-THERAPEUTI C 0.006109 0 71.230 0 0 56.00 59.00 05500 RADI AC CATHETERI ZATI ON 0.072670 0 120,657 0 0 59.00 63.00 05500 RADI AC CATHETERI ZATI ON 0.072670 0 120,657 0 0 59.00 63.00 05500 RADI AC CATHETERI ZATI ON 0.072670 0 120,657 0 0 0 0 63.00 055					0			0	
53.01 05301 ASC AMESTHESI OLOGY 0.015055 0 51.098 0 0.53.01					0			0	53. 00
55. 00 05500 RADIO LOGY-THERAPEUTIC 0.000000 0 0 0 0 0 55. 00	53. 01				0			0	53. 01
55.00 05500 RADIO LOGY-THERAPEUTIC 0.000000 0 0 0 0 0 55.00	54.00	05400 RADI OLOGY-DI AGNOSTI C			0			0	54.00
99 00 05900 CARDIA C CATHETERI ZATION					0	,		0	55. 00
99 00 05900 CARDIA C CATHETERI ZATION	56.00	05600 RADI OI SOTOPE	0. 066109		0	71, 23	0 0	0	56. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 219414 0 4. 688 0 0. 63.00					0			0	
65.00 06500 RESPI RATORY THERAPY 0. 218559 0 27,690 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 314919 0 14,450 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0. 383302 0 10,066 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 300758 0 7,905 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 069647 0 190,432 0 0 69.00 70.00 07000 CLECTROCARDI OLOGY 0. 175748 0 0 0 0 0 0 71.00 07100 MDI CAL SUPPLIES CHARGED TO PATI ENTS 0. 231229 0 267,744 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0. 137494 0 795,587 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0. 213408 0 2,264,165 0 0 73.01 74.00 07400 RENAL DI LAYSI S 0. 213408 0 2,264,165 0 0 73.01 74.00 07400 RENAL DI LAYSI S 0. 403431 0 12,507 0 0 74.00 75.00 07500 ASC (NON-DI STI NCT PART) 0. 000000 0 0 0 0 0 75.01 07500 ASC (NON-DI STI NCT PART) 0. 063852 0 1,007,881 0 0 75.01 76.00 03950 CARDI AC CATHERI ZATI ON 0. 000000 0 0 0 0 0 76.01 03951 OUTPATI ENT WOUND CARE CENTER 0. 089833 0 21,086 0 0 0 76.01 76.00 03950 CARDI AC CATHERI ZATI ON 0. 000000 0 0 0 0 0 76.00 07500 ALCIOGENICA CHARELI TATI ON 0. 000000 0 0 0 0 0 76.00 07500 ALCIOGENICA CHARELI CHARLON 0. 000000 0 0 0 0 0 76.00 07600 CARDI AC REHABILI TATI ON 0. 000000 0 0 0 0 0 0 76.00 07600 CARDI AC REHABILI TATI ON 0. 000000 0 0 0 0 0 0 76.00 07600 CARDI AC REHABILI TATI ON 0. 000000 0 0 0 0 0 0 76.00 07600 0. 00000 0 0 0 0 0 0 76.00 07600 0. 00000 0 0 0 0 0 0 76.00 07600 0. 00000 0 0 0 0 0 76.00 07600 0. 00000 0 0 0 0 0 76.00 07600 0. 00000 0 0 0 0 0 76.00 07600 0. 00000 0 0 0 0 0 76.00 07600 0. 000000 0 0 0 0 0 76.	60.00		1		0			0	60.00
66.00 06600 PHYSICAL THERAPY 0.314919 0 14,450 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.383302 0 10,066 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.300758 0 7,905 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.069647 0 190,432 0 0 0 0 71.00 07000 ELECTROCREPHALOGRAPHY 0.175748 0 0 0 0 0 71.00 07100 DELICAL SUPPLIES CHARGED TO PATIENTS 0.231229 0 267,744 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.137494 0 795,587 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.137494 0 795,587 0 0 72.00 73.01 07301 RETAIL PHARMACY 1.349174 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 0 76.01 07501 ASC (NON-DISTINCT PART) 0.063852 0 1,007,881 0 0 0 75.00 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 0 76.01 03950 03000000 0 0 0 0 0 0 0	63.00	06300 BLOOD STORING, PROCESSING & TRANS.			0			0	
67:00 06700 05CUPATIONAL THERAPY 0.383302 0 10.066 0 0 67.00 68:00 06800 SPEECH PATHOLOGY 0.300758 0 7,905 0 0 68.00 69:00 06900 ELECTROCARDI OLOGY 0.069647 0 190.432 0 0 0 0 70:00 07000 ELECTROCARDI OLOGY 0.175748 0 0 0 0 0 71:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.21229 0 267,744 0 0 0 71.00 72:00 07200 IMPL DEV. CHARGED TO PATIENTS 0.137494 0 795,587 0 0 72.00 73:00 07300 DRUGS CHARGED TO PATIENTS 0.137494 0 795,587 0 0 73.00 73:01 07301 RETAIL PHARMACY 1.349174 0 0 0 0 0 74:00 07400 RENAL DIALYSIS 0.403431 0 12,507 0 0 74.00 75:00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 75:01 07501 ASC (NON-DISTINCT PART) 0.063852 0 1,007,881 0 0 0 76:01 07597 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 76:01 03951 OUTPATIENT WOUND CARE CENTER 0.89833 0 21,086 0 0 0 77:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 77:00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 0 77:00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 77:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 78:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 78:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 78:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 79:00 09000 CARDI AC REHABI LITATI ON 0.000000 0 0 0 79:00 09000 00000 0 0 0 0 79:00 09000 000000 0 0 0 0 79:00 09000 0000000 0 0 0 0 79:00 09000 00000000000 0 0 0 79:00 090000000000000000000000000000000	65.00	06500 RESPI RATORY THERAPY	0. 218559		0	27, 69	0 0	0	65. 00
67:00 06700 05CUPATIONAL THERAPY 0.383302 0 10.066 0 0 67.00 68:00 06800 SPEECH PATHOLOGY 0.300758 0 7,905 0 0 68.00 69:00 06900 ELECTROCARDI OLOGY 0.069647 0 190.432 0 0 0 0 70:00 07000 ELECTROCARDI OLOGY 0.175748 0 0 0 0 0 71:00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.21229 0 267,744 0 0 0 71.00 72:00 07200 IMPL DEV. CHARGED TO PATIENTS 0.137494 0 795,587 0 0 72.00 73:00 07300 DRUGS CHARGED TO PATIENTS 0.137494 0 795,587 0 0 73.00 73:01 07301 RETAIL PHARMACY 1.349174 0 0 0 0 0 74:00 07400 RENAL DIALYSIS 0.403431 0 12,507 0 0 74.00 75:00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 75:01 07501 ASC (NON-DISTINCT PART) 0.063852 0 1,007,881 0 0 0 76:01 07597 CARDI AC CATHERI ZATI ON 0.000000 0 0 0 0 76:01 03951 OUTPATIENT WOUND CARE CENTER 0.89833 0 21,086 0 0 0 77:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 76:00 07600 CARDI AC REHABI LITATI ON 0.000000 0 0 0 77:00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 0 77:00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 77:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 78:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 78:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 78:00 07800 CARDI AC REHABI LITATI ON 0.000000 0 0 0 79:00 09000 CARDI AC REHABI LITATI ON 0.000000 0 0 0 79:00 09000 00000 0 0 0 0 79:00 09000 000000 0 0 0 0 79:00 09000 0000000 0 0 0 0 79:00 09000 00000000000 0 0 0 79:00 090000000000000000000000000000000	66.00	06600 PHYSI CAL THERAPY	0. 314919		0	14, 45	0 0	0	66. 00
68. 00 06800 SPECCH PATHOLOGY 0. 300758 0 7, 905 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 069647 0 190, 432 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 175748 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 231229 0 267, 744 0 0 71. 00 72. 00 072. 00 DRUGS CHARGED TO PATIENTS 0. 313494 0 795, 587 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 213408 0 2, 264, 165 0 0 73. 00 73. 01 07301 RETAIL PHARMACY 1. 349174 0 0 0 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 0. 403431 0 12, 507 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 0 0 0 76. 00 03950 CARDIA C CATHERI ZATION 0. 000000 0 0 0 0 0 76. 01 03951 OUTPATIENT WOUND CARE CENTER 0. 089833 0 21, 086 0 0 0 77. 00 77. 00 07700 ALLOGENEIC HIST ACQUISITION 0. 000000 0 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0 0 0 0 79. 01 044950 SLEEP CLINIC 0. 000000 0 0 0 0 0 79. 02 09001 CMPATIENT INFUSION CENTER 0. 087737 0. 283, 727 0 0 0 0 79. 00 09000 CLINIC 0. 000000 0 0 0 0 0 79. 01 04950 SLEEP CLINIC 0. 04950 SLEEP CLINIC 0. 079681 0. 3, 571, 618 0 0 0 0 79. 01 04950 SLEEP CLINIC 0. 079681 0. 3, 571, 618 0 0 0 0 79. 01 09201 OBSERVATION BEDS (IDSTINCT PART) 0. 260907 0 656, 411 0 0 92. 00 79. 01 09201 OBSERVATION BEDS (IDSTINCT PART) 0. 260907 0 656, 411 0 0 92. 00 79. 00 09200 OBSERVATION BEDS (IDSTINCT PART) 0. 260907 0 656, 411 0 0 92. 00 79. 00 09200 OBSERVATION BEDS (IDSTINCT PART) 0. 260907 0 656, 411 0 0 92. 00 79. 00 09201 OBSERVATION BEDS (IDSTINCT PART) 0. 000000 0 0 0 0 0 70. 00 001900 OSSERVATION BEDS (IDSTINCT PART) 0. 000000 0 0 0 0 0 70. 00 001900 OSSERVATIO	67.00	06700 OCCUPATI ONAL THERAPY	0. 383302	2	0	10, 06	6 0	0	67. 00
70. 00 07000 DELECTROENCEPHALOGRAPHY 0.175748 0 0 0 0 0 70. 00 0 70. 00 0 71. 00 0 710. 00 0 71. 00 0 71. 00 0 71. 00 0 71. 00 0 71. 00 0 71. 00 0 71. 00 0 71. 00 0 72. 00 0 73. 00 0 73. 00 0 73. 00 0 73. 00 0 73. 00 0 74. 00 0 73. 00 0 74. 00 0 74. 00 0 74. 00 0 74. 00 0 74. 00 0 74. 00 0 74. 00 0 74. 00 0 74. 00 0 75. 00 0	68.00	06800 SPEECH PATHOLOGY			0	7, 90	5 0	0	68. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 231229 0 267, 744 0 0 71. 00 72. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 0. 137494 0 795, 587 0 0 72. 00 73. 0	69.00	06900 ELECTROCARDI OLOGY	0. 069647	'	0	190, 43	2 0	0	69. 00
72. 00 07200 IMPL DEV CHARGED TO PATIENTS 0. 137494 0 795, 587 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 01 7	70.00	07000 ELECTROENCEPHALOGRAPHY	0. 175748	3	0		0 0	0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 213408 0 2, 264, 165 0 0 73. 00 73. 01 73.01 07301 RETAIL PHARMACY 1. 349174 0 0 0 0 0 73. 01 74. 00 07400 RENAL DIALYSIS 0. 403431 0 12, 507 0 0 74. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 231229		0	267, 74	4 0	0	71. 00
73. 01 07301 RETAIL PHARMACY 1. 349174 0 0 0 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0. 403431 0 12,507 0 0 74. 00 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 137494	ļ.	0	795, 58	7 0	0	72. 00
74. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0. 213408	3	0	2, 264, 16	5 0	0	73. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 0 0 0 75. 00			1. 349174	H	0		0	0	
75. 01 07501 ASC (NON-DISTINCT PART)			1		-	12, 50			
76. 00 03950 CARDÍAC CATHERIZATION 0.000000 0 0 0 0 0 76. 00 76. 01 03951 OUTPATI ENT WOUND CARE CENTER 0.089833 0 21,086 0 0 76. 01 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 0 0 76. 01 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 77. 00 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 78. 00 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 78. 00 00 09000 CLINIC 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0. 000000		0		0	0	75. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER 0. 089833 0 21,086 0 0 76. 01 76. 97 07697 CARDIAC REHABILITATION 0. 000000 0 0 0 0 0 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0. 000000 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 0 0 0 0 0 0 78. 00 90. 00 07900 CLINIC 0. 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0					-	1, 007, 88		1	
76. 97 07697 CARDI AC REHABILITATION 0.000000 0 0 0 0 76. 97 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0.000000 0 0 0 0 0 77. 00 78. 00 07800 CAR T - CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 0.000000 0 0 0 0 0 90. 01 04950 SLEEP CLI NI C 0.148341 0 36,558 0 0 90. 01 90. 02 09001 COMP MED REV CLI NI C 2.291158 0 1,809 0 0 90. 02 90. 03 09002 ARNETT CANCER CARE CENTER 0.087737 0 283,727 0 0 90. 03 90. 04 09003 OUTPATI ENT INFUSI ON CENTER 0.091549 0 0 0 0 0 91. 00 09100 EMERGENCY 0.079681 0 3,571,618 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0.260907 0 656,411 0 0 92. 00 92. 01 09201 OBSERVATI ON BEDS (DI STI NCT PART) 1.034617 0 0 0 0 92. 01 93. 00 04951 OTHER OUTPATI ENT SERVI CES 0.000000 0 0 0 0 93. 00 200. 00 Subtotal (see instructions) Less PBP Cli nic Lab. Servi ces-Program 0 0 12,223,217 0 0 200. 00 201. 00 Only Charges			1	1	-		-	1	1
77. 00			l .		_	21, 08			
78. 00			l .		ŭ		-	1	
OUTPATI ENT SERVI CE COST CENTERS O			l .		-		-	1	
90. 00	78. 00		0.000000)	0		0 0	0	78. 00
90. 01	00.00		0.000000						00.00
90. 02					_				
90. 03								1	
90. 04 09003 0UTPATIENT INFUSION CENTER 0. 091549 0 0 0 0 90. 04 91. 00 09100 EMERGENCY 0. 079681 0 3,571,618 0 0 91. 00 92. 00 92. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 260907 0 656,411 0 0 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 1. 034617 0 0 0 0 92. 01 092			1		_				1
91. 00 09100 EMERGENCY 0. 079681 0 3,571,618 0 0 91. 00 92. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0. 260907 0 656,411 0 0 92. 00 92. 01 09201 0BSERVATION BEDS (DISTINCT PART) 1. 034617 0 0 0 0 0 92. 01 092			1		_	283, 72			
92. 00 09200 08SERVATION BEDS (NON-DISTINCT PART) 0. 260907 0 656, 411 0 0 92. 00 92. 01 09201 08SERVATION BEDS (DISTINCT PART) 1. 034617 0 0 0 0 92. 01 093. 00 04951 0THER OUTPATIENT SERVICES 0. 000000 0 0 0 0 93. 00 0201. 00 0 0 0 0 0 0 0 0 0			1		-	2 571 41	-	1	
92. 01 09201 08SERVATION BEDS (DISTINCT PART) 1. 034617 0 0 0 92. 01 093. 00 04951 0THER OUTPATIENT SERVICES 0. 000000 0 0 93. 00 0201. 00 0 0 0 0 0 0 0 0 0		I I			_				1
93. 00 04951 OTHER OUTPATIENT SERVICES 0.000000 0 0 0 93. 00 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 0 0 0 201. 00 201. 00 0 0 0 0 0 0 0 0 0					-	030, 41		1	
200.00 Subtotal (see instructions) 0 12,223,217 0 0 200.00 201.00 Less PBP Clinic Lab. Services-Program Only Charges 0 0 0 201.00			1		-		-		
201.00 Less PBP Clinic Lab. Services-Program 0 0 201.00 Only Charges			0.00000	1		12 222 21			
Only Charges					O	12,223,21			
202.00 Net Charges (line 200 - line 201) 0 12, 223, 217 0 0 202.00	201.00								
	202.00		1		0	12, 223, 21	7 O	0	202. 00

