IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1311 Worksheet S Peri od. From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: То 6/29/2020 8:41 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 6/29/2020 Time: 8:41 am Manually prepared cost report use only 2. []If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [6. Date Received: 7. Contractor No Contractor 10. NPR Date: 5.]Cost Report Status [

 (1) As Submitted
 7. Contractor No.
 11. Contractor's Vendor Code:
 4

 (2) Settled without Audit 8.
 [N] Initial Report for this Provider CCN
 11. Contractor's Contractor's Vendor Code:
 4

 (3) Settled with Audit 9.
 [N] Final Report for this Provider CCN
 number of times reopened = 0-9.

 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations. [X] have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) CARA BREIDSTER Officer or Administrator of Provider(s) CF0

Title

(Dated when report is electronically signed.)

Date

			Title XVIII				
	Cost Center Description		Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	367, 544	425, 293	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	61, 695	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	429, 239	425, 293	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.

SPL	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		TH TIPTON ATA	Provi de		15-1311	Period: From 01/01	/2019	u of For Workshe Part I	eet S-2	2
							To 12/31	/2019	Date/Ti 6/29/20		
	<u>1.00</u> Hospital and Hospital Health Care Co		00	3	3.00			4.00			
00	Street: 1000 SOUTH MAIN STREET	P0 Box:									1.0
00	City: TIPTON	State: I Component Na		ip Code: CCN	: 46072 CBSA	Provi dei	ty: TIPTON r Date	Payme	ent Syst	em (P,	2.0
			Nu	umber	Number	Туре	Certi fi ed	T	, 0, or XVIII		-
		1.00		2.00	3.00	4.00	5.00	6. 00			
00	<u>Hospital and Hospital-Based Componer</u> Hospital	it Identification IU HEALTH TIPTON		51311	99915	1	11/12/200	5 N	0	0	3. (
		HOSPI TAL			,,,,,		117 127 2001				
)0)0	Subprovider - IPF Subprovider - IRF										4.
00	Subprovider - (Other) Swing Beds - SNF	IU HEALTH TIPTON	11	5Z311	29020		11/12/200	5 N	0	N	6.
		HOSPITAL		52511	29020		11/12/200				
0	Swing Beds - NF Hospital-Based SNF										8.
00	Hospital-Based NF										10.
00 00	Hospital-Based OLTC Hospital-Based HHA										11.
00 00	Separately Certified ASC										13.
00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14.
00 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16.
00	Renal Dialysis										18.
00	Other						From	:	To	:	19.
00	Cost Reporting Period (mm/dd/yyyy)						1.0		2. (12/31/		20.
	Type of Control (see instructions)						2	2019	12/31/	2019	20.
						1.00	2.0	<u>ר</u>	3. (00	-
	Inpatient PPS Information										
00	Does this facility qualify and is it disproportionate share hospital adju					Ν	N				22.
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo	r yes or "N" for	no.								
01	Did this hospital receive interim un cost reporting period? Enter in colu					Ν	N				22.
	the portion of the cost reporting pe	riod occurring p	rior to Oc [.]	tober 1.	.						
	Enter in column 2, "Y" for yes or "N reporting period occurring on or aft				ost						
02	Is this a newly merged hospital that payments to be determined at cost re					Ν	N				22.
	Enter in column 1, "Y" for yes or "N	" for no, for th	e portion (of the							
	cost reporting period prior to Octob or "N" for no, for the portion of th										
റാ	October 1.	1 5				NI	B.I				1 22
03	Did this hospital receive a geograph rural as a result of the OMB standar	ds for delineati	ng statisti	ical are		Ν	N		N		22.
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin										
	in column 2, "Y" for yes or "N" for	no for the porti-	on of the o	cost							
	reporting period occurring on or aft Does this hospital contain at least	100 but not more	than 499 l	beds (as							
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in	column 3,	"Y" foi	r						
00	Which method is used to determine Me						3 N				23.
	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										
	reporting period: in cordinitiz, ente		In-State	In-Sta		Dut-of		Medi ca		ther	
			Medicaid paid days	Medica eligil		State edi cai d	State Medicaid	HMO da	- I	li cai d Iays	
				unpai days	id pa		el i gi bl e unpai d				
					0			F 00			1
			1.00	2.00	<u>с</u>	3.00	4.00	5.00		o. 00	
00	If this provider is an IPPS hospital		1.00 C	2.00	0 0	3.00	4.00	5.00	0		24.
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	n 1, in-state umn 2,		2.00				5.00			24.
00	in-state Medicaid paid days in colum	n 1, in-state umn 2, olumn 3,	C	2.00				5.00			24.

