Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Δ

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	129, 542	391, 734	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	232, 356	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00) Total	0	361, 898	391, 734	0	0	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		I FRANKFORT			N: 15-1316	Period From O			of For Workshe Part I		
									2019	Date/Ti 6/29/20		
	1.00		00		3.00			4	. 00	0/2//20	20 0.0	
00	Hospital and Hospital Health Care Co Street: 1300 SOUTH JACKSON STREET	pplex Address: P0 Box:										1.0
00	City: FRANKFORT	State: I	N Z	ip Code	e: 4604	41 Cou	unty: CLIN	ITON				2.0
		Component Na		CCN umber	CBS Numb					nt Syst 0, or XVIII	N)	-
	I	1.00		2.00	3.0	0 4.00	5.0	0	6.00	7.00		
00	Hospital and Hospital-Based Componen Hospital	t Identification:		51316	999	15 1	01/21/	2003	N	0	0	3.
00		HOSPI TAL		51510	,,,,		01/21/	2005				
00 00 00 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	IU HEALTH FRANKF(HOSPITAL	DRT 1	5Z316	999 ⁻	15	01/21/	2003	N	0	N	4. 5. 6. 7.
00 00 00 00 00 00 00 00 00 00 00 00 00	Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC Hospital-Based (CMHC) I Renal Dialysis Other											8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
								From:		To		-
. 00	Cost Reporting Period (mm/dd/yyyy)						01/	<u>1.00</u> 01/20)19	2.0		20.
	Type of Control (see instructions)							2				21.
					-	1.00		2.00		3. (0	-
. 00	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" f0	stment, in accord r yes or "N" for 412.106(c)(2)(Pic	lance with no. Is thi kle amendm	42 CFR s		N		N				22.
	Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft	mn 1, "Y" for yes riod occurring pr " for no for the er October 1. (se	or "N" for ior to Oct portion of ee instruct	or no f tober 1 f the c tions)	or ost	N		N				22.
02	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1.	port settlement? " for no, for the er 1. Enter in co	(see instr portion c lumn 2, "Y	ruction of the (" for	s) yes	N		Ν				22.
03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ds for delineatin olumn 1, "Y" for g period prior to no for the portio er October 1. (se 100 but not more	ng statisti yes or "N" o October 1 on of the c ee instruct than 499 b	cal ar for n Ente cost ions) peds (a	eas o r	Ν		Ν		Ν		22.
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 i of identifying th method used in th	f census c ne days in ne prior co <u>"N" for no</u>	lays, o this c ost o <u>.</u>	r 3 ost		3	N				23.
			In-State Medicaid paid days	unpa day	caid ble aid /s	Out-of State Medicaid paid days	Out-of State Medicai eligibl unpaid	d H e	edicai MO day	/s Mec	ther li cai d lays	
. 00	If this provider is an IPPS hospital	, enter the	1.00	2.0	00	3.00	4.00	0	5.00	0	<u>. 00</u>) 24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in			0			,				

	Financial Systems IU HEALTH TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	H FRANKFORT	Provider CC	CN: 15-1316	Peri od:	In Lieu		et S-2	
					From 01/0 To 12/3	1/2019		ime Pre 020 8:3	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicai HMO day	d O /s Mea	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		5.00	
. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0 0	0		0		25.
					Urban/R		Date of 2.		
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	ginning of t	he	2			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r	ural. If ap		t	2			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status in		0			35.
					Begi nr		Endi		
. 00	Enter applicable beginning and ending dates of SCH st	tatus. Subs	cript line	36 for numb	1. (er	JU	2.	00	36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ds MDH statu	S	0			37
01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
	,				Y/		Y/		
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage i)? Enter	(iii)? Ent requiremer in column 2	ter in colum nts in 2 "Y" for ye	n s		N		39.
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for y				N		40
						V 1.00	XVIII 2.00	XI X 3.00	-
	Prospective Payment System (PPS)-Capital					1.00		-	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	ary circumst	ances	N N	N N	N N	45
00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c				5	N	N	N	47
	Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in					N	<u>N</u>	N	48
00	"N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting p	mpacted by no in colu	CR 11642 (mn 2.	(or subseque	nt CR), MA				56
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N th of this (", complet	" for no ir cost report e Worksheet	n column 1. ting period?	If column 1 Enter "Y"				
00	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	ans' service	s as	N			58
00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59
				NAHE 413.8 Y/N	35 Worksh Line	e #		hrough cation on Code	
				1.00	2.0	00	3.	00	1
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (see umn 1. If CR) NAHE MA	column 1	N					60.

OSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/29/2020 8:3	parec
		Y/N	IME	Direct GME	IME	Direct GME	
	1	1.00	2.00	3.00	4.00	5.00	
1. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	0. OC	61.
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.
1. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		
						1.00	
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cen ee instructio	ter (THC) into		0.00	
. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this c	<u>67. (see instru</u>	ictions)	N	63.
				Unwei ghted FTEs Nonprovi der Si te	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Spotion 5504 of the ACA Pass Year ETE Desidents in No	opprovid	lor Sottings	1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit	re June	30, 2010.	0.00	-		64.

	PLEX IDENTIFICATION DA	ATA Provi der		om 01/01/2019	Worksheet S-2	
			To	12/31/2019	Date/Time Pre 6/29/2020 8:3	pared 7 am
	Program Name	Program Code	Unweighted	Unwei ghted	Ratio (col. 3/	
			FTES	FTEs in	(col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, if line 63	1.00	2.00	0.00	0.00		65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovi der	Hospi tal	2))	
			Si te			
	Vera FTF Desidente i	. Namana di dana Catti a	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 2		n Nonprovider Settir	igsErrective ro	r cost reporti	ing periods	
FTEs attributable to rotations Enter in column 2 the number of	occurring in all nonp unweighted non-prima	rovider settings. ry care resident	0.00	0.00	0.00000	66. (
FTEs attributable to rotations	occurring in all nonp unweighted non-prima tal. Enter in column	rovider settings. ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	0.00 Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	66. C
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in:	rovider settings. ry care resident 3 the ratio of structions)	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 divided by (column 1) .00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) 	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in: Program Name 1.00	Provider settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	67.0
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility on Is this facility an Inpatient P Enter "Y" for yes or "N" for n on If line 70 is yes: Column 1: Di recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) C program in accordance with 42 C Column 3: If column 2 is Y, ind (see instructions) 	occurring in all nonp unweighted non-prima tal. Enter in column + column 2)). (see in Program Name 1.00 1.00 sychiatric Facility (o. d the facility have ai before November 15, 20 olumn 2: Did this fac FR 412.424 (d)(1)(iii) icate which program yet	IPF), or does it con n approved GME teach 00/2? Enter "Y" for ility train resident 00/2? Enter "Y" for	Unweighted FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.0 1.0 1.0 rovi der? N he most o. (see i ng 0.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	67. (
 FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi (column 1 divided by (column 1 OO Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility Enter "Y" for yes or "N" for n 1f line 70 is yes: Column 1: Di recent cost report filed on or 42 CFR 412.424(d)(1)(iii)(c)) C program in accordance with 42 C Column 3: If column 2 is Y, ind 	PPS Sychiatric Facility (o. d the facility have an before November 15, 22 olumn 2: Did this fac FR 412.424 (d)(1)(iii i cate which program ye ty PPS	IPF), or does it con n approved GME teach 00/2 Enter "Y" for ear began during thi	Unweighted FTEs Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in t yes or "N" for m s in a new teach yes or "N" for m s cost reporting	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.0 1.0 1.0 rovi der? N he most o. (see i ng 0.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	

Heal th	Financial Systems IU HEALTH FRANKFORT HOSPITA		In Lie	u of Form CMS	-2552-10
		CCN: 15-1316	Peri od:	Worksheet S-	
			From 01/01/2019 To 12/31/2019	Part I Date/Time Pr	renared [.]
			10 12/31/2019	6/29/2020 8:	
				1.00	_
	Long Term Care Hospital PPS			1.00	
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for	- no		N	80.00
	Is this a LTCH co-located within another hospital for part or all of the		g period? Enter	N	81.00
	"Y" for yes and "N" for no.				
	TEFRA Provi ders				
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? End	2		N	85.00
	Did this facility establish a new Other subprovider (excluded unit) unde §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	er 42 CFR Sectro			86.00
	Is this hospital an extended neoplastic disease care hospital classified	d under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				
			V	XI X	
			1.00	2.00	
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services?	Entor "V" for	N	Y	90.00
	yes or "N" for no in the applicable column.	Enter i Tor	IN	T	90.00
	is this hospital reimbursed for title V and/or XIX through the cost repo	ort either in	N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable colur				
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certifica	ation)? (see		N	92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V a	and VIV2 Entor	N	N	93.00
93.00	"Y" for yes or "N" for no in the applicable column.		IN	IN	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for	no in the	N	N	94.00
	applicable column.				
	If line 94 is "Y", enter the reduction percentage in the applicable colu		0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for	no in the	N	N	96.00
97.00	applicable column. If line 96 is "Y", enter the reduction percentage in the applicable colu	Imn	0.00	0.00	97.00
	Does title V or XIX follow Medicare (title XVIII) for the interns and re		N	Y	98.00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N				
	column 1 for title V, and in column 2 for title XIX.				
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of a		. N	Y	98.01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and i title XIX.	n corumn 2 ror			
	Does title V or XIX follow Medicare (title XVIII) for the calculation of	observati on	Ν	Y	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no	o in column 1			
	for title V, and in column 2 for title XIX.				
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for		N N	N	98.03
	for title V, and in column 2 for title XIX.		1		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed ?	101% of	N	N	98.04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 fo	or title V, and			
00.05	in column 2 for title XIX.		N	V	00.05
	Does title V or XIX follow Medicare (title XVIII) and add back the RCE of Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for			Y	98.05
	column 2 for title XIX.				
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed 1	°or Wkst. D,	N	Y	98.06
	Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title	eV, and in			
	column 2 for title XIX. Rural Providers				-
105 00	Does this hospital qualify as a CAH?		Y		105.00
	If this facility qualifies as a CAH, has it elected the all-inclusive me	ethod of paymen			106.00
	for outpatient services? (see instructions)				
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimburse	ement for I&R	N		107.00
	training programs? Enter "Y" for yes or "N" for no in column 1. (see in Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train 18				
	approved medical education program in the CAH's excluded IPF and/or IRF				
	Enter "Y" for yes or "N" for no in column 2. (see instructions)				
	Is this a rural hospital qualifying for an exception to the CRNA fee sch	nedul e? See 42	N		108.00
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Physical	Occupati ona	Speech	Respi ratory	
		2.00	3.00	4.00	<u></u>
109.00	If this hospital qualifies as a CAH or a cost provider, are Y	Y	N	N	109.00
	therapy services provided by outside supplier? Enter "Y"				
	for yes or "N" for no for each therapy.				
				1 00	_
110 00	Did this hospital participate in the Rural Community Hospital Demonstrat	tion project (8,	410A	1.00 N	110.00
	Demonstration) for the current cost reporting period? Enter "Y" for yes o				
	complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2,	lines 200 throu	ugh 215, as		
	appl i cabl e.				

alth Financial Systems IU HEALTH FRANKFC SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-1316	Peri od:	Lieu of Form CMS Worksheet S-	
			From 01/01/2 To 12/31/2		reparec 37 am
			1.00	2.00	_
1.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting p umn 1 is Y, e ticipating in	period? Enter enter the column 2.	N	2.00	111.
		1.00	2.00	3.00	_
2.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscell aneous Cost Reporting Information	oeriod? "Y", enter e	N			112.
5.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) 3" percent ncludes	N			0115.
6.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	for yes or	Ν			116.
7.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.		N			117.
8.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre			2		118.
8.01 List amounts of malpractice premiums and paid losses:		1.00 30,6	2.00	3.00 0	0 118.
			1.00	2.00	_
8. 02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein. 9. 00 D0 NOT USE THIS LINE			N		118.
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" alifies for th	for yes or ne Outpatient		N	120.
.00Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable devices	charged to	Y		121.
2.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.				5.00	122.
Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N"	for no. If	N		125.
yes, enter certification date(s) (mm/dd/yyyy) below. 0.00 f this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2.		ication date			126
7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			127
8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			128
. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		ation date i	n		129
0.00 of this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu		i fi cati on			130.
. 00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu	enter the ce	erti fi cati on			131.
.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certifi	cation date			132.
					133. 134.
3. OO Removed and reserved 4. OO If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2. All Providers	e OPO number i	n column 1			_

	X IDENTIFICATION DAT	A	Provider CC	N: 15-1310	Fr	riod: om 01/01/2019		
					Tc	12/31/2019	Date/Time Pr 6/29/2020 8:	
1.00		2.00				3.00	0/2//2020 0	
If this facility is part of a cha					ne nam	e and address	of the	
home office and enter the home of			tractor numbe		aatar	o Numbers 001	1	-141 /
11.00 Name: INDIANA UNIVERSITY HEALTH 12.00 Street: 340 WEST 10TH STREET	Contractor's Na PO Box:	ame: wPS		Contr	actor	s Number: 0810		141. (
43. 00 City: INDIANAPOLIS	State:	IN		Zip C	ode:	4620	12	142.0
	10.000							
							1.00	
44.00 Are provider based physicians' cos	sts included in Works	sheet A?					Y	144. (
						1.00	2.00	_
15.00 If costs for renal services are cl	aimed on Wkst. A. Li	ne 74. a	are the costs	for		1.00	2.00	145.
inpatient services only? Enter "Y					s			
no, does the dialysis facility in	clude Medicare utiliz							
period? Enter "Y" for yes or "N"				10				
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in					ι£	N		146.
yes, enter the approval date (mm/			-z, chapter 4	0, 34020)	11			
	,,,,,, corumi 21							
							1.00	
47.00Was there a change in the statisti							N	147.
48.00Was there a change in the order o 49.00Was there a change to the simplifi					for n	2	N	148. 149.
47. Oolwas there a change to the shipirn			Part A	Part		Title V	Title XIX	147.
			1.00	2.00		3.00	4.00	_
Does this facility contain a prov	ider that qualifies f	for an e	xemption from	the appl	icati	on of the lowe	er of costs	
or charges? Enter "Y" for yes or	"N" for no for each o	componen			B. (S			
55.00Hospi tal			N	N		N	N	155.
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N		N N	N	156. 157.
58. 00 SUBPROVI DER			N IN	IN		IN	IN IN	157.
59. 00 SNF			N	Ν		Ν	N	159.
60.00 HOME HEALTH AGENCY			N	Ν		Ν	N	160. (
61.00 CMHC				N		N	N	161. (
							1.00	_
Multicampus							1.00	
65.00 s this hospital part of a Multica	ampus hospital that h	nas one d	or more campu	ses in di	ffere	nt CBSAs?	N	165. (
	production of the second							
Enter "Y" for yes or "N" for no.								
Enter "Y" for yes or "N" for no.	Name		County	State		Code CBSA	FTE/Campus	_
	Name O		County 1.00	State 2.00	Zip 3.		5.00	
66.00 fline 165 is yes, for each							5.00	00 166. (
66.00 f ine 165 is yes, for each campus enter the name in column							5.00	
66.00 fline 165 is yes, for each							5.00	
56.00 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							5.00	
56.00 f 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,							5.00	
66.00 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							5.00	
56.00 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	American	1.00	2.00	3.	00 4.00	5.00	
56.00 f ine 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) Health Information Technology (HI	0 T) incentive in the A		1.00 Recovery and	2.00	3.	00 4.00	5.00	00 166.
56.00 f 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) Health Information Technology (HI 57.00 s this provider a meaningful user 58.00 f this provider is a CAH (line 10	0 T) incentive in the A r under §1886(n)? Er D5 is "Y") and is a m	nter "Y" neaningfi	1.00 Recovery and for yes or " ul user (line	2.00	3. (tment	00 4.00	5.00	167.
 66.00 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) Health Information Technology (HI 67.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the line 10 reasonable cost incurred for the	0 T) incentive in the A r under §1886(n)? Er 55 is "Y") and is a m HIT assets (see instr	nter "Y" neani ngfu ructi ons)	Recovery and for yes or " ul user (line)	2.00	3. (tment). Y"),	Act enter the	5.00	167. (168. (
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Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1316 Peri od: Worksheet S-2 From 01/01/2019 Part II Date/Time Prepared: То 12/31/2019 6/29/2020 8:37 am Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 γ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Ν 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. Y 12.00 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions. Part B Part A Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? 16.00 Ν 16.00 Ν If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/01/2020 Y 04/01/2020 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 Ν Ν Report data for corrections of other PS&R Report

information? If yes, see instructions.

Health Financial Systems

In Lieu of Form CMS-2552-10

IDEEPTTAL AND MOSPITAL HEALTH CARE REFUBBIOS/MENT QUESTIONNAL RE Provider CDN: 15-1316 Period From 01/07/2017 Monochabet S- From 01/07/2017 Monochabet S- From 01/07/2017 20.00 If fine 16 or 17 is yes, were adjustments made to PS&R N N V/R 0.0 3.00 V/R 0.0 3.00 21.00 Was the cost report prepared only using the provider'S N N N N 21.00 Was the cost report prepared only using the provider'S N N N N 21.00 Was the cost report prepared only using the provider'S N N N 1.00 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions N N N 22.00 Have changes occurred in the Medicare degreed ation expense due to appraisals made during the cost reporting period? If yes, see N N N 23.00 Have changes occurred in the Medicare purposes? If yes, see instructions N N 24.00 Have sasts been repliced cost N N N 25.00 Have there been new costs as instructions N N N 25.00	Heal th	Financial Systems IU HEALTH FRANK	KFORT HOSPITAL		In Lie	eu of Form C	MS-2552-10
Use the other 1/1 is yes, were adjustments made to PSMV/NV/NV/NV/NV/NV/NN20.00If 1 is or 1/1 is yes, were adjustments made to PSMNNNV/NDateV/NPriorV/NPriorV/NPriorV/NPriorV/NPriorV/NPriorV/NPrior </td <td></td> <td></td> <td>Provider C</td> <td> </td> <td>From 01/01/2019</td> <td>Part II Date/Time</td> <td>Prepared:</td>			Provider C		From 01/01/2019	Part II Date/Time	Prepared:
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31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N Purchased Services N 22.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. N 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. N 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. N 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? Y 36.00 Were home office Costs Y Date 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Y 38.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. N 38.00 If line 36 is yes, did the provider render services to the home office? Y 39.00 If line 36 is yes, did the provider render services to the home office? N 31.00 If line 36 is yes, did the provider rend	30.00			debt? If yes,	see	N	30.00
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Image: Note of the system o	39.00	3	er chain compon	ents? If yes,	N		39.00
Instructions. Instructions. 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 1.00 2.00 Instructions. Instructions 1.00 1.00 1.00<	10.00			1.6			10.00
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respectively. Enter the employer/company name of the cost report INDLANA UNIVERSITY HEALTH preparer.							
preparer.		respectively.					
	2.00	Enter the employer/company name of the cost report	INDIANA UNIVER	SITY HEALTH			42.00
43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG	43.00		317. 962. 1093		RUTTER@I UHEALT	H. ORG	43.00
report preparer in columns 1 and 2, respectively.	I	report preparer in columns I and 2, respectively.	1				II

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN		Peri od:	Worksheet S-2	
					From 01/01/2019 To 12/31/2019		pared: <u>7 am</u>
			3.0	0			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the t	itle/position	GOVERNMENT PROG	RAMS DI RECTOF	2		41.00
	held by the cost report preparer in colum	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the co	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respe	cti vel y.					

	Financial Systems I AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	U HEALTH FRANKE	Provi der CC	N. 15_1316	Peri od:	u of Form CMS-2 Worksheet S-3	
103FT 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC			. 13-1310	From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 6/29/2020 8:3	pared: 7 am
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	25	9, 1	25 28, 872. 00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	4.00
5.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 1	25 28, 872.00	0	7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00 10.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						9.0 10.0
10.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						13.0
4.00	Total (see instructions)		25	9, 1	25 28, 872. 00	0	
15.00	CAH visits					0	15.0
16.00	SUBPROVIDER - IPF						16.0
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						17.0 18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	101.00				0	22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25.0 26.0
6.00 6.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.0
7.00	Total (sum of lines 14-26)	09.00	25			0	20.2
8.00	Observation Bed Days		20			0	
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction)						30.0
1.00	Employee discount days - IRF						31.0
2.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room						32.0
33.00	outpatient days (see instructions) LTCH non-covered days						33.0
	LTCH non-covered days LTCH site neutral days and discharges						33.0

ISPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1316		eriod: com 01/01/2019 o 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/29/2020 8:3	pare
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	707	2	1, 20	03			1.
00	HMO and other (see instructions)	232	102					2.
00	HMO IPF Subprovider	0	0					3.
00	HMO IRF Subprovider	0	0					4.
00	Hospital Adults & Peds. Swing Bed SNF	183	0		83			5.
00	Hospital Adults & Peds. Swing Bed NF		0		75			6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	890	2	1, 50	61			7.
00								8.
00	CORONARY CARE UNIT							9
00	BURN INTENSIVE CARE UNIT							10
. 00 . 00	SURGI CAL I NTENSI VE CARE UNI T							11
. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY							13
. 00	Total (see instructions)	890	2	1, 50	61	0.00	100. 98	
00	CAH visits	0	2	1, 50	0	0.00	100. 98	15
. 00	SUBPROVIDER - IPF	0	0		U			16
00	SUBPROVIDER - IRF							17
00	SUBPROVI DER							18
00	SKILLED NURSING FACILITY							19
00	NURSING FACILITY							20
00	OTHER LONG TERM CARE							21
00	HOME HEALTH AGENCY	0	0		0	0.00	0.00	22
00	AMBULATORY SURGICAL CENTER (D. P.)							23
00	HOSPICE							24
10	HOSPICE (non-distinct part)				0			24
00	CMHC - CMHC							25
00	RURAL HEALTH CLINIC							26
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26
00	Total (sum of lines 14-26)					0.00	100. 98	
00	Observation Bed Days		1	48	86			28
00	Ambulance Trips	0						29
00	Employee discount days (see instruction)				0			30
. 00	Employee discount days - IRF				0			31
. 00	Labor & delivery days (see instructions)	0	0		0			32
. 01	Total ancillary labor & delivery room				0			32
00	outpatient days (see instructions)							1
. 00	LTCH non-covered days	0						33

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CCN: 15-1316		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/29/2020 8:3	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.00 25.00 26.00 26.25 27.00 28.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SCILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0.00	0	21	03 1 59 25 0 0 0 0 0 1	339	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 21.00 22.00 23.00 24.00 24.00 25.00 24.00 25.00 24.00 25.00 24.00 25.00 26.00 27.00 28.00 20.0
29. 00 30. 00 31. 00 32. 00 32. 01 33. 00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		29. 0 30. 0 31. 0 32. 0 32. 0 33. 0 33. 0

Heal th	Financial Systems IU HEALTH FRANKFOR	RT HOSPI TAL		In Lie	u of Form CMS-	2552-10
H0SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-1316	Peri od:	Worksheet S-1	0
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:3	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lir	ne 202 colum		0. 455810	1.00
1.00	Medicaid (see instructions for each line)	i vi ded by i li		1 0)	0. 400010	1.00
2.00	Net revenue from Medicaid				2, 248, 405	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	ntal payments	s from Medica	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments t	from Medicaid	b		0	
6.00	Medicaid charges				9, 277, 033	
7.00	Medicaid cost (line 1 times line 6)				4, 228, 564	
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)			nes 2 and 5; if	1, 980, 159	8.00
	Children's Health Insurance Program (CHIP) (see instructions f	for each line	e)			
9.00	Net revenue from stand-al one CHIP				0	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-alone CHIP	(ling 11 mir	nus lino 0 i	f < zero then		
12.00	enter zero)			I < Zero then		12.00
	Other state or local government indigent care program (see ins	structions fo	or each line)	1		
13.00	Net revenue from state or local indigent care program (Not ind				5, 455	13.00
14.00	Charges for patients covered under state or local indigent can	re program (N	Not included	in lines 6 or	10, 438	14.00
	10)					
15.00	State or local indigent care program cost (line 1 times line				4, 758	
16.00	Difference between net revenue and costs for state or local in 13; if < zero then enter zero)	ndigent care	program (III	ne 15 minus line	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IIP and state	/local indic	ent care program	ns (see	
	instructions for each line)			jent care program	13 (300	
17.00	Private grants, donations, or endowment income restricted to 1	funding chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	al indigent o	care programs	s (sum of lines	1, 980, 159	19.00
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
		-	1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)	.				
20.00	Charity care charges and uninsured discounts for the entire fa (see instructions)	acility	2, 321, 6	46, 159	2, 367, 851	20.00
21.00	Cost of patients approved for charity care and uninsured disco instructions)	ounts (see	1, 058, 2	50 46, 159	1, 104, 409	21.00
22.00	Payments received from patients for amounts previously writter charity care	n off as		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		1, 058, 2	50 46, 159	1, 104, 409	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	ant days heve	ond a length	of stay limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond	e program?	Ũ	3	0	
	stay limit	0		i s rength of		
26.00 27.00	Total bad debt expense for the entire hospital complex (see in Medicare reimbursable bad debts for the entire hospital complete		cuctions)		2, 332, 160 316, 748	
27.00	Medicare allowable bad debts for the entire hospital complex				487, 305	•
	Non-Medicare bad debt expense (see instructions)				1, 844, 855	•
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	xpense (see i	nstructions)	1, 011, 460	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 115, 869	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			4, 096, 028	31.00