Provider CCN: 15-0173 Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Ti me Prepared: 5/39/2024 11:39 am

					5/29/2024 11:	
		Ti tl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subj ect To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	94, 807		1			50.00
51.00 05100 RECOVERY ROOM	14, 125	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	15, 539	0				52. 00
53. 00 05300 ANESTHESI OLOGY	3, 685	0				53.00
53. 01 05301 ASC ANESTHESI OLOGY	769	0				53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	86, 869	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI OI SOTOPE	4, 709	0				56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 783	0				59. 00
60. 00 06000 LABORATORY	147, 625	0				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 029					63.00
65. 00 06500 RESPIRATORY THERAPY	6, 052					65.00
66. 00 06600 PHYSI CAL THERAPY	4, 551					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	3, 858					67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 377					68.00
69. 00 06900 ELECTROCARDI OLOGY	13, 263					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	Ö				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	61, 910					71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	109, 388					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	483, 191					73. 00
73. 01 07301 RETAIL PHARMACY	100, 171	0				73. 01
74. 00 07400 RENAL DI ALYSI S	5, 046	l e	1			74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	3,040	0				75. 00
75. 01 07501 ASC (NON-DISTINCT PART)	64, 355		•			75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON	04, 555	0	•			76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER	1, 894		•			76. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	1,074	0				76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0	1			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY			1			78.00
OUTPATIENT SERVICE COST CENTERS						78.00
90. 00 09000 CLINI C	1 0	0				90.00
90. 01 04950 SLEEP CLINIC	5, 423		1			90. 01
90. 02 09001 COMP MED REV CLINIC	4, 145					90.01
90. 03 09001 COMP MED REV CLIMIC 90. 03 09002 ARNETT CANCER CARE CENTER	24, 893		•			90.02
	24, 093	0				90.03
	204 500	1	1			
91. 00 09100 EMERGENCY	284, 590		1			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	171, 262		1			92.00
92. 01 09201 0BSERVATI ON BEDS (DI STI NCT PART)	0	0	1			92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES	1 (04 (00)	0	1			93. 00
200.00 Subtotal (see instructions)	1, 624, 138	0	1			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	1 (24 120					202 00
202.00 Net Charges (line 200 - line 201)	1, 624, 138	0	Ί			202. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der	CCN: 15-0173	Period: From 01/01/2023	Worksheet D-1
				Date/Time Prepared: 5/29/2024 11:29 am
	Ti 1	tle XVIII	Hospi tal	PPS