	Financial Systems IU HEAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TH TIPTON I	Provider CC	CN: 15-1311	Peri od:		Worksł	neet S-2	2552- 2
						2/31/2019	Date/1		
		In-State Medicaid	In-State Medicaid	Out-of State	Out-of State	Medic HMO d		Other dicaid	
		pai d days	eligible	Medi cai d	Medi cai o	d	<i>J</i>	days	
			unpai d days	paid days	el i gi bl (unpai d				
. 00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	0 5.0	0	6.00	25.
	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.								
						n/Rural S 1.00		f Geogr 00	1
. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		s at the be	ginning of	the	:	2		26.
. 00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) status r "2" for r	rural. If a		st	:	2		27
. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.			iCH status i	n	(D		35
						i nni ng: 1. 00		i ng: 00	
. 00	Enter applicable beginning and ending dates of SCH s		script line	e 36 for num		1.00	2.	00	36
00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		er of perio	ods MDH stat	us	(C		37
01	Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)								37
00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o								38
	enter subsequent dates.					Y/N		/N	
. 00	Does this facility qualify for the inpatient hospita	l payment a	adiustment	for low vol		<u>1.00</u> N		00 N	39
	hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage ii)? Enter	r (iii)? En e requireme in column	ter in colu ents in 2 "Y" for y	imn 'es				
. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for			N		N	40
						V		_	-
	Prospective Payment System (PPS)-Capital								
00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	proportiona	ite share in	accorda	nce N	N	N	45
00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					gh N	N	N	46
00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen					N	N N	N N	47 48
00	Teaching Hospitals Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you	impacted by	/ CR 11642	ns? Enter "Y (or subsequ	" for yes ent CR),	sor N MA			56
00	GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	period duri r yes or "N th of this Y", complet	ng which r W for no i cost repor e Workshee	n column 1. ting period	If colur P Enter	nn 1 "Y"			57
00	If line 56 is yes, did this facility elect cost reim	bursement f	°or physici	ans' servic	es as				58
00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If ye			. Pt. I		N			59
		<u>o, comprote</u>	<u>, motr b 2</u>	NAHE 413. Y/N		sheet A ine #	Qualif Crit	Through i cati on eri on	
				1.00		2.00	-	ode 00	-
. 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 co is "Y", are you impacted by CR 11642 (or subsequent	.85? (see lumn 1. lf	°column 1	N					60

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TΑ	Provider C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/29/2020 8:4	pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 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) Enter the current year total unweighted primary care 	N			0.00	0.00	61. 00 61. 0
FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
 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) 						61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 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. 1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program name. Enter in column 4, the direct GME 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		61. 1
					1.00	
ACA Provisions Affecting the Health Resources and Ser				ind for which	0.00	42.0
 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 Teach gram. (ing Health Cer see instructio	nter (THC) into			62.0
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this o	67. (see instr	uctions)	N	63.0
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settinas-	1.00 -This base year	2.00 is your cost	3.00 reporting	
period that begins on or after July 1, 2009 and before 4.00 Enter in column 1, if line 63 is yes, or your facility in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	re June ty trai n-prima all no d non-p n colum	e 30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	5		64.0

	EX IDENTIFICATION D	ATA Provider C	Fr	eriod: com 01/01/2019	Worksheet S-2 Part I	
			To	12/31/2019	Date/Time Pre 6/29/2020 8:4	epareo 41 am
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	-
00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3			0.00	0.00	0. 000000	ο5.
divided by (column 3 + column 4)). (see instructions)			Unwei ghted FTEs	Unweighted FTEsin	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	Hospi tal	col . 2))	
Section 5504 of the ACA Current	Voar ETE Docidort- :	n Nonnrouidor Cotti-	1.00	2.00	3.00	
beginning on or after July 1, 20		n Nonprovider Settin	ysLitective i	or cost report	ing perious	
00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospita	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. mry care resident 3 the ratio of	0.00	0.00	0. 000000	66.
00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	provider settings. mry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	
<pre>00 Enter in column 1 the number of o FTEs attributable to rotations oo Enter in column 2 the number of o FTEs that trained in your hospita (column 1 divided by (column 1 + 00 Enter in column 1, the program</pre>	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings ary care resident 3 the ratio of astructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	
00 Enter in column 1 the number of o FTEs attributable to rotations of Enter in column 2 the number of o FTEs that trained in your hospita (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name	provider settings. Ary care resident 3 the ratio of astructions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	_
 OD Enter in column 1 the number of the FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospita (column 1 divided by (column 1 + (column 2 divided by (column 1 + (column 2 divided by (column 3 divided by column 3 divided by (column 3 divided by (column	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	provider settings. Ary care resident 3 the ratio of astructions) 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	_
 OD Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospita (column 1 divided by (column 1 + OD 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 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> <u>Program Name</u> <u>1.00</u>	Provi der settings. Iny care resident 3 the ratio of Istructions) 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	0 67.
 OD Enter in column 1 the number of the FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospitations (column 1 divided by (column 1 + (column 2 divided by (column 1 + (column 2 divided by (column 1 + (column 2 divided by (column 1 divided by (column 1 divided by (column 1 divided by (column 1 divided by (column 3 divided by (column 3 divided by (column 3 + column 4)). (see instructions) 	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 1.00 2.00 2.00 2.00 2.00 2.00	TPF), or does it con napproved GME teach (D)? Enter "Y" for	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in yes or "N" for is s in a new teacl yes or "N" for is	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	_