RECLASSIFICATION AND AUJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CR: 15-1316 Perol der CR: 15-1316 Perol der CR: 15-1316 Perol der CR: 15-1316 Morksheet A Erem 10/07/2015 Cost Center Description Salaries Other Total (col. 1) Notassified (col. 3) Notassified (col. 4) 1 00 2.00 3.00 4.00 5.00 1.00 00100 (CaP EL COSTS BLD & FLYT - NOSPTAL 0 0 1.60.7.245 1.60.2 1.00 00100 (CaP EL COSTS BLD & FLYT - NOSPTAL 0 0 1.60.7.245 1.60.2 1.00 00100 (CaP EL COSTS BLD & FLYT - NOSPTAL 0 0 1.67.245 1.60.2 1.00 00100 (CaP EL COSTS BLD & FLYT - NOSPTAL 0 0 1.67.245 1.60.2 1.00 00100 (CaP EL COSTS BLD & FLYT - NOSPTAL 0 0 1.27.246 1.07.245 1.00 00200 (DERATION OF PLATT 0.00200 (DERATION OF PLATT 0.00200 (DERATION OF PLATT 1.26.7.193 1.27.193 1.27.193 1.27.193 1.00.17.35 1.33.727 1.00.17.35 1.33.727 1.00.13.992 1.27.193	Health Financial Systems	U HEALTH FRANKFO	ORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Salaries Other To 12/31/2012 12/31/2012 Cost 7 and 7/31 and		F EXPENSES	Provider CO			Worksheet A	
Cost Center Description Salaries Other Total (col. 1 + col. 2) Total (col. 3) + col. 3) Total (col. 3) + col. 3) 1:00 2:00 3:00 4:00 0:00 1 1:00 2:00 3:00 4:00 0:00 0 1:00 0:00 0 1:00 2:00 3:00 4:00 1:00 0:0102 (AP REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL COSTS-BLDG & FLXT - HOSPITAL 0:000000 (CPR REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:0000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS-BLDG & FLXT - HOSPITAL 0:00000 (CPR REL MO CTS - REL COSTS - REL C						Data (Tima Dra	norod.
Cost Center Description Salaries Other Total (col.) (col. 2) Reclassificat (col. 3) Reclassificat (col. 4) ENERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 1.01 0101 (CAP ELC COST-ENDCA FIXT (Col. 3) 1.00 2.00 3.00 4.00 5.00 1.02 0012 (CAP ELC COST-ENDCA FIXT - HOSP ITAL (Col. 2) 0 0 1.621 (A)				1	0 12/31/2019		
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Constraint Constraint <thconstraint< th=""> Constraint Constrai</thconstraint<>				+ col. 2)	ons (See A-6)		
THERAL SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 10 00100 CAP REL COSTS-BLIG & FIXT 0 0 1.61,021 1.6,021							
GENERAL SERVICE COST CENTERS 0 0 0100 0100 (QAP REL COSTS -BLDG & FIXT - MOB 1, 000) 0 1.61, 021 1.60, 021 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
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1. 01 00101 CAP REL COSTS-BLOG & FLXT - MOSPITAL 0 0 1, 621, 245 1, 621, 246 1, 1, 621, 246 1, 1, 621, 246 1, 1, 621, 246 1, 1, 621, 246 1, 1, 621, 246 1, 1, 1, 127 4, 00 0			0		16 021	16 021	1 00
1. 02 00102 CAP REL 001 0 58. 130 58. 130 1. 02 4. 00 00500 APMINISTRATIVE & GENERAL 747, 102 4. 486, 112 5. 03. 575 5. 03. 575 5. 03. 575 5. 03. 575 5. 03. 575 5. 03. 575 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 5. 03. 570 7. 01 7. 02 7. 02 070 070 070 070 07. 02 070 07. 02 070 0. 0 0 0 0 0 0 0 7. 02 070 070 07. 02 070 070 07. 02 070 000 000 000 0			-				
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 39, 458 40, 714 80, 772 1, 051, 555 1, 131, 272 4. 00 5. 00 00500 OPERATION OF PLANT 406, 642 3, 370, 258 3, 776, 900 -3, 248, 417 528, 483 7, 00 7, 00 00701 OPERATION OF PLANT - MOSH TAL 0 0 0 1, 257, 193 1, 257, 193 1, 257, 193 1, 257, 193 1, 257, 193 7, 914 8, 00 0 0 0 7, 01 0700 OPERATION OF PLANT - MOSH 0 0 0 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 7, 914 8, 00 1, 00, 130 1, 00, 130 0, 130 0, 130 1, 00, 140 0 0 0 1, 00, 130 1, 00, 140 0, 0 0 0 0 0 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 1, 00, 130 <t< td=""><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></t<>			-				
5.00 00500 ADM IN STRATI VE & GENERAL 747, 102 4, 486, 112 5, 233, 214 670, 753 5, 903, 907 5, 00 7.00 00700 OPERATION OF PLANT HOSPI TAL 406, 642 3, 370, 258 3, 776, 900 -5, 248, 417 5, 258, 483 7, 00 7.00 00701 OPERATION OF PLANT HOSPI TAL 406, 642 3, 370, 258 37, 714 37, 914 37, 914 37, 914 37, 914 8, 00 0 7, 02 7, 02 000 000 0 0 7, 02 7, 02 072, 02 13, 914 8, 000 0 0 13, 992 356, 446, 25 9, 00 020, 0 0 0 127, 735 11, 00, 133, 992 356, 41, 205 10, 00 148, 071 148, 071 318, 611 466, 642 14, 001 13, 36, 014 -542, 209 1, 020, 835 1, 00 15, 00 10, 00 100 10 00 0 0 0 0 0 14, 001 33, 611 466, 642 14, 001 33, 611 466, 642 <td< td=""><td></td><td>39 458</td><td>0</td><td>-</td><td>,</td><td></td><td></td></td<>		39 458	0	-	,		
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7. 01 00701 DEPENTION OF PLANT - HOSPITAL 0 0 1, 257, 193 1, 257, 193 7, 01 7. 02 07020 DPERATION OF PLANT - MOBE 0 0 0 7, 02 8. 00 00800 LAINDRY & LINEN SERVICE 0 0 37, 914 37, 914 8, 00 0.00 00000 HOUSEKEEPING 248, 855 229, 762 478, 617 -113, 902 346, 465 10, 00 0 217, 315 217, 315 11, 00 110, 00 1000 CARTERIA 80, 09 0 0 0 17, 315 3217, 315 11, 00 14, 00 1000 1000 CENTRAL SERVICES & SUPPLY 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
7. 02 00702/ DPERATION OF PLANT - MOB 0 0 0 0 7. 02 80.0 00800 LAUNDRY & LINEN SERVICE 0 0 0 37. 914 37. 914 37. 914 8. 605 9.00 00900 HOUSEKEEPI NG 248, 855 229, 762 478, 617 -113. 992 364, 625 9. 00 11.00 01100 CAFETERI A 0 0 0 217, 315 217, 315 116, 605 10. 00 13.00 01300 NURSI NG ADMINISTRATION 816, 986 199, 431 1, 016, 417 -96, 633 920, 654 13. 00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td></t<>			0				
9. 00 00900(H0JEKEEPING 248.855 229.7c2 478.617 -113.992 364.625 9. 00 10.00 10000 DIETARY 138.628 260.928 399.556 -272.851 126.705 10.00 13.00 01300 NURSING ADMINISTRATION 816.986 199.431 1.016.417 -96.363 920.054 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 380.630 982.414 1.363.044 -342.209 1.020.835 15.00 15.00 01500 PIARMACY 0 <td< td=""><td>7.02 00702 OPERATION OF PLANT - MOB</td><td>0</td><td>0</td><td>C</td><td></td><td></td><td>7.02</td></td<>	7.02 00702 OPERATION OF PLANT - MOB	0	0	C			7.02
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11.00 01100 0217,315 217,315 217,315 11.00 13.00 01300 NURSI NG ADMINI STRATION 816,986 199,431 1.016,417 -96,363 920,054 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 380,630 982,414 1.363,044 -342,209 1,020,835 15.00 16.00 01500 PEARMACY 0	9. 00 00900 HOUSEKEEPI NG	248, 855	229, 762	478, 617	-113, 992	364, 625	9.00
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60.00 06000 LABORATORY 0 1, 159, 585 1, 159, 585 -12, 930 1, 146, 655 60.00 66.00 06600 PHYSI CAL THERAPY 262 530, 958 531, 220 -10, 980 520, 240 66.00 67.00 06700 0COUPATI IONAL THERAPY 0 187, 033 187, 033 0 187, 033 67.00 0 68.00 06800 SPEECH PATHOLOGY 69, 986 19, 885 89, 871 -14, 612 75, 259 68.00 69.00 06900 ELECTROCARDIOLOGY 42, 558 17, 326 59, 884 -8, 607 51, 277 70.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 14, 479 14, 479 73.01<							
66.00 06600 PHYSI CAL THERAPY 262 530, 958 531, 220 -10, 980 520, 240 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 187, 033 187, 033 0 187, 033 67.00 68.00 06800 SPECH PATHOLOGY 69, 986 19, 885 89, 871 -14, 612 75.25 % 68.00 69.00 06900 ELECTROCARDIOLOGY 42, 558 17, 326 59, 884 8, 607 51, 277 69.00 71.00 7300 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 14, 479 14, 479 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 105, 039 105, 039 73.01 73.01 07301 INCCLOGY DRUGS 0 0 0 11, 204 -11, 204 0 90.00 01000 DOUDE MERGENCY 10.080 83 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91.00 92.00 DSECIAL PURPOSE COST C							
67.00 06700 0CCUPATI 0NAL THERAPY 0 187,033 187,033 0 187,033 67.00 68.00 06800 SPEECH PATHOLOGY 69,986 19,885 89,871 -14,612 75,259 68.00 69.00 06900 ELECTROCARD IOLOGY 42,558 17,326 59,884 -8,607 51,129 35,129 35,129 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 14,479 14,479 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 187,033 0.73.01 000,000 218,789 218,789 73.01 73.01 07301 DRUGOS CHARGED TO PATIENTS 0 0 0 105,039 105,039 73.01 76.00 03160 CARDI OPULMONARY 664,901 221,649 886,550 -156,889 729,661 76.00 90.00 09000 CLI NI C 0 11,204 11,204 -11,204 0 90.00 91.00 D9000 CLI NI C 0 0 0 0 <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td></td>		-					
68.00 06800 SPECH PATHOLOGY 69,986 19,885 89,871 -14,612 75,259 68.00 69.00 06900 ELECTROCARDI OLOGY 42,558 17,326 59,884 -8.607 51,277 69.00 71.00 OT200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 35,129 35,129 71.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0 0 14,479 14,479 73.00 73.01 O7301 ONCLOGY DRUGS 0 0 0 156,389 72.9,661 76.00 03160 CARDI DPULMONARY 664,901 221,649 886,550 -15,6,889 72.9,661 76.00 01PATI ENT SERVICE COST CENTERS 1,080,883 2,595,817 3,676,700 -363,282 3,313,418 91.00 90.00 OSERVATI ON BEDS (NON-DI STI NCT PART) 1,080,883 2,595,817 3,676,700 -363,282 3,313,418 91.00 92.00 OSERVATI ON BEDS (NON-DI STI NCT PART) 1,080,883 2,595,817							
69.00 06900 ELECTROCARDIOLOGY 42,558 17,326 59,884 -8,607 51,277 69.00 71.00 MCDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 35,129 35,129 71.00 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 14,479 14,479 72.00 73.00 ORUGS CHARGED TO PATIENTS 0 0 0 14,479 14,479 73.00 73.01 073.01 NOLOLOGY DRUGS 0 0 0 14,479 14,479 73.00 73.01 073.01 NOLOLOGY DRUGS 0 0 0 0 105.039 105.039 73.01 76.00 03160 CARDI OPULMONARY 664,901 221,649 886,550 -156,889 729,61 70 0 70 0 0 0 90.00 90.00 90.00 91.00 9200 085610 11,204 11,204 -11,204 0 90.00 92.00 92.00 92.00 9200 0 0		-					
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 35, 129 35, 129 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 14, 479 14, 479 72.00 73.01 07300 DRUGS CHARGED TO PATIENTS 0 0 0 218, 789 218, 709 209, 73, 01 76.00 0 0 0 0 0 100, 823 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91.00 92.00 92.00 92.00 92.00 92.01 90.00 0 0 0 0 0 0 0 0							
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 14, 479 14, 479 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 218, 789 218, 789 73.00 73.01 07301 ONCOLOGY DRUGS 0 0 0 105, 039 105, 039 73.01 76.00 03160 CARDI OPULMONARY 664, 901 221, 649 886, 550 -156, 889 729, 661 76.00 0017PATIENT SERVICE COST CENTERS 0 11, 204 11, 204 -11, 204 0 90.00 90.00 09000 CLINIC 0 11, 080, 883 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 1, 080, 883 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STINCT PART) 1, 080, 883 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91.00 92.00 OPTHER RELIMBURSABLE_COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 510,							
73. 01 07301 0NCOLOGY DRUGS 0 0 105, 039 105, 039 73. 01 76. 00 03160 CARDI OPULMONARY 664, 901 221, 649 886, 550 -156, 889 729, 661 76. 00 00TPATIENT SERVICE COST CENTERS 0 11, 204 11, 204 -11, 204 0 90. 00 90. 00 09100 DMERGENCY 1, 080, 883 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91. 00 92. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 0 0 0 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 0 0 0 0 0 0 92. 00 92. 00 91. 00 101.00 HOME REALTH AGENCY 0 0 0 0 0 0 0 0 92. 00 92. 00 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 101. 00 100.	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	14, 479	14, 479	72.00
76.00 03160 CARDI OPULMONARY 664, 901 221, 649 886, 550 -156, 889 729, 661 76.00 0UTPATI ENT SERVICE COST CENTERS 0 11, 204 11, 204 -11, 204 0 90.00 90.00 09100 CLI NI C 0 11, 204 11, 204 -11, 204 0 90.00 91.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 1, 080, 883 2, 595, 817 3, 676, 700 -363, 282 3, 313, 418 91.00 92.00 OPSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 92.00 011.00 10100 HOME HEALTH AGENCY 0	73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	C	218, 789	218, 789	73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 11,204 11,204 -11,204 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 90.00 91.00 92.00 92.00 09200 0BES (NON-DI STINCT PART) 91.00 92.01 92.01 92.01 92.01 92.01 92.01 92.01 92.02 92.02 92.02 92.01 92.02 92.02 92.02 92.02 92.02		0	0	C	105, 039	105, 039	73.01
90.00 09000 CLINIC 0 11,204 11,204 -11,204 0 90.00 91.00 09100 EMERGENCY 1,080,883 2,595,817 3,676,700 -363,282 3,313,418 91.00 92.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 0 92.00 92.00 0 01010 HOME HEALTH AGENCY 0 0 0 0 101.00 0 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6,510,078 16,504,896 23,014,974 2,998 23,017,972 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 192.00 192.02 192.02 192.02 192.02 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.02 192.02 19200 NONREI MBURSABLE		664, 901	221, 649	886, 550	-156, 889	729, 661	76.00
91. 00 09100 EMERGENCY 1,080,883 2,595,817 3,676,700 -363,282 3,313,418 91.00 92.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 01100 HOME RELIMBURSABLE COST CENTERS 0 0 0 0 0 101.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECI AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6,510,078 16,504,896 23,014,974 2,998 23,017,972 118.00 190.00 I9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.02 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.02 192.02 19202 MOB 0 9,311 9,311 -2,998 6,313 192.02 192.02 19200 NONREI MBURSABLE 0 0 0 0 192.02		1					
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 0THER REIMBURSABLE COST CENTERS 0		-				-	
OTHER REIMBURSABLE COST CENTERS IOT. 00 IOT. 00<		1, 080, 883	2, 595, 817	3, 676, 700	-363, 282	3, 313, 418	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6,510,078 16,504,896 23,014,974 2,998 23,017,972 118.00 NONREI MBURSABLE COST CENTERS 190.00 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 IPYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.00 192.02 192002 MOB 0 9,311 9,311 -2,998 6,313 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 510, 078 16, 504, 896 23, 014, 974 2, 998 23, 017, 972 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 0 190.00 190.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 192.00 193.00 NONPAI D WORKERS 0 0 193.00 193.00 193.00 193.00 193.00 193.00 193.00 194.00 0 0 0 193.00 194.00 0 0 194.00 0 0 194.00 0 0 194.00 0 0 0 194.00 0 0 194.00 0 0 194.00 0 0 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 <td></td> <td>0</td> <td>0</td> <td>C C</td> <td></td> <td>0</td> <td>101 00</td>		0	0	C C		0	101 00
I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 6, 510, 078 16, 504, 896 23, 014, 974 2, 998 23, 017, 972 118.00 NONREL MBURSABLE COST CENTERS NONREL MBURSABLE COST CENTERS 0 0 0 0 190.00 1910.00 1910.00 1910.00 1910.00 1910.00 1910.00 1910.00 1910.00 1910.00 1910.00 1910.00 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 193.00 193.00 193.00 0 0 0 193.00 193.00 193.00 194.00 0 0 0 194.00 0 0 194.00 0 0 0 194.00 0 0 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00 194.00		<u> </u>	0		0	0	101.00
NONRE MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 192.02 19202 MOB 0 9, 311 9, 311 -2, 998 6, 313 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00		6 510 078	16 504 896	23 014 974	2 998	23 017 972	118 00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19100 RESEARCH 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.02 MOB 0 9, 311 9, 311 -2, 998 6, 313 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00		0,010,010	10/001/070	20/011////	2,770	20/01///2	
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 192.02 19202 MOB 0 9, 311 9, 311 -2, 998 6, 313 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00		0	0	C	0 0	0	190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 192.02 19202 MOB 0 9, 311 9, 311 -2, 998 6, 313 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00		o	-		-		
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00	192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0 0	0	192.00
194.00 07950 LEASED SPACE 0 0 0 0 194.00		0	9, 311	9, 311	-2, 998	6, 313	192. 02
		0	0	C	0		
200.00 TOTAL (SUM OF LINES 118 through 199) 6,510,078 16,514,207 23,024,285 0 23,024,285 200.00		-	0	C	-		
	200.00 TOTAL (SUM OF LINES 118 through 199)	6, 510, 078	16, 514, 207	23, 024, 285	0	23, 024, 285	200. 00

RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet A Date/Time Pr 6/29/2020 8:	epared: 37 am
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00			0,2,,2020 01	
	GENERAL SERVICE COST CENTERS	0.00	7.00				_
1.00	00100 CAP REL COSTS-BLDG & FIXT	0	16, 021				1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	124, 348					1.0
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB	124, 340	58, 130				1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	390, 540					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	-95, 125					5.00
7.00	00700 OPERATION OF PLANT	-36, 598					7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL	-44, 344					7.0
7.02	00702 OPERATION OF PLANT - MOB	0	1, 212, 047				7.02
7.02 B.00	00800 LAUNDRY & LINEN SERVICE	0					8.00
7.00 7.00	00900 HOUSEKEEPING	0	364, 625				9.00
7.00 10.00			126, 705				10.00
10.00 11.00		-71, 459					11.00
13.00		30, 381					13.00
13.00 14.00							
		24,635					14.00
15.00		-361, 960					15.00
16.00		0	0				16.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-273, 292	1, 139, 973				30. 00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	-213, 292	1, 139, 973				
50.00		-141, 268	618, 195				50.00
50.00 54.00		-211					54.00
54.00 50.00		0					60.00
66. 00		0	520, 240				66.00
67.00		0	187, 033				67.00
68. 00		0	75, 259				68.00
69.00		0	51, 277				69.00
71.00			35, 129				71.00
72.00		0	14, 479				72.00
72.00			218, 789				73.00
73.00 73.01	07301 ONCOLOGY DRUGS		105, 039				73.0
76.00		77,972					76.00
70.00	OUTPATIENT SERVICE COST CENTERS	11, 712	007,033				/0.00
90.00		0	0				90.00
91.00		-675, 532					91.00
92.00		075,552	2,037,000				92.00
/2.00	OTHER REIMBURSABLE COST CENTERS						/2.00
101 0	D 10100 HOME HEALTH AGENCY	0	0				101.00
	SPECIAL PURPOSE COST CENTERS						
118.0		-1,051,913	21, 966, 059				118.00
	NONREI MBURSABLE COST CENTERS						
190. 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	0 19100 RESEARCH	0	0				191.0
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.0
	2 19202 MOB	0	6, 313				192.0
	0 19300 NONPAI D WORKERS	0	0,010				193.00
	007950 LEASED SPACE	0	0				194.00
0	D TOTAL (SUM OF LINES 118 through 199)	-1, 051, 913	-				200.00

/01/2019 /31/2019 6/29/2020 8:37 am 1.00 1.00 2.00 3.00 4.00 5.00 6.00
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Heal th	Financial Systems		IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider C	CN: 15-1316	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 6/29/2020 8:	epared:
		Increases					6/29/2020 8:	3/ am
	Cost Center	Li ne #	Salary	Other				
	2.00	3,00	4.00	5.00				
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
	TOTALS	T	0	1,051,555				
	I – HOUSEKEEPING							
1.00	HOUSEKEEPI NG	9.00	0	2, 055				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	0	0				7.00
8.00		0.00	0	<u>0</u>				8.00
	TOTALS		0	2, 055				_
	K - MOB MAINTENANCE AND RENT							_
	CAP REL COSTS-BLDG & FIXT -	1. 02	0	3, 000				1.00
	MOB	+						
	TOTALS		0	3, 000				-
	L - ONCOLOGY	F0.00		44.001				1.00
	OPERATING_ROOM	<u>50.00</u>	및	<u> </u>				1.00
	TOTALS		0	11, 204				500.00
500.00	Grand Total: Increases		87, 570	5, 643, 132				500.00

	Financial Systems SIFICATIONS	1	U HEALTH FRANKF		CCN: 15-1316	Period:	eu of Form CMS-255 Worksheet A-6
						From 01/01/2019 To 12/31/2019	Date/Time Prepar
		Decreases					6/29/2020 8:37 a
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref.	1	
	6.00	7.00	8.00	9.00	10.00		
00	A - CAFETERIA	10.00	97 570	120 745	0	N	
00	<u>DI ETARY</u>	10.00	8 <u>7,570</u> 87,570	<u>129, 7</u> 45 129, 745			
	B – DRUGS	1			1	1	
00	PHARMACY	15.00	0	286, 540			1
00 00	ADULTS & PEDIATRICS OPERATING ROOM	30.00 50.00	0	4, 445 1, 135			
00	RADI OLOGY-DI AGNOSTI C	54.00	0	20, 836			
00	PHYSI CAL THERAPY	66.00	o	96			5
00	CARDI OPULMONARY	76.00	0	1, 897	C		6
00	EMERGENCY	91.00	0	8, 879)	7
	TOTALS		0	323, 828	1		
00	C - MEDICAL SUPPLIES OPERATION OF PLANT	7.00	0	34, 178	C		1
00	HOUSEKEEPING	9.00	o	5, 376	-		
00	DI ETARY	10.00	0	38			
00	PHARMACY	15.00	0	2, 846	C		4
00	ADULTS & PEDIATRICS	30.00	0	70, 757			Ę
00	OPERATING ROOM	50.00	0	80, 586			6
00	RADI OLOGY-DI AGNOSTI C	54.00	0	18, 898			
00 00	LABORATORY PHYSI CAL THERAPY	60.00 66.00	0	12, 930 7, 562			8
. 00	ELECTROCARDI OLOGY	69.00	0	5, 874			10
. 00	CARDI OPULMONARY	76.00	0	10, 994			11
. 00	EMERGENCY	91.00	0	144, 022			12
	TOTALS		o	394, 061]	
~~	D - LAUNDRY	44.00		E E0/	1	.]	
00	CENTRAL SERVICES & SUPPLY	14.00	0	5, 596			1
00 00	ADULTS & PEDIATRICS OPERATING ROOM	30.00 50.00	0	10, 108 1, 830			
00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 447	-		
00	PHYSI CAL THERAPY	66.00	o	2, 417			Ę
00	ELECTROCARDI OLOGY	69.00	0	927			6
00	CARDI OPULMONARY	76.00	0	250			7
00	EMERGENCY	91.00	0	<u> </u>)	8
	TOTALS E - DEPRECIATION		0	37, 914	•		
00	OPERATION OF PLANT	7.00	0	1, 305, 648	9		1
00	HOUSEKEEPING	9.00	0	1, 736			
00	DI ETARY	10.00	0	6, 107			3
00	PHARMACY	15.00	0	1, 488	C		4
00	ADULTS & PEDIATRICS	30.00	0	23, 645			Ę
00	OPERATING ROOM	50.00	0	380, 194			6
00 00	RADI OLOGY-DI AGNOSTI C PHYSI CAL THERAPY	54.00 66.00	0	53, 931 631			5
00	CARDI OPULMONARY	76.00	0	53, 958			
. 00	EMERGENCY	91.00	o	13, 790			10
	TOTALS		<u>_</u>	1, 841, 128			
	F - OTHER CAPITAL				1		
00	OPERATION OF PLANT	7.00	0	549, 167			1
00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 021			2
00	ADMI NI STRATI VE & GENERAL	5.00	0	547			3
00	ADMI NI STRATI VE & GENERAL TOTALS		0	2 <u>5, 7</u> 14 591, 449			4
	G - OPERATION OF PLANT		<u> </u>	571, 447		1	
00	OPERATION OF PLANT	7.00	0	1, 257, 193	C)	1
	TOTALS		0	1, 257, 193			
	H - EMPLOYEE BENEFITS				1	J	
00	ADMINISTRATIVE & GENERAL	5.00 7.00	0	27, 302			1
00 00	OPERATION OF PLANT HOUSEKEEPING	9.00	0	102, 231 108, 935	-		4
00	DI ETARY	10.00	0	49, 349			
00	NURSING ADMINISTRATION	13.00	0	96, 451			5
00	PHARMACY	15.00	Ō	50, 747			6
00	ADULTS & PEDIATRICS	30.00	О	171, 733	C		1
00	OPERATING ROOM	50.00	о	45, 444			8
00	RADI OLOGY-DI AGNOSTI C	54.00	0	110, 667			9
. 00	PHYSI CAL THERAPY	66.00	0	11			10
. 00 . 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68.00 69.00	0	14, 612 1, 806			11
. 00	CARDI OPULMONARY	76.00	0	89, 762			13
. 00	EMERGENCY	91.00	0	182, 505			12
	TOTALS	+		1,051,555		1	1 .