		TI II 200111		5/29/2024 11:	29 am
	Cost Center Description	Title XVIII	Hospi tal	PPS	
	cost center bescription			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			42, 435	
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		ivata room dave	42, 435 0	1
3.00	do not complete this line.	ys). If you have only pr	i vate i ooni days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		37, 107	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period			1	
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roor	21 of the cost	0	7. 00	
7.00	reporting period	ii days) tiii ougii beceiibei	31 OF THE COST	0	7.00
8. 00	Total swing-bed NF type inpatient days (including private roor	m davs) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			- 1	
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	13, 169	9. 00
40.00	newborn days) (see instructions)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	0	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	Conly (including private	e room days)	0	12. 00
40.00	through December 31 of the cost reporting period				10.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	am (ana aan ng am ng aaa		0	1
16.00	Nursery days (title V or XIX only)	0	16. 00		
	SWING BED ADJUSTMENT		-		
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period		10.00		
19. 00	Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
20.00	reporting period	£t D 21 -£ tl		0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after becember 31 of the	ne cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		65, 000, 368	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
00.00	5 x line 17)	24 6 11			00.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)		3 1	· · · · · · · · · · · · · · · · · · ·	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		65, 000, 368	1
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	<u>(</u>		337 3337 333	1
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi - pri vate room charges (excluding swing-bed charges)	1: 20)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ 11 ne 28)		0. 000000 0. 00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	•
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line			0.00	1
36. 00					36. 00 37. 00
37. 00	i i i i i i i i i i i i i i i i i i i				
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			†
38.00	Adjusted general inpatient routine service cost per diem (see			1, 531. 76	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		20, 171, 747	
40.00	Medically necessary private room cost applicable to the Progra	*		0	
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)		20, 171, 747	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH ARNET	T HOSPITAL Provider Co	CN: 15-0173	In Lie	u of Form CMS- Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 11:	
	Cost Center Description	Total	Total	XVIII Average Per		PPS Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00 0	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	9, 684, 957	3, 789	2, 556. (07 850	2, 172, 660	43. 00 44. 00
45. 00 45. 01	BURN INTENSIVE CARE UNIT BURN INTENSIVE CARE UNIT	0	0			0	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	5, 414, 287	3, 091			0	46. 00
47.00	Cost Center Description	5, 414, 267	3, 091	1, 751. 0	0		47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1. 00 21, 243, 463	48. 00
48. 01 49. 00	Program inpatient cellular therapy acquisition total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	on cost (Workshe	et D-6, Part		column 1)	0 43, 587, 870	
50. 00	Pass through costs applicable to Program inpull!!	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	2, 997, 148	50. 00
51. 00	Pass through costs applicable to Program inpand IV)	,	services (fr	om Wkst. D, s	sum of Parts II	1, 169, 909	
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	ding capital rel	ated, non-phy	rsician anesth	netist, and	4, 167, 057 39, 420, 813	
54. 00	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02 56. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0. 00 0	1
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	line 53)	0	57. 00			
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	1
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, market basket)	updated by the	0.00	60. 00			
61. 00	Continuous improvement bonus payment (if lin- 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	0	61.00				
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruc	tions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reporti	na period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos					0	
	instructions)(title XVIII only)				, ,		
66. 00	Total Medicare swing-bed SNF inpatient routil CAH, see instructions		•			0	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)			•	orting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of				1		70.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		(lino 14 v li	no 25)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)	•			74.00
75. 00 76. 00	Capital -related cost allocated to inpatient 26, line 45) Per diem capital -related costs (line 75 ÷ line 15)		costs (from W	orksheet B, F	Part II, column		75. 00 76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovi der record	ls)			78. 00 79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		st limitation	ı(line 78 mir	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:)				83. 00 84. 00
85. 00 86. 00	Utilization review - physician compensation	(see instruction					85. 00 86. 00
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	ougii oo <i>j</i>				
87. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per					5, 328	87. 00

Heal th Financ	cial Systems	IU HEALTH ARNE	IU HEALTH ARNETT HOSPITAL In Lie			u of Form CMS-2	2552-10
COMPUTATION (OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 11:	
Title XVIII Hospital					PPS		
	1.00						
89.00 Observ	vation bed cost (line 87 x line 88) (se	e instructions)				8, 161, 217	89. 00
	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	
COMPUT	TATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capi ta	al -related cost	8, 952, 622	65, 000, 368	0. 13773	8, 161, 217	1, 124, 061	90.00
91.00 Nursir	ng Program cost	0	65, 000, 368	0.00000	0 8, 161, 217	0	91.00
92.00 Allied	d health cost	0	65, 000, 368	0. 00000	0 8, 161, 217	0	92.00
93. 00 All of	ther Medical Education	0	65, 000, 368	0.00000	0 8, 161, 217	0	93.00

Health Financial Systems	IU HEALTH ARNETT H	HOSPI TAL			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	F	Provi der	CCN:	15-0173	Peri od: From 01/01/2023	Worksheet D-1	
						Date/Time Pre 5/29/2024 11:	
		Ti	tle X	ΙX	Hospi tal	PPS	

Pre-			T' II VIV	11 11	5/29/2024 11:	29 am
NATE OF THE PROVIDER COMPONENTS		Cost Center Description	Title XIX	Hospi tal	PPS	
MPATIENT DAYS 1.00 Inpatient days (including private room days and saing-bed days, excluding newtorm) 42, 435 2.00 2		Cost Center Description			1. 00	
Inpatient days (Including private room days and swing-bed days, excluding newborn)						
Inpatient days (including private room days, excluding saing-bed and newborn days) 1 you have only private room days. 62, 35 2, 00	1 00				42.425	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 0 3.00						
do not complete this line.				ivate room days		1
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reporting period (if callendar year, enter 0 on this line) 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.0	4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		37, 107	4. 00
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28. 00 29. 00 29. 00 29. 00 30			(line 21 minus line 26)			1
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 Semi-private room charges (excluding swing-bed charges) 32.00 Semi-private room per diem charge (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Private room cost differential adjustment (line 3 x line 35) 35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65, 000, 368) 37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 1, 470, 490 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65,000, 368 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 A0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00			d and observation bed ch	arges)		1
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65,000, 368 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.0000000000000000000000000000000000						
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 37.00) Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Average per diem private room cost differential (line 3 x line 35) 0.00 34.00 36.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 36.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 36.00 Average per diem private room cost differential (line 4 x line 35) 0.00 35.00 36.00 Average per diem private room cost differential (line 5 x line 35) 0.00 36.00 36.00 Average per diem private room cost differential (line 6 x line 35) 0.00 36.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 36.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 36.00 37.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private room cost differential (line 3 x line 35) 0.00 Average per diem private			: line 28)			
Average per diem private room charge differential (line 32 minus line 33) (see instructions) 34. 00 35. 00 Average per diem private room cost differential (line 34 x line 31) 9. 00 36. 00 37. 00 Output Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65, 000, 368 and 65, 000, 3						1
35. 00 Average per diem private room cost differential (line 34 x line 31) 0.00 35. 00 36. 00 Private room cost differential adjustment (line 3 x line 35) 0 36. 00 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65, 000, 368 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 531. 76 38. 00 39. 00 Program general inpatient routine service cost (line 9 x line 38) 1, 470, 490 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00					0.00	
36. 00 37. 00 Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 65, 000, 368 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 531. 76 39. 00 Program general inpatient routine service cost (line 9 x line 38) 1, 470, 490 1, 470, 490 1, 470, 490 1, 470, 490 1, 470, 490 1, 470, 00				tions)		•
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 58.00 1,531.76 38.00 1,470,490 39.00						•
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,531.76 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,470,490 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,531.76 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,470,490 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)				
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,531.76 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,470,490 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 1,470,490 39.00						1
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,470,490 39.00 0 40.00	20.00				1 501 77	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	•			1
			•			1
			•		1, 470, 490	1

	ATION OF INPATIENT OPERATING COST		Provi der CO	CN: 15-0173	Peri od: From 01/01/2023	Worksheet D-1		
					To 12/31/2023	5/29/2024 11:		
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	PPS Program Cost		
	·	Inpatient Cost		Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)		
2. 00	NURSERY (title V & XIX only)	1. 00 1, 968, 516	2. 00	3. 00 806. 1	4. 00 11 1, 480	5. 00 1, 193, 043	42.0	
2.00	Intensive Care Type Inpatient Hospital Units	1, 700, 510	2, 442	000.	1, 400	1, 175, 045	42.0	
3.00	INTENSIVE CARE UNIT	9, 684, 957	3, 789	2, 556. 0	102	260, 719	1	
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	o	0	0. 0	00 0	0	44. C	
5. 01	BURN INTENSIVE CARE UNIT	O	0	0.0		0	45.0	
6. 00 7. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	5, 414, 287	3, 091	1, 751. <i>6</i>	53 252	441, 411	46. 0 47. 0	
7.00	Cost Center Description	5, 414, 267	3, 091	1, 751. 0	202	441, 411	47.0	
						1.00		
8. 00 8. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti	·	. ,	III line 10	column 1)	928, 629 0	48. (
9. 00	Total Program inpatient costs (sum of lines				001 dilli1 1)	4, 294, 292		
0 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.			William D. T.		422 411	1 -0 /	
0. 00	Pass through costs appricable to Program The	atrent routine	services (Irom	WKSt. D, Sull	i or Parts i and	432, 411	50.0	
1. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	51, 819	51. (
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				484, 230	52.0	
3. 00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and	3, 810, 062		
	medical education costs (line 49 minus line	52)						
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. (
5. 00	Target amount per discharge					0. 00	1	
5. 01 5. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uso only)				0. 00 0. 00	55. (55. (
6. 00	Target amount (line 54 x sum of lines 55, 55					0.00	1	
7. 00	Difference between adjusted inpatient operat	line 53)	0					
8. 00 9. 00	Bonus payment (see instructions)	0 0. 00						
7. 00	O Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)							
0. 00	Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the market basket)							
1. 00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						61. (
2. 00	enter zero. (see instructions) Relief payment (see instructions)					0	62.0	
3. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0		
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. (
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	nst renortino	neriod (See	0	65.0	
	instructions)(title XVIII only)				, , , ,			
6. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66.0	
7. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	eporting period	0	67.0	
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68.0	
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69. 0	
0. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil						70. (
1. 00	Adjusted general inpatient routine service c						71. (
2. 00	Program routine service cost (line 9 x line	•	(1: 14 1:	25)			72.	
3. 00 4. 00	Medically necessary private room cost application. Total Program general inpatient routine serv		•	ne 35)			73.0	
5. 00	Capital-related cost allocated to inpatient	•		orksheet B, F	Part II, column		75. 0	
6. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. (
7. 00	Program capital -related costs (line 9 x line						77. 0	
8. 00	Inpatient routine service cost (line 74 minu			`			78.	
9. 00 0. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.		79. (80. (
1. 00	Inpatient routine service cost per diem limi	tati on					81. (
2. 00	Inpatient routine service cost limitation (I		•				82.	
3. 00 4. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		5)				83.0	
5. 00	Utilization review - physician compensation	(see instruction					85. (
6. 00	Total Program inpatient operating costs (sum	of lines 83 th	rough 85)				86. (
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THEOLICH COST					1	