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1311	Period: From 01/01/2 To 12/31/2	2019 F 2019 E	Norksheet Part I Date/Time 6/29/2020	Prepared:
	-	1.00	2.00 3.	00
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program recent cost reporting period ending on or before November 15, 2004? Enter "Y" for ye no. Column 2: Did this facility train residents in a new teaching program in accords CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 indicate which program year began during this cost reporting period. (see instruction)	es or "N" for ance with 42 s Y,			76.00
Long Term Care Hospital PPS			1.00	
30.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 31.00 Is this a LTCH co-located within another hospital for part or all of the cost repor "Y" for yes and "N" for no. TEFRA Providers	ing period? E	nter	N N	80.00 81.00
 35.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for y 36.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 		no.	Ν	85.00 86.00
 3413.40(1)(1)(1)? Enter Y for yes and N for no. 37.00 Is this hospital an extended neoplastic disease care hospital classified under section (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 			Ν	87.00
	V		XI X 2.00	
Title V and XIX Services	1.00		2.00	
20.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			Y	90.00
P1.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column. P2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see	n N		N N	91.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 03.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Ent	er N		N	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N		Ν	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		0. 00 N	95.00 96.00
 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents possistepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 	0. 00 N		0. 00 Y	97.00 98.00
28.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on WI C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 title XIX.			Y	98.01
28.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column			Y	98.02
for title V, and in column 2 for title XIX. 28.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CA reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in columnation of the context of			Ν	98.03
for title V, and in column 2 for title XIX. 28.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, a in column 2 for title XIX.	N		Ν	98.04
PR.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and column 2 for title XIX.			Y	98.05
28.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers	N		Y	98.06
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payı	nent N			105.00 106.00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L& training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	R N			107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	42 N			108.00