Heal th	Financial Systems	I	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2552-
RECLAS	SI FI CATI ONS			Provider (CCN: 15-1316	Period: From 01/01/2019	Worksheet A-6
						To 12/31/2019	Date/Time Prepared 6/29/2020 8:37 am
		Decreases					
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	· .	
	6.00	7.00	8.00	9.00	10.00		
	I - HOUSEKEEPING						
1.00	DI ETARY	10.00	0	42		0	1.
2.00	PHARMACY	15.00	0	588		0	2.
3.00	ADULTS & PEDIATRICS	30.00	0	164		0	3.
4.00	OPERATING ROOM	50.00	0	96		0	4.
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	127		0	5.
6.00	PHYSI CAL THERAPY	66.00	0	263		0	6.
7.00	CARDI OPULMONARY	76.00	0	28		0	7.
8.00	EMERGENCY	91.00	0	747		0	8.
	TOTALS		0	2, 055			
	K - MOB MAINTENANCE AND RENT						
1.00	MOB	192.02	0	3, 000	1	0	1.
	TOTALS		o	3,000			
	L - ONCOLOGY						
1.00		90.00	0	11, 204		0	1.
	TOTALS	— — — T	ī	11, 204		7	
500.00	Grand Total: Decreases		87, 570	5, 643, 132			500.

Heal th	Financial Systems	U HEALTH FRANK	FORT HOSPITAL			In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Fro	riod: om 01/01/2019 12/31/2019		pared:
				Acqui si ti on	IS			
		Begi nni ng Bal ances	Purchases	Donati on		Total	Disposals and Retirements	
		1,00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2.00	0.00		1.00	0.00	
1.00	Land	807, 164	143, 883		0	143, 883	0	1.00
2.00	Land Improvements	0	16, 117		0	16, 117		
3.00	Buildings and Fixtures	47, 253	0		0	0	11, 938	
4.00	Building Improvements	1, 425, 477	0		0	0	0	
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	5, 339, 042	157, 727		0	157, 727	751, 574	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	7, 618, 936	317, 727		0	317, 727	763, 512	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	7, 618, 936	317, 727		0	317, 727	763, 512	10.00
		Ending Balance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	951, 047	0					1.00
2.00	Land Improvements	16, 117	0					2.00
3.00	Buildings and Fixtures	35, 315	0					3.00
4.00	Building Improvements	1, 425, 477	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	4, 745, 195	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	7, 173, 151	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	7, 173, 151	0					10.00

Heal th	Financial Systems	U HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1316	Period: From 01/01/2019 To 12/31/2019		
			SL	JMMARY OF CAP	'I TAL		
	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 & FIXT	0	0		0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0		0 0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0		0 0	0	1.02
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)		-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0				1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0				1.02
3.00	Total (sum of lines 1-2)	0	0	1			3.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			-	Period: From 01/01/2019 To 12/31/2019	Date/Time Prep 6/29/2020 8:37	
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	-				
1.00 CAP REL COSTS-BLDG & FIXT	0	,		0 0. 000000	0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	7, 013, 152		7, 013, 15		0	1.01
1.02 CAP REL COSTS-BLDG & FIXT - MOB	160, 000	0	160, 00	0 0. 022305	0	1.02
3.00 Total (sum of lines 1-2)	7, 173, 152		7, 173, 15			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0)	0 0	0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0)	0 1, 014, 669	549, 167	1.01
1.02 CAP REL COSTS-BLDG & FIXT - MOB	0	0)	0 29, 416	3, 000	1.02
3.00 Total (sum of lines 1-2)	0	0)	0 1, 044, 085	552, 167	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	1	1		14 001	
1.00 CAP REL COSTS-BLDG & FLXT	0	16, 021		0 0	16, 021	1.00
1.01 CAP REL COSTS-BLDG & FLXT - HOSPITAL	181, 210			0	1, 745, 593	1.01
1.02 CAP REL COSTS-BLDG & FIXT - MOB	181, 210	0 16, 568	20,71		58, 130 1, 819, 744	1.02 3.00
3.00 Total (sum of lines 1-2)						

DJUSTMENTS TO EXPEN	JL J				Period: From 01/01/2019 To 12/31/2019		pared
			1	Expense Classification on o/From Which the Amount is			
Cost Cen	ter Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
00 Investment ind	come - CAP REL	1.00	2.00	3.00 AP REL COSTS-BLDG & FIXT	4.00	5.00	1. (
01 Investment inc COSTS-BLDG & F	IXT (chapter 2) come - CAP REL IXT - HOSPITAL	В		AP REL COSTS-BLDG & FIXT - IOSPITAL	1.01	11	1. (
(chapter 2) 02 Investment ind COSTS-BLDG & F				AP REL COSTS-BLDG & FIXT - 10B	1.02	0	1. (
(chapter 2) 00 Investment inc			0 *	** Cost Center Deleted ***	2.00	0	2.
COSTS-MVBLE EC 00 Investment inc	OUIP (chapter 2)		0		0.00	0	3.
(chapter 2) 00 Trade, quantit	v and time		0		0.00	0	4.
di scounts (cha	pter 8)		-				
00 Refunds and re expenses (char			0		0.00	0	5.
00 Rental of prov suppliers (cha	ider space by		0		0.00	0	6.
00 Tel ephone serv stations exclu 21)	ices (pay		0		0.00	0	7.
00 Tel evi si on and	l radio service		0		0.00	0	8.
(chapter 21) 00 Parking lot (d	hapter 21)		о		0.00	0	9.
.00 Provider-based adjustment		A-8-2	-1, 251, 223			0	
.00 Sale of scrap, (chapter 23)	waste, etc.		0		0.00	0	11.
. 00 Related organi transactions (A-8-1	1, 729, 508			0	12.
8.00 Laundry and Li	nen servi ce		О		0.00		
	oyees and guests ters to employee		-71, 4590 0	AFETERI A	11.00 0.00		
	l and surgical her than		О		0.00	0	16
.00 Sale of drugs	to other than		О		0.00	0	17.
patients 8.00 Sale of medica	I records and		0		0.00	0	18.
2.00 Nursing and al education (tui			О		0.00	0	19.
books, etc.) 0.00 Vending machir	ies		о		0.00	0	20.
.00 Income from in interest, fina charges (chapt	ince or penalty		0		0.00	0	21.
2.00 Interest exper overpayments a repay Medicare	nd borrowings to		0		0.00	0	22.
Adjustment for therapy costs limitation (ch	respiratory in excess of	A-8-3	0*	** Cost Center Deleted ***	65.00		23.
. 00 Adjustment for therapy costs limitation (ch	physical in excess of	A-8-3	OF	HYSI CAL THERAPY	66.00		24.
.00 Utilization re physicians' co (chapter 21)	eview -		0*	** Cost Center Deleted ***	114.00		25.
00 Depreciation -			oc	AP REL COSTS-BLDG & FIXT	1.00	0	26.
. 01 Depreciation -	CAP REL	А		AP REL COSTS-BLDG & FIXT -	1.01	9	26.
0.02 Depreciation -			oc	IOSPITAL CAP REL COSTS-BLDG & FIXT -	1.02	0	26.
COSTS-BLDG & F 7.00 Depreciation -	CAP REL			IOB ** Cost Center Deleted ***	2.00	0	27.
COSTS-MVBLE EC 3.00 Non-physician			0	** Cost Center Deleted ***	19.00		28.
9.00 Physicians' as			Ō		0.00		29.

IU HEALTH FRANKFORT HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

Health Financial Systems	IU HEALTH FRANKFO	RT HOSPI TAL	In Lie	u of Form CMS-2	552-10
ADJUSTMENTS TO EXPENSES		Provider CCN: 15-1316	Period: From 01/01/2019	Worksheet A-8	
				Date/Time Prep 6/29/2020 8:37	
	Тс	Expense Classification o D/From Which the Amount i			

			A	Cont Contor	1.5		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	<u>Line #</u> 4.00	Wkst. A-7 Ref. 5.00	
30,00	Adjustment for securational	A-8-3		OCCUPATI ONAL THERAPY	4.00		30, 00
30.00	Adjustment for occupational	A-8-3	0	UCCUPATIONAL THERAPY	67.00		30.00
	therapy costs in excess of						
20.00	limitation (chapter 14)		0		20.00		30, 99
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
21 00		A-8-3	0	SPEECH PATHOLOGY	(0,00		21 00
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
32.00	Depreciation and Interest		0		0.00	0	32.00
33.00	EMPLOYEE BENEFITS	А	1 052 000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.00	MEDICALD HAF FEES	A		ADMI NI STRATI VE & GENERAL	4.00 5.00		33.00
33.01	MI SCELLANEOUS I NCOME	B		ADMINI STRATI VE & GENERAL	5.00	0	33.02
33.02	ACCRUED PTO			EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.02 33.03
33.03	ACCRUED PTO	A		ADMINISTRATIVE & GENERAL			33.03 33.04
33.04	CONTRIBUTION EXPENSE	A			5.00		
		A		ADMI NI STRATI VE & GENERAL	5.00		33.05
33.06	AMORTIZED START UP COSTS	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.06
33.07	MARKETING	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.07
33.08	MARKETING	A		RADI OLOGY-DI AGNOSTI C	54.00		33.08
33.09	MARKETING	A		EMERGENCY	91.00	0	33.09
33.10	DEPRECIATION ON CAPITALIZED	A		CAP REL COSTS-BLDG & FIXT -	1.01	9	33.10
	ASSETS			HOSPITAL			
33.11	START UP COST NEW HOSPITAL	A		ADMINISTRATIVE & GENERAL	5.00	0	33.11
50.00	TOTAL (sum of lines 1 thru 49)		-1, 051, 913				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1316 Period: OFFICE COSTS Provider CCN: 15-1316 Period: From 01/01/ To 12/31/	
	6/29/2020 8:37 am
Line No. Cost Center Expense I tems Amount o	
Allowable (
	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. 01 CAP REL COSTS-BLDG & FIXT - HOME OFFICE -254,	451 0 1.00
2.00 4.00 EMPLOYEE BENEFITS DEPARTMENT HOME OFFICE 1,477,	250 0 2.00
3. 00 5. 00 ADMI NI STRATI VE & GENERAL HOME OFFICE 3, 811,	551 3, 418, 885 3. 00
3. 01 5. 00 ADMI NI STRATI VE & GENERAL RELATED PARTY 765,	560 502, 768 3. 01
3. 02 7. 00 OPERATION OF PLANT RELATED PARTY 49,	919 86, 517 3. 02
3. 03 7. 01 OPERATION OF PLANT - HOSPITA RELATED PARTY 56,	744 101, 088 3. 03
4. 00 13. 00 NURSI NG ADMI NI STRATI ON RELATED PARTY 30,	381 0 4.00
4. 01 14. 00 CENTRAL SERVICES & SUPPLY RELATED PARTY 162,	587 137, 952 4. 01
4. 02 15. 00 PHARMACY RELATED PARTY 217,	946 579, 906 4. 02
4. 03 30. 00 ADULTS & PEDI ATRI CS RELATED PARTY 105,	726 48, 372 4. 03
4. 04 50. 00 OPERATING ROOM RELATED PARTY 193,	052 92, 266 4. 04
4. 05 76. 00 CARDI OPULMONARY RELATED PARTY 77,	972 0 4.05
4. 06 91. 00 EMERGENCY RELATED PARTY 71,	68, 939 4. 06
4. 07 30. 00 ADULTS & PEDI ATRI CS SHARED EMPLOYEES 330,	330, 646 4. 07
4.08 50.00 OPERATING ROOM SHARED EMPLOYEES 262,	262, 054 4. 08
4. 09 60. 00 LABORATORY SHARED EMPLOYEES 1, 138,	281 1, 138, 281 4. 09
5.00 TOTALS (sum of lines 1-4). 8,497,	182 6, 767, 674 5. 00
Transfer column 6, line 5 to	
Worksheet A-8, column 2,	
Line 12.	

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

1103 1101	been posted to worksheet A,	corumns ranu/or z, the amount	it allowable si		FOI this part.	
				Related Organization(s) and	'or Home Office	
						1
						1
						
	Symbol (1)	Name	Percentage of	Name	Percentage of	1
			Ownershi p		Ownershi p	1
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELAT	FED ORGANIZATION(S) AND/OR HO	ME_OFFLCE:			

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	0.00	6.00
7.00	В	I UH ARNETT	1.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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 provider.

Health Financial Sys	tems	IU HEALTH FRAI	KFORT HOS	PI TAL		In Lieu	u of Form C	MS-2552-10
STATEMENT OF COSTS (OFFICE COSTS	F SERVICES FROM RELATED	O ORGANIZATIONS AND HO	ME Prov	ider CCN:	15-1316	d: 01/01/2019 12/31/2019		Prepared:

					6/29/2020 8:	37 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRAI	NSACTIONS WITH RELATED O	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO		1			_
1.00	-254, 451					1.00
2.00	1, 477, 250					2.00
3.00	392, 666					3.00
3.01	262, 792					3. 01
3.02	-36, 598					3. 02
3.03	-44, 344					3. 03
4.00	30, 381					4.00
4.01	24, 635					4.01
4.02	-361, 960					4. 02
4.03	57, 354					4.03
4.04	100, 786	0				4.04
4.05	77, 972	0				4.05
4.06	3, 025	0				4.06
4.07	0	0				4.07
4.08	0	0				4.08
4.09	0	0				4.09
5.00	1, 729, 508					5.00
* Tho	amounts on Lin	os 1 4 (and sub	oscrints as annronriate) are trans	forred in detail to Worl	kehoot A column 6 lines os	

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.

Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED 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	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
100.00	100.00
(1) Use the fallowing symbols to indicate intervalationship to related ergeni	zati enc.

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

Heal th I	Financial Syste	ems	IU HEALTH FRAN	KFORT HOSPITAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC		-		CN: 15-1316	Period:	Worksheet A-8	
						From 01/01/2019 To 12/31/2019	Date/Time Pre	
	With the table of table o	Cont Conton (Dhuri si an	T-+-1	Durfereiteurel	Durautiataur	DOE Amount	6/29/2020 8: 3	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component	
		rdentifier	Remuneration	component	component		Hours	
	1.00	2.00	3.00	4.00	5.00	6, 00	7,00	
1.00		ADULTS & PEDIATRICS	330, 646			0.00		1.00
2.00		OPERATING ROOM	242, 054					
3.00		EMERGENCY	1, 977, 905		1, 299, 38		-	
4.00	0.00		0	0			0	
5.00	0.00		0				0	
6.00	0.00		0	0		ol o	0	
7.00	0, 00		0	0			0	
8.00	0.00		0	0			0	
9.00	0.00		0	0			0	
10.00	0.00		0	0			0	
200.00	01.00		2, 550, 605	1, 251, 223	1, 299, 38		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200100
		I denti fi er		Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0			0 0	0	1.00
2.00		OPERATING ROOM	0		(0	2.00
3.00		EMERGENCY	0	0	(0 0	0	3.00
4.00	0.00		0	0	(0 0	0	4.00
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0.00		0	0	(0 0	0	
8.00	0.00		0	0	(°	0	
9.00	0.00		0	0	(0 0	0	
10.00	0.00		0	0	(-	0	
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1 00	2.00	14 15. 00	16.00	17.00	10.00		
1.00	1.00	2.00 ADULTS & PEDIATRICS	15.00	16.00 0	17.00	18.00 330,646		1.00
2.00		OPERATING ROOM	0			242,054		2.00
3.00		EMERGENCY	0			678, 523		2.00 3.00
4.00	91.00 0.00		0	0				4.00
4.00 5.00	0.00			0		°		4.00 5.00
5.00 6.00	0.00			0				5.00 6.00
7.00	0.00		0					7.00
8.00	0.00							7.00 8.00
9.00	0.00		0					9.00
10,00	0.00							9.00 10.00
200.00	0.00		0			1, 251, 223		200.00
200.00			1 0	0	l '	1,201,220	I	200.00

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CC	N: 15-1316	Period: From 01/01/2019 To 12/31/2019		pared:				
					Physical Therapy						
						1.00					
	PART I - GENERAL INFORMATION										
. 00 . 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruct	ions)			52 780					
. 00	Number of unduplicated days in which supervis	sor or therapist	was on provid	der site (se	e instructions)	288	•				
. 00	Number of unduplicated days in which therapy	assistant was o				15					
. 00	nor therapist was on provider site (see inst		nicto (coo in	structions)		0	5.00				
. 00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				by therapy	0	6.00				
	assistant and on which supervisor and/or the										
. 00	instructions) Standard travel expense rate					5.80	7.00				
. 00	Optional travel expense rate per mile					0.00					
		Supervi sors	Therapi sts	Assi stants		Trai nees					
. 00	Total hours worked	1.00	2.00 6,578.20	3.00	4.00 32 1,105.96	5.00	9.00				
0.00	AHSEA (see instructions)	0.00	84.94		21 33.60		•				
1. 00	Standard travel allowance (columns 1 and 2,	42.47	42.47	27.	61		11.00				
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)										
2.00	Number of travel hours (provider site)	0	о		0		12.00				
2. 01	Number of travel hours (offsite)	0	0		0		12.01				
3.00	Number of miles driven (provider site)	0	0		0		13.00				
3.01	Number of miles driven (offsite)	U	0		U		13.01				
						1.00					
1 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	lino 10)				0	14.00				
4.00 5.00	Therapists (column 2, line 9 times column 2,					558, 752					
6.00	Assistants (column 3, line 9 times column 3,					5, 428					
7.00	Subtotal allowance amount (sum of lines 14 and	nd 15 for respir	atory therapy	or lines 14	-16 for all	564, 180	17.00				
8.00	others) Aides (column 4, line 9 times column 4, line	10)				37, 160	18.00				
9.00	Trainees (column 5, line 9 times column 5, li					0	19.00				
0.00	Total allowance amount (sum of lines 17-19 fo						20.00				
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than										
	the amount from line 20. Otherwise complete	lines 21-23.				11110 20					
1.00	Weighted average rate excluding aides and tra			m of columns	s 1 and 2, line 9	0.00	21.00				
2.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained					0	22.00				
3.00	Total salary equivalency (see instructions)					601, 340	•				
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPL	JTATION - PF	ROVIDER SITE		-				
4 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					12, 231	24 00				
5.00	Assistants (line 4 times column 3, line 11)					414					
6.00						12, 645					
7 00		for respiratory	therapy or su								
7.00	· ·	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others)									
7.00 8.00	Total standard travel allowance and standard	travel expense	at the provide			1, 757 14, 402					
	27)	•	at the provide								
8. 00	27) Optional Travel Allowance and Optional Travel	Expense	•			14, 402	28.00				
	27)	Expense of columns 1 and	•				28. 00 29. 00				
8.00 9.00 0.00 1.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	Expense of columns 1 and line 12) sum of lines 29	2, line 12) and 30 for al	er site (sum	n of lines 26 and	14, 402 0 0 0 0	28.00 29.00 30.00 31.00				
8.00 9.00 0.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	Expense of columns 1 and line 12) sum of lines 29	2, line 12) and 30 for al	er site (sum	n of lines 26 and	14, 402 0 0	28. 00 29. 00 30. 00 31. 00				
8.00 9.00 0.00 1.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line	12, line 12) and 30 for al 13 for respira	er site (sum	n of lines 26 and	14, 402 0 0 0 0	28.00 29.00 30.00 31.00 32.00				
8.00 9.00 0.00 1.00 2.00 3.00 4.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o	1 2, line 12) and 30 for al 13 for respira 28) f lines 27 and	er site (sum	n of lines 26 and	14, 402 0 0 0 14, 402 0	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00				
8.00 9.00 0.00 1.00 2.00 3.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and optional travel	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	12, line 12) and 30 for al 13 for respira 28) of lines 27 and f lines 31 and	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 0 14, 402 0 0	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00				
8.00 9.00 0.00 1.00 2.00 3.00 4.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	12, line 12) and 30 for al 13 for respira 28) of lines 27 and f lines 31 and	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 0 14, 402 0 0	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00				
8.00 9.00 0.00 1.00 2.00 3.00 4.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11)	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	12, line 12) and 30 for al 13 for respira 28) of lines 27 and f lines 31 and	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o	12, line 12) and 30 for al 13 for respira 28) of lines 27 and f lines 31 and	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00				
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37)	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL	and 30 for al and 30 for al 13 for respira 28) of Lines 27 and f Lines 31 and EXPENSE COMPU	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL	and 30 for al and 30 for al 13 for respira 28) of Lines 27 and f Lines 31 and EXPENSE COMPU	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL n of lines 5 and Expense D1 times column	and 30 for al and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00				
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 0.00 1.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Assistants (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NCE AND TRAVEL n of lines 5 and Expense D1 times column	and 30 for al and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPUT	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.01 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL n of lines 5 and Expense 1 times column n 3, line 10)	and 30 for al 13 for respira 28) f lines 27 and f lines 31 and EXPENSE COMPU 6) 2, line 10)	er site (sum I others) atory therap d 31) d 32)	n of lines 26 and	14, 402 0 0 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00				
8.00 9.00 0.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 0.00 1.00 2.00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - C	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o NNCE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) n of columns 1-3	and 30 for al 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPU () 2, line 10) () 1 ine 13.01)	er site (sum ll others) atory therap d 31) d 32) FATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	14, 402 0 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00				
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 0. 00 0. 00 1. 00 2. 00	27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum o expense (sum o INCE AND TRAVEL m of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-3 offsite Services	2, line 12) and 30 for al 13 for respira 28) of lines 27 and f lines 31 and EXPENSE COMPUT (6) 2, line 10) 5, line 13.01) ; Complete one	er site (sum ll others) atory therap d 31) d 32) FATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	14, 402 0 0 0 14, 402 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00				

alth Financial Systems I EASONABLE COST DETERMINATION FOR THERAPY SERVICES JTSIDE SUPPLIERS	U HEALTH FRANKFO FURNI SHED BY	Provider CO	CN: 15-1316	Period: From 01/01/2019 To 12/31/2019		-3
					6/29/2020 8:3	
				Physical Therapy	Cost	
					1.00	
6.00 Optional travel allowance and optional travel	expense (sum o		d 43 - see ir	istructions)		46.0
	Therapists	Assistants	Aides	Trai nees	Total	
PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7.00 Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.0
period (if column 5, line 47, is zero or						
equal to or greater than 2,080, do not						
complete lines 48-55 and enter zero in each						
column of line 56) 8.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
9.00 Total overtime (including base and overtime	0.00	0.00				49.0
allowance) (multiply line 47 times line 48)						
CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
(divide the hours in each column on line 47 by the total overtime worked - column 5,						
line 47)						
1.00 Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51. C
for one full-time employee times the						
percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE						
2.00 Adjusted hourly salary equivalency amount	84. 94	55. 21	33. 6	0.00		52.0
(see instructions)	01.71	00.21	00.0	0.00		02.0
3.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.0
52)						
4.00 Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.0
5.00 Portion of overtime already included in	0	0		0 0		55.0
hourly computation at the AHSEA (multiply		0		0		
line 47 times line 52)						
6.00 Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.0
if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A 7.00 Salary equivalency amount (from line 23)	IND EXCESS CUST A	ADJUSTMENT			601, 340	57.0
B. 00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			14, 402	
9.00 Travel allowance and expense - Offsite servic)		0	59.0
0.00 Overtime allowance (from column 5, line 56)					0	60. (
1.00 Equipment cost (see instructions)					0	61.0
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62)					0	
3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from	vour records)				615, 742 506, 873	
5.00 Excess over limitation (line 64 minus line 63		enter zero)				65.0
LINE 33 CALCULATION	¥					
00.00 Line 26 = line 24 for respiratory therapy or					12, 645	
00.01 Line 27 = line 7 times line 3 for respiratory	/ therapy or sum	of lines 3 a	nd 4 for all	others	1, 757	
					14, 402	100. 0
00.02 Line 33 = line 28 = sum of lines 26 and 27		<u> </u>	nd 4 for all	others	1, 757	101 0
LINE 34 CALCULATION	thorapy or sum			others		101.0
LINE 34 CALCULATION D1.00 Line 27 = line 7 times line 3 for respiratory					()	
LINE 34 CALCULATION					0 1, 757	
LINE 34 CALCULATION D1.00 Line 27 = line 7 times line 3 for respiratory D1.01 Line 31 = line 29 for respiratory therapy or D1.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29	and 30 for a	II others			
LINE 34 CALCULATION D1.00 Line 27 = line 7 times line 3 for respiratory D1.01 Line 31 = line 29 for respiratory therapy or D1.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION D2.00 Line 31 = line 29 for respiratory therapy or	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	II others		1, 757	101. (102. (
LINE 34 CALCULATION D1.00 Line 27 = line 7 times line 3 for respiratory D1.01 Line 31 = line 29 for respiratory therapy or D1.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	II others	mns 1-3, line	1, 757	101. (

	IABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provider CC	N: 15-1316	Peri od: From 01/01/2019 To 12/31/2019 Occupati onal Therapy	Worksheet A-8 Parts I-VI Date/Time Pre 6/29/2020 8:3 Cost	pared:		
					-	1.00			
1 00	PART I - GENERAL INFORMATION) (coo i potruo	ti ana)			52	1 00		
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see finstruc	tions)			52 780	1.00		
3.00	Number of unduplicated days in which supervis	or or therapis	t was on provid	der site (see	e instructions)	192			
4.00	Number of unduplicated days in which therapy		on provider si	te but neithe	er supervisor	221	4.00		
5.00	nor therapist was on provider site (see instr	0	5.00						
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions) 0 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy 0								
	assistant and on which supervisor and/or therapist was not present during the visit(s)) (see								
7.00	instructions) Standard travel expense rate					5.80	7.00		
3.00	Optional travel expense rate per mile					0.00			
		Supervi sors 1.00	Therapists 2.00	Assistants 3.00	Ai des 4.00	Trai nees 5. 00			
9.00	Total hours worked	0.00	1, 405. 15	1, 672. 4		0.00	9.00		
10.00	AHSEA (see instructions)	0.00	80.52	55.5		0.00			
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	40. 26	40. 26	27. 7	78		11.00		
	one-half of column 3, line 10)								
12.00	Number of travel hours (provider site)	0	0		0		12.00		
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01 13.00		
13.00	Number of miles driven (provider site)	0	0		0		13.00		
					-	1 00			
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00			
14.00	Supervisors (column 1, line 9 times column 1,					0			
15.00 16.00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					113, 143 92, 919			
17.00	Subtotal allowance amount (sum of lines 14 ar		ratory therapy	or lines 14-	-16 for all	206, 062			
	others)								
18.00	Aides (column 4, line 9 times column 4, line					17, 252			
19.00 20.00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo	for all others)	223, 314	19.00 20.00					
	If the sum of columns 1 and 2 for respiratory	therapy or co	lumns 1-3 for p	ohysical ther	apy, speech path	ology or			
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on i	Thes 21 and	22 and enter on	line 23			
21.00	Weighted average rate excluding aides and tra	ainees (line 17		n of columns	1 and 2, line 9	0.00	21.00		
	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					0	22.00		
22.00 23.00	Total salary equivalency (see instructions)	0 223, 314							
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPU	JTATION - PRO	OVIDER SITE				
1 00	Standard Travel Allowance						24.00		
24.00 25.00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					7, 730 6, 139			
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for al	I others)		13, 869			
27.00	Standard travel expense (line 7 times line 3	for respirator	y therapy or su	um of lines 3	3 and 4 for all	2, 395	27.00		
28.00	others) Total standard travel allowance and standard	travel expense	at the provide	er site (sum	of lines 26 and	16, 264	28.00		
	27)	· .							
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		d 2 line 12)			0	29.00		
30.00	Assistants (column 3, line 10 times column 3,		u z, Tine iz)			0	30.00		
31.00							31.00		
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of								
33.00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	expense (line	28)			16, 264	33.00		
34.00	Optional travel allowance and standard travel	0	34.00						
35.00	Optional travel allowance and optional travel			,	// 050 0UTOLDE DD0	0	35.00		
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	INCE AND TRAVEL	EXPENSE COMPU	TATION - SERV	TCES OUTSIDE PRO	VIDER SITE			
36.00	Therapists (line 5 times column 2, line 11)	0	36.00						
37.00	Assistants (line 6 times column 3, line 11)	0							
38.00 39.00									
	Optional Travel Allowance and Optional Travel	Expense				0	1		
40.00									
41.00 42.00	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	0	41.00 42.00						
42.00 43.00									
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,								
	lor 16 ac appropriato						1		
14 00	or 46, as appropriate. Standard travel allowance and standard travel	expense (sum	of lines 38 and	1 39 - SAD ir	structions)	0	44.00		

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider C		Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared:
					Occupati onal Therapy	Cost	1
						1.00	
	Optional travel allowance and standard travel Optional travel allowance and optional travel				,	0	
+0. 00	optional travel arrowance and optional travel	Therapists	Assi stants	Ai des	Trai nees	Total	40.00
		1.00	2.00	3.00	4.00	5.00	
17.00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0. 00	0.00	0.0	00 0.00	0.00	47.00
8. 00 9. 00	column of line 56) Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0. 00 0. 00				48.00 49.00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0. 00	0.0	0.00	0.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	O. C	00 0.00	0.00	51.00
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	80. 52	55. 56	33.8	0.00		52.00
3. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53.00
4.00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	О	0		0 0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	O	0		0 0		55. OC
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0		0 0	0	56.00
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
8.00 9.00 0.00 1.00 2.00 3.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62)	es (from lines)		223, 314 16, 264 0 0 0 239, 578 184, 908	58.00 59.00 60.00 61.00 62.00 63.00
5.00	5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION						
00. 01 00. 02	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	/ therapy or sur	m of lines 3 a	nd 4 for all		13, 869 2, 395 16, 264	100. 01
01. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line $31 =$ line 29 for respiratory therapy or Line $32 =$ line 8 times columns 1 and 2, line				mns 1-3, line		102. 00 102. 01
102. 02	13 for all others Line 35 = sum of lines 31 and 32					0	1(

Health F	- Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 15-1316		Period: From 01/01/2019 To 12/31/2019	Date/Time Prepared	
			CAP	TAL RELATED	COSTS	6/29/2020 8:3	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - MOB	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	1.01	1. 02	4.00	
	ENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	16, 021	16, 021				1.00
	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	1, 745, 593	0	1, 745, 59	3		1.01
1.02 0	00102 CAP REL COSTS-BLDG & FIXT - MOB	58, 130	0		0 58, 130		1.02
4.00 0	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 522, 267	59	6, 89	2 0	1, 529, 218	4.00
5.00 C	00500 ADMI NI STRATI VE & GENERAL	5, 808, 842	2, 650	307, 98	1 0	176, 565	5.00
7.00 C	00700 OPERATION OF PLANT	491, 885	238	27, 61		96, 103	7.00
	00701 OPERATION OF PLANT - HOSPITAL	1, 212, 849	2, 999	348, 28	0 0	0	7.01
	00702 OPERATION OF PLANT - MOB	0	0		0 0	0	7.02
	00800 LAUNDRY & LINEN SERVICE	37, 914	0		0 0	0	8.00
9.00 0	00900 HOUSEKEEPI NG	364, 625	528	61, 38	6 0	58, 813	9.00
10.00 0	1000 DI ETARY	126, 705	378	43, 91	7 0	12, 067	10.00
11.00 0	01100 CAFETERI A	145, 856	648	75, 33	4 0	20, 696	11.00
	1300 NURSI NG ADMI NI STRATI ON	950, 435	88	10, 24	7 0	193, 081	13.00
	1400 CENTRAL SERVICES & SUPPLY	511, 317	290	33, 70	3 0	0	
	1500 PHARMACY	658, 875	271	31, 49		89, 955	
	1600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDI ATRI CS	1, 139, 973	1, 718	199, 68	4 0	223, 928	30.00
	NCI LLARY SERVICE COST CENTERS		= .				
	05000 OPERATING ROOM	618, 195	1, 453	168, 84		59, 838	
	05400 RADI OLOGY-DI AGNOSTI C	757, 158	740	85, 99		158, 930	
	6000 LABORATORY	1, 146, 655	562	65, 30		0	
	06600 PHYSI CAL THERAPY	520, 240	415	48, 24		62	
	06700 OCCUPATIONAL THERAPY	187,033	182	21, 15		0	
	06800 SPEECH PATHOLOGY	75, 259	99 297	11, 54		16, 540	
	06900 ELECTROCARDI OLOGY	51, 277	297	34, 46	0 0	10, 058	
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	35, 129	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	14, 479 218, 789	0		0 0	0	
	07301 ONCOLOGY DRUGS	105, 039	0		0 0	0	
	03160 CARDI OPULMONARY	807, 633	388	45, 06		157, 138	
	UTPATIENT SERVICE COST CENTERS	007,033	500	43,00	7 0	137, 130	/0.00
	9000 CLINIC	0	0		0 0	0	90.00
	09100 EMERGENCY	2, 637, 886	708	82, 30		255, 444	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,007,000	700	02,00	0	200, 111	92.00
	THER REIMBURSABLE COST CENTERS	<u> </u>					72.00
	0100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	PECIAL PURPOSE COST CENTERS				0 0		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21, 966, 059	14, 711	1, 709, 45	6 0	1, 529, 218	118.00
	IONREI MBURSABLE COST CENTERS		,	.,		.,	
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	9100 RESEARCH	0	0		0 0		191.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	9202 MOB	6, 313	999		0 58, 130		192.02
	9300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 LEASED SPACE	0	311	36, 13	7 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)	21, 972, 372	16, 021	1, 745, 59	3 58, 130		
1							

COST ALLOCATION - GENERAL SERVICE COSTS Provider COX: 15-131c Period: Provider COX: 12-131c Worksheet B Frag Worksheet B Data Cost Center Description Subtotal ADM NISTRATIVE 0 GENERAL OPERATION OF PLANT Period: Provider COX: 12-131c OPERATION OF PLANT OPERATION OF PLANT PERATION OF PLANT PO O O D D D D PERATION OF PLANT D D D D D D D D	Heal th	Financial Systems I	U HEALTH FRANKF	ORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description Subtotal AUMM INSTRATILY OPERATION OF PLANT OPERATION 1.01 OPERATION OF 0.00 OPERATION OF PLANT OPERATION 0.00 OPERATION 0.00 </td <td></td> <td></td> <td></td> <td>Provider CO</td> <td></td> <td>From 01/01/2019</td> <td>Part I Date/Time Pre</td> <td>pared:</td>				Provider CO		From 01/01/2019	Part I Date/Time Pre	pared:
CHEREAL SERVICE COST CENTERS 1 1.00 00100 CAP REL COSTS-BLDG & FIXT - NOB 1.01 1.01 00101 CAP REL COSTS-BLDG & FIXT - NOB 1.01 1.00 00100 CAP REL COSTS-BLDG & FIXT - NOB 1.01 1.01 00101 CAP REL COSTS-BLDG & FIXT - NOB 1.02 0.00 00000 DEPEATION OF PLANT - HOSPITAL 6.596,038 247,339 863,182 7.00 00700 DEPEATION OF PLANT - HOSPITAL 1.564,128 62.3196 197,812 2,390,205 7.00 7.01 00700 DEPEATION OF PLANT - HOSPITAL 1.564,532 194,930 34,878 139,098 9,900 9.00 000000 HOUSEKEEPING 445,532 194,930 34,878 139,098 9,900 11.00 01100 CAFEREI A SUPPLY 183,067 73,252 24,953 99,516 10.00 13.00 0100 CHEITAKY SEBAY 7.00 13.00 14.00 11.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00		Cost Center Description	Subtotal A			PLANT -	OPERATION OF	
1:00 00100 (AP REL COSTS-BLDG & FLXT - HOSPITL 1.00 1:01 00100 (AP REL COSTS-BLDG & FLXT - HOSPITL 1.01 1:02 00102 (AP REL COSTS-BLDG & FLXT - HOSPITL 1.01 1:02 00100 (AP REL COSTS-BLDG & FLXT - HOSPITL 1.02 0:00 00000 (DPLOVEC EERENT IS DEPARTHENT 6.5, 296, 038 6, 296, 038 7, 00 0:00 00000 (DPLANTION OF PLANT - HOSPITAL 1, 564, 128 628, 190 0 0 7, 00 0:00 000000 (DUSKEEPING 485, 532 194, 930 34, 878 139, 098 9, 00 0 0 7, 00 0			4A	5.00	7.00	7.01	7.02	
1. 01 00101 CAP REL COSTS -BLDG & FLXT - HOSPI TAL 1. 02 1. 02 0012 CAP REL COSTS -BLDG & FLXT - MOS 1. 02 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 6. 296. 038 6. 296. 038 7. 00 00700 OPERATION OF PLANT - MOS 6. 296. 038 6. 296. 038 7. 00 7. 01 00701 OPERATION OF PLANT - MOS 0 0 7. 01 7. 02 00702 OPERATION OF PLANT - MOS 0 0 7. 01 8. 00 00000 LUMIDRY RL INTENS 1. 564. 128 628. 196 197. 681 2. 390. 205 7. 01 8. 00 00000 DUTERNTY 183. 067 73. 525 244. 953 399. 9516 0 0. 00 10. 00 10100 CAFTERIA 242. 534 47. 49. 53 179. 495 79. 70 0 1. 00 11. 00 1.153. 851 463. 418 5. 622 32. 220 0 13. 00 13. 00 01400 CHTRAL SERVICE S & SUPPLY 545. 310 27. 70 48. 852 95 0 16. 00 16. 00 10100 CAFTERIA SERVICE COST CENTERS								
1. 02 00102 CAP REL COSTS-BLDG & FLXT - MOB 1. 02 4. 00 00400 DMPO (YEE BRENT TS DEPARTIMENT 6. 296, 038 6. 296, 038 5. 00 7. 01 00701 OPERATION OF PLANT 6. 15, 843 247, 339 863, 182 7. 00 7. 01 00701 OPERATION OF PLANT HOSP HAR 6. 296, 038 0								
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 00700 OPERATION OF PLANT 6.296,038 6.296,038 7.00 7.00 00700 OPERATION OF PLANT - MOS 0 0 7.00 0 7.00 00700 OPERATION OF PLANT - MOS 0 0 0 7.01 7.01 0701 0700 OPERATION OF PLANT - MOS 0 0 0 7.01 8.00 00800 LAURNY SE AL INEN SERVICE 37,914 15.227 0 0 0 8.00 9.00 00000 LURINY SE AL INEN SERVICE SE 37,914 15.227 0								
5: 00 00500 ADMINISTRATIVE & GENERAL 6, 296, 038 6, 296, 038 5.00 7: 00 00700 OPERATION OF PLANT H055, 843 247, 339 863, 182 7.00 7.00 7: 00 00701 OPERATION OF PLANT H055, 843 247, 339 863, 182 7.00 0 7.00 7: 00 00 OPENATION OF PLANT H055, 143 247, 339 863, 182 7.00 0 7.00 7.00 0 7.00 0 7.00 0 8.00 000000 000000 0 0 8.00 0.00 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>								
7.00 00700 0PERATI ON OF PLANT 1615, 443 247, 339 863, 182 7.01 7.01 7.01 00701 0PERATI ON OF PLANT - MOSE 0 0 0 7.01 070 0<								
7. 00 00701 0PERATI ON 0F PLANT - HOSPITAL 1, 564, 128 628, 196 197, 881 2, 390, 205 7, 01 7. 02 0702 00 0								
7. 02 00702 (DPERATION OF PLANT - MOB 0								
8. 00 00800 LAUNDRY & LINEN SERVICE 37,914 15,227 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>_</td> <td></td>							_	
9.00 00900 HOUSEKEEPING 485,352 194,930 34,878 139,098 0 9.00 01.00 01000 DIETARY 183,067 73,525 24,953 99,516 0 0.00 11.00 01100 CAFETERIA 242,534 97,408 42,803 170,705 0 11.00 11.00 01300 NURSING ADMINISTRATION 1,153,851 463,418 5,622 23,220 0 13.00 14.00 1400 CENTRAL SERVICE & SUPPLY 545,310 219,011 19,149 76,370 0 14.00 16.00 01600 MEDICAL RECORDS LIBRARY 0 <td< td=""><td></td><td></td><td>, v</td><td>0</td><td></td><td>-</td><td></td><td></td></td<>			, v	0		-		
10.00 D1000 DITARY 183,067 73,525 24,953 99,516 0 10.00 11.00 D100 CAFTERIA 242,534 77,408 42,803 170,705 0 13.00 13.00 D1300 DISON FRAL SERVICES & SUPPLY 545,310 219,011 19,119,011 19,149 76,370 0 14.00 15.00 D1500 FHARAKCY 780,600 313,510 17,897 71,376 0 16.00 16.00 D1500 FHARAKCY SPEDIATRIC SCOST CENTERS						0		
11.00 OH100 CAPETERIA 242, 534 97, 408 42, 803 170, 705 0 11.00 13.00 01300 NURSI ROMIN IN STATI ON 1, 153, 851 463, 418 5, 822 23, 220 0 13.00 14.00 01400 CENTRAL SERVI CES & SUPPLY 545, 310 219, 011 19, 149 76, 370 0 14.00 15.00 01500 MEDI CAL RECORDS & LI BRARY 0								
13.00 01300 NURSI NG ADMINI STRATI ON 1, 153, 851 463, 418 5, 822 23, 220 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 545, 310 219, 011 19, 149 76, 370 0 0 14.00 15.00 01500 PHARMACY 780, 600 313, 510 17, 897 71, 376 0 15.00 16.00 01600/HARMACY 0 0 0 0 0 0 0 0 0 0 15.00 16.00 113, 455 452, 481 0 30.00 0								
14.00 01400 CENTRAL SERVICES & SUPPLY 545,310 219,011 19,149 76,370 0 14.00 15.00 01500 PHARMACY 780,600 313,510 17,897 71,376 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0								
15.00 01500 PHARMACY 780, 600 313, 510 17, 897 71, 376 0 0 15.00 16.00 MEDICAL RECORDS & LIBRARY 0<								
16.00 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 ANCI LLARY SERVI CE COST CENTERS 30. 00 50. 00 05000 ADULTS & PEDI ATI OS 340, 712 95, 932 382, 595 0 50. 00 50. 00 05000 ADULTS 1, 002, 821 4402, 760 488, 858 194, 4857 0 54. 00 60. 00 06000 PHYSI CAL THERAPY 1, 212, 517 486, 980 37, 102 147, 969 0 60. 00 66. 00 06700 OCUPATI ONAL THERAPY 568, 960 228, 510 27, 410 109, 318 0 66. 00 67. 00 06700 OCUPATI ONAL THERAPY 208, 368 83, 686 12, 018 47, 952 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 103, 445 41, 546 6, 561 26, 165 0 68. 00 69. 00 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 31, 479 5, 815 0 0 0 72. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 21, 879 87, 872 0 0 73. 00 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>								
30.00 03000 ADULTS & PEDIATRICS 1,565,303 628,668 113,455 452,481 0 ANCULARY SERVICE COST CENTERS	16.00	UIGUU MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM 848,329 340,712 95,932 382,595 0 50.00 54.00 05400 RADIOLOGY-DIAKNOSTIC 1,002,821 402,760 48,858 194,857 0 54.00 60.00 06000 LABORATORY 1,212,517 486,980 37,102 147,969 0 60.00 67.00 06700 OCCUPATIONAL THERAPY 568,960 228,510 27,410 109,318 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 208,368 83,686 12,018 47,932 0 67.00 68.00 06800 SPECH PATHOLOGY 103,445 41,546 6,561 26,165 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 35,129 14,109 0 0 71.00 73.00 07300 INPL. DEV. CHARGED TO PATIENTS 218,789 87,872 0 0 73.00 73.01 73.01 73.01 7301 07301 0000 73.00 73.01	20.00	02000 ADULTS & DEDLATRICS	1 545 202	420 440	112 /5	E 4E2 401	0	20.00
50.00 05000 OPERATING ROM 848, 329 340, 712 95, 932 382, 595 0 50.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 002, 821 402, 760 48, 858 194, 857 0 54.00 60.00 06000 LABORATORY 1, 212, 517 466, 980 37, 102 147, 969 0 60.00 66.00 06000 PHYSI CAL THERAPY 568, 960 228, 510 27, 410 109, 318 0 66.00 67.00 06CUPATI ONAL THERAPY 208, 368 83, 686 12, 018 47, 932 0 67.00 68.00 06800 SPEECH PATHOLOCY 103, 445 41, 546 6, 561 26, 165 0 68.00 69.00 06900 ELECTROCARDI OLOGY 96, 092 38, 593 19, 579 78, 084 0 69.00 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 14, 479 5, 815 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.01 73.01 73.01 <td>30.00</td> <td>ANCILLADY SEDVICE COST CENTEDS</td> <td>1, 565, 303</td> <td>028, 008</td> <td>113, 45</td> <td>5 452, 481</td> <td>0</td> <td>30.00</td>	30.00	ANCILLADY SEDVICE COST CENTEDS	1, 565, 303	028, 008	113, 45	5 452, 481	0	30.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 1,002,821 402,760 48,858 194,857 0 54.00 60.00 06000 LABORATORY 1,212,517 486,980 37,102 147,969 0 60.00 67.00 06700 OCCUPATI ONAL THERAPY 268,368 83,686 12,018 47,932 0 67.00 68.00 06800 SPEECH PATHOLOGY 103,445 41,546 6,561 26,165 0 68.00 69.00 G6900 ELECTROCARDI OLOGY 96,092 38,593 19,579 78,084 0 69.00 71.00 OT200 IMPL. DEV. CHARGED TO PATI ENTS 14,479 5,815 0 0 71.00 73.00 OX300 DRUGS CHARGED TO PATI ENTS 14,479 5,815 0 0 0 73.00 73.00 73.00 0 0 73.00 73.00 0 0 0 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 74.00 0 0 0 74.	50 00	ANCIELART SERVICE COST CENTERS	848 320	340 712	05.03	2 382 505	0	50.00
60.00 06000 LABORATORY 1, 212, 517 486, 980 37, 102 147, 969 0 60.00 66.00 06600 PHYSI CAL THERAPY 568, 960 228, 510 27, 410 109, 318 0 66.00 67.00 0C0UPATIONAL THERAPY 208, 368 83, 686 12, 018 47, 932 0 67.00 68.00 06800 SPEECH PATHOLOGY 103, 445 41, 546 6, 561 26, 165 0 68.00 69.00 0ELECTROCARDI OLOGY 103, 445 41, 109 0 0 0 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 35, 129 14, 109 0 0 72.00 73.00 07300 DRUGS 105, 039 42, 186 0 0 73.00 73.01 07301 0000 CLINIC 0 0 0 73.00 73.01 07301 0000 CLINIC 2, 976, 346 1, 195, 380 46, 765 186, 508 0 91.00 92.00 00 0 0 0 0 0 0 0 0 0 0 0<								
66.00 06600 PHYSI CAL THERAPY 568,960 228,510 27,410 109,318 0 66.00 67.00 06700 OCUPATI ONAL THERAPY 208,368 83,666 12,018 47,932 0 67.00 68.00 06800 SPECCH PATHOLOGY 103,445 41,546 6,561 26,165 0 68.00 69.00 06900 ELECTROCARDI OLOGY 96,092 38,593 19,579 78,084 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 35,129 14,109 0 0 0 73.00 73.00 O7300 DRUGS CHARGED TO PATIENTS 218,789 87,872 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 105,039 42,186 0 0 0 73.01 74.00 DPULMONARY 1,010,228 405,735 25,607 102,125 0 76.00 00 0 0 0 0 0 0 92.00 92.00								
67.00 06700 0CCUPATIONAL THERAPY 208,368 83,686 12,018 47,932 0 67.00 68.00 06800 SPEECH PATHOLOGY 103,445 41,546 6,551 26,165 0 68.00 69.00 06900 ELECTROCARDIOLOGY 96,092 38,593 19,579 78,084 0 67.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 35,129 14,109 0 0 0 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 218,789 87,872 0 0 73.01 07301 0XCLOGY DRUGS 105,039 42,186 0 0 0 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 74.00 0 0 0 0 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 73.01 74.00 0 0 0 0 73.01 73.01 73.01 74.00 0 0 0 0 74.00 0 0 <								
68.00 06800 SPEECH PATHOLOGY 103, 445 41, 546 6, 561 26, 165 0 68.00 69.00 06900 ELECTROCARDI OLOGY 96, 092 38, 593 19, 579 78, 084 0 69.00 71.00 OT100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 35, 129 14, 109 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 479 5, 815 0 0 0 73.00 73.01 07301 ORCLOGY DRUGS 105, 039 42, 186 0 0 73.00 73.01 07301 ORCLOGY DRUGS 1,010, 228 405, 735 25, 607 102, 125 0 76.00 01100 D9100E BERGENCY 2, 976, 346 1, 195, 380 46, 765 186, 508 0 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00								
69.00 06900 ELECTROCARDIOLOGY 96,092 38,593 19,579 78,084 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 35,129 14,109 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14,479 5,815 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 218,789 87,872 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 1,010,228 405,735 25,607 102,125 0 76.00 90.00 09000 CLI NI C 0 0 0 0 90.00								
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 35,129 14,109 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14,479 5,815 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 218,789 87,872 0 0 0 73.01 73.01 07301 ONCLOGY DRUGS 105,039 42,186 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 1,010,228 405,735 25,607 102,125 0 76.00 01700 EMERGENCY 2,976,346 1,195,380 46,765 186,508 0 91.00 91.00 92.00								
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14,479 5,815 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 218,789 87,872 0 0 0 73.00 73.01 07301 OKOLOGY DRUGS 105,039 42,186 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 1,010,228 405,735 25,607 102,125 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.00 09000 CLINIC 2,976,346 1,195,380 46,765 186,508 0 91.00 92.00 90.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 0 0 0 0 0 0 0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00								
73.00 07300 DRUGS CHARGED TO PATIENTS 218,789 87,872 0 0 73.00 73.01 07301 ONCOLOGY DRUGS 105,039 42,186 0 0 0 73.01 76.00 03160 CARDI OPULMONARY 1,010,228 405,735 25,607 102,125 0 76.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 90.00 09000 CLINIC 0 0 0 90.00						0 0		
73. 01 07301 0NCOLOGY DRUGS 105,039 42,186 0 0 0 73. 01 76. 00 03160 CARDI OPULMONARY 1,010,228 405,735 25,607 102,125 0 76. 00 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 90. 00 0 0 0 0 0 90. 00 90						0 0	0	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 0 0 0 0 90.00 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 90.00 0 <th< td=""><td>73.01</td><td></td><td></td><td></td><td></td><td>0 0</td><td>0</td><td>73.01</td></th<>	73.01					0 0	0	73.01
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 </td <td>76.00</td> <td></td> <td></td> <td></td> <td></td> <td>7 102, 125</td> <td>0</td> <td>76.00</td>	76.00					7 102, 125	0	76.00
91.00 09100 EMERGENCY 2,976,346 1,195,380 46,765 186,508 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 92.00 92.00 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 92.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 0 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,870,482 6,255,116 776,670 2,308,319 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 191.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192.02 192.00 19300 NONPAI D WORKERS 65,442 26,283 65,980 0 0 192.02		OUTPATIENT SERVICE COST CENTERS			•			
92.00 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 101.00 101.00 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,870,482 6,255,116 776,670 2,308,319 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 191.00 191.00 191.00 191.00 191.00 191.00 192.00 192.00 192.00 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.02 19202 MOB 65,442 26,283 65,980 0 0 192.02 193.00 19300 NONPAID WORKERS 0 0 0 0 193.00	90.00	09000 CLI NI C	0	0		0 0	0	90.00
OTHER REIMBURSABLE COST CENTERS 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 101.00 0 0 0 0 0 0 0 0 0 0 0 118.00 SPECIAL PURPOSE COST CENTERS 1800 0 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 0 118.00 190.00 190.00 190.00 0 0 0 0 0 0 0 0 0 0 192.02	91.00		2, 976, 346	1, 195, 380	46, 76	5 186, 508	0	91.00
101.00 HOME HEALTH AGENCY 0	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,870,482 6,255,116 776,670 2,308,319 0 118.00 NONREI MBURSABLE COST CENTERS								
I18.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,870,482 6,255,116 776,670 2,308,319 0 118.00 NONREI MBURSABLE COST CENTERS	101.00		0	0		0 0	0	101.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 02 192. 02 19200 NONPAI D WORKERS 0 0 0 0 192. 02								
191.00 19100 RESEARCH 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 192.02 19202 MOB 65, 442 26, 283 65, 980 0 0 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00		NONREI MBURSABLE COST CENTERS	21, 870, 482	6, 255, 116	776, 67	0 2, 308, 319	0	118.00
192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 192.00 192.02 19202 MOB 65, 442 26, 283 65, 980 0 0 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00			0	0		0 0	0	190.00
192.02 MOB 65, 442 26, 283 65, 980 0 0 192.02 193.00 193000 NONPAI D WORKERS 0 0 0 0 193.00			0	0		0 0	0	191.00
193.00 19300 NONPAID WORKERS 0 0 0 0 193.00			0	0				
			65, 442	26, 283	65, 98	0 0		
			0	0				
194. 00 07950 LEASED SPACE 36, 448 14, 639 20, 532 81, 886 0 194. 00				14, 639	20, 53	2 81, 886	0	
200.00 Cross Foot Adjustments 0 200.00			°,					
201.00 Negative Cost Centers 0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td>				0		0		
202.00 TOTAL (sum lines 118 through 201) 21,972,372 6,296,038 863,182 2,390,205 0202.00	202.00) IOTAL (sum lines 118 through 201)	21, 972, 372	6, 296, 038	863, 18	2, 390, 205	0	202.00