Health Financial Systems IU HEALTH ARNETT HOSPITAL In Lie						2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od: From 01/01/2023	Worksheet D-1	
					Date/Time Prep 5/29/2024 11:3	pared: 29 am_
Ti tle XIX Hospi tal						
Cost Center Description						
	1. 00					
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				8, 161, 217	89. 00
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 C	OST					
90.00 Capital -related cost	8, 952, 622	65, 000, 368	0. 13773	2 8, 161, 217	1, 124, 061	90.00
91.00 Nursing Program cost	0	65, 000, 368	0.00000	0 8, 161, 217	0	91.00
92.00 Allied health cost	0	65, 000, 368	0.00000	0 8, 161, 217	0	92.00
93.00 All other Medical Education	o	65, 000, 368	0. 00000	0 8, 161, 217	0	93. 00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	IU HEALTH ARNETT		CCN: 15-0173	In Lie Period:	u of Form CMS-2 Worksheet D-3	
INPATTENT ANCIELARY SERVICE COST APPORTIONWENT		Provider (From 01/01/2023	WOLKSHEET D-3	
				To 12/31/2023		
		Ti +I	e XVIII	Hospi tal	5/29/2024 11: PPS	29 alli
Cost Center Description		11 (1	Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
INDATIONT DOUTING CODY OF COCT CONTEDC			1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				47 400 125		20.00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT				47, 698, 125 7, 984, 219		30. 00 31. 00
33. 00 03300 BURN INTENSIVE CARE UNIT				7, 704, 217		33.00
33. 01 03301 BURN INTENSIVE CARE UNIT				0		33. 01
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				0		35. 00
43. 00 04300 NURSERY						43. 00
ANCILLARY SERVICE COST CENTERS			<u>'</u>			1
50.00 05000 OPERATING ROOM			0. 12269	3 20, 961, 445	2, 571, 823	50. 00
51.00 05100 RECOVERY ROOM			0. 10919	1 1, 583, 411	172, 894	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 23916	3 126, 157	30, 172	52. 00
53. 00 05300 ANESTHESI OLOGY			0. 08589	8 1, 272, 310	109, 289	
53. 01 05301 ASC ANESTHESI OLOGY			0. 01505		41	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 09282			
55. 00 05500 RADI OLOGY-THERAPEUTI C			0.00000		0	55. 00
56. 00 05600 RADI 01 SOTOPE			0. 06610		61, 542	56.00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 07267		714, 199	59.00
60. 00 06000 LABORATORY			0. 17166		1, 909, 957	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY			0. 21941 0. 21855		325, 415 960, 966	
66. 00 06600 PHYSI CAL THERAPY			0. 21633			
67. 00 06700 OCCUPATI ONAL THERAPY			0. 38330			1
68. 00 06800 SPEECH PATHOLOGY			0. 30075			1
69. 00 06900 ELECTROCARDI OLOGY			0. 06964		605, 784	
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 17574		42, 361	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 23122		1, 847, 203	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 13749		3, 003, 829	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 21340	8 19, 354, 922	4, 130, 495	73. 00
73. 01 07301 RETAI L PHARMACY			1. 34917	4 0	0	73. 01
74.00 07400 RENAL DIALYSIS			0. 40343	1 984, 127	397, 027	
75.00 07500 ASC (NON-DISTINCT PART)			0.00000		0	75. 00
75. 01 07501 ASC (NON-DISTINCT PART)			0. 06385		5, 718	
76. 00 03950 CARDI AC CATHERI ZATI ON			0.00000		0	76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER			0. 08983		5, 092	
76. 97 07697 CARDI AC REHABI LI TATI ON			0.00000		0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY			0.00000		0 0	77. 00 78. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS			0.00000	0 0	U	76.00
90. 00 09000 CLINIC			0.00000	0	0	90.00
90. 01 04950 SLEEP CLINIC			0. 14834			
90. 02 09001 COMP MED REV CLINIC			2. 29115		_	
90. 03 09002 ARNETT CANCER CARE CENTER			0. 08773		9, 200	
90. 04 09003 OUTPATIENT INFUSION CENTER			0. 09154		441	
91. 00 09100 EMERGENCY			0. 07968			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 26090	7 287, 641	75, 048	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)			1. 03461		0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES			0.00000		0	93. 00
200.00 Total (sum of lines 50 through 94 and				151, 248, 754	21, 243, 463	
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			1	151, 248, 754	l	202. 00

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 15-0173	Peri od:	Worksheet D-3	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/29/2024 11:	29 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				J	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				2, 198, 678		30.00
31. 00 03100 NTENSI VE CARE UNI T				498, 541		31. 00
				470, 341		1
l +				0		33. 00
33. 01 03301 BURN INTENSIVE CARE UNIT				1 ((4 100		33. 01
35. 00 02060 NEONATAL INTENSIVE CARE UNIT				1, 664, 192		35. 00
43. 00 04300 NURSERY				303, 620		43. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM			0. 12269	374, 740	45, 978	50. 00
51.00 05100 RECOVERY ROOM			0. 10919	28, 560	3, 118	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0. 23916	368, 804	88, 204	52.00
53. 00 05300 ANESTHESI OLOGY			0. 08589	27, 903	2, 397	53.00
53. 01 05301 ASC ANESTHESI OLOGY			0. 01505		0	53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 09282		69, 971	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C			0. 00000		0,,,,,	55. 00
56. 00 05600 RADI OI SOTOPE			0. 06610		688	56. 00
			l .			59.00
			0.07267		8, 524	•
60. 00 06000 LABORATORY			0. 17166		115, 412	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 21941		10, 036	63. 00
65. 00 06500 RESPIRATORY THERAPY			0. 21855		108, 071	
66. 00 06600 PHYSI CAL THERAPY			0. 31491	9 48, 604	15, 306	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 38330	35, 459	13, 592	67.00
68. 00 06800 SPEECH PATHOLOGY			0. 30075	37, 444	11, 262	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0. 06964	264, 983	18, 455	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 17574		1, 358	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 23122		71, 279	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS			0. 13749		10, 813	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 21340		271, 980	73. 00
73. 01 07301 RETAIL PHARMACY			1. 34917		271, 700	73. 00
			1			1
			0.40343		5, 388	74.00
75. 00 07500 ASC (NON-DISTINCT PART)			0.00000		0	75. 00
75. 01 07501 ASC (NON-DI STI NCT PART)			0.06385		0	75. 01
76. 00 03950 CARDI AC CATHERI ZATI ON			0.00000		0	76. 00
76. 01 03951 OUTPATIENT WOUND CARE CENTER			0. 08983	33 0	0	76. 01
76. 97 07697 CARDIAC REHABILITATION			0.00000	00	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION			0.00000	00	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY			0.00000	00	0	78. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C			0.00000	0 0	0	90.00
90. 01 04950 SLEEP CLINIC			0. 14834		0	90. 01
90. 02 09001 COMP MED REV CLI NI C			2. 29115		0	90. 02
90. 03 09002 ARNETT CANCER CARE CENTER			l .			90. 03
			0. 08773		_	
90. 04 09003 OUTPATIENT INFUSION CENTER			0. 09154		0 E1 7E7	90.04
91. 00 09100 EMERGENCY			0. 07968		51, 757	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 26090		5, 040	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)			1. 03461		0	92. 01
93. 00 04951 OTHER OUTPATIENT SERVICES			0. 00000	0	0	93. 00
200.00 Total (sum of lines 50 through 94 and 9	96 through 98)			5, 631, 769	928, 629	200. 00
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		·		5, 631, 769		202. 00
				,		

	Title XVIII Hospital	PPS	
	DADT A LINDATIENT HASDITAL SEDVICES LINDED LDDS	1.00	
1.00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS DRG Amounts Other than Outlier Payments	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see	24, 550, 054	1. 01
1. 02	Instructions) DRG amounts other than outlier payments for discharges occurring on or after October 1 (see	8, 162, 760	1. 02
1. 03	<pre>instructions) DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)</pre>	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after loctober 1 (see instructions)	0	1. 04
2.00	Outlier payments for discharges. (see instructions)		2. 00
2.01	Outlier reconciliation amount	0	2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0	2. 02
2. 03 2. 04	Outlier payments for discharges occurring prior to October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see instructions)	568, 487 56, 692	2. 03 2. 04
3.00	Managed Care Simulated Payments	25, 018, 799	1
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	179. 78	1
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on	0.00	5. 00
5. 01	or before 12/31/1996. (see instructions)	0.00	5. 01
6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6. 00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §127 of	0.00	6. 26
7. 00	the CAA 2021 (see instructions) MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7. 01
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for rural track programs with a rural track for Medicare GME affiliated programs in accordance with 413.75(b)	0.00	7. 02
8. 00	and 87 FR 49075 (August 10, 2022) (see instructions) Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for	0.00	8. 00
	affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (see instructions)	0.00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plus or minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	0.00	9. 00
10. 00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	1
11.00	FTE count for residents in dental and podiatric programs.		11.00
12. 00 13. 00	Current year allowable FTE (see instructions)	0. 00 0. 00	1
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997,	0.00	•
15.00	otherwise enter zero.	0.00	15.00
	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)		15. 00 16. 00
	Adjustment for residents displaced by program or hospital closure		17. 00
18. 00	Adjusted rolling average FTE count	14. 59	ı
19. 00	Current year resident to bed ratio (line 18 divided by line 4).	0. 081155	1
	Prior year resident to bed ratio (see instructions)	0. 082820	1
21.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)	0. 081155 1, 417, 904	1
22. 00	IME payment adjustment - Managed Care (see instructions)	1, 417, 904	1
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 $(f)(1)(iv)(C)$.	0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)	0.00	1
25. 00	If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see instructions)	0.00	
26. 00	Resident to bed ratio (divide line 25 by line 4)	0.000000	1
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)	0.000000	27. 00 28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)	Ö	28. 01
29. 00	Total IME payment (sum of lines 22 and 28)	1, 417, 904	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	1, 084, 415	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3. 54	1
31. 00	Percentage of Medicaid patient days (see instructions)	24. 41	1
32. 00 33. 00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions)	27. 95 12. 27	1
	Disproportionate share adjustment (see instructions)	1, 003, 466	1
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	Financial Systems IU HEALTH ARNETT ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0173	Peri od: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet E Part A Date/Time Pre	pared:
-		Title XVIII	Hospi tal	5/29/2024 11: PPS	29 am_
		II tie xviii	Prior to 10/1		
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
35. 00 35. 01 35. 02	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital UCP, including supplemental UCP (see instructions)		0. 000298256 2, 050, 333		35. 01 35. 02
35. 03 36. 00	Pro rata share of the hospital UCP, including supplemental UCI Total UCP adjustment (sum of columns 1 and 2 on line 35.03)	(See Thistructions)	1, 533, 536 1, 973, 413		35. 03 36. 00
30.00		scharges (lines 40 throug			30.00
40. 00 41. 00 41. 01 42. 00	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46) 40.00 Total Medicare discharges (see instructions) 10 Total ESRD Medicare discharges (see instructions) 11 Total ESRD Medicare covered and paid discharges (see instructions) 12 Total ESRD Medicare covered and paid discharges (see instructions)				40. 00 41. 00 41. 01 42. 00
43. 00	Total Medicare ESRD inpatient days (see instructions)	ry ron day do tilioner	0.00		43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided ldays)		0. 000000		44. 00
45. 00	Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
46. 00 47. 00	Total additional payment (line 45 times line 44 times line 41. Subtotal (see instructions)	. 01)	37, 732, 776		46. 00 47. 00
48. 00	Hospital specific payments (to be completed by SCH and MDH, si only. (see instructions)	mall rural hospitals	37, 732, 776		48. 00
			•	Amount	
				1. 00	
49. 00	Total payment for inpatient operating costs (see instructions)			38, 817, 191	1
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and			2, 693, 584	
51.00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		591, 703	•
53.00	Nursing and Allied Health Managed Care payment			41, 254	53.00
54. 00 54. 01	Special add-on payments for new technologies			64, 527 0	54. 00 54. 01
55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	0)		0	55. 00
55. 00	Cellular therapy acquisition cost (see instructions)	7)		0	55. 00
56. 00	Cost of physicians' services in a teaching hospital (see intri	uctions)		0	56.00
57. 00	Routine service other pass through costs (from Wkst. D, Pt. 1)		rough 35)	0	57.00
58. 00	Ancillary service other pass through costs from Wkst. D, Pt.		n ough oo).	30, 716	•
59. 00	Total (sum of amounts on lines 49 through 58)	,		42, 238, 975	•
60.00	Primary payer payments			24, 477	ı
61.00	Total amount payable for program beneficiaries (line 59 minus	line 60)		42, 214, 498	61. 00
62.00	Deductibles billed to program beneficiaries			3, 661, 036	62.00
63.00	Coinsurance billed to program beneficiaries			112, 000	1
64. 00	Allowable bad debts (see instructions)			143, 178	1
65. 00	Adjusted reimbursable bad debts (see instructions)			93, 066	
66.00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		37, 056	1
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	!: - +- MC DDC- (38, 534, 528	1
68. 00	Credits received from manufacturers for replaced devices for a			0	ł
69. 00 70. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(FOI 3CH See THSTI UCTIONS	5)	0	ı
70. 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see i	nstructions)	0	70. 50
70. 75	N95 respirator payment adjustment amount (see instructions)	ration, adjustment (see i	nstructions)	0	70. 75
70. 87	Demonstration payment adjustment amount before sequestration			0	70. 87
70. 88	SCH or MDH volume decrease adjustment (contractor use only)			0	70. 88
70. 89	Pioneer ACO demonstration payment adjustment amount (see insti	ructions)			70. 89
70. 90	HSP bonus payment HVBP adjustment amount (see instructions)	•		0	70. 90
70. 91	HSP bonus payment HRR adjustment amount (see instructions)			0	70. 91
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 92
70. 93	HVBP payment adjustment amount (see instructions)			-9, 608	1
70. 94	HRR adjustment amount (see instructions)			-90, 156	•
70. 95	Recovery of accelerated depreciation			0	70. 95