	Provider C		eriod: -om 01/01/2019		
		To	0 12/31/2019	Date/Time Pr 6/29/2020 8:	
	Physi cal	Occupati onal	Speech	Respi ratory	
9.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1.00 Y	2.00 N	3.00 N	4.00 N	109.
				1.00	
0.00 Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes o	r "N" for no. I	f yes,	N	110.
			1.00	2.00	_
1.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained in the response to constrain the program of the FCHIP demonstration that apply: "A" for Ambulance services; "B" for an for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the n column 2.	N		111.
		1.00	2.00	3.00	_
2.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in th demonstration. In column 3, enter the date the hospital cea participation in the demonstration, if applicable.	period? s "Y", enter ne	N			112.
Miscellaneous Cost Reporting Information .00 Is this an all-inclusive rate provider? Enter "Y" for yes or	r "N" for no	N			0115.
in column 1. If column 1 is yes, enter the method used (A, E in column 2. If column 2 is "E", enter in column 3 either "G for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	B, or E only) 93" percent (includes				
.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.
".00 s this facility legally-required to carry malpractice insur "Y" for yes or "N" for no.		N			117.
3.00 Is the malpractice insurance a claims-made or occurrence policy is claim-made. Enter 2 if the policy is occurr		1			118.
		Premi ums	Losses	Insurance	
		1.00	2.00	3.00	_
.01 List amounts of malpractice premiums and paid losses:		1. 00 55, 271		3.00	0118.
.01 List amounts of malpractice premiums and paid losses:					0118
.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.		55, 271	(2	118
 02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein. 00 DO NOT USE THIS LINE 	dule listing of d Harmless pro n column 1, "Y ualifies for	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient	1. 00	2	118
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 DO NOT USE THIS LINE .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 que Hold Harmless provision in ACA §3121 and applicable amendment for no. .00 DD did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no. 	dule listing of d Harmless pro n column 1, " ualifies for nts? (see ins antable device	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to	1.00 N N	2.00 N	118 119 120
 .02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schect and amounts contained therein. .00 D0 NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. 	dule listing of d Harmless pro- n column 1, "" ualifies for " nts? (see ins antable devico fined in §1903	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the	1.00 N N	2.00	118 119 120
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 DO NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? .00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for 	dule listing of d Harmless pro- n column 1, "" ualifies for " nts? (see ins antable device fined in §1903 1 is "Y", ento	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N	2.00 N	0 118. 118. 119. 120. 121. 122. 125.
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 D0 NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost implationts? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, enter enter enter for the center for the center? 	dule listing of d Harmless pro- n column 1, "" ualifies for nts? (see inst antable device fined in §1903 1 is "Y", ento pr yes and "N" nter the certi	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N Y Y	2.00 N	118 119 120 121 122
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 D0 NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? .00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. .00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. .00 If this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2 	dule listing of d Harmless pro- n column 1, "" ualifies for nts? (see ins antable device fined in §1900 1 is "Y", ento pr yes and "N" nter the certi 2. ter the certi	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	1.00 N N Y Y	2.00 N	118 119 120 121 122 125
 .02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. .00 D0 NOT USE THIS LINE .00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. .00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. .00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information .00 Does this is a Medicare certified kidney transplant center, er in column 1 and termination date, if applicable, in column 2. .00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 	dule listing of d Harmless pro- n column 1, " ualifies for nts? (see ins antable device fined in §1903 1 is "Y", ento fined in §1903 1 is "Y", ento pr yes and "N" nter the certi 2. ter the certi 2. ter the certi	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If i fication date fication date	1.00 N N Y Y	2.00 N	118 119 120 121 122 125 126
 3. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 5. 00 NOT USE THIS LINE 5. 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 que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 6. 00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 5. 00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2. 8. 00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2. 8. 00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2. 	dule listing of d Harmless pro- n column 1, " ualifies for nts? (see inst antable device fined in §1903 1 is "Y", ento for yes and "N" nter the certi 2. ter the certi 2.	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If ification date fication date	1.00 N N Y Y	2.00 N	118 119 120 121 122 125 126 127
 and amounts contained therein. and amounts contained therein. 000D NOT USE THIS LINE 000 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 que Hold Harmless provision in ACA \$3121 and applicable amendmer Enter in column 2, "Y" for yes or "N" for no. 00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 00 If this is a Medicare certified heart transplant center, entin column 1 and termination date, if applicable, in column 2. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 	dule listing of d Harmless pro- n column 1, "" ualifies for nts? (see ins antable device fined in §1900 1 is "Y", ento or yes and "N" nter the certifi 2. ter the certifi en the certifi enter the certifi	55,271 than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 ' for no. If fication date fication date fication date in	1.00 N N Y Y	2.00 N	1118 119 120 121 122 125 126 127 128