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST /	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1316	Peri od:	Worksheet B	
					From 01/01/2019		
					To 12/31/2019	Date/Time Pre 6/29/2020 8:3	pareu: 7 am
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	nooceneer mo	51217411	0,11 21 211 11	ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS					•	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	53, 141					8.00
9.00	00900 HOUSEKEEPI NG	0	854, 258				9.00
10.00	01000 DI ETARY	0	37, 765	418, 82	26		10.00
11.00	01100 CAFETERI A	0	64, 780		0 618, 230		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	8, 812		0 72, 109		
14.00	01400 CENTRAL SERVICES & SUPPLY	0	28, 981		0 0	0	
15.00	01500 PHARMACY	0	27, 086		0 30, 755	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1				1	
30.00	03000 ADULTS & PEDIATRICS	53, 141	171, 708	418, 82	26 115, 712	728, 687	30.00
	ANCI LLARY SERVI CE COST CENTERS	1				1	
50.00	05000 OPERATING ROOM	0	145, 189		0 32, 843		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	73, 945		0 75, 081	0	
60.00	06000 LABORATORY	0	56, 152		0 54, 203		
66.00	06600 PHYSI CAL THERAPY	0	41, 484		0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	18, 189		0 0	-	
68.00	06800 SPEECH PATHOLOGY	0	9, 929		0 6, 183	0	
69.00	06900 ELECTROCARDI OLOGY	0	29, 632		0 5, 139		
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	1
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 ONCOLOGY DRUGS	0	0		0 0	0	
76.00	03160 CARDI OPULMONARY	0	38, 755		0 79, 497	209	76.00
00.00	OUTPATIENT SERVICE COST CENTERS		0		0		1 00 00
90.00	09000 CLINIC	0	0		0 0	-	
91.00	09100 EMERGENCY	0	70, 777		0 146, 708	894, 400	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 0	OTHER REIMBURSABLE COST CENTERS		0		0		101 00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
110 0	SPECIAL PURPOSE COST CENTERS	FD 141	000 104	410.0	2/ /10.000	1 707 000	110 00
118.00		53, 141	823, 184	418, 82	26 618, 230	1, 727, 232	118.00
100.00	NONREIMBURSABLE COST CENTERS	0	0		0 0	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0 0 0		190.00
	19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		191.00 192.00
		0	° °				
	2 19202 MOB 19300 NONPALD WORKERS	0	0				192.02 193.00
	07950 LEASED SPACE	0	31, 074				193.00
200.00		0	31,074		0	0	200.00
200.00		_	0		0		200.00
201.00		53, 141	854, 258	418, 82	26 618, 230		
202.00	TOTAL (Sum THES TTO THEOUGH 201)	55, 141	054, 250	410,02	010,230	1,121,232	202.00

0001 /1	Financial Systems I LOCATION - GENERAL SERVICE COSTS	U HEALTH FRANKF	Provider CC	`N· 15_1316	Peri od:	eu of Form CMS-2 Worksheet B	2332-10
	LECCATION - GENERAL SERVICE COSTS			N. 13-1310	From 01/01/2019	Part I	
					To 12/31/2019		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	6/29/2020 8:3 Intern &	
		SERVICES &	110000	RECORDS &	Subtotui	Residents Cost	
		SUPPLY		LIBRARY		& Post	
						Stepdown	
						Adjustments	
		14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	ГГ			I	1	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00701 OPERATION OF PLANT - HOSPITAL						7.01
	00702 OPERATION OF PLANT - MOB						7.02
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	888, 821					14.00
15.00	01500 PHARMACY	7, 552	1, 248, 776				15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	171, 872	15, 954		0 4, 435, 807	0	30.00
	ANCI LLARY SERVI CE COST CENTERS	L				I	-
	05000 OPERATING ROOM	119, 985	3, 668		0 2, 073, 189	0	
	05400 RADI OLOGY-DI AGNOSTI C	46, 410	1, 077		0 1, 845, 809	0	
	06000 LABORATORY	31, 504	0		0 2, 026, 427	0	
	06600 PHYSI CAL THERAPY	17, 572	0		0 993, 254	0	
	06700 OCCUPATI ONAL THERAPY	0	0		0 370, 193	0	
	06800 SPEECH PATHOLOGY	0	0		0 193, 829	0	
	06900 ELECTROCARDI OLOGY	14, 271	0		0 281, 390	0	69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	83, 905	0		0 133, 143	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	34, 583	0		0 54,877	0	
	07300 DRUGS CHARGED TO PATIENTS	0	807, 269		0 1, 113, 930	0	
	07301 ONCOLOGY DRUGS	0	387, 564		0 534, 789	0	
	03160 CARDI OPULMONARY	24, 193	594		0 1, 686, 943	0	76.00
	OUTPATIENT SERVICE COST CENTERS		0		0 0	0	00.00
	09000 CLINIC	0	0		0 0	0	
	09100 EMERGENCY	336, 974	32, 650		0 5, 886, 508	0	
-	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	101 00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	888, 821	1, 248, 776		0 21, 630, 088	0	118.00
	NONREI MBURSABLE COST CENTERS	000, 02 1	1, 240, 770		0 21,030,000	0	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19100 RESEARCH	0	0				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				191.00
	19202 MOB	0	0		0 157, 705		192.00
	19300 NONPAID WORKERS	0	0		0 137,703		192.02
	17500 NUM ALD WUNKENS	0	0		0 104 570		
193.00	07950 LEASED SPACE		0			^	
193. 00 194. 00	07950 LEASED SPACE	0	0		0 184, 579		194.00
193.00	Cross Foot Adjustments	0	0		0 184, 579	0	200.00 201.00

Health Financial Systems	IU HEALTH FRANKFO	ORT HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1316	Period:	Worksheet B
			From 01/01/2019 To 12/31/2019	Part I Date/Time Prepared:
Cost Center Description	Total			6/29/2020 8:37 am
	26.00			
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT - MOB				1.02
00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINISTRATIVE & GENERAL				5.00
2.00 00700 OPERATION OF PLANT				7.00
7.01 00701 OPERATION OF PLANT - HOSPITAL				7.01
7.02 00702 OPERATION OF PLANT - MOB				7.02
3. 00 00800 LAUNDRY & LINEN SERVICE				8.00
2.00 00900 HOUSEKEEPI NG				9.00
0. 00 01000 DI ETARY				10.00
1.00 01100 CAFETERIA				11.00
3. 00 01300 NURSI NG ADMI NI STRATI ON				13.00
4. 00 01400 CENTRAL SERVICES & SUPPLY				14.00
5.00 01500 PHARMACY				15.00
6.00 01600 MEDI CAL RECORDS & LI BRARY				16.00
0.00 INPATI ENT ROUTI NE SERVI CE COST CENTERS	4, 435, 807			30.00
ANCI LLARY SERVICE COST CENTERS	4, 435, 807			30.00
0. 00 05000 OPERATI NG ROOM	2, 073, 189			50.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 845, 809			54.00
0. 00 06000 LABORATORY	2, 026, 427			60.00
6. 00 06600 PHYSI CAL THERAPY	993, 254			66.00
7. 00 06700 OCCUPATI ONAL THERAPY	370, 193			67.00
8. 00 06800 SPEECH PATHOLOGY	193, 829			68.00
9. 00 06900 ELECTROCARDI OLOGY	281, 390			69.00
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	133, 143			71.00
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	54, 877			72.00
3. 00 07300 DRUGS CHARGED TO PATIENTS	1, 113, 930			73.00
3. 01 07301 ONCOLOGY DRUGS	534, 789			73.00
6. 00 03160 CARDI OPULMONARY	1, 686, 943			76.00
OUTPATIENT SERVICE COST CENTERS	1,000,710			/0.00
0.00 09000 CLINIC	0			90.00
1.00 09100 EMERGENCY	5, 886, 508			91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS	- I I -			
01.00 10100 HOME HEALTH AGENCY	0			101.00
SPECIAL PURPOSE COST CENTERS				
18.00 SUBTOTALS (SUM OF LINES 1 through 117)) 21, 630, 088			118.00
NONREI MBURSABLE COST CENTERS	· · ·			
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
91. 00 19100 RESEARCH	0			191.00
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
92. 02 19202 MOB	157, 705			192. 02
93. 00 19300 NONPAID WORKERS	0			193.00
94.0007950 LEASED SPACE	184, 579			194.00
200.00 Cross Foot Adjustments	0			200.00
201.00 Negative Cost Centers	0			201.00
202.00 TOTAL (sum lines 118 through 201)	21, 972, 372			202.00

	Financial Systems TION OF CAPITAL RELATED COSTS		Provider C	CNI 1E 1014		u of Form CMS-	2002 10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider U		Period: From 01/01/2019	Worksheet B Part II	
					To 12/31/2019	Date/Time Pre	
			CAP	TAL RELATED (COSTS	6/29/2020 8:3	
	Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -		Subtotal	
		Assigned New		HOSPI TAL	MOB		
		Capital Related Costs					
		0	1.00	1.01	1. 02	2A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB				_		1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	59			6, 951	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	2,650			310, 631	5.00
7.00	00700 OPERATION OF PLANT	0	238			27,855	
7.01	00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - MOB	0	2, 999	348, 28		351, 279	
7.02 8.00		0	0		0 0	0	
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	528	41 20	с С	61, 914	
10.00	01000 DI ETARY	0	378			44, 295	
11.00	01100 CAFETERI A	0	648			75, 982	
	01300 NURSING ADMINI STRATI ON	0	88			10, 335	
	01400 CENTRAL SERVICES & SUPPLY	0	290			33, 993	
	01500 PHARMACY	0	271	31, 49		31, 770	
	01600 MEDICAL RECORDS & LI BRARY	0	0		0 0	0	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0	1, 718	199, 68	4 0	201, 402	30.00
	ANCILLARY SERVICE COST CENTERS	· · · · ·					
50.00	05000 OPERATING ROOM	0	1, 453			170, 296	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	740			86, 733	
60.00	06000 LABORATORY	0	562	65, 30		65, 862	
66.00	06600 PHYSI CAL THERAPY	0	415			48, 658	
67.00	06700 OCCUPATIONAL THERAPY	0	182	21, 15		21, 335	
68.00	06800 SPEECH PATHOLOGY	0	99			11, 646	
	06900 ELECTROCARDI OLOGY	0	297	34, 46		34, 757	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0		0 0 0 0	0	
	07301 ONCOLOGY DRUGS	0	0		0 0	0	
	03160 CARDI OPULMONARY	0	388	45, 06	-	45, 457	
70.00	OUTPATIENT SERVICE COST CENTERS	V	500	43,00	/	40,407	/0.00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0	708			83, 016	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				-	0	
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	14, 711	1, 709, 45	6 0	1, 724, 167]118. OC
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19202 MOB	0	999		0 58, 130	59, 129	
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 LEASED SPACE	0	311	36, 13	7 0		194.00
200.00			-				200.00
201.00 202.00			0	4 745 50	0		201.00
	u uuuu (cum unoc 11V through 201)	0	16, 021	1, 745, 59	3 58, 130	1 819 /44	1707 00

ALLOC	ATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2019	Worksheet B Part II	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:3	pared: 7 am
	Cost Center Description	EMPLOYEE A BENEFITS DEPARTMENT	MMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
		4.00	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.0
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.0
1. 02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	6, 951					4.0
5.00	00500 ADMI NI STRATI VE & GENERAL	802	311, 433				5.0
7.00	00700 OPERATION OF PLANT	437	12, 234	40, 52			7.0
7.01	00701 OPERATION OF PLANT - HOSPITAL	0	31, 073	9, 29	0 391, 642		7.0
7.02	00702 OPERATION OF PLANT - MOB	0	0		0 0	0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	753		0 0	0	
9.00	00900 HOUSEKEEPI NG	267	9, 642	1, 63		0	
10.00	01000 DI ETARY	55	3, 637	1, 17		0	
11.00	01100 CAFETERI A	94	4, 818	2, 01		0	
13.00	01300 NURSI NG ADMI NI STRATI ON	877	22, 922	27		0	
14.00		0	10, 833	89		0	
15.00	01500 PHARMACY	409	15, 507	84		0	
16.00		0	0		0 0	0	16.0
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 018	31, 096	5, 32	7 74, 141	0	30.0
30.00	ANCI LLARY SERVICE COST CENTERS	1,010	51,090	5, 52	74,141	0	30.0
50.00		272	16, 853	4, 50	62, 689	0	50.0
54.00		722	19, 922	2, 29		0	
60.00		0	24, 088	1, 74		0	
66.00	06600 PHYSI CAL THERAPY	0	11, 303	1, 28		0	66.0
67.00	06700 OCCUPATI ONAL THERAPY	0	4, 139	56		0	67.0
68.00	06800 SPEECH PATHOLOGY	75	2, 055	30		0	68.0
69.00	06900 ELECTROCARDI OLOGY	46	1, 909	91	9 12, 794	0	69.0
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	698		0 0	0	71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	288		0 0	0	72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 346		0 0	0	73.0
73.01	07301 ONCOLOGY DRUGS	0	2, 087		0 0	0	73.0
76.00	03160 CARDI OPULMONARY	714	20, 069	1, 20	2 16, 733	0	76.0
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0		0 0	0	
91.00		1, 163	59, 137	2, 19	6 30, 560	0	
92.00							92.0
	OTHER REIMBURSABLE COST CENTERS				_		
101.0	D 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.0
110 0	SPECIAL PURPOSE COST CENTERS	(051	200 400	24.44	4 270 225	0	110 0
118.0	0 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	6, 951	309, 409	36, 46	4 378, 225	0	118.0
190. 0	D 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 0
	0 19100 RESEARCH	0	0		0 0		191.0
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.0
	2 19202 MOB	0	1, 300	3, 09	8 0	0	192.0
	0 19300 NONPAI D WORKERS	0	0		0 0	0	193.0
	007950 LEASED SPACE	0	724	96	4 13, 417	0	194.0
200. 0						-	200. 0
201.0	3	О	о		0 0	0	201.0
	0 TOTAL (sum lines 118 through 201)	6, 951	311, 433	40, 52	6 391, 642		202.0