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CO	CN: 15-0173	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/29/2024 11:	
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70 96 Low volume adjustment for federal fiscal	vear (vvvv) (Enter in	n column O		0	0	70 96

			1	o 12/31/2023	Date/Time Pre 5/29/2024 11:	
-		Title	XVIII	Hospi tal	PPS	
			FFY (уууу)	Amount	
)	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	n column 0	()	0	70. 96
70.07	the corresponding federal year for the period prior to 10/1)			_	0	70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in		()	0	70. 97
70. 98	the corresponding federal year for the period ending on or aft Low Volume Payment-3	ter 10/1)	,		0	70. 98
70. 98	HAC adjustment amount (see instructions)		`	1	0	70. 98
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 6	59 & 70)			38, 434, 764	71.00
71. 01	Sequestration adjustment (see instructions)	,, a ,0,			768, 695	1
71. 02	Demonstration payment adjustment amount after sequestration				0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				37, 387, 534	72. 00
72. 01	Interim payments-PARHM					72. 01
73.00	Tentative settlement (for contractor use only)				0	73. 00
73. 01	Tentative settlement-PARHM (for contractor use only)					73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02	2, 72, and			278, 535	74. 00
	[73]					
74. 01	Balance due provider/program-PARHM (see instructions)				4 040 470	74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordar	nce with			1, 242, 470	75. 00
	CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of	nf 2 03			0	90.00
70.00	plus 2.04 (see instructions)	2.00			· ·	70.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instruct				0	93. 00
94.00	The rate used to calculate the time value of money (see instru	uctions)			0.00	94. 00
95. 00	Time value of money for operating expenses (see instructions)				0	95. 00
96. 00	Time value of money for capital related expenses (see instruct	tions)			0	96. 00
				Prior to 10/1	On/After 10/1	
	luon n			1.00	2. 00	
100.00	HSP Bonus Payment Amount			1. 00	2. 00	100.00
100.00	HSP bonus amount (see instructions)				2. 00	100. 00
	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			1.00	2.00	
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	2)		1. 00 0 0. 0000000000	2. 00 0 0. 0000000000	101. 00
101.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions	5)		1.00	2. 00 0 0. 0000000000	
101. 00 102. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	5)		1.00 0 0.0000000000 0	2. 00 0 0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions			1. 00 0 0. 0000000000	2.00 0 0.000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions))	stment	1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions)) ration) Adjus		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.) ration) Adjus		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement) ration) Adjus riod under th		1.00 0 0.0000000000 0	2.00 0 0.000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line) ration) Adjus riod under th		1.00 0 0.0000000000 0	2.00 0.0000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions)) ration) Adjus riod under th		1.00 0 0.0000000000 0	2.00 0.0000000000 0.0000000000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	ration) Adjus riod under tl	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	ration) Adjus riod under tl	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adjus riod under tl	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204)	ration) Adjus riod under tl	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount	ration) Adjus riod under tl	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)	ration) Adjus riod under th e 49) first year (he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	ration) Adjustion and and and and and and and and and an	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HVBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	ration) Adjustion and and and and and and and and and an	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instr Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Adjustment to Medicare IPPS payments (see instructions) Reserved for future use	ration) Adjustion and and and and and and and and and an	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions)	ration) Adjustion and and and and and and and and and an	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBP adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement	first year of	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	first year of	he 21st	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.ration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	ration) Adjustion and adjustic first year of the	of the current	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00 212. 00 213. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 210. 00 211. 00 211. 00 212. 00 213. 00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRBR adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstr Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 205)	ration) Adjustion and adjustic first year of the	of the current	0.000000000000000000000000000000000000	2.00 0.0000000000 0.0000 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00 211. 00

| Period: | Worksheet E | From 01/01/2023 | Part A Exhibit 4 | Date/Time Prepared: | 5/29/2024 | 11: 29 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0173

						12/31/2023	5/29/2024 11: 2	
					XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Period	Total (Col 2	
		l i ne 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier		0	0		0	0.00	1. 00
	payments							
1. 01	DRG amounts other than outlier payments for discharges	1. 01	24, 550, 054	0	24, 550, 054		24, 550, 054	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier	1. 02	8, 162, 760	0		8, 162, 760	8, 162, 760	1. 02
	payments for discharges occurring on or after October							
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		O	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to	2. 03	568, 487	0	568, 487		568, 487	2. 02
2. 03	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2. 04	56, 692	0		56, 692	56, 692	2. 03
3. 00	instructions) Operating outlier	2. 01	0	0	0	0	0	3. 00
4. 00	reconciliation Managed care simulated	3. 00	25, 018, 799	0	18, 541, 706	6, 477, 093	25, 018, 799	4. 00
	payments Indirect Medical Education Adj	ustment						
5.00	Amount from Worksheet E, Part	21.00	0. 081155	0. 081155	0. 081155	0. 081155		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	1, 417, 904	0		353, 807	1, 417, 904	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	1, 084, 415	0	, ,	280, 743	1, 084, 415	
0.01	managed care (see instructions)					2007 7 10	., 551, 115	0.0.
	Indirect Medical Education Adj							
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see	28. 01	0	0	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	1, 417, 904	0	1, 064, 097	353, 807	1, 417, 904	9. 00
9. 01	Total IME payment for managed	29. 01	1, 084, 415	0	803, 672	280, 743	1, 084, 415	9. 01
	care (sum of lines 6.01 and 8.01)							
10.00	Disproportionate Share Adjustm		0 1007	0 1227	0 1227	0 1007		10.00
10. 00	Allowable disproportionate share percentage (see instructions)	33.00	0. 1227	0. 1227	0. 1227	0. 1227		10. 00
11. 00	Disproportionate share adjustment (see instructions)	34.00	1, 003, 466	0	753, 073	250, 393	1, 003, 466	11. 00
11. 01	Uncompensated care payments Additional payment for high pe	36.00	1, 973, 413	0	1, 533, 536	439, 877	1, 973, 413	11. 01
12. 00	Total ESRD additional payment	46.00		ui scharges 0	0	0	Ω	12. 00
12.00	(see instructions)	40.00		U				12.00
13.00	Subtotal (see instructions)	47. 00	37, 732, 776	0	28, 469, 247	9, 263, 529	37, 732, 776	13.00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48.00	0	0	0	0	0	14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	38, 817, 191	0	29, 272, 919	9, 544, 272	38, 817, 191	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	2, 693, 584	0	88, 128	2, 605, 456	2, 693, 584	16. 00

						To 12/31/2023	Date/Time Pre 5/29/2024 11:	pared:
				Title	xVIII	Hospi tal	972972024 TT. PPS	29 alli
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54.00	64, 527	0	64, 52	7 0	64, 527	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0		0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)		О	0		0	0	18. 00
19. 00	1			0	29, 425, 57	4 12, 149, 728	41, 575, 302	19 00
		W/S L, line	(Amounts from L)	-	21, 120, 31	12, 11, 12	, ,	
		0	1.00	2. 00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	2, 475, 568	0		0 2, 475, 568		20. 00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0	-	0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	96, 996	0	88, 12	8, 868	96, 996	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0341	0. 0341	0. 034	0. 0341		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	84, 417	0		0 84, 417	84, 417	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0582	0. 0582	0.000	0. 0582		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11.00	36, 603	0		36, 603	36, 603	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	2, 693, 584	0	88, 12	2, 605, 456	2, 693, 584	26. 00
		W/S E, Part A						
		line	Part A)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			0.00000	0. 000000	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lieu	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION ((HAC) REDUCTION CALCULATION EXHIBIT 5	Provider CCN: 15-0173	From 01/01/2023	Worksheet E Part A Exhibit 5 Date/Time Prepared