ealth Financial Systems OSPITAL AND HOSPITAL HEALTH CARE COMPLEX		TA Provider	CCN: 15-1311	In Period:	Lieu of Form CMS Worksheet S	
USPITAL AND HUSPITAL HEALTH CARE COMPLEX	TDENTIFICATION DA		CCN. 15-1311	From 01/01/2 To 12/31/2	2019 Part I	repared:
				1.00	2.00	_
32.00 If this is a Medicare certified isl in column 1 and termination date, i			tification date	1.00	2.00	132.00
 33.00 Removed and reserved 34.00 If this is an organ procurement org and termination date, if applicable 	anization (OPO), e		er in column 1			133.00 134.00
All Providers 40.00 Are there any related organization chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the	" for no in column	1. If yes, and h	ome office cos	ts Y	15H059	140.00
1.00 If this facility is part of a chain	organization, ent	2.00 er on lines 141 t	hrough 143 the	3.0 name and add		
office and enter the home office co 41.00Name: INDIANA UNIVERSITY HEALTH	ntractor name and Contractor's Na			tas'a Numbasi	00101	141 00
41.00 Name: INDIANA UNIVERSITY HEALTH 42.00 Street: 340 WEST 10TH STREET	PO Box:	ame: wPS	Contrac	tor's Number:	08101	141.00 142.00
43. 00 Ci ty: I NDI ANAPOLI S	State:	IN	Zip Cod	e:	46202	143.00
					1.00	_
44.00 Are provider based physicians' cost	s included in Work	sheet A2			1.00 Y	144.00
He borne provider based physicians cost		Sheet A:				144.00
				1.00	2.00	
45.00 If costs for renal services are cla inpatient services only? Enter "Y" no, does the dialysis facility incl period? Enter "Y" for yes or "N" f	for yes or "N" for ude Medicare utili or no in column 2.	no in column 1. zation for this c	lf column 1 is ost reporting			145.00
46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/dd	column 1. (See CMS	Pub. 15-2, chapt		f		146.00
					1.00	
47.00 Was there a change in the statistic	al basis? Enter "Y	" for yes or "N"	for no.		N	147.00
48.00Was there a change in the order of 49.00Was there a change to the simplifie				or po	N	148.00 149.00
The sharper of the sharper to the sharper the		Part A	Part B	Title \		
		1.00	2.00	3.00	4.00	
Does this facility contain a provid or charges? Enter "Y" for yes or "N						
55.00Hospi tal		N	N	N	N	155.00
56.00 Subprovi der – IPF		N	N	N	N	156.00
57.00 Subprovi der – I RF		N	N	N	N	157.00
58. 00 SUBPROVI DER 59. 00 SNF		N	N	N	N	158.00
60.00HOME HEALTH AGENCY		N	N	N	N	160.00
61. 00 СМНС			N	N	N	161.00
					1.00	_
Multicampus 65.00Is this hospital part of a Multicam	nus hosnital that	has one or more c	ampuses in dif	ferent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.						
	Name	County		ip Code CBS		_
66.00 If line 165 is yes, for each	0	1.00	2.00	3.00 4.0		00 166. 00
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					0.0	
column 5 (see instructions)						-
					1.00	-
Health Information Technology (HIT)				ent Act		
67.00Is this provider a meaningful user 68.00If this provider is a CAH (line 105	is "Y") and is a	meaningful user ('), enter the	Y	167.00 168.00
reasonable cost incurred for the HI 68.01 If this provider is a CAH and is no			ider qualify fo	or a hardship	N	168.01
exception under §413.70(a)(6)(ii)?	Enter "Y" for yos					

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT					
			From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginnin period respectively (mm/dd/yyyy)			170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provider ha			Y	27	171.00
section 1876 Medicare cost plans reported					
"Y" for yes and "N" for no in column 1. I 1876 Medicare days in column 2. (see ins	on				
The medical eluays The Column 2. (See Ths			1		1

	Financial Systems IU HEALTH TIPT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1311	Period:	Worksheet S-2	
10591 1.	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		From 01/01/2019 To 12/31/2019	Part II	epare
				Y/N	Date	
	r			1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NO r	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation	boginning of	the cost	N	1	1 1
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	column 2. (see	instructions			1.
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary.		N			2.
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other selections of constructions.	offices, drug der or its of the board	Y			3.
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" to or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4
	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit real statements?		N			5
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	lfves ist	he provider i	s N	1	6
	the legal operator of the program?	3				
	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		8
. 00	Are costs claimed for Interns and Residents in an approved		cal education	Ν		9
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		the current	N		10
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	l & R in an Ap	proved	Ν		11
					Y/N	
	Ded Debte				1.00	_
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s. see instruc	tions.		Y	12
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Ν	13
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see in	structions.	N	14
	Did total beds available change from the prior cost reporti	ng period?lf	yes, see ins	tructions.	N	15
			rt A		rt B	_
		Y/N 1.00	Date 2.00	Y/N 3.00	Date 4.00	
	PS&R Data		2100	0100		
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		N		16
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2020	Y	04/01/2020	17
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19

Health Financial Syste

ΙΙΙ ΗΓΑΙ ΤΗ ΤΙΡΤΟΝ ΗΟΥΡΙΤΑΙ

In Lieu of Form CMS_2552_10

Health	Financial Systems IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet S- Part II Date/Time Pr 6/29/2020 8:	epared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
	<u> </u>	1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHI LDRENS	HOSPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ng the cost	Ν	23.00		
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	, the cost repo	rting period?	lf yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during t instructions.	he cost report	ing period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during th copy.	ne cost reporti	ng period? If	yes, submit	Ν	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	reporti ng	Ν	28.00		
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	Ν	29.00			
30.00	Has existing debt been replaced prior to its scheduled mat	see	Ν	30.00		
31.00	instructions. Has debt been recalled before scheduled maturity without i	see	Ν	31.00		
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competit	ive bidding? If	-	33.00
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a lf yes, see instructions.	nrrangement wit	h provider-bas	ed physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based	Ν	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Data	_
				1.00	Date 2.00	_
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en			Ν		38.00
39.00	If line 36 is yes, did the provider render services to oth see instructions.			Y		39.00
40.00	If line 36 is yes, did the provider render services to the	e home office?	lfyes, see	Ν		40.00
	instructions.					
		2.	00			
44 00	Cost Report Preparer Contact Information	DUONDA		UTTED		44.05
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
42.00	respectively. Enter the employer/company name of the cost report	INDIANA UNIVER	RSITY HEALTH			42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 962. 1093		RUTTER@I UHEALT	H. ORG	43.00
	report property in corumns rand z, respectively.	I		1		11