Cost Center Description LAUNDRY & LINEN SERVICE HOUSEKEEPING NURSING DIETARY CAFETERIA NURSING ADMINISTRATION 1.00 00100 CAP REL COSTS - BLDG & FIXT 1.01 00100 CAP REL COSTS - BLDG & FIXT 1.02 010.00 11.00 13.00 1.00 00102 CAP REL COSTS - BLDG & FIXT 1.00 6 FIXT - HOSPITAL 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMIN ISTRATIVE & GENEFAL 8.00 6 FIXT - HOSPITAL 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMIN ISTRATIVE & GENEFAL 8.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMIN ISTRATION OF PLANT 7.01 00700 OPERATION OF PLANT 7.01 00700 DEPERATION OF PLANT 7.01 00700 DEPERATION OF PLANT 7.01 04.255 69,720 11.00 01000 CAPETERIA ADMINISTRATION 0 0 4.255 69,720 118,174 13.00 01300 ON UNESKEEPI NG 0 0 753 9.00 0 13,784 52,989 14.00 01400 CENTAL SERVICES & SUPPLY 0 3,265 0 0 0 15.00 01600 MUSISTRATION 0 9.322 0 13,784 52,989 16.00 01600 MEDICAL RECORDS & LIBRARY 0 3.052 </th <th></th> <th></th> <th>IU HEALTH FRANK</th> <th>FORT HOSPITAL</th> <th></th> <th>In Lie</th> <th>eu of Form CMS-:</th> <th>2552-10</th>			IU HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-:	2552-10
Cost Center Description LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA ADMINISTRATION 1.00 00100 (CAP REL COSTS-BLDG & FLXT 1.00 60100 (CAP REL COSTS-BLDG & FLXT 0.00 00100 (CAP REL COSTS-BLDG & FLXT 0.00 00000 (PHUQUYEE PERFET TS DEPARTHENT 0.00 00000 (PHUQUYEE PERFET TS DEPARTHENT 0.00 00000 (DHUQUYEE PERFET TS DEPARTHENT 0.00 00000 (DHUQUYEE PERFET TS DEPARTHENT 0.00 00000 (DHUDUYEE PERFET PERFET TS DEPARTHENT 0.00 00000 (DHUDUYEE PERFET PE	ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1316			
Cost Center Description LAUNDRY & LINEN SERVICE DI ETARY CAFETERIA NURSING ADMINI STRATION 1.00 00010 CAP REL COSTS-BLDG & FLXT 0 10.00 10.00 11.00 13.00 1.01 00110 CAP REL COSTS-BLDG & FLXT 0 10.00 11.00 13.00 1.02 00102 CAP REL COSTS-BLDG & FLXT 0.00 10.00 11.00 13.00 1.02 00102 CAP REL COSTS-BLDG & FLXT 0.00 0.00 0.00 10.00 11.00 13.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 0.00								pared:
LINEN SERVICE ADMIN IN STRATION 0.00 00100 CAP REL COSTS BLDG & FIXT 0010 CAP REL COSTS BLDG & FIXT 0000 CAP REL COSTS BLDG & FIXT 00000 CAP REL COST CAP REL COSTS BLDG & FIXT 00000 CAP REL COSTS BLDG & FIXT 00000 CAP REL COST							6/29/2020 8:3	7 am
B.00 9.00 10.00 11.00 13.00 IOD 00100 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.01 00101 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00102 (AP REL COSTS -BLDG & FIXT - HOSPITAL 1.02 00100 (AP RETIVE & GENERAL 1.02 00000 (ADMIN ISTRATIVE & GENERAL 1.02 00000 (ADMIN ISTRATIVE & GENERAL 1.02 000000 (ADMIN ISTRATION OF PLANT 1.02 000000 (ADMIN ISTRATION 1.02 00000 (ADMIN ISTRATION 1.0		Cost Center Description		HOUSEKEEPI NG	DI ETARY	CAFETERI A		
GENERAL SERVICE COST CENTERS Control 1.00 O0100 CAP REL COSTS-BLDG & F1XT HOSP1TAL 1.01 O0101 CAP REL COSTS-BLDG & F1XT HOSP1TAL 1.02 O0100 CAP REL COSTS-BLDG & F1XT HOSP1TAL 1.00 O0100 CAP REL COSTS-BLDG & F1XT HOSP1TAL 1.00 O0100 CAP REL COSTS-BLDG & F1XT HOSP1TAL 1.00 O000 CEMPLOYE BENFEITS DEPARTMENT Solo OOSCO ADMINI STRATI VE & GENERAL 1.00 OOT00 OPERATION OF PLANT HOSP1TAL 7.02 OOT00 OPERATION OF PLANT HOBB 9.00 OOSCOOL AUMINI STRATI VE & GENERITS 0 1.00 OIT00 OEFERTION 0 4,255 9.00 OOSCOOL AUMINI STRATI ON 0 993 0 1.00 OIT00 OEFERTION 0 9,3,265 0 0 1.00 OIT00 OEFERTION 0 3,052 0 5,879 0 1.00 OIT00 OEFERTIN ROUTINE SERVI CE COST CENTERS 5 0 0 0 0 1.00 OISOOO OADULT & SERVI CE COST CENTERS								
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT HOSPITAL 1.02 00102 CAP REL COSTS-BLDG & FIXT HOSPITAL 7.00 00701 OPERATION OF PLANT HOSPITAL 7.00 00701 OPERATION OF PLANT HOSPITAL 7.01 00701 OPERATION OF PLANT HOSPITAL 7.00 00701 OPERATION OF PLANT HOSPITAL 7.01 00701 OPERATION OF PLANT HOSPITAL 7.00 00700 DERATION OF PLANT HOSPITAL 7.01 00710 OPERATION OF PLANT HOSPITAL 7.00 00700 DERATION OF PLANT HOSPITAL 1.00 10100 CAPERERIA 0 7,299 0 118,174 13.00 013000 NURSING ADMINISTRATION 0 9,252 0 0 0 14.00 14.00 CHANMACY 0 </td <td></td> <td></td> <td>8.00</td> <td>9.00</td> <td>10.00</td> <td>11.00</td> <td>13.00</td> <td></td>			8.00	9.00	10.00	11.00	13.00	
1.01 OD10 CAP REL COSTS-BLOG & FIXT - HOSPITAL 1.02 OD102 CAP REL COSTS-BLOG & FIXT - MOB 1.00 OD400 EMPLOYEE BENEFITS DEPARTMENT 5.00 OD500 ADMINISTRATIVE & GENERAL 7.01 OO701 OPERATION OF PLANT 7.02 OO720 OPERATION OF PLANT - MOB 8.00 00800 LAUNDRY & LINEN SERVICE 753 9.00 OO9000 DISTRAY 0 4,255 11.00 OID00 DISTRAY 0 4,255 11.00 OID00 NUSEK GOM INISTRATION 0 993 0 13,784 52,989 11.00 OID00 ADUST KER SUPLY 0 3,265 0 0 0 15.00 OIS00 ADUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 10.00 OIS00 OPERATION OF PLANT 0 16,359 0 6,278 3,189 13.00 OIS00 NUSING BOMINISTRATION 0 9,093 0 13,784 52,989 14.00 OHA			1		1			
1.02 O102 CAP REL COSTS-BLOG & FIXT - MOB								1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT - 7. 01 00701 OPERATI ON OF PLANT - 7. 02 00702 OPERATI ON OF PLANT - 7. 00 00700 OPERATI ON OF PLANT - 7. 00 00700 OPERATI ON OF PLANT - 8. 00 00800 LAUNDRY & LI NEN SERVICE 753 9. 00 00900 HOUSEKEPING 0 4, 255 69, 720 11.00 01100 CAFETERI A 0 7, 299 0 118, 174 13.00 01300 NRSI NG ADMINI STRATI ON 0 9, 3265 0 0 0 16.00 D1600 MARMACY 0 3, 265 0 0 0 10.00 OS000 ADULTS ERVICE COST CENTERS 53 19, 346 69, 720								1.01
5.00 00500 ADMINI STRATI VE & GENERAL								1.02
7.00 00700 OPERATI ON OF PLANT Image: Constraint of the constrai								4.00
7.01 00701 0PERATI ON OF PLANT - HOSPI TAL.								5.00
7. 02 00702 OPERATI ON OF PLANT - MOB 8. 00 00800 LAUNDRY & LINEN SERVICE 753 9. 00 00900 HULNDRY & LINEN SERVICE 753 10. 00 01000 DI ETARY 0 4,255 69,720 11. 00 01300 NURSI NG ADMI NI STRATI ON 0 7,299 0 118,174 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 993 0 13,784 52,989 14. 00 01400 CENTRAL SERVICES & SUPPLY 0 3,052 0 0 0 15. 00 01500 MARMACY 0 3,052 0 5,879 0 16. 00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 0 0 0 0.00 03000 ADUET SERVICE COST CENTERS 5 19,346 69,720 22,118 22,355 ANCI LLARY SERVICE COST CENTERS 5 5 0 6,278 3,189 54.00								7.00
8.00 00800 LAUNDRY & LINEN SERVICE 753								7.01
9.00 00900 HOUSEKEEPI NG 0 96, 252 10.00 01000 D ETARY 0 4, 255 69, 720 11.00 01100 CAFETERIA 0 7, 299 0 118, 174 13.00 01300 NURSI NG ADMINI STRATI ON 0 993 0 13, 784 52, 989 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 3, 265 0 0 0 0 15.00 01600 MEDI CAL RECORDS & LI BRARY 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>7.02</td>								7.02
10.00 01000 DI ETARY 0 4,255 69,720 11.00 01100 CAFETERIA 0 7,299 0 118,174 13.00 01300 NURSING ADMINISTRATION 0 993 0 13,784 52,993 14.00 01400 CENTRAL SERVICES & SUPPLY 0 3,265 0								8.00
11.00 01100 CAFETERIA 0 7,299 0 118,174 13.00 01300 NURSI NG ADMI NI STRATI ON 0 993 0 13,784 52,989 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 3,265 0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>9.00</td></td<>			0					9.00
13.00 01300 NURSI NG ADMI NI STRATI ON 0 993 0 13, 784 52, 989 14.00 01400 CENTRAL SERVI CES & SUPPLY 0 3, 265 0 0 0 15.00 01400 CENTRAL SERVI CE S & LI BRARY 0 3, 052 0 0 0 0 16.00 01601 AL RECORDS & LI BRARY 0<			0		69, 7			10.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 3, 265 0 0 0 15.00 01500 PHARMACY 0 3, 052 0 5, 879 0 16.00 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 0 18.00 03000 ADULTS & PEDI ATRI CS 753 19, 346 69, 720 22, 118 22, 355 ANCI LLARY SERVICE COST CENTERS 0 16, 359 0 6, 278 3, 189 54.00 05000 OPERATING ROOM 0 16, 359 0 6, 278 3, 189 54.00 05000 OPERATING ROOM 0 16, 359 0 6, 278 3, 189 54.00 05000 OPERATING ROOM 0 16, 359 0 6, 278 3, 189 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 8, 332 0 14, 352 0 60.00 06400 PHYSI CAL THERAPY 0 4, 674 0 0 0 0 64.00 06800 SPEECH PATHOLOGY 0 1, 119			0					11.00
15.00 01500 PHARMACY 0 3,052 0 5,879 0 16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0 0 0 18.00 0300 ADULTS & PEDI ATRI CS 753 19,346 69,720 22,118 22,355 ANCI LLARY SERVICE COST CENTERS 0 16,359 0 6,278 3,189 50.00 05000 PERATI NG ROOM 0 16,359 0 6,278 3,189 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 8,332 0 14,352 0 66.00 06600 PHYSI CAL THERAPY 0 4,674 0 0 0 0 67.00 06700 OCUPATI ONAL THERAPY 0 1,119 0 1,182 0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td></td><td>1</td></td<>			0					1
16.00 OIGO0 MEDICAL RECORDS & LIBRARY 0			u u			-	0	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 753 19, 346 69, 720 22, 118 22, 355 ANCILLARY SERVI CE COST CENTERS								
30.00 O3000 ADULTS & PEDIATRICS 753 19,346 69,720 22,118 22,355 ANCILLARY SERVICE COST CENTERS 0 16,359 0 6,278 3,189 50.00 05000 OPERATING ROM 0 16,359 0 6,278 3,189 54.00 05400 RADIOLOGY-DIAGNOSTIC 0 8,332 0 14,352 0 60.00 06000 LABORATORY 0 6,327 0 10,361 0 64.00 06000 OPENATIONAL THERAPY 0 4,674 0 0 0 65.00 06600 SPEECH PATHOLOGY 0 1,119 0 1,182 0 69.00 06900 ELECTROCARDI OLOGY 0 3,339 0 982 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 73.01 07301 ONCOLOGY DRUGS 0 0 0 0 0 0 0 0 74.00 07301 ONCOLOGY DRUGS 0 0 <td>16.00</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>16.00</td>	16.00		0	0		0 0	0	16.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 PERATI NG ROOM 0 16,359 0 6,278 3,189 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 8,332 0 14,352 0 60.00 06000 LABORATORY 0 6,327 0 10,361 0 66.00 06600 PHYSI CAL THERAPY 0 4,674 0 0 0 66.00 06600 SPEECH PATHOLOGY 0 1,119 0 1,182 0 67.00 06700 OCCUPATI ONAL THERAPY 0 3,339 0 982 0 68.00 06800 SPEECH PATHOLOGY 0 3,339 0 982 0 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73.01 07301 ONCOLOGY DRUGS <						- 1		
50.00 05000 0PERATING ROOM 0 16, 359 0 6, 278 3, 189 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 8, 332 0 14, 352 0 60.00 06000 LABORATORY 0 6, 327 0 10, 361 0 60.00 06600 PHYSI CAL THERAPY 0 4, 674 0 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 2, 049 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 119 0 1, 182 0 68.00 06800 SPEECH PATHOLOGY 0 3, 339 0 982 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73.01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74.00 03160 CARDI OPULMONARY 0	30.00		753	19, 346	69, 7	20 22, 118	22, 355	30.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 8, 332 0 14, 352 0 60.00 06000 LABORATORY 0 6, 327 0 10, 361 0 66.00 06600 PHYSI CAL THERAPY 0 4, 674 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 2, 049 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 1, 119 0 1, 182 0 69.00 06900 ELECTROCARDI OLOGY 0 3, 339 0 982 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
60.00 06000 LABORATORY 0 6, 327 0 10, 361 00 66.00 06600 PHYSI CAL THERAPY 0 4, 674 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 2, 049 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 1, 119 0 1, 182 0 69.00 06900 ELECTROCARDI OLOGY 0 3, 339 0 982 0 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>50.00</td></td<>								50.00
66.00 06600 PHYSI CAL THERAPY 0 4, 674 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 2, 049 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 1, 119 0 1, 182 0 69.00 06900 ELECTROCARDI OLOGY 0 3, 339 0 982 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73.01 07301 ONCOLOGY DRUGS 0 0 0 0 0 0 0 0 76.00 03160 CARDI OPULMONARY 0 4, 367 0 15, 196 6 00.00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>-</td> <td>0</td> <td></td>			0			-	0	
67.00 06700 0CCUPATI ONAL THERAPY 0 2,049 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 1,119 0 1,182 0 69.00 06900 ELECTROCARDI OLOGY 0 3,339 0 982 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>0</td> <td></td>			0				0	
68.00 06800 SPEECH PATHOLOGY 0 1, 119 0 1, 182 0 69.00 06900 ELECTROCARDI OLOGY 0 3, 339 0 982 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	
69.00 06900 ELECTROCARDIOLOGY 0 3,339 0 982 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 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 73.01 07301 ONCOLOGY DRUGS 0			0				0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 <	69.00		0	3, 339		0 982	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0			0	0		-	0	
73.01 07301 ONCOLOGY DRUGS 0			0	0		-	0	
76. 00 03160 CARDI OPULMONARY 0 4, 367 0 15, 196 66 OUTPATI ENT SERVICE COST CENTERS 0 <td< td=""><td>73.00</td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>73.00</td></td<>	73.00		0	0		0 0	0	73.00
OUTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC 0 0 0 0 91. 00 09100 EMERGENCY 0 7, 975 0 28, 042 27, 439 92. 00 09200 OBSERVATI ON_BEDS_(NON-DI STINCT_PART) 0 7, 975 0 28, 042 27, 439	73.01		0	0		0 0	0	73.01
90. 00 09000 CLINIC 0	76.00	03160 CARDI OPULMONARY	0	4, 367		0 15, 196	6	76.00
91. 00 09100 EMERGENCY 0 7, 975 0 28, 042 27, 439 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 0 7, 975 0 28, 042 27, 439								
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				-			0	
			0	7, 975		0 28, 042	27, 439	
OTHER RELIMBURSABLE COST CENTERS	92.00							92.00
		OTHER REIMBURSABLE COST CENTERS				- 1		
	101.00		0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS								
	118.00		753	92, 751	69, 7	20 118, 174	52, 989	118.00
NONREI MBURSABLE COST CENTERS							1	
			0					190.00
191.00 19100 RESEARCH 0 0 0 0 0	191.00	0 19100 RESEARCH	0	0		0 0	0	191.00
			0	0		0 0		192.00
			0			0 0		192. 02
193.00 19300 NONPAI D WORKERS 0 0 0 0 0	193.00	0 19300 NONPALD WORKERS	0	0		0 0	0	193.00
	194.00		0	3, 501		0 0	0	194.00
200.00 Cross Foot Adjustments	200.00	Cross Foot Adjustments						200.00
	201.00		0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201) 753 96, 252 69, 720 118, 174 52, 989	202.00) TOTAL (sum lines 118 through 201)	753	96, 252	69, 7	20 118, 174	52, 989	202.00

Heal th	Financial Systems	U HEALTH FRANKF	ORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/29/2020 8:3	pared: 7 am
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 1.02	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - MOB						1.01 1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.00	00701 OPERATION OF PLANT - HOSPITAL						7.00
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	61, 503					14.00
15.00	01500 PHARMACY	523	69, 675				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
30.00	03000 ADULTS & PEDI ATRI CS	11, 893	890		0 460, 059	0	30.00
	ANCI LLARY SERVICE COST CENTERS	0.000					
50.00	05000 OPERATING ROOM	8, 302	205		0 288, 947	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 211	60 0		0 167, 554	0	54.00
60. 00 66. 00	06000 LABORATORY 06600 PHYSI CAL THERAPY	2, 180 1, 216	0		0 134, 805 0 85, 050	0	60. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	1,210	0		0 35, 941	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 20, 672	0	68.00
69.00	06900 ELECTROCARDI OLOGY	988	0		0 55, 734	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 806	0		0 6, 504	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 393	0		0 2,681	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	45, 041		0 49, 387	0	73.00
73.01	07301 ONCOLOGY DRUGS	0	21, 624		0 23, 711	0	73.01
76.00	03160 CARDI OPULMONARY	1, 674	33		0 105, 451	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	23, 317	1, 822		0 264, 667	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS					-	
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
440.00	SPECIAL PURPOSE COST CENTERS	(1.500	(0. (75		0 1 701 1/0	0	110 00
118.00		61, 503	69, 675		0 1, 701, 163	0	118.00
100.00	NONREI MBURSABLE COST CENTERS	0	0		0 0	0	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00 191. 00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES		0				191.00 192.00
	19202 MOB		0		0 63, 527		192.00
	19300 NONPALD WORKERS		0		0 00, 027		192.02
	07950 LEASED SPACE	0	0		0 55, 054		194.00
200.00			J.		0		200.00
201.00		0	о		0 0		201.00
202.00		61, 503	69, 675		0 1, 819, 744	0	202.00
		•					

	i nanci al Systems I ON OF CAPI TAL RELATED COSTS	U HEALTH FRANKFO	Provider CCN: 15-1316	Peri od:	u of Form CMS-2 Worksheet B	-552-
ALLUCATI	UN OF CAPITAL RELATED COSTS		PLOVIDEL CON. 15-1310	From 01/01/2019 To 12/31/2019	Part II Date/Time Prep	oared
					6/29/2020 8:3	7 am
	Cost Center Description	<u>Total</u> 26.00				
GE	ENERAL SERVICE COST CENTERS	20.00				
	D100 CAP REL COSTS-BLDG & FIXT					1.0
	D101 CAP REL COSTS-BLDG & FIXT - HOSPITAL					1.0
	D102 CAP REL COSTS-BLDG & FIXT - MOB					1. (
	0400 EMPLOYEE BENEFITS DEPARTMENT					4.
	D500 ADMI NI STRATI VE & GENERAL					5.
	0700 OPERATION OF PLANT					7.
	0701 OPERATION OF PLANT - HOSPITAL					7.
	0702 OPERATION OF PLANT - MOB					7.
	D800 LAUNDRY & LINEN SERVICE					8. (
	0900 HOUSEKEEPI NG					9.1
	1000 DI ETARY					10.
	1100 CAFETERI A					11. (
13.00 01	1300 NURSING ADMINISTRATION					13.0
14.00 01	1400 CENTRAL SERVICES & SUPPLY					14.
15.00 01	1500 PHARMACY					15.0
16.00 01	1600 MEDICAL RECORDS & LIBRARY					16.0
	NPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03	3000 ADULTS & PEDIATRICS	460, 059				30.
	VCI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM	288, 947				50.
	5400 RADI OLOGY-DI AGNOSTI C	167, 554				54.
	5000 LABORATORY	134,805				60. (
	6600 PHYSI CAL THERAPY	85,050				66.1
	6700 OCCUPATI ONAL THERAPY	35, 941				67.0
	5800 SPEECH PATHOLOGY	20, 672				68.0
	5900 ELECTROCARDI OLOGY	55, 734				69.0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 504				71.0
	7200 I MPL. DEV. CHARGED TO PATIENTS					
		2,681				72.0
	7300 DRUGS CHARGED TO PATIENTS	49, 387				73.0
	7301 ONCOLOGY DRUGS	23, 711				73.0
	3160 CARDI OPULMONARY	105, 451				76.
	JTPATIENT SERVICE COST CENTERS	a				~~
	9000 CLINIC	0				90.
	9100 EMERGENCY	264, 667				91.0
	9200 OBSERVATION BEDS (NON-DISTINCT PART)					92. (
	THER REIMBURSABLE COST CENTERS	I				
	D100 HOME HEALTH AGENCY	0				101. (
	PECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 701, 163				118.
	DNREIMBURSABLE COST CENTERS	0				190.
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					
		0				191. 102
	9200 PHYSI CLANS' PRI VATE OFFI CES	0				192.
92.0219		63, 527				192.
	9300 NONPAI D WORKERS	0				193.
	7950 LEASED SPACE	55, 054				194.
200.00	Cross Foot Adjustments	0				200.
201.00	Negative Cost Centers	0				201. (
202.00	TOTAL (sum lines 118 through 201)	1, 819, 744				202. (

		cial Systems TON - STATISTICAL BASIS	U HEALTH FRANK	FORT HOSPITAL	CN: 15-1316 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
001 A	LLOOAI				Fi	rom 01/01/2019		
					Т	0 12/31/2019	Date/Time Pre 6/29/2020 8:3	7 am
			CAPI	ITAL RELATED CO	OSTS			
		Cost Center Description	BLDG & FIXT	BLDG & FIXT -	BLDG & FIXT -	EMPLOYEE	Reconciliation	
		•	(SQUARE FEET)	HOSPI TAL	MOB	BENEFI TS		
				(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		
						(GROSS SALARI ES)		
			1.00	1.01	1.02	4. 00	5A	
		AL SERVICE COST CENTERS						
. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - HOSPITAL	113, 185	106, 125				1.
. 01 . 02		CAP REL COSTS-BEDG & FIXT - HOSPITAL CAP REL COSTS-BLDG & FIXT - MOB		100, 125	7, 060			1.
. 00		EMPLOYEE BENEFITS DEPARTMENT	419	419	0	6, 470, 620		4.
. 00		ADMINISTRATIVE & GENERAL	18, 724	18, 724	0	747, 102	-6, 296, 038	
. 00		OPERATION OF PLANT	1, 679	1, 679	0	406, 642	0	
. 01		OPERATION OF PLANT - HOSPITAL	21, 174	21, 174	0	0	0	
. 02 . 00		OPERATION OF PLANT - MOB LAUNDRY & LINEN SERVICE	0	0	0	0	0	
. 00		HOUSEKEEPING	3, 732	3, 732	0	248, 855	0	
0.00		DI ETARY	2,670			51, 058	0	1
	1	CAFETERIA	4, 580	4, 580		87, 570	0	1
		NURSING ADMINISTRATION	623	623	0	816, 986	0	13.
		CENTRAL SERVICES & SUPPLY	2,049	2, 049		0	0	
		PHARMACY	1, 915	1, 915		380, 630	0	
6. 00		MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.
0. 00		ADULTS & PEDIATRICS	12, 140	12, 140	0	947, 509	0	30.
		LARY SERVICE COST CENTERS				,		
0. 00	05000	OPERATING ROOM	10, 265			253, 194	0	50.
4.00		RADI OLOGY-DI AGNOSTI C	5, 228	5, 228		672, 484	0	
0.00			3, 970	3, 970	0	0	0	
6.00 7.00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	2, 933 1, 286	2, 933 1, 286	0	262	0	66. 67.
		SPEECH PATHOLOGY	702	702	0	69, 986	0	68.
9.00		ELECTROCARDI OLOGY	2,095	2, 095	0	42, 558	0	69.
1.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.
		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
		DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
		ONCOLOGY DRUGS CARDI OPULMONARY	2,740	2, 740	0	0 664, 901	0	
0.00		TI ENT SERVICE COST CENTERS	2,740	2,740	0	004, 901	0	/0.
0. 00		CLINIC	0	0	0	0	0	90.
		EMERGENCY	5,004	5, 004	0	1, 080, 883	0	91.
2.00		OBSERVATION BEDS (NON-DISTINCT PART)						92.
01 00		REIMBURSABLE COST CENTERS	0			0	0	101
01.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	0	0	0	101.
18.00		SUBTOTALS (SUM OF LINES 1 through 117)	103, 928	103, 928	0	6, 470, 620	-6, 296, 038	118
10.00		IMBURSABLE COST CENTERS	100,720	100,720		0, 170, 020	0,270,000	1.10.
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.
		RESEARCH	0	0	0	0		191.
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.
	19202	MOB NONPALD WORKERS	7,060	0	7,060	0		192. 193.
		LEASED SPACE	2, 197	2, 197	0	0		193.
00.00		Cross Foot Adjustments	2,177	2,177	Ŭ	0		200.
01.00		Negative Cost Centers						201.
02.00		Cost to be allocated (per Wkst. B,	16, 021	1, 745, 593	58, 130	1, 529, 218		202.
		Part I)						
03.00		Unit cost multiplier (Wkst. B, Part I)	0. 141547	16. 448462	8. 233711	0. 236333		203.
04.00		Cost to be allocated (per Wkst. B,				6, 951		204.
05.00		Part II) Unit cost multiplier (Wkst. B, Part				0. 001074		205.
55.00		II)				0.0010/4		200.
~ ~ ~		NAHE adjustment amount to be allocated						206.
06.00							1	1
06.00 07.00		(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.

	ncial Systems TION - STATISTICAL BASIS	IU HEALTH FRANK	Provi der C		eri od:	worksheet B-1	
				F	rom 01/01/2019 0 12/31/2019		
				1	0 12/31/2019	6/29/2020 8: 3	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	OPERATION OF	LAUNDRY &	
		& GENERAL	PLANT	PLANT -	PLANT - MOB	LINEN SERVICE	
		(ACCUM. COST)	(SQUARE FEET)	HOSPITAL (SQUARE FEET)	(SQUARE FEET)	(PATIENT DAYS)	
		5.00	7.00	7.01	7.02	8.00	+
GENER	AL SERVICE COST CENTERS						
	CAP REL COSTS-BLDG & FIXT						1
	CAP REL COSTS-BLDG & FIXT - HOSPITAL						
	CAP REL COSTS-BLDG & FIXT - MOB						1
	EMPLOYEE BENEFITS DEPARTMENT	45 (7(00)					
	ADMINISTRATIVE & GENERAL	15, 676, 334					
	OPERATION OF PLANT - HOSPITAL	615, 843 1, 564, 128					.
	OPERATION OF PLANT - MOB	1, 304, 120	21, 174	04, 129			
	LAUNDRY & LINEN SERVICE	37, 914	-		0		
	HOUSEKEEPING	485, 352		3, 732	-	0	
	DIETARY	183,067				0	1 10
00 01100	CAFETERIA	242, 534	4, 580	4, 580	0	0	1
00 01300	NURSING ADMINISTRATION	1, 153, 851	623	623	0	0	1
	CENTRAL SERVICES & SUPPLY	545, 310		2, 049	0	0	1
	PHARMACY	780, 600					
	MEDICAL RECORDS & LIBRARY	0	0	C	0	0	1
	I ENT ROUTI NE SERVI CE COST CENTERS	1 5 (5 202	10.140	10.140		1 5/1	
	ADULTS & PEDIATRICS LARY SERVICE COST CENTERS	1, 565, 303	12, 140	12, 140	0	1, 561	30
	OPERATING ROOM	848, 329	10, 265	10, 265	0	0	5
	RADI OLOGY-DI AGNOSTI C	1, 002, 821					
	LABORATORY	1, 212, 517					
	PHYSI CAL THERAPY	568, 960					
00 06700	OCCUPATIONAL THERAPY	208, 368				0	6
00 06800	SPEECH PATHOLOGY	103, 445	702	702	0	0	6
00 06900	ELECTROCARDI OLOGY	96, 092	2, 095	2, 095	0	0	6
	MEDICAL SUPPLIES CHARGED TO PATIENTS	35, 129		C	0	0	1
	IMPL. DEV. CHARGED TO PATIENTS	14, 479		C	0	0	
	DRUGS CHARGED TO PATIENTS	218, 789		C	0		
	ONCOLOGY DRUGS	105,039		0 740	0		
	CARDIOPULMONARY	1, 010, 228	2, 740	2,740	0	0	7
	CLINIC	0	0	0	0	0	9
	EMERGENCY	2, 976, 346	-	-			
	OBSERVATION BEDS (NON-DISTINCT PART)	2, 770, 010	0,001	0,001		0	9
	REIMBURSABLE COST CENTERS					1	1
1.0010100	HOME HEALTH AGENCY	0	0	C	0	0	10
	AL PURPOSE COST CENTERS	-	1	1	1	1	
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	15, 574, 444	83, 106	61, 932	0	1, 561	11
	I MBURSABLE COST CENTERS						1.0
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190
	RESEARCH PHYSI CI ANS' PRI VATE OFFI CES				0		19
2.0019200		65, 442	7,060		7,060		19
	NOD NONPALD WORKERS	03, 442	7,000		, 000 0		19
	LEASED SPACE	36, 448	2, 197	2, 197	0		19
). 00	Cross Foot Adjustments						20
. 00	Negative Cost Centers						20
. 00	Cost to be allocated (per Wkst. B,	6, 296, 038	863, 182	2, 390, 205	0	53, 141	20
	Part I)						
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 401627					
1.00	Cost to be allocated (per Wkst. B,	311, 433	40, 526	391, 642	0	753	20,
- 00	Part II)	0.0100//	0 400740	/ 107007	0 000000	0 100000	
5.00	Unit cost multiplier (Wkst. B, Part	0. 019866	0. 438769	6. 107097	0. 000000	0. 482383	20
5. 00	<pre>III) NAHE adjustment amount to be allocated</pre>						20
	(per Wkst. B-2)						20
7.00	NAHE unit cost multiplier (Wkst. D,						20
		1	1	I	1	1	1-2