				Ť	0 12/31/2023	Date/Time Pre 5/29/2024 11:	pared:
			Title	XVIII	Hospi tal	PPS	29 alli
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt.	Period to		Total (cols. 2 and 3)	
		74, 11110	A)	10701	41101 10701	una o)	
		0	1. 00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	24, 550, 054	24, 550, 054		24, 550, 054	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	8, 162, 760		8, 162, 760	8, 162, 760	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2.00					2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	568, 487	568, 487		568, 487	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	56, 692		56, 692	56, 692	2. 03
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0 25, 018, 799	0 18, 541, 706	0 6, 477, 093	0 25, 018, 799	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 081155	0. 081155	0. 081155		5. 00
4 00	(see instructions)	22.00	1 417 004	1 0/4 007	252 007	1 417 004	4 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	1, 417, 904 1, 084, 415	1, 064, 097 803, 672		1, 417, 904 1, 084, 415	6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000		7. 00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0	0	0	0	8. 00 8. 01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 00 29. 01	1, 417, 904 1, 084, 415	1, 064, 097 803, 672		1, 417, 904 1, 084, 415	9. 00 9. 01
	Disproportionate Share Adjustment						
10. 00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 1227	0. 1227	0. 1227		10.00
11. 00	Disproportionate share adjustment (see instructions)	34.00	1, 003, 466	753, 073	250, 393	1, 003, 466	11. 00
11. 01	Uncompensated care payments	36. 00	1, 973, 413	1, 533, 536	439, 877	1, 973, 413	11. 01
12.00	Additional payment for high percentage of ESF		di scharges	_			12.00
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	U	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	47. 00 48. 00	37, 732, 776 0	28, 469, 247 0	9, 263, 529 0	37, 732, 776 0	13. 00 14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	38, 817, 191	29, 272, 919	9, 544, 272	38, 817, 191	15. 00
16. 00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50. 00	2, 693, 584	88, 128	2, 605, 456	2, 693, 584	16. 00
17. 00 17. 01	Special add-on payments for new technologies Net organ acquisition cost	54. 00	64, 527	64, 527	0	64, 527	17. 00 17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	18. 00
19. 00				29, 425, 574	12, 149, 728	41, 575, 302	19. 00

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-2552-10
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5		From 01/01/2023	Worksheet E Part A Exhibit 5

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	IION EXHIBIT 5	Provider CC		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 11:	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	2, 475, 568		0 2, 475, 568	2, 475, 568	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00 Capital DRG outlier payments	2.00	96, 996	88, 12	8, 868	96, 996	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0341	0. 034	0. 0341		22. 00
23.00 Indirect medical education adjustment (see instructions)	6. 00	84, 417		0 84, 417	84, 417	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10. 00	0. 0582	0.000	0. 0582		24. 00
25.00 Di sproporti onate share adjustment (see i nstructi ons)	11. 00	36, 603		0 36, 603	36, 603	25. 00
26.00 Total prospective capital payments (see instructions)	12. 00	2, 693, 584	88, 12	2, 605, 456	2, 693, 584	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
	0	1.00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28.00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see instructions)	70. 93	-9, 608		0 -9, 608	-9, 608	30.00
30.01 HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00 HRR adjustment (see instructions)	70. 94	-90, 156	-71, 38	2 -18, 774	-90, 156	31.00
31.01 HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	1
					(Amt. to Wkst. E, Pt. A)	
	0	1. 00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	IU HEALTH ARNETT HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN		Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/29/2024 11: 29 am
	T: +1 - \	VA /I I I	11! 4-1	DDC

		Title XVIII	Hospi tal	5/29/2024 11: PPS	29 am
			·	1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			4, 835	1
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS or REH payments	i ons)		30, 776, 421 31, 565, 706	1
4. 00	Outlier payment (see instructions)			233, 065	
4. 01	Outlier reconciliation amount (see instructions)			0	1
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	1
6.00	Line 2 times line 5			0	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	*		02.011	
9. 00	Ancillary service other pass through costs including REH direc Wkst. D, Pt. IV, col. 13, line 200	t graduate medical educ	ation costs from	92, 811	9.00
10. 00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)				11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			.,, 222	1
	Reasonable charges				1
12.00	Ancillary service charges			22, 657	1
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			22, 657	14. 00
15 00	Customary charges	sumant for complete on	a abarras basis	0	15 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for p Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e		i a chargebasis	U	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	17.00
18.00	Total customary charges (see instructions)			22, 657	18. 00
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	17, 822	19. 00
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
21. 00	instructions) Lesser of cost or charges (see instructions)			4, 835	21. 00
	Interns and residents (see instructions)			4, 633	1
23. 00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			31, 891, 582	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				Ī
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions			0	
26. 00	Deductibles and Coinsurance amounts relating to amount on line			5, 399, 754	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	lus the sum of lines 22	and 23] (see	26, 496, 663	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		419, 287	28. 00
	REH facility payment amount (see instructions)	ne 50)		417, 207	28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			26, 915, 950	30.00
31.00	Primary payer payments			4, 647	31.00
32. 00	Subtotal (line 30 minus line 31)			26, 911, 303	32.00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		0	1 22 00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 365, 816	
35. 00	Adjusted reimbursable bad debts (see instructions)			237, 780	1
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		230, 404	
	Subtotal (see instructions)			27, 149, 083	
38.00	MSP-LCC reconciliation amount from PS&R			108	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
	Pioneer ACO demonstration payment adjustment (see instructions)			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	1
39. 97	Demonstration payment adjustment amount before sequestration	od dovi oce (coe i peterre	tions)	0	
39. 98 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	eu uevices (see instruc	LI UIIS)	0	
	Subtotal (see instructions)			27, 148, 975	1
40. 01	Sequestration adjustment (see instructions)			542, 980	1
	Demonstration payment adjustment amount after sequestration			0	1
40.03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			26, 588, 414	
	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	
	Tentative settlement-PARHM (for contractor use only) Ralance due provider/program (see instructions)			17 E01	42.01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			17, 581	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2	chapter 1	72, 465	1
. 1. 00	§115. 2	Smo r ab. 10 Z, 1	ap . 0. 1,	, 2, 400	55
	TO BE COMPLETED BY CONTRACTOR]
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	1
73. UU	Time Value of Money (see instructions)			0	93.00

Health Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0173	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023		pared:
				5/29/2024 11:	29 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems IU FANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0173

					5/29/2024 11:2	29 am
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		37, 387, 53	4	26, 588, 414	1. 00
2.00	Interim payments payable on individual bills, either			o	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider			_		
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3. 04				0	0	3. 04
3. 05				0	0	3. 05
	Provi der to Program			_		
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3.51				0	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3. 53
3. 54 3. 99	Cultural (Clines 2 01 2 40 minus			0	0	3. 54 3. 99
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		'	U	ا	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		37, 387, 53	4	26, 588, 414	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		37, 307, 33		20, 300, 414	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					,
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		270 52	_	17, 581	6. 01
6. 01	SETTLEMENT TO PROGRAM		278, 53	0	17,581	6. 01
6. 02 7. 00			37, 666, 06	-	26, 605, 995	7. 00
7.00	Total Medicare program liability (see instructions)		37,000,00	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· · · · · · · · · · · · · · · · · · ·			1	. '	

Heal th	Financial Systems	IU HEALTH ARNETT	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-0173	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-1 Part II Date/Time Pre 5/29/2024 11:	pared:
			Title XVIII	Hospi tal	PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	N AND CALCULATION				
1.00	Total hospital discharges as defined in AARA	§4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days (see instructions)					2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col	. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)					4. 00
5.00	Total hospital charges from Wkst C, Pt. I, c	ol. 8 line 200				5. 00
6. 00	Total hospital charity care charges from Wks	t. S-10, col. 3 li	ne 20			6. 00
7. 00	CAH only - The reasonable cost incurred for line 168	the purchase of ce	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (se	e instructions)				8. 00
9. 00	Sequestration adjustment amount (see instruc	tions)				9. 00
10. 00	Calculation of the HIT incentive payment aft	er sequestration ((see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &		,			
30. 00	Initial/interim HIT payment adjustment (see	instructions)				30.00
	Other Adjustment (specify)					31. 00
	Dalance due provider (line 0 (en line 10) mi	nua lina 20 and li	no 21) (coo i notrusti on	\		22 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