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der	CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
					6/29/2020 8:4	1 am
			3.00			
Cost Report Preparer Contact Information						
41.00 Enter the first name, last name and the titl	le/position	DIRECTOR OF	GOVERNMENT			41.00
held by the cost report preparer in columns	1, 2, and 3,	PROGRAMS				
respecti vel y.						
42.00 Enter the employer/company name of the cost	report					42.00
preparer.						
43.00 Enter the telephone number and email address	s of the cost					43.00
report preparer in columns 1 and 2, respecti	i vel y.					
	-					-

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>IU HEALTH TIPT</u> AL DATA	Provider C	CN: 15-1311	Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		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, 12	5 50, 400. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
4.00 5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 12	5 50, 400. 00	0	7.00
8.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00 16.00	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF		25	9, 12	5 50, 400. 00	0 0	13.00 14.00 15.00 16.00
17.00 18.00 19.00 20.00	SUBPROVI DER – I RF SUBPROVI DER SKI LLED NURSI NG FACI LI TY NURSI NG FACI LI TY						17.00 18.00 19.00 20.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						20.00 21.00 22.00 23.00
24.00 24.10 25.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30.00					24.00 24.10 25.00
26. 00 26. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	89.00	25			0	26. 00 26. 25
27.00 28.00 29.00	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips		25			0	27.00 28.00 29.00
30.00 31.00 32.00 32.01	Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		D		30.00 31.00 32.00 32.01
33.00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						33.00 33.01

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>IU HEALTH TIPTC</u> AL DATA	Provider C	CN: 15-1311	Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019	Part I	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 217	13	2, 10	00		1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	423 0	82 0				2.00 3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	180	0	18			5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)	1, 397	0 13	2, 29	0 00		6.00 7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	1 207	10	2.00		170 75	13.00
14.00 15.00	Total (see instructions) CAH visits	1, 397 0	13 0	2, 29	0.00	172.75	14.00
16.00	SUBPROVIDER - IPF	0	0		0		16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)				0		24.10
25.00	CMHC - CMHC						25.00
26.00 26.25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0.00	172.75	
28.00	Observation Bed Days		6	60		172.75	28.00
29.00	Ambul ance Trips	0	0	00	· E		29.00
30.00	Employee discount days (see instruction)	-			0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	О	0		0		32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IU HEALTH TIPTO	Provi der C	N. 1E 1011	Peri od:	u of Form CMS-2 Worksheet S-3	
HUSPI I	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	JN: 15-1311	From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 6/29/2020 8:4	pared:
		Full Time		Di s	charges	0/2//2020 0.4	
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Patients	
1.00	Hernital Adults & Dods (columns 5 6 7 and	11.00	12.00	13.00	14.00 44 4	<u>15.00</u> 595	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	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGI CAL INTENSI VE CARE UNIT SURGI CAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D.P.) HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00	0	1(44 4 44 4	595	2. 00 3. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 23. 00 24. 00 24. 00 26. 00 26. 00 26. 00 26. 00 26. 00 27. 00 27. 00 28. 00 29. 00 20. 00 21. 00 20. 00 21. 00 20. 00 21. 00 22. 00 23. 00 24. 00 26. 00 26. 00 26. 00 27. 00 27. 00 28. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 20. 00 21. 00 22. 00 23. 00 24. 00 26. 00 26. 00 26. 00 27. 00 27. 00 28. 00 29. 00 20. 0
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00 29.00	Observation Bed Days Ambulance Trips						28.00 29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days (see Thist detroit)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days				0		33.00
33 01	LTCH site neutral days and discharges				0		33.01