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provider CC		Period:	Worksheet B-1	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre 6/29/2020 8:3	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	•	(SQUARE FEET)	(PATIENT DAYS)	(FTE'S)	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
					(DI RECT	(COSTED	
		9.00	10.00	11 00	NURSING HOURS)	REQUIS.)	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	13.00	14.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	(0.007					8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	60, 397					9.00
10. 00 11. 00	01100 CAFETERIA	2,670 4,580		7,699			10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	623		898			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2,049		(372, 130	1
	01500 PHARMACY	1, 915		383	-		15.00
	01600 MEDI CAL RECORDS & LI BRARY	0		(0	
	INPATIENT ROUTINE SERVICE COST CENTERS	-					1
30.00	03000 ADULTS & PEDIATRICS	12, 140	1, 561	1, 441	24, 405	71, 959	30.00
	ANCI LLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATING ROOM	10, 265		409		50, 235	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 228		935		19, 431	1
60.00	06000 LABORATORY	3, 970		675		13, 190	1
66.00	06600 PHYSI CAL THERAPY	2,933		(7, 357	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 286		(77		0	
	06900 ELECTROCARDI OLOGY	2,095		64		5, 975	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,075	1	(35, 129	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0	(Ó	14, 479	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	
73.01	07301 ONCOLOGY DRUGS	0	0	(0 0	0	73.01
76.00	03160 CARDI OPULMONARY	2, 740	0	990) 7	10, 129	76.00
	OUTPATIENT SERVICE COST CENTERS	1			1 1		
	09000 CLINIC	0	-	(-	0	
	09100 EMERGENCY	5,004	. 0	1, 827	29, 955	141, 084	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REI MBURSABLE COST CENTERS	0	0	(0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	0		<u>и</u> 0	0	101.00
118.00		58, 200	1, 561	7, 699	57, 848	372, 130	118.00
	NONREI MBURSABLE COST CENTERS	-1		· · · ·			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190. 00
191.00	19100 RESEARCH	0	0	(0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
	2 19202 MOB	0	0	(0		192.02
	19300 NONPAI D WORKERS	0	0	(0		193.00
	07950 LEASED SPACE	2, 197	0	(0	0	194.00
200.00 201.00	5						200. 00 201. 00
201.00		05/ 250	418, 826	610 220	1 7 7 7 2 2 2	888, 821	
202.00	Part I)	854, 258	410,020	618, 230	1, 727, 232	000, 021	202.00
203.00		14. 144047	268. 306214	80. 300039	29. 858111	2. 388469	203.00
204.00		96, 252		118, 174			204.00
	Part II)						
205.00		1. 593655	44. 663677	15.349266	0. 916004	0. 165273	205.00
206.00							206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						
		1			1 I		•

ST ALLUUR	ATION - STATISTICAL BASIS		Provider CCN: 15-1			Worksheet	B-1
				From To	n 01/01/2019 12/31/2019	Date/Time 6/29/2020	
	Cost Center Description	PHARMACY (COSTED REQUIS.) 15.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16. 00				
GENE	RAL SERVICE COST CENTERS	13.00	10.00	· · · ·			
00 0010 01 0010 02 0010 00 0040 00 0050 00 0050 00 0070 01 0070 02 0070 00 0080 00 0090 00 0100 00 0110 00 0130 00 0140	0 CAP REL COSTS-BLDG & FIXT 1 CAP REL COSTS-BLDG & FIXT - HOSPITAL 2 CAP REL COSTS-BLDG & FIXT - MOB 0 EMPLOYEE BENEFITS DEPARTMENT 0 ADMINI STRATI VE & GENERAL 10 OPERATION OF PLANT 11 OPERATION OF PLANT - HOSPITAL 2 OPERATION OF PLANT - MOB 10 LAUNDRY & LINEN SERVICE 10 HOUSEKEEPING 10 DI ETARY 10 CAFETERIA 10 NURSI NG ADMINI STRATION 10 CENTRAL SERVICES & SUPPLY 10 PHARMACY	338 448					1 1 4 5 7 7 7 7 7 8 9 10 11 13 14 15
	0 PHARMACY 0 MEDICAL RECORDS & LIBRARY	338, 448	0				15
	TIENT ROUTINE SERVICE COST CENTERS	0	0				
	0 ADULTS & PEDIATRICS	4, 324	0				30
	LLARY SERVICE COST CENTERS	994	0				50
	0 RADI OLOGY-DI AGNOSTI C	292	0				54
	0 LABORATORY	0	0				60
. 00 0660	0 PHYSI CAL THERAPY	0	0				66
	O OCCUPATI ONAL THERAPY	0	0				6
	O SPEECH PATHOLOGY	0	0				68
	0 ELECTROCARDI OLOGY	0	0				69
	0 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 IMPL. DEV. CHARGED TO PATIENTS	0	0				7
	O DRUGS CHARGED TO PATIENTS	218, 789	o				73
	1 ONCOLOGY DRUGS	105, 039	0				7:
	O CARDI OPULMONARY	161	0				70
	ATIENT SERVICE COST CENTERS	r					
		0	0				90
	0 EMERGENCY 0 OBSERVATION BEDS (NON-DISTINCT PART)	8, 849	0				9
	R REIMBURSABLE COST CENTERS	<u> </u>					
	O HOME HEALTH AGENCY	0	0				10
	I AL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	338, 448	0				118
	EIMBURSABLE COST CENTERS 0 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				10
	0 RESEARCH	0	0				190 191
	0 PHYSICIANS' PRIVATE OFFICES	o	o				19:
2.02 1920		0	0				193
	O NONPAID WORKERS	0	0				193
	O LEASED SPACE	0	0				19
0.00	Cross Foot Adjustments						200
1.00 2.00	Negative Cost Centers Cost to be allocated (per Wkst. B,	1, 248, 776	o				20 ² 202
2.00	Part I)	1, 240, 770	0				202
3.00	Unit cost multiplier (Wkst. B, Part I)	3. 689713	0.000000				203
4.00	Cost to be allocated (per Wkst. B,	69, 675	0				204
	Part II)						
5.00	Unit cost multiplier (Wkst. B, Part	0. 205866	0. 000000				205
)						
5.00	NAHE adjustment amount to be all costed						1204
6.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 8:3	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description		Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	4, 435, 807		4, 435, 80)7 0	0	30.00
ANCI LLARY SERVI CE COST CENTERS	1			-		
50. 00 05000 OPERATI NG ROOM	2, 073, 189		2, 073, 18		0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 845, 809		1, 845, 80		0	54.00
60. 00 06000 LABORATORY	2, 026, 427		2, 026, 42		0	60.00
66. 00 06600 PHYSI CAL THERAPY	993, 254		993, 25		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	370, 193		370, 19		0	67.00
68.00 06800 SPEECH PATHOLOGY	193, 829		193, 82		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	281, 390		281, 39		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	133, 143		133, 14		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	54, 877		54, 87		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 113, 930		1, 113, 93		0	73.00
73.01 07301 ONCOLOGY DRUGS	534, 789		534, 78		0	73.01
76.00 03160 CARDI OPULMONARY	1, 686, 943		1, 686, 94	3 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0			0 0	0	90.00
91.00 09100 EMERGENCY	5, 886, 508		5, 886, 50		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 146, 202		1, 146, 20)2	0	92.00
OTHER REIMBURSABLE COST CENTERS	1					
101.0010100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	22, 776, 290		22, 776, 29			200. 00
201.00 Less Observation Beds	1, 146, 202		1, 146, 20			201.00
202.00 Total (see instructions)	21, 630, 088	0	21, 630, 08	38 0	0	202.00

Health Financial Systems	IU HEALTH FRANK	ORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	6/29/2020 8:3	pared: 7 am
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 973, 785		2, 973, 78	5		30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	65, 575	3, 379, 061				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	291, 790	6, 364, 508				54.00
60. 00 06000 LABORATORY	464,067	3,047,457		4 0. 577079	0.00000	60.00
66. 00 06600 PHYSI CAL THERAPY	473, 193	1, 762, 448				
67.00 06700 OCCUPATI ONAL THERAPY	301, 140	687, 495				
68.00 06800 SPEECH PATHOLOGY	110, 925	253, 264			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	736, 786	736, 78		0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 097	176, 508	177, 60	5 0. 749658	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	157, 925	157, 92	5 0. 347488	0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	833, 482	1, 401, 415				
73.01 07301 ONCOLOGY DRUGS	0	785, 357	785, 35	7 0. 680950	0.00000	73.01
76.00 03160 CARDI OPULMONARY	509, 579	2, 982, 759	3, 492, 33	8 0. 483041	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS	- - - - - -		r	- T		
90. 00 09000 CLI NI C	0	0		0 0. 000000		1
91. 00 09100 EMERGENCY	296, 285	17, 169, 197				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 229, 115	2, 229, 11	5 0. 514196	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	6, 320, 918	41, 133, 295	47, 454, 21	3		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 320, 918	41, 133, 295	47, 454, 21	3		202.00

Health Financial Systems	IU HEALTH FRANKFO	ORT HOSPI TAL	In Lie	u of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepar 6/29/2020 8:37 a	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				30	0. 00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50	0.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				4.00
60. 00 06000 LABORATORY	0. 000000				0.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				6.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				7.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				8.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				1.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				3.00
73.01 07301 ONCOLOGY DRUGS	0. 000000				3. 01
76. 00 03160 CARDI OPULMONARY	0. 000000			76	6.00
OUTPATIENT SERVICE COST CENTERS	1				
90. 00 09000 CLINIC	0. 000000				0.00
91.00 09100 EMERGENCY	0. 000000				1.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000			92	2.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					1.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				202	2.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 7 am
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	2.00	3.00	4,00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	4, 435, 807		4, 435, 80	7 0	4, 435, 807	30.00
ANCI LLARY SERVICE COST CENTERS	4,435,607		4, 435, 80	/ 0	4, 433, 807	30.00
50. 00 05000 OPERATING ROOM	2,073,189		2, 073, 18	9 0	2, 073, 189	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 845, 809		1, 845, 80		1, 845, 809	
60. 00 06000 LABORATORY	2, 026, 427		2, 026, 42		2, 026, 427	
66. 00 06600 PHYSI CAL THERAPY	993, 254	0	993, 25		993, 254	•
67.00 06700 OCCUPATI ONAL THERAPY	370, 193		370, 19		370, 193	•
68.00 06800 SPEECH PATHOLOGY	193, 829		193, 82		193, 829	68.00
69. 00 06900 ELECTROCARDI OLOGY	281, 390		281, 39	0 0	281, 390	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	133, 143		133, 14	3 0	133, 143	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	54, 877		54, 87	7 0	54, 877	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 113, 930		1, 113, 93	0 0	1, 113, 930	
73.01 07301 ONCOLOGY DRUGS	534, 789		534, 78	9 0	534, 789	•
76.00 03160 CARDI OPULMONARY	1, 686, 943		1, 686, 94	3 0	1, 686, 943	76.00
OUTPATIENT SERVICE COST CENTERS				1		
90. 00 09000 CLINIC	0			0 0	0	,0.00
91.00 09100 EMERGENCY	5, 886, 508		5, 886, 50		5, 886, 508	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 146, 202		1, 146, 20	2	1, 146, 202	92.00
OTHER REIMBURSABLE COST CENTERS	-			-	-	
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	22, 776, 290		22, 776, 29		22, 776, 290	
201.00 Less Observation Beds	1, 146, 202		1, 146, 20		1, 146, 202	
202.00 Total (see instructions)	21, 630, 088	0	21, 630, 08	8 0	21, 630, 088	J202. 00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 8:3	pared: 7 am
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 973, 785		2, 973, 78	5		30.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	65, 575	3, 379, 061				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	291, 790	6, 364, 508				54.00
60. 00 06000 LABORATORY	464, 067	3,047,457				60.00
66. 00 06600 PHYSI CAL THERAPY	473, 193	1, 762, 448				
67.00 06700 OCCUPATI ONAL THERAPY	301, 140	687, 495				
68.00 06800 SPEECH PATHOLOGY	110, 925	253, 264			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	736, 786			0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 097	176, 508				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	157, 925				
73.00 07300 DRUGS CHARGED TO PATIENTS	833, 482	1, 401, 415				
73.01 07301 ONCOLOGY DRUGS	0	785, 357				1
76.00 03160 CARDI OPULMONARY	509, 579	2, 982, 759	3, 492, 33	8 0. 483041	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS	-		1			
90. 00 09000 CLINIC	0	0		0 0.00000		1
91.00 09100 EMERGENCY	296, 285	17, 169, 197				91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	2, 229, 115	2, 229, 11	5 0. 514196	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	6, 320, 918	41, 133, 295	47, 454, 21	3		200.00
201.00 Less Observation Beds	(220 010	41 100 005	47 45 4 04			201.00
202.00 Total (see instructions)	6, 320, 918	41, 133, 295	47, 454, 21	3		202.00

Health Financial Systems	IU HEALTH FRANKF	ORT HOSPITAL	In Lieu of Form CMS-25			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019			
		Title XIX	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio 11.00					
INPATIENT ROUTINE SERVICE COST CENTERS	· · · · ·					
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS				30. 0		
50. 00 05000 OPERATING ROOM	0. 000000			50.0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0		
60, 00 06000 LABORATORY	0.000000			60.0		
66. 00 06600 PHYSI CAL THERAPY	0, 000000			66. 0		
67.00 06700 OCCUPATIONAL THERAPY	0. 000000			67.0		
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.0		
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0		
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0		
73.01 07301 ONCOLOGY DRUGS	0. 000000			73.0		
76. 00 03160 CARDI OPULMONARY	0. 000000			76.0		
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000			90.0		
91.00 09100 EMERGENCY	0. 000000			91.0		
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 000000			92.0		
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY				101.0		
200.00 Subtotal (see instructions)				200. 0		
201.00 Less Observation Beds				201.0		
202.00 Total (see instructions)				202. 0		

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:3	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1			
50.00 05000 OPERATING ROOM	288, 947				0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	167, 554	6, 656, 298			3, 131	54.00
60. 00 06000 LABORATORY	134, 805					
66. 00 06600 PHYSI CAL THERAPY	85, 050	2, 235, 641	0. 03804			66.00
67.00 06700 OCCUPATI ONAL THERAPY	35, 941	988, 635	0. 03635	49, 318	1, 793	67.00
68.00 06800 SPEECH PATHOLOGY	20, 672	364, 189	0. 05676	2 80, 958	4, 595	68.00
69. 00 06900 ELECTROCARDI OLOGY	55, 734	736, 786	0. 07564	5 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 504	177, 605	0. 03662	1 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 681	157, 925	0. 01697	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	49, 387	2, 234, 897	0. 02209	429, 374	9, 488	73.00
73.01 07301 ONCOLOGY DRUGS	23, 711	785, 357	0. 03019	0 0	0	73.01
76.00 03160 CARDI OPULMONARY	105, 451	3, 492, 338	0. 03019	95 311, 673	9, 411	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91.00 09100 EMERGENCY	264, 667	17, 465, 482			156	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	118, 878				0	92.00
200.00 Total (lines 50 through 199)	1, 359, 982			1, 344, 099	41, 511	200.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019		
				To 12/31/2019		pared:
					6/29/2020 8: 3	/ am
			e XVIII	Hospi tal	Cost	
Cost Center Description				I Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	c c		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	c		o o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73. 01 07301 ONCOLOGY DRUGS	0	0		0 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			1	<u> </u>		10100
90. 00 09000 CLINIC	0	0)	0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	0	92.00
200.00 Total (lines 50 through 199)				0 0	Ű	200.00
	0	1 0	1	ч 0	U U	200.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	6/29/2020 8:3	
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 OPERATING ROOM	0	0		0 3, 444, 636		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 6, 656, 298		54.00
60. 00 06000 LABORATORY	0	0		0 3, 511, 524		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 235, 641		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 988, 635		
68.00 06800 SPEECH PATHOLOGY	0	0		0 364, 189		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 736, 786		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 177, 605		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 157, 925		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 234, 897		
73.01 07301 ONCOLOGY DRUGS	0	0		0 785, 357		
76.00 03160 CARDI OPULMONARY	0	0		0 3, 492, 338	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS			1	-		
90. 00 09000 CLINIC	0	0		0 0	0. 000000	
91. 00 09100 EMERGENCY	0	0		0 17, 465, 482		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 229, 115		•
200.00 Total (lines 50 through 199)	0	0	1	0 44, 480, 428		200. 00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO	CN: 15-1316	Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
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		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	i			-	-	
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	124, 386		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	216, 044		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	122, 043		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	49, 318		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	80, 958		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	429, 374		0 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 000000	0		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	311, 673		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 000000	10, 303		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 344, 099		0 0	0	200. 00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge		Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 601860		905, 65		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 277303		1, 582, 64	2 0	0	54.00
60. 00 06000 LABORATORY	0. 577079		769, 55		0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 444282	0	495, 43	1 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 374449	0	216, 10	3 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 532221	0	35, 40	8 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 381916	0	202, 63	8 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 749658	0	9, 94	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 347488	0	56, 89	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 498426	0	328, 03	5 1, 052	0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 680950	0	534, 24	7 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 483041	0	1, 302, 66	6 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		•	•			1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 337037	0	3, 916, 13	5 680	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 514196	0	1, 093, 12	8 0	0	92.00
200.00 Subtotal (see instructions)		0	11, 448, 47	6 1, 732	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	11, 448, 47	6 1, 732	0	202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	O VACCINE COST	Provider CO		Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/29/2020 8:3	
		Title	XVIII	Hospi tal	Cost	
	Co	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50. 00 05000 OPERATI NG ROOM	545, 077					50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	438, 871					54.00
60. 00 06000 LABORATORY	444, 095					60.00
66. 00 06600 PHYSI CAL THERAPY	220, 111					66.00
67.00 06700 OCCUPATIONAL THERAPY	80, 920					67.00
68.00 06800 SPEECH PATHOLOGY	18, 845					68.00
69. 00 06900 ELECTROCARDI OLOGY	77, 391	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 452	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 770	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	163, 501	524				73.00
73.01 07301 ONCOLOGY DRUGS	363, 795	0				73.01
76.00 03160 CARDI OPULMONARY	629, 241	0				76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	1, 319, 882	229				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	562, 082					92.00
200.00 Subtotal (see instructions)	4, 891, 033	753				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	4, 891, 033	753				202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2019	Worksheet D Part V	
		Component		To 12/31/2019	6/29/2020 8:3	pared: 7 am
		Title	e XVIII S	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				_		
50.00 O5000 OPERATING ROOM	0. 601860	0		0 0	0	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 277303	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 577079	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 444282	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 374449	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 532221	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 381916	0		o o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 749658			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 347488			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 498426			0 0	0	1
73. 01 07301 ONCOLOGY DRUGS	0, 680950			0 0	0	1
76. 00 03160 CARDI OPULMONARY	0. 483041			0	0	
OUTPATIENT SERVICE COST CENTERS	01100011	<u> </u>		<u> </u>		10100
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 337037			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 514196			0 0	0	
200.00 Subtotal (see instructions)	0.0.1170			0 0	, s	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ			0	201.00
Only Charges				0		201.00
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1316	Peri od:	Worksheet D	
			001 45 704/	From 01/01/2019	Part V	
		Component	CCN: 15-Z316	To 12/31/2019	Date/Time Pre 6/29/2020 8:3	
		Title	XVIII	Swing Beds - SNF		
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
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				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
73.01 07301 ONCOLOGY DRUGS	0	0				73.01
76.00 03160 CARDI OPULMONARY	0	0				76.00
OUTPATIENT SERVICE COST CENTERS		•				1
90. 00 09000 CLI NI C	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2019 To 12/31/2019		
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS		-				
50.00 05000 OPERATING ROOM	0. 601860	0		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 277303	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 577079	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 444282	0)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 374449	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 532221	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 381916	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 749658	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 347488	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 498426			0 0	0	
73.01 07301 ONCOLOGY DRUGS	0. 680950			0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 483041	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		-	1			1
90, 00 09000 CLINIC	0.00000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 337037			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 514196	-		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ		0 0	Ű	201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/29/2020 8:3	
		Titl	e XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS		0				
50. 00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	0	0				60.00
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				69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
73. 01 07301 ONCOLOGY DRUGS	0	0				73.01
76.00 03160 CARDI OPULMONARY	0	0				76.00
90. 00 09000 CLINIC	0	0				
90. 00 109000 CLINIC 91. 00 109100 EMERGENCY	0					90.00 91.00
91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					91.00
200.00 Subtotal (see instructions)	0					200.00
201.00 Less PBP Clinic Lab. Services-Program	0	0				200.00
Only Charges	0					201.00
202.00 Net Charges (line 200 - line 201)	0	0				202.00
202.00 Inet that yes (The 200 - The 201)	0	1 0	I			1202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1316	Period: From 01/01/2019	Worksheet D-1	
		Title XVIII	To 12/31/2019 Hospi tal	Date/Time Prep 6/29/2020 8:3 Cost	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	c oveluding nowhern)	I	2,047	1 1.
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 689	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	aveb ba		1, 203	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 203	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	175	7
~~	reporting period				
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December	31 OF THE COST	0	8
00	Total inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	707	9
00	newborn days) (see instructions)	nlu (including privata	na an dava)	102	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc		room days)	183	
00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		to room dave)	0	12
. 00	through December 31 of the cost reporting period	x only (including priva	te room days)	0	
00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	an (excluding swing bed	uays)	0	
00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31	of the cost		17
. 00	reporting period	es thiough becember 51	of the cost		''
. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18
.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	118.90	19
~~	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s after December 31 of	the cost	0.00	20
00	Total general inpatient routine service cost (see instruction	s)		4, 435, 807	21
. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost repor	ting period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	na period (line 6	0	23
	x line 18)	•			
00	Swing-bed cost applicable to NF type services through Decembe 7 x line 19)	r 31 of the cost report	ing period (line	20, 808	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25
00	x line 20) Tatal aming had east (and instantions)			452 402	
. 00 . 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		452, 403 3, 983, 404	
. 00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			0, 700, 101	1 - '
	General inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	
00 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost d	ifferential (line	3, 983, 404	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		· · · · · · · · · · · · · · · · · · ·		1
. 00	Adjusted general inpatient routine service cost per diem (see			2, 358. 44	
		181		1, 667, 417	1 39
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			0	

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	veriod: rom 01/01/2019 o 12/31/2019	Worksheet D-1 Date/Time Pre	pared:
			Title	× XVIII	Hospi tal	6/29/2020 8: 3	7 am
	Cost Center Description	Total	Total	Average Per	Program Days	Cost Program Cost	
			Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42.00		1.00	2.00	3.00	4.00	5.00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNI T						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46.00 47.00
47.00	Cost Center Description						47.00
		_				1.00	
	Program inpatient ancillary service cost (Wk					642, 978	48.00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ins)		2, 310, 395	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. sum	of Parts I and	0	50.00
	Pass through costs applicable to Program inp					0	51.00
	and IV)		,				
52.00	Total Program excludable cost (sum of lines					0	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erated, non-pny	sician anestne	tist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program discharges					0	
	Target amount per discharge						55.00
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (1	ine 56 minus l	ine 53)	0	56.00 57.00
	Bonus payment (see instructions)	The cost and to	inger amount (i		The bby	0	58.00
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and com	pounded by the	0.00	59.00
(0.00	market basket	aget report up	datad by the m	arkat baakat		0.00	60.00
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				he amount by	0.00	61.00
	which operating costs (line 53) are less that					_	
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions)	ont (coo inctru	uctions)			0	62.00 63.00
03.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reportir	g period (See	431, 595	64.00
(5 . 00	instructions) (title XVIII only)	+£+ D					(5.00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is after Decemb	per 31 of the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVIII	only). For	431, 595	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	of the cost rep	orting period	0	67.00
(0.00	(line 12 x line 19)						
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter L	ecember 31 or	the cost repor	ting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service c						71.00
72.00	Program routine service cost (line 9 x line	71)					72.00
73.00	Medically necessary private room cost applic						73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				rt II column		74.00 75.00
/ 5. 00	26, line 45)	routine service		or Kaneet D, Ta			/ 5. 00
	Per diem capital-related costs (line 75 ÷ li						76.00
	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		provi der record	ls)			78.00 79.00
80.00	Total Program routine service costs for comp	• •		· .	s line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00 83.00	Inpatient routine service cost limitation (I		· .				82.00 83.00
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83.00
	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum		nrough 85)				86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					104	87.00
	Adjusted general inpatient routine cost per		line 2)			2, 358. 44	
	Observation bed cost (line 87 x line 88) (se	•	,			1, 146, 202	

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	460, 059	4, 435, 807	0. 10371	5 1, 146, 202	118, 878	90.00
91.00 Nursing School cost	0	4, 435, 807	0.00000	0 1, 146, 202	0	91.00
92.00 Allied health cost	0	4, 435, 807	0.00000	0 1, 146, 202	0	92.00
93.00 All other Medical Education	0	4, 435, 807	0.00000	0 1, 146, 202	0	93.00

:OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1316	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 6/29/2020 8:3	pared:
	Cost Costor Description	Title XIX	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
. 00	Inpatient days (including private room days and swing-bed day	ys, excluding newborn)		2,047	1.0
2.00	Inpatient days (including private room days, excluding swing-			1, 689	
. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	rivate room days,	0	3.0
. 00	Semi-private room days (excluding swing-bed and observation b	oed days)		1, 203	4. C
. 00	Total swing-bed SNF type inpatient days (including private ro	oom days) through Decembe	er 31 of the cost	183	5.0
. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom davs) after December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)	5.		-	
. 00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	175	7.0
8. 00	Total swing-bed NF type inpatient days (including private roc	om days) after December 3	31 of the cost	0	8.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	swing-bed and	2	9.0
0.00	Swing-bed SNF type inpatient days applicable to title XVIII c		room days)	0	10. C
1.00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		coom dave) after	0	11.0
1.00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	
2.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12. C
3.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13. C
	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this lir	ne)	-	
	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	ram (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
7.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces through December 31 d	of the cost		17.0
8.00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18.0
9.00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through December 21 of	the cost	118.90	10.0
9.00	reporting period	es through becember 31 of	the cost	118.90	19.0
0. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	he cost	0.00	20. C
1. 00	reporting period Total general inpatient routine service cost (see instruction	าร)		4, 435, 807	21.0
2.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	1
3. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	a 21 of the cost reportin	a ported (line 6	0	23.0
3.00	x line 18)	ST OF the cost reportin		0	23.0
4. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	20, 808	24.0
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. C
	x line 20)	·····	,		
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		452, 403 3, 983, 404	
7.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			3, 903, 404	27.0
8.00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
9.00 0.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
2.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
4.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
5.00	Average per diem private room cost differential (line $34 \times 1i$	ne 31)		0.00	
0.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 983, 404	
7.00	27 minus line 36)	•			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
		JUSTMENTS			
7.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2, 358. 44	38.0
87.00 88.00 9.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	e instructions) e 38)		2, 358. 44 4, 717	1

Heal th	Financial Systems I	U HEALTH FRANK	FORT HOSPITAL		ln Li€	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
					From 01/01/2019 Fo 12/31/2019	Date/Time Pre	pared:
						6/29/2020 8:3	7 am
	Cast Contor Description	Total	Total	e XIX	Hospital	Cost Program Cost	
	Cost Center Description	Total Innatient Cost	Inpatient Days	Average Per Diem (col 1 -	Program Days	(col. 3 x col.	
				col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			9, 139	48.00
49.00	Total Program inpatient costs (sum of lines 4	41 through 48)(see instructio	ns)		13, 856	49.00
50.00	PASS THROUGH COST ADJUSTMENTS				<u> </u>		50.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (Trom	IWKST. D, SUM	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	om Wkst. D, su	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 5	50 and 51)				0	52.00
	Total Program inpatient operating cost exclud		elated, non-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line 5	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	ending 1996, u	pdated and con	pounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines	s 55, 59 or 60	enter the less	er of 50% of t	the amount by	0	61.00
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see i	nstructions)				0	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	63.00
00100	PROGRAM INPATIENT ROUTINE SWING BED COST						00,00
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	te aftar Dacamh	or 21 of the e	act reporting	pariod (Saa	0	65.00
05.00	instructions)(title XVIII only)	is after Decenic		ust reputting	period (see	0	05.00
66.00	Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
(7.00	CAH (see instructions)			C 11			17 00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	of the cost rep	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
	(line 13 x line 20)				0		
69.00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili		•				70.00
	Adjusted general inpatient routine service co	5					71.00
	Program routine service cost (line 9 x line 7	71)					72.00
	Medically necessary private room cost applica						73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				art II column		74.00 75.00
75.00	26, line 45)	outine service	COSTS (ITOM W	ULKSHEEL D, FO	art II, Corumn		75.00
76.00	Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus	,		>			78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				is line 79)		79.00 80.00
81.00	Inpatient routine service costs for compa						81.00
82.00	Inpatient routine service cost limitation (li	ne 9 x line 81					82.00
	Reasonable inpatient routine service costs (s		ıs)				83.00
	Program inpatient ancillary services (see ins		ne)				84.00 85.00
	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85.00 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
	Total observation bed days (see instructions)						87.00
88.00 89.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see					2, 358. 44 1, 146, 202	
J7. UU	Topservation bed cost (THE OF A THE OD) (See					1, 140, 202	07.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	460, 059	4, 435, 807	0. 10371	5 1, 146, 202	118, 878	90.00
91.00 Nursing School cost	0	4, 435, 807	0.00000	0 1, 146, 202	0	91.00
92.00 Allied health cost	0	4, 435, 807	0.00000	0 1, 146, 202	0	92.00
93.00 All other Medical Education	0	4, 435, 807	0. 00000	0 1, 146, 202	0	93.00

Health Financial Systems IU HEALTH FRA	NKFORT HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1316	Peri od:	Worksheet D-3	3
			From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
			10 12/31/2017	6/29/2020 8: 3	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1	1, 476, 235		30, 00
ANCI LLARY SERVICE COST CENTERS			1, 470, 233		30.00
50. 00 05000 OPERATI NG ROOM		0.60186	0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 27730		-	
60. 00 06000 LABORATORY		0.57707		124, 674	
66.00 06600 PHYSI CAL THERAPY		0. 44428			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 37444			
68.00 06800 SPEECH PATHOLOGY		0. 53222	80, 958	43, 088	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 38191	16 0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0. 74965	58 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34748	38 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 49842	429, 374	214, 011	73.00
73.01 07301 ONCOLOGY DRUGS		0. 68095		0	
76.00 03160 CARDI OPULMONARY		0. 48304	311, 673	150, 551	76.00
OUTPATIENT SERVICE COST CENTERS		1			
90. 00 09000 CLINIC		0.0000		0	
91.00 09100 EMERGENCY		0. 33703			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 51419		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 344, 099	642, 978	
201.00 Less PBP Clinic Laboratory Services-Program only cha	arges (line 61)		1 244 200		201.00
202.00 Net charges (line 200 minus line 201)		I	1, 344, 099		202.00

Health Financial Systems IU HEALTH FR	ANKFORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	3
	Component	CCN: 15-Z316	From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
	component	CCN. 15-2510	10 12/31/2019	6/29/2020 8: 3	
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		I	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 60186		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 27730			
60. 00 06000 LABORATORY		0. 57707			
66. 00 06600 PHYSI CAL THERAPY		0. 44428			
67. 00 06700 OCCUPATIONAL THERAPY		0. 37444			
68. 00 06800 SPEECH PATHOLOGY		0. 53222			
69. 00 06900 ELECTROCARDI OLOGY		0. 38191		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0.74965		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.34748		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 49842			
73. 01 07301 0NC0L0GY DRUGS 76. 00 03160 CARDI 0PULMONARY		0. 68095		0	
OUTPATIENT SERVICE COST CENTERS		0. 48304	10,000	5, 147	1 /0.00
90. 00 09000 CLINIC		0.0000		0	90.00
91. 00 09100 EMERGENCY		0. 33703			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 51419			
200.00 Total (sum of lines 50 through 94 and 96 through 94	8)	0. 5141	344, 466	-	
201.00 Less PBP Clinic Laboratory Services-Program only cl			0	130,404	201.00
202.00 Net charges (line 200 minus line 201)			344, 466		202.00
202.00 [Net charges (The 200 III has The 201)		I	344, 400	I	1202.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL		In Lie	u of Form CMS-	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CCN: 15-1316	Peri od:	Worksheet D-3	3
			From 01/01/2019 To 12/31/2019		narod
			10 12/31/2019	6/29/2020 8: 3	
	Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDIATRICS			14, 840		30.0
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.60180		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 27730			
		0. 5770			
66.00 06600 PHYSI CAL THERAPY		0. 44428		0	
67. 00 06700 OCCUPATIONAL THERAPY		0. 3744		0	67.0
68. 00 06800 SPEECH PATHOLOGY		0. 53222		0	1 00.0
59. 00 06900 ELECTROCARDI OLOGY		0. 3819		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0.74965		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34748		0	
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 ONCOLOGY DRUGS		0. 49842		4, 617	
73. 01 07301 ONCOLOGY DRUGS 76. 00 03160 CARDI OPULMONARY		0. 68095		0 987	
OUTPATIENT SERVICE COST CENTERS		0. 48304	41 2,044	987	1 /0.0
90. 00 09000 CLINIC		0.0000	0	0	90.0
21. 00 109100 EMERGENCY		0. 33703		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5141		1, 1/3	
200.00 Total (sum of lines 50 through 94 ar		0. 5141	20, 117	, i i i i i i i i i i i i i i i i i i i	200.0
201.00 Less PBP Clinic Laboratory Services			20, 117	7,137	200.0
202.00 Net charges (line 200 minus line 20			20, 117		201.0
202.00 [Net charges (The 200 minus The 20)	I	20, 117	I	1202.0

CALCUL	Financial Systems IU HEALTH FRANKFORT HO: ATION OF REIMBURSEMENT SETTLEMENT Prov	vider CCN: 15-1316	Peri od:	u of Form CMS-2 Worksheet E	'
			From 01/01/2019 To 12/31/2019	Part B Date/Time Pre	pared:
		Title XVIII	Hocpi tal	6/29/2020 8:3	
			Hospi tal	Cost	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			4, 891, 786	1.0
2.00	Medical and other services reimbursed under OPPS (see instructions))		4, 071, 700	
3.00	OPPS payments			0	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	4.0 4.0
5.00	Enter the hospital specific payment to cost ratio (see instruction	s)		0.000	5.0
5.00	Line 2 times line 5			0	6. C
7.00 3.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	
9.00 9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, c	ol. 13, line 200		0	9.0
10.00	Organ acquisitions			0	10.0
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			4, 891, 786	11.0
	Reasonabl e charges				
12.00	Ancillary service charges			0	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 6 Total reasonable charges (sum of lines 12 and 13)	9)		0	13.0 14.0
14.00	Customary charges			0	14.0
15.00	Aggregate amount actually collected from patients liable for payme			0	
16.00	Amounts that would have been realized from patients liable for pay	ment for services o	on a chargebasis	0	16.0
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.0
18.00	Total customary charges (see instructions)			0	18.0
19.00	Excess of customary charges over reasonable cost (complete only if instructions)	line 18 exceeds li	ne 11) (see	0	19.0
20.00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds li	ne 18) (see	0	20. C
	instructions)				
21.00 22.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			4, 940, 704 0	
23.00	Cost of physicians' services in a teaching hospital (see instructi	ons)		0	23.0
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.0
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions)			22, 561	25.0
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH, see instr	ructions)	2, 110, 077	26. C
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 22	2 and 23] (see	2, 808, 066	27. C
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line 5	.0)		0	28.0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	- /		0	29.0
30.00	Subtotal (sum of lines 27 through 29)			2, 808, 066	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			5, 581 2, 802, 485	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			_,,	
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			474, 448 308, 391	34.0 35.0
36.00	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)		474, 660	
37.00	Subtotal (see instructions)			3, 110, 876	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38. C 39. C
39.50	Pioneer ACO demonstration payment adjustment (see instructions)			-	39.5
39.97	Demonstration payment adjustment amount before sequestration			0	39.9
39.98 39.99	Partial or full credits received from manufacturers for replaced d RECOVERY OF ACCELERATED DEPRECIATION	evices (see instruc	ctions)	0	39.9 39.9
40.00	Subtotal (see instructions)			3, 110, 876	
40.01	Sequestration adjustment (see instructions)			62, 218	
10. 02 10. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. C 40. C
41.00	Interim payments			2, 656, 924	
41.01	Interim payments-PARHM				41.0
42.00 42.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. C 42. C
43. 00	Balance due provider/program (see instructions)			391, 734	
43.01	Balance due provider/program-PARHM (see instructions)				43. C
44.00	Protested amounts (nonallowable cost report items) in accordance w §115.2	ith CMS Pub. 15-2,	chapter 1,	176, 955	44.0
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91. C 92. C
<i>72.00</i>	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.0

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	:N: 15-1316	Period: From 01/01/2019 To 12/31/2019		
		Title		Hospi tal	Cost	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		1, 955, 6	59 0	2, 656, 924 0	1. C 2. C
. 00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. C
01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02 . 03 . 04 . 05				0 0 0 0	0	3. (3. (3. (3. (
	Provider to Program	II		-		
50 51 52 53 54 99	ADJUSTMENTS TO PROGRAM Subtotal (sum of lines 3.01-3.49 minus sum of lines			0 0 0 0 0	0 0 0 0 0	3. 3. 3. 3. 3. 3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 955, 6	59	2, 656, 924	4.
~ ~	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.0
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.
50 51	ILIVIATIVE TU PRUGRAW			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
DO D1	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER		129, 54	12	391, 734	6. 6.
02	SETTLEMENT TO PROGRAM		127, 0	0	0	6.
00	Total Medicare program liability (see instructions)		2, 085, 20	-	3, 048, 658	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
00	Name of Contractor	0		1.00	2.00	8.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider Co	CN: 15-1316 CCN: 15-Z316	Period: From 01/01/2019 To 12/31/2019		
					6/29/2020 8:3	7 am
				Swing Beds - SN		
		Inpatien	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		343, 70		0	1.
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,			0	0	2.
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment 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)					3.
	Program to Provider		<u>.</u>		1	
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	
04 05				0	0	
72	Provider to Program			0	0	3
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		343, 70	70	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as			-		
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				1	
D1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	
)3				0	0	5
	Provider to Program				1	
50 51	TENTATI VE TO PROGRAM			0	0	
52				0	0	
99 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
01	the cost report. (1) SETTLEMENT TO PROVIDER		232, 3	56	0	6
)2	SETTLEMENT TO PROVIDER		232, 33	0	0	
02	Total Medicare program liability (see instructions)		576, 00	0	0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	Financial Systems IU HEALTH FRANKFO	ORT HOSPI TAL	In Lie	u of Form CMS-	2552-10		
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1316 Period: From 01/01/2019 To 12/31/2019						
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00							
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00		
3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2						
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7.00		
8.00	Calculation of the HIT incentive payment (see instructions)				8.00		
9.00	Sequestration adjustment amount (see instructions)				9.00		
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00		
	Other Adjustment (specify)				31.00		
32.00	2.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)						

ALCULA	Financial Systems IU HEALTH FRANKFORT TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	rovider CCN: 15-1316	Peri od:	u of Form CMS-2 Worksheet E-2	
	с	omponent CCN: 15-Z316	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:3	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
C	COMPLITATION OF NET COST OF COVERED SEDVICES		1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		435, 911	0	1 1.
	Inpatient routine services - swing bed SM (see instructions)		433, 711	0	2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	and sum of West D	151, 908	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-			0	J 3.
	instructions)				
	Nursing and allied health payment-PARHM (see instructions)				3.
00	Per diem cost for interns and residents not in approved teaching	, program (see		0.00	4
ļi	instructions)				
	Program days		183	0	
	Interns and residents not in approved teaching program (see inst			0	
	Jtilization review - physician compensation - SNF optional metho	od only	0		7
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		587, 819	0	
	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9)		587, 819	0	
	Deductibles billed to program patients (exclude amounts applicat	ne to physician	0	0	11
	professional services)		E07 010	0	112
	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records) (ovelude coi neurance	587, 819 0	0	
	for physician professional services)		0	0	13
	30% of Part B costs (line 12 x 80%)			0	14
	Subtotal (see instructions)		587, 819	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		Ŭ	0	16
	Rural community hospital demonstration project (§410A Demonstrat	ion) payment	0		16
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	16
. 00 /	Allowable bad debts (see instructions)		0	0	17
. 01 /	Adjusted reimbursable bad debts (see instructions)		0	0	17
. 00 /	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0	0	18
. 00	Total (see instructions)		587, 819	0	19
	Sequestration adjustment (see instructions)		11, 756	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
	Sequestration adjustment-PARHM pass-throughs				19
	Interim payments		343, 707	0	
	Interim payments-PARHM				20
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)		000.05/	0	21
	Balance due provider/program (line 19 minus lines 19.01, 20, and	1 21)	232, 356	0	
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 1E 2	21, 113	0	22
	chapter 1, §115.2	e with CMS Pub. 15-2,	21, 113	0	23
	Rural Community Hospital Demonstration Project (§410A Demonstrat	ion) Adjustment			
	Is this the first year of the current 5-year demonstration period				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				
C	Cost Reimbursement				1
1.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from W	/kst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in fineriod)	ist year of the curre	nt s-year demonst	ration	
	Medicare swing-bed SNF target amount				205
	Medicare swing bed SNF inpatient routine cost cap (line 205 time	es line 204)			206
	Indjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburser				1
	Program reimbursement under the §410A Demonstration (see instruc				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				
	Total adjustment to Medicare swing-bed SNF PPS payment (line 209) nus line 210) (see			215

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Pre	
				6/29/2020 8:3	
		Title XVIII	Hospi tal	Cost	
				1.00	-
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR ME	DICARE PART A SERVICES - COS	T REIMBURSEMENT	1.00	
00	Inpatient services			2, 310, 395	1 1
00	Nursing and Allied Health Managed Care payment (see ins	structions)		0	2
00	Organ acqui si ti on			0	3
00	Subtotal (sum of lines 1 through 3)			2, 310, 395	
00	Primary payer payments	、 、		0	5
00	Total cost (line 4 less line 5). For CAH (see instructi	ons)		2, 333, 499	6
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
00	Routi ne servi ce charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	1 7
). 00	Total reasonable charges			0	10
	Customary charges				
. 00	Aggregate amount actually collected from patients liabl			0	
2. 00	Amounts that would have been realized from patients lia		on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 41	3.13(e)		0.000000	
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (compl	ata anly if line 14 avecade l	ino 6) (soo	0	
5. 00	instructions)	ete oni y 11 11ne 14 exceeds 1	The of (see	0	
5.00	Excess of reasonable cost over customary charges (compl	ete only if line 6 exceeds li	ne 14) (see	0	1
	instructions)	<u> </u>		-	
7.00	Cost of physicians' services in a teaching hospital (se	e instructions)		0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
3.00	Direct graduate medical education payments (from Worksh	neet E-4, line 49)		0	
00	Cost of covered services (sum of lines 6, 17 and 18)			2, 333, 499	
. 00	Deductibles (exclude professional component) Excess reasonable cost (from line 16)			214, 100 0	
2.00	Subtotal (line 19 minus line 20 and 21)			2, 119, 399	
3.00	Coi nsurance			2, 117, 377	
. 00	Subtotal (line 22 minus line 23)			2, 119, 399	
5.00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		12, 857	
. 00	Adjusted reimbursable bad debts (see instructions)			8, 357	26
. 00	Allowable bad debts for dual eligible beneficiaries (se	e instructions)		12, 857	
8. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 127, 756	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instr			0	
9.99).00	Demonstration payment adjustment amount before sequestr Subtotal (see instructions)	ation		0	
0.00 0.01	Sequestration adjustment (see instructions)			2, 127, 756 42, 555	
0.01	Demonstration payment adjustment amount after sequestra	ntion		42, 555	
0.02	Sequestration adjustment-PARHM			0	30
. 00	Interim payments			1, 955, 659	
. 01	Interim payments-PARHM				3
2. 00	Tentative settlement (for contractor use only)			0	32
2. 01	Tentative settlement-PARHM (for contractor use only)				32
8. 00	Balance due provider/program (line 30 minus lines 30.01			129, 542	
8. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and				33
1.00	Protested amounts (nonallowable cost report items) in a	accordance with CMS Pub. 15-2,	chapter 1,	83, 812	34

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet G Date/Time Pre 6/29/2020 8:3	pare 7 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-81, 071	(0 0	0	1 1.
00	Temporary investments	0	(0 0	0	2.
00	Notes receivable	0	0	0 0	0	3
00	Accounts receivable	1, 710, 782		0 0	0	4
00	Other receivable	2, 598, 235		-	0	
00	Allowances for uncollectible notes and accounts receivable	0	(-	0	6
00	Inventory	204, 374		-	0	
00 00	Prepaid expenses Other current assets	187, 271		- -	0	8
00	Due from other funds			-	0	10
	Total current assets (sum of lines 1-10)	4, 619, 591		-	0	11
	FIXED ASSETS	1,01,70,1	· · · · · ·			1
. 00	Land	951, 048	(0 0	0	12
. 00	Land improvements	16, 117	0	0 0	0	13
. 00	Accumulated depreciation	-1, 343			0	14
. 00	Buildings	35, 315		-	0	15
. 00	Accumulated depreciation	-5, 585		- -	0	16
. 00 . 00	Leasehold improvements	496, 826 -278, 646		-	0	17
	Accumulated depreciation Fixed equipment	-278, 640		-	0	19
	Accumulated depreciation			-	0	20
	Automobiles and trucks	0		-	0	21
	Accumul ated depreciation	0		o o	0	22
	Major movable equipment	5, 762, 595	0	0 0	0	23
	Accumulated depreciation	-2, 339, 952	(0 0	0	24
	Minor equipment depreciable	0	0	0 0	0	25
	Accumulated depreciation	0	0	- -	0	26
	HIT designated Assets	0	(-	0	27
	Accumulated depreciation	0		- -	0	28
	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	4, 636, 375			0	
. 00	OTHER ASSETS	4,000,070			0	
. 00	Investments	0	(0 0	0	31
. 00	Deposits on leases	0	0	0 0	0	32
. 00	Due from owners/officers	0	(0 0	0	33
. 00	Other assets	6, 004, 063		-	0	34
	Total other assets (sum of lines 31-34)	6, 004, 063			0	35
. 00	Total assets (sum of lines 11, 30, and 35)	15, 260, 029	(0 0	0	36
. 00	CURRENT LIABILITIES Accounts payable	21, 813, 697		0 0	0	37
. 00	Salaries, wages, and fees payable	647, 554			0	38
	Payrol I taxes payable	32, 697			0	
	Notes and Loans payable (short term)	0		0	0	
	Deferred income	0	0	0 0	0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	1, 897, 744			0	
. 00	Other current liabilities	457, 687			0	
. 00	Total current liabilities (sum of lines 37 thru 44)	24, 849, 379	(0 0	0	45
. 00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46
. 00	Notes payable	0			0	47
. 00	Unsecured Loans	Ő		o o	0	
. 00	Other long term liabilities	82, 399	0	0 0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	82, 399	0	0 0	0	50
00	Total liabilities (sum of lines 45 and 50)	24, 931, 778	(0 0	0	51
~ ~	CAPI TAL ACCOUNTS	0 (74 740				
00	General fund balance	-9, 671, 749				52
00	Specific purpose fund Donor created - endowment fund balance - restricted		0			53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Governing body created - endowment fund balance			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	-9, 671, 749			0	
. 00	Total liabilities and fund balances (sum of lines 51 and	15, 260, 029	0	ס ור	0	60

Heal th	Financial Systems	U HEALTH FRANKF	ORT HOSPITAL			In Lie	u of Form CMS-	2552-10
STATE	STATEMENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1316		eriod: com 01/01/2019 o 12/31/2019	Worksheet G- Date/Time Pre 6/29/2020 8:3	epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	I
1.00		1.00	2.00	3.00		4.00	5.00	1.00
$\begin{array}{c} 1. 00\\ 2. 00\\ 3. 00\\ 4. 00\\ 5. 00\\ 6. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 12. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ 18. 00\\ 19. 00\end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET INTERCOMPANY TRANSACTIONS ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	5, 499, 640 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-11, 853, 684 -3, 317, 706 -15, 171, 390 5, 499, 641 -9, 671, 749 0 -9, 671, 749			0 0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
19.00	sheet (line 11 minus line 18)							19.00
		Endowment Fund	Pl ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) NET INTERCOMPANY TRANSACTIONS ROUNDING	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	000000000000000000000000000000000000000	0 0 0 0 0 0		0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-1316	Period: From 01/01/2019 To 12/31/2019	Worksheet G-2 Parts I & II Date/Time Pre	pared:
	Cost Center Description		Inpatient	Outpati ent	6/29/2020 8:3 Total	/ am
	Cost Center Description	-	1.00	2.00	3.00	
	PART I - PATIENT REVENUES	1	1.00	2.00	0.00	
	General Inpatient Routine Services					1
1.00	Hospi tal		2, 651, 3	51	2, 651, 351	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		322, 4	34	322, 434	5.00
6.00	Swing bed - NF			0	0	
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)		2, 973, 7	85	2, 973, 785	10.00
	Intensive Care Type Inpatient Hospital Services					1
11.00	I NTENSI VE CARE UNI T					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
17 00	11-15)		2 072 7	0.5	2 072 705	17 00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services)	2, 973, 7 3, 050, 8		2, 973, 785 24, 785, 831	
19.00	Outpatient services					•
20.00	RURAL HEALTH CLINIC		296, 2	0 19, 390, 312	19, 094, 597	1
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
21.00	HOME HEALTH AGENCY			0 0	0	
22.00	AMBULANCE SERVICES			0	0	22.00
24.00	CMHC					24.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECIFY)			0 0	0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	6, 320, 9	-	47, 454, 213	•
20.00	G-3, line 1)		0,020,,	10 11,100,270	177 10 17 210	20.00
	PART II - OPERATING EXPENSES	I				1
29.00	Operating expenses (per Wkst. A, column 3, line 200)			23, 024, 285		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00		1		0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4)	2)(transfer		23, 024, 285		43.00
	to Wkst. G-3, line 4)					

Heal th	th Financial Systems IU HEALTH FRANKFORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN:			Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	arod
			10 12/31/2019	6/29/2020 8: 3	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			47, 454, 213	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		27, 599, 611	2.00
3.00	Net patient revenues (line 1 minus line 2)			19, 854, 602	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		23, 024, 285	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-3, 169, 683	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	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 other t	han 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
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			0	24.00
25.00	Total other income (sum of lines 6-24)			0	25.00
26.00	Total (line 5 plus line 25)			-3, 169, 683	
27.00	MI SCELLANEOUS I NCOME			148, 023	
28.00	Total other expenses (sum of line 27 and subscripts)			148, 023	
29.00	Net income (or loss) for the period (line 26 minus line 28)		I	-3, 317, 706	29.00