30. 00 31. 00 32. 00

	Financial Systems IU HEALTH ARNETT				u of Form CMS-2	2552-10
	GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT L EDUCATION COSTS	Provi der CC	N: 15-0173	Period: From 01/01/2023 To 12/31/2023	Worksheet E-4 Date/Time Prep 5/29/2024 11:2	
		Title	XVIII	Hospi tal	PPS	29 alli
	· · · · · · · · · · · · · · · · · · ·				1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1. 00	Unweighted resident FTE count for allopathic and osteopathic ending on or before December 31, 1996.	programs for	cost reporti	ng periods	0.00	1. 00
1.01	FTE cap adjustment under §131 of the CAA 2021 (see instructio			\	0.00	1. 01
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CF Rural track program FTE cap limitation adjustment after the c the CAA 2021 (see instructions)				0. 00 0. 00	2. 00 2. 26
3.00	Amount of reduction to Direct GME cap under section 422 of MM	Α			0.00	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance instructions for cost reporting periods straddling 7/1/2011)	with 42 CFR	§413.79 (m).	(see	0.00	3. 01
3. 02	Adjustment (increase or decrease) to the hospital's rural traprograms with a rural track Medicare GME affiliation agreemen 49075 (August 10, 2022) (see instructions)				0. 00	3. 02
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and		orograms due	to a Medicare	0. 00	4. 00
4. 01	GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f) ACA Section 5503 increase to the Direct GME FTE Cap (see inst straddling 7/1/2011)		cost reporti	ng periods	0. 00	4. 01
4. 02	ACA Section 5506 number of additional direct GME FTE cap slot periods straddling 7/1/2011)	s (see instr	ructions for	cost reporting	0. 00	4. 02
4. 21	The amount of increase if the hospital was awarded FTE cap slinstructions)	ots under §12	26 of the CAA	A 2021 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus lin 3.01, plus or minus line 3.02, plus or minus line 4, plus lin			nus lines 3 and	0. 00	5. 00
6. 00	Unweighted resident FTE count for allopathic and osteopathic records (see instructions)	programs for	the current	year from your	0. 00	6. 00
7. 00	Enter the lesser of line 5 or line 6				0.00	7. 00
		-	Primary Care	0ther 2.00	<u>Total</u> 3. 00	
8. 00	Weighted FTE count for physicians in an allopathic and osteop	athi c	0. (0.00	8. 00
9. 00	program for the current year. If line 6 is less than 5 enter the amount from line 8, otherw multiply line 8 times the result of line 5 divided by the amo	unt on line	0.0	0.00	0. 00	9. 00
10. 00	6. For cost reporting periods beginning on or after October 1 if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the curr			0.00		10. 00
10. 01	Unweighted dental and podiatric resident FTE count for the cu	-		0.00		10. 01
11. 00 12. 00	Total weighted FTE count Total weighted resident FTE count for the prior cost reportin	a voar (soo	0. (0. (11. 00 12. 00
12.00	instructions)	g year (see	0. (0.00		12.00
13. 00	Total weighted resident FTE count for the penultimate cost re year (see instructions)	porting	0. 0	0.00		13. 00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided	by 3).	0. (14.00
15. 00 15. 01	Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new p	rograms	14. § 0. (15. 00 15. 01
16. 00	Adjustment for residents displaced by program or hospital clo		0. (16. 00
16. 01	Unweighted adjustment for residents displaced by program or h		0. (16. 01
17. 00	Adjusted rolling average FTE count		14. 5			17. 00
18.00	Per resident amount		126, 258.			18.00
18. 01 19. 00	Per resident amount under §131 of the CAA 2021 Approved amount for resident costs		0. (1, 842, 1		1, 842, 115	18. 01 19. 00
		,		,	1. 00	
20. 00	Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4)	TE resident o	cap slots red	cei ved under 42	0.00	20. 00
21. 00	Direct GME FTE unweighted resident count over cap (see instru	ctions)			0. 00	21. 00
22. 00	Allowable additional direct GME FTE Resident Count (see instr	•				22. 00
23. 00	Enter the locality adjustment national average per resident a	mount (see ir	nstructions)			23. 00
24. 00	Multiply line 22 time line 23				1 042 115	24. 00
.) P UU) Total direct GME amount (sum of lines 19 and 24) 1,842,115 25.0					

DI RECT	Financial Systems IU HEALTH ARNETT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider Co	CN: 15-0173	Peri od:	Worksheet E-4	2552-10
	L EDUCATION COSTS			From 01/01/2023		
				To 12/31/2023	Date/Time Prep 5/29/2024 11:	
		Title	: XVIII	Hospi tal	PPS	27 aiii
			Inpatient Par	t Managed Care	Total	
			Α			
	COMPUTATION OF PROGRAM PATIENT LOAD		1.00	2. 00	3. 00	
24 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I)	/ Lino	14, 0	10, 981		26. 00
20.00	3.02, column 2)	V, TITIE	14,0	10, 901		20.00
27. 00	Total Inpatient Days (see instructions)		44. 89	98 44, 898		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 31224			28. 00
29. 00	Program direct GME amount		575, 18		1, 025, 723	29. 00
29. 01	Percent reduction for MA DGME			3. 27		29. 01
30.00	Reduction for direct GME payments for Medicare Advantage			14, 733	14, 733	30.00
31.00	Net Program direct GME amount				1, 010, 990	31.00
	DUDGOT NEDLON EDUONTLON COOTS FOR FORD COMPOSITE DATE. THE		/		1. 00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE EDUCATION COSTS)	XVIII ONLY	(NURSING PRO	GRAM AND PARAMEL	OI CAL	
22 00	Renal dialysis direct medical education costs (from Wkst. B, F	O+ I sum o	of col 20 and	1 22 linos 74	0	32. 00
32.00	and 94)	t. I, Sull O	n cor. 20 and	1 23, 111165 74	U	32.00
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	. col. 8. s	um of lines 7	'4 and 94)	3, 336, 091	33.00
34. 00	Ratio of direct medical education costs to total charges (line				0. 000000	
35. 00	Medicare outpatient ESRD charges (see instructions)		,		0	1
36. 00	Medicare outpatient ESRD direct medical education costs (line	34 x line 3	5)		0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY]
	Part A Reasonable Cost					
37. 00	Reasonable cost (see instructions)	_			43, 587, 870	1
38. 00	Organ acquisition and HSCT acquisition costs (see instructions				0	
39. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)			0	39. 00
40.00	Primary payer payments (see instructions)	1.1 (0)			24, 477	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus Part B Reasonable Cost	s line 40)			43, 563, 393	41. 00
42. 00	Reasonable cost (see instructions)				30, 874, 067	42. 00
43. 00	Primary payer payments (see instructions)				4, 647	1
	Total Part B reasonable cost (line 42 minus line 43)				30, 869, 420	
45. 00	Total reasonable cost (sum of lines 41 and 44)				74, 432, 813	1
46. 00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line	45)		0. 585271	
	Ratio of Part B reasonable cost to total reasonable cost (line				0. 414729	1
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B				
48. 00	Total program GME payment (line 31)				1, 010, 990	
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				591, 703	
	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	/!	:\		419, 287	

Heal th	Financial Systems IU HEALTH ARNET	T HOSPITAL	In Lie	u of Form CMS-2	552-10
OUTLI E	OUTLIER RECONCILIATION AT TENTATIVE SETTLEMENT Provider CCN: 15-0173 Period:				
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 11:2	
		Title XVIII		PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR				
1.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sun	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, line 2			0	2.00
3.00	Operating outlier reconciliation adjustment amount (see inst	ructions)		0	3.00
4.00	Capital outlier reconciliation adjustment amount (see instru	ctions)		0	4.00
5.00 The rate used to calculate the time value of money (see instructions)			0.00	5.00	
6.00	Time value of money for operating expenses (see instructions)		0	6.00
7.00	Time value of money for capital related expenses (see instru	ctions)		0	7.00

Health Financial Systems

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only)