leal th Fir	ancial Systems IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	INCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-1311	Period: From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
					1.00	
Unc	ompensated and indigent care cost computation				1.00	
	t to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	in 8)	0. 336493	1.00
Med	icaid (see instructions for each line)			,		
	revenue from Medicaid				689, 444	2.00
	you receive DSH or supplemental payments from Medicaid?				N	3.00
	line 3 is yes, does line 2 include all DSH and/or supplement			ai d?		4.00
	line 4 is no, then enter DSH and/or supplemental payments 1	from Medicai	d		0	5.00
	icaid charges icaid cost (line 1 times line 6)				10, 171, 043 3, 422, 485	
	ference between net revenue and costs for Medicaid program	(line 7 min	us sum of li	nes 2 and 5 if	2, 733, 041	
	ero then enter zero)				2,755,041	0.00
Chi	Idren's Health Insurance Program (CHIP) (see instructions f	or each lin	e)			
	revenue from stand-alone CHIP		·		0	9.00
	nd-alone CHIP charges				0	
	nd-alone CHIP cost (line 1 times line 10)				0	
	ference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0	12.00
	er zero) er state or local government indigent care program (see ins	structions f	or oach line)		-
	revenue from state or local indigent care program (See This				0	13.00
	rges for patients covered under state or local indigent can			,	0	
	te or local indigent care program cost (line 1 times line ²	14)			0	15.00
	ference between net revenue and costs for state or local in		program (li	ne 15 minus line	0	16.00
	if < zero then enter zero)					
	nts, donations and total unreimbursed cost for Medicaid, CH	IP and stat	e/local indi	gent care progra	ims (see	
	tructions for each line) vate grants, donations, or endowment income restricted to 1	Funding char	ity care		0	17.00
	ernment grants, appropriations or transfers for support of				0	
. 00 Tot	al unreimbursed cost for Medicaid , CHIP and state and loca 12 and 16)			s (sum of lines	2, 733, 041	
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col. 2)	
			1.00	2.00	3.00	
	ompensated Care (see instructions for each line)		1 202 20		1 220 040	00.00
	rity care charges and uninsured discounts for the entire fa e instructions)	actifity	1, 283, 38	32 56, 566	1, 339, 948	20.00
	t of patients approved for charity care and uninsured disc	ounts (see	431, 84	19 56, 566	488, 415	21.00
	tructions)		101,0	.,	100, 110	21.00
00 Pay	ments received from patients for amounts previously writter	n off as	3, 04	94 0	3, 094	22.00
	rity care					
. 00 Cos	t of charity care (line 21 minus line 22)		428, 75	55 56, 566	485, 321	23.00
					1.00	
00 Doe	s the amount on line 20 column 2, include charges for patie	ent days bev	ond a length	of stay limit	N	24.00
	osed on patients covered by Medicaid or other indigent care		ond a ronger	or stuy rimit		21.00
	line 24 is yes, enter the charges for patient days beyond t y limit		care progra	m's length of	0	25.00
	al bad debt expense for the entire hospital complex (see in	nstructions)			2, 377, 515	26.00
sta						
. 00 sta	icare reimbursable bad debts for the entire hospital complex	ex (see inst	ructions)		436, 935	
00 Tot 00 Mec 01 Mec					672, 207	27.01
. 00 Sta . 00 Tot . 00 Mec . 01 Mec . 00 Nor	icare reimbursable bad debts for the entire hospital compleicare allowable bad debts for the entire hospital complex of -Medicare bad debt expense (see instructions)	(see instruc	tions)		672, 207 1, 705, 308	27.01 28.00
sta 6.00 Tot 7.00 Med 7.01 Med 8.00 Nor 9.00 Cos	icare reimbursable bad debts for the entire hospital comple- icare allowable bad debts for the entire hospital complex of -Medicare bad debt expense (see instructions) t of non-Medicare and non-reimbursable Medicare bad debt exp	(see instruc	tions))	672, 207 1, 705, 308 809, 096	27.01 28.00 29.00
sta 6.00 Tot 7.00 Med 7.01 Med 8.00 Nor 9.00 Cos 0.00 Cos	icare reimbursable bad debts for the entire hospital compleicare allowable bad debts for the entire hospital complex of -Medicare bad debt expense (see instructions)	(see instruc kpense (see	tions))	672, 207 1, 705, 308	27.01 28.00 29.00 30.00

Heal th	Financial Systems	IU HEALTH TIPTON	I HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider C	CN: 15-1311	Peri od:	Worksheet A	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col	1 Reclassi fi cat	6/29/2020 8:4 Recl assi fi ed	l am
	cost center bescription	Salaries	Utilei	+ col. 2	i ons (See	Trial Balance	
				,	A-6)	(col . 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		0 774, 627		1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES		0		0 702, 804		1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	70.00/	0	100.00	0 1, 198, 787		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	70, 986	38, 817				4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	797, 328 904, 318	9, 799, 577 3, 328, 831				5.00 7.00
7.00	00701 OPERATION OF PLANT - OFFSITE	904, 318	3, 328, 831		0 -44, 847 0 35, 590		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	52, 083	88, 984				8.00
9.00	00900 HOUSEKEEPING	313, 132	176,003				9.00
10.00	01000 DI ETARY	460, 173	519, 282				10.00
11.00	01100 CAFETERI A	400, 175	0 0		0 693, 861		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	499, 596	160,008				1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	18, 511				14.00
15.00	01500 PHARMACY	646, 617	4, 315, 550				1
	INPATIENT ROUTINE SERVICE COST CENTERS		., ,			.,,	
30.00	03000 ADULTS & PEDIATRICS	1, 827, 857	1, 152, 529	2, 980, 38	-472, 881	2, 507, 505	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	894, 294	2, 685, 623	3, 579, 91	7 -2, 196, 129	1, 383, 788	50.00
53.00	05300 ANESTHESI OLOGY	179, 225	329, 132				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 092, 126	611, 389				54.00
60.00	06000 LABORATORY	0	1, 343, 257				
65.00	06500 RESPI RATORY THERAPY	507, 211	185, 018				65.00
66.00	06600 PHYSI CAL THERAPY	721, 786	427, 523				66.00
67.00	06700 OCCUPATI ONAL THERAPY	176, 101	44, 348				67.00
68.00	06800 SPEECH PATHOLOGY	15, 854	2, 278				68.00
69.00	06900 ELECTROCARDI OLOGY	499, 318	283, 622				1
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0 366, 200		
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 164, 957 0 3, 714, 917		72.00 73.00
73.00	03480 ONCOLOGY	196, 558	80, 856	277, 41			73.00
76.00	03160 CARDI OPULMONARY	190, 556	60, 630 O	277,41	4 -43, 493 0 0		76.00
76.97	07697 CARDI AC REHABI LI TATI ON	103, 344	44, 182	147, 52	0	Ŭ Ŭ	76.97
10. 71	OUTPATIENT SERVICE COST CENTERS	100,011	11, 102	117,02	10,070	100,001	/0. //
91.00	09100 EMERGENCY	1, 101, 951	1, 933, 990	3, 035, 94	-283, 705	2, 752, 236	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	.,	.,,			_,,	92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · ·					1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	11, 059, 858	27, 569, 310	38, 629, 16	8 195, 231	38, 824, 399	118.00
	NONREI MBURSABLE COST CENTERS		-	-	-	-	
	19200 PHYSI CLANS' PRI VATE OFFI CES	94, 651	183, 990				
	19201 OCCUPATIONAL MEDICINE	35, 669	65, 947	101, 61			
	19202 VACANT SPACE	0	0		0 0		192.02
200.00) TOTAL (SUM OF LINES 118 through 199)	11, 190, 178	27, 819, 247	39,009,42	25 0	39, 009, 425	200.00

alth Financial Systems ECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IU HEALTH TIPT F EXPENSES	Provider CC	CN: 15-1311	Peri od:	ı of Form CMS- Worksheet A	-
				From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
					6/29/2020 8:4	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
	6. 00	Allocation 7.00				
GENERAL SERVICE COST CENTERS	0.00	7.00				-
00 00100 CAP REL COSTS-BLDG & FIXT	748, 609	1, 523, 236				1.
01 00101 CAP REL COSTS-BLDG & FIXT - INTERES	-157,066	545, 738				1
00 00200 CAP REL COSTS-MVBLE EQUIP	313, 056	1, 511, 843				2
00 00400 EMPLOYEE BENEFITS DEPARTMENT	573, 331	2, 535, 655				4
00 00500 ADMINI STRATI VE & GENERAL	-1,081,038	7,086,441				5
00 00700 OPERATION OF PLANT	-37,653	4, 150, 849				7
01 00701 OPERATION OF PLANT - OFFSITE	-11, 939	23, 651				7
00 00800 LAUNDRY & LINEN SERVICE	0	116, 123				8
00 00900 HOUSEKEEPI NG	-15, 986	348, 820				9
. 00 01000 DI ETARY	0	178, 642				10
. 00 01100 CAFETERI A	-219, 040	474, 821				11
. 00 01300 NURSING ADMINISTRATION	-660	630, 469				13
. 00 01400 CENTRAL SERVICES & SUPPLY	0	789, 001				14
. 00 01500 PHARMACY	-489, 211	778, 489				15
INPATIENT ROUTINE SERVICE COST CENTERS		· · · · ·				
0. 00 03000 ADULTS & PEDIATRICS	-516, 499	1, 991, 006				30
ANCI LLARY SERVICE