Provider CCN: 15-0173 Period From

11.00 Total current assets (sum of lines 1-10) 396,446,266 0 0 0 0	oni y)				10 12/01/2020	5/29/2024 11:	29 am
Cubernt Assets 1.00 2.00 3.00 4.00			General Fund		Endowment Fund	Plant Fund	
Cash on hand in banks			1.00		3. 00	4. 00	
Temporary Investments			1				
Notes receivable 0			324, 267, 522	1	0		
A.Coo. A		' 3	0	1	-		
October Characteristic Characteris			54 319 179	1			
All lowances for uncoll lectible notes and accounts receivable 0				1	o o		
Prepart of expenses	6. 00	Allowances for uncollectible notes and accounts receivable	0	1	0	0	6.00
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,		1	0		
10.00 Due from other funds			1, 209, 684	(0		
11.00			0		0		
TIXED ASSETS			206 446 266				•
12.00 Land improvements	11.00		370, 440, 200	1	<u>)</u>		11.00
13.00 Land improvements	12. 00		2, 221, 221		0	0	12. 00
15.00 Buildings					0		
16.00 Accumul ated depreciation -72, 142, 367 0 0 0 0 0 18.00 Accumul ated depreciation -56, 546 0 0 0 0 0 0 0 0 0	14. 00	Accumulated depreciation	-105, 824		0	0	14. 00
17.00 Leasehold Improvements				1	-		
18.00 Accumul ated depreciation -56,546 0 0 0 0 0 0 0 0 0				1	-		•
19.00 Fixed equipment				1	1		
20.00 Accumulated depreciation 0 0 0 0 0 0 0 0 0			-56, 546	i	1		
21.00 Automobil es and trucks			0				
22.00 Accumul ated depreciation -134, 144 0 0 0 0 0 0 0 0 0		· ·	134, 144		o o		
24.00 Accumul ated depreciation				1	0	0	
25.00 Minor equipment depreciable 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23. 00	Major movable equipment	87, 114, 038	(0	0	23.00
26.00 Accumul ated depreciation			-67, 403, 252	(0		
27.00 HIT designated Assets 0 0 0 0 0 0 0 0 0			0	(0		
28. 00 Accumula face depreciation 0 0 0 0 0 0 0 0 0			0		0		
29.00 Minor equipment-nondepreciable 0 0 0 0 0 0 0 0 0			0				
30.00 Total fixed assets (sum of lines 12-29) 137,242,949 0 0 0 0 0 0 0 0 0		· ·		`	1		
OTHER ASSETS Investments S, 209, 922 O O O O O O O O O			137, 242, 949	1	-		
32.00 Deposits on leases 0 0 0 0 0 0 0 0 0				•			
33.00 Due from owners/officers	31. 00	Investments	5, 209, 922	(0	-	
34.00 Other assets 8,800,752 0 0 0 0 0 0 0 0 0		•	0		1		
35.00			0		1		1
Total assets (sum of lines 11, 30, and 35) 547,699,889 0 0 0 0				1	1		
CURRENT LIABILITIES				1	٥ -		
37. 00 Accounts payable	30. 00		347, 077, 007		<u> </u>		30.00
39.00 Payroll taxes payable 0 0 0 0 0 0 0 0 0	37. 00		30, 907, 849	(0	0	37. 00
40.00 Notes and loan's payable (short term)	38. 00		4, 729, 284		0	0	38. 00
41.00 Deferred income 42.00 Accelerated payments 0			0	(0		•
42.00 Accelerated payments			0	(0		
43.00 Due to other funds 4,410,473 0 0 0 0 0 0 0 0 0			0		0	0	
44.00 Other current liabilities 112,724 0 0 0 45.00 Total current liabilities (sum of lines 37 thru 44) 40,160,330 0 0 0 46.00 Mortgage payable 0 0 0 0 0 47.00 Notes payable 0 0 0 0 0 48.00 Unsecured loans 0 0 0 0 0 49.00 Other long term liabilities 1,640,286 0 0 0 0 50.00 Total long term liabilities (sum of lines 45 and 50) 41,800,616 0 0 0 0 51.00 Total liabilities (sum of lines 45 and 50) 41,800,616 0 0 0 0 0 52.00 General fund balance 505,899,273 0 0 0 0 0 53.00 Specific purpose fund 0<			/ / /10 /73	,	0	0	42. 00 43. 00
45.00 Total current liabilities (sum of lines 37 thru 44) 40, 160, 330 0 0 0 0 0 0 0 0 0				1			
LONG TERM LIABILITIES					0		
47.00 Notes payable 0 0 0 0 0 0 0 48.00 Unsecured loans 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
48.00 Unsecured Loans 49.00 Other Long term Liabilities 50.00 Total Long term Liabilities (sum of Lines 46 thru 49) 50.00 Total Liabilities (sum of Lines 46 thru 49) 51.00 Total Liabilities (sum of Lines 45 and 50) CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total Liabilities and fund balances (sum of Lines 51 and 547, 699, 889) 50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	`	٥ -		
49.00 Other long term liabilities 1,640,286 0 0 0 50.00 Total long term liabilities (sum of lines 46 thru 49) 1,640,286 0 0 0 51.00 Total liabilities (sum of lines 45 and 50) 41,800,616 0 0 0 52.00 General fund balance 505,899,273 0 1 53.00 Specific purpose fund 0 0 1 54.00 Donor created - endowment fund balance - restricted 0 0 1 55.00 Donor created - endowment fund balance 0 1 1 56.00 Governing body created - endowment fund balance 0 1 1 57.00 Plant fund balance - invested in plant 0 1 1 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 0 1 0 1 59.00 Total fund balances (sum of lines 52 thru 58) 505,899,273 0 0 0 0 60.00 Total liabilities and fund balances (sum of lines 51 and 547,699,889 0 0 0			0	•			•
50.00 Total long term liabilities (sum of lines 46 thru 49) 1,640,286 0			1 (40 20)				
51.00 Total liabilities (sum of lines 45 and 50) 41,800,616 0 0 0 0							
CAPITAL ACCOUNTS 52.00 General fund balance 53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 60 Governing body created - endowment fund balance 60 Plant fund balance - invested in plant 60 Plant fund balance - reserve for plant improvement, replacement, and expansion 60 Total fund balances (sum of lines 52 thru 58) 60 Total liabilities and fund balances (sum of lines 51 and 60 Total liabilities and fund balances (sum of lines 51 and 60 Total Sum of lines 51 and 60 Total Sum of lines 52 thru 58) 60 Total liabilities and fund balances (sum of lines 51 and 60 Total Sum of lines 52 thru 58) 60 Total Sum of lines 51 and 60 Total Sum of lines 52 thru 58)		, ,		1			
53.00 Specific purpose fund 54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 577,699,889 0 0 0 0					-	-	1
54.00 Donor created - endowment fund balance - restricted 55.00 Donor created - endowment fund balance - unrestricted 56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 547,699,889 0	52. 00	General fund balance	505, 899, 273				52. 00
55.00 Donor created - endowment fund balance - unrestricted 60 Governing body created - endowment fund balance 77.00 Plant fund balance - invested in plant 78.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 79.00 Total fund balances (sum of lines 52 thru 58) 70 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				(53.00
56.00 Governing body created - endowment fund balance 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 547,699,889 0 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9 9					0		54.00
57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 57.00 Plant fund balance - invested in plant 58.00 Plant fund balance - invested in plant 59.00 Plant fund balance - invested in plant 50 Plant fund balance - inve					0		55.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 60.00 Total liabilities and fund balances (sum of lines 51 and 547,699,889 0 0 0					0	_	56. 00 57. 00
replacement, and expansion 59.00 Total fund balances (sum of lines 52 thru 58) 505,899,273 0 0 0 0 0 0 0 0 0		·					
59.00 Total fund balances (sum of lines 52 thru 58) 505, 899, 273 0 0 0 0 60.00 Total liabilities and fund balances (sum of lines 51 and 0 547, 699, 889 0 0 0						ĺ	55.00
	59. 00		505, 899, 273	(0	0	59. 00
[59]	60. 00		547, 699, 889		0	0	60.00
		[59]	I	I			

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0173

Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/29/2024 11:29 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 389, 823, 546 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 116, 075, 726 2.00 3.00 Total (sum of line 1 and line 2) 505, 899, 272 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 5.00 ROUNDI NG 0 5.00 1 0 0 0 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 505, 899, 273 Subtotal (line 3 plus line 10) 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 505, 899, 273 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 ROUNDI NG 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0 0 19.00 Fund balance at end of period per balance 19.00 sheet (line 11 minus line 18)

Health Financial Systems I STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0173

			0 12/31/2023	5/29/2024 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	137, 683, 456		137, 683, 456	1. 00
2.00	SUBPROVIDER - I PF	, , , , , , , , , , , , , , , , , , , ,		,	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF)	o	5. 00
6.00	Swing bed - NF			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)	137, 683, 456		137, 683, 456	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	29, 630, 373	3	29, 630, 373	11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT)	0	13.00
13. 01	BURN INTENSIVE CARE UNIT)	0	13. 01
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	NEONATAL INTENSIVE CARE UNIT	17, 144, 208	3	17, 144, 208	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	46, 774, 581		46, 774, 581	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	184, 458, 037	'	184, 458, 037	17.00
18.00	Ancillary services	426, 304, 748	914, 680, 756	1, 340, 985, 504	18.00
19. 00	Outpati ent servi ces	53, 930, 927	271, 455, 372	325, 386, 299	19. 00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	664, 693, 712	1, 186, 136, 128	1, 850, 829, 840	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		0.40 4.40 4.00	I	
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		349, 649, 609		29. 00
30.00	ADD (SPECIFY)				30.00
31.00					31.00
32. 00			1		32. 00
33. 00					33. 00
34. 00			1		34. 00
35. 00	T-t-1 -dditi (f 1: 20 25)	()		35. 00
36.00	Total additions (sum of lines 30-35)		J		36. 00
37. 00	DEDUCT (SPECIFY)		1		37. 00
38. 00 39. 00					38. 00 39. 00
40. 00			1		39. 00 40. 00
40.00					40.00
41.00	Total deductions (sum of lines 37-41)		<u></u>		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	r	349, 649, 609		43. 00
43.00	to Wkst. G-3, line 4)	'	347, 047, 007		73.00
	100 11.00 1, 11.110 1,	1	I	1	

Heal th	Financial Systems IU HEALTH AR	RNETT HOSPITAL	Inlie	u of Form CMS-2	2552_10
	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0173	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 11:2	
4.00	T. I. I. I. (C. W. I. O.O. D. I. I. O.	11 00)		1.00	4 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3,			1, 850, 829, 840	
2.00	Less contractual allowances and discounts on patients' ac Net patient revenues (line 1 minus line 2)	counts		1, 404, 641, 882	2.00
3. 00 4. 00	Less total operating expenses (from Wkst. G-2, Part II, I	ino 42)		446, 187, 958 349, 649, 609	3. 00 4. 00
4. 00 5. 00	Net income from service to patients (line 3 minus line 4)	The 43)		96, 538, 349	
5.00	OTHER INCOME			90, 330, 349	3.00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			ő	7. 00
8.00	Revenues from telephone and other miscellaneous communica	tion services		ol	
9. 00	Revenue from television and radio service			ol	
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			o	11. 00
12.00	Parking Lot receipts			o	12.00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to oth	er than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			0	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23.00	Governmental appropriations			0	23. 00
	MI SCELLANEOUS I NCOME			19, 537, 377	24. 00
	COVI D-19 PHE Fundi ng			0	24. 50
	Total other income (sum of lines 6-24)			19, 537, 377	25. 00
	Total (line 5 plus line 25)			116, 075, 726	
	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 2	8)		116, 075, 726	29. 00

Heal th	Financial Systems IU HEALTH ARNETT	T HOSPITAL	In Lie	eu of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0173	Peri od: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
			Urban Post 10/1	Rural Pre 10/1	
			1. 00	1. 01	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		628, 913	1, 846, 655	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		C	0	1. 01
2.00	Capital DRG outlier payments		96, 996		2. 00
2. 01	Model 4 BPCI Capital DRG outlier payments		C	1	2. 01
3.00	Total inpatient days divided by number of days in the cost re instructions)	eporting period (see	123. 01		3. 00
4.00	Number of interns & residents (see instructions)		14. 59		4. 00
5. 00	Indirect medical education percentage (see instructions)		3. 41	l .	5. 00
6.00	Indirect medical education adjustment (multiply line 5 by the	e sum of lines 1 and 1.01	, 84, 417	,	6. 00
7. 00	columns 1 and 1.01)(see instructions) Percentage of SSI recipient patient days to Medicare Part A p	oatient days (Worksheet E	, 3.54		7. 00
	part A line 30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instru	ıcti ons)	24. 41		8. 00
9.00	Sum of lines 7 and 8		27. 95	5	9. 00
10.00	Allowable disproportionate share percentage (see instructions	s)	5. 82	2	10. 00
11.00	Disproportionate share adjustment (see instructions)		36, 603	3	11. 00
12.00	Total prospective capital payments (see instructions)		2, 693, 584		12. 00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstanc	ces (see instructions)		0	2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
4.00	Applicable exception percentage (see instructions)			0.00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see in			0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary	, circumstances (line 2 x	line 6)	0	1
8.00	Capital minimum payment level (line 5 plus line 7)			0	
9.00	Current year capital payments (from Part I, line 12, as appli		l	0	
10. 00 11. 00	Current year comparison of capital minimum payment level to c Carryover of accumulated capital minimum payment level over c			0 0	10. 00 11. 00
	Worksheet L, Part III, line 14)		,		
12.00	Net comparison of capital minimum payment level to capital pa	• •	,	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter			0	13.00
14. 00	Carryover of accumulated capital minimum payment level over c (if line 12 is negative, enter the amount on this line)	capital payment for the f	orrowing period	0	14. 00
15. 00	Current year allowable operating and capital payment (see ins	structions)		0	15. 00
16. 00	Current year operating and capital costs (see instructions)	on don ons,		0	16.00
	Current year exception offset amount (see instructions)				
	1 - 2 J. 2 2 2 2 2 2			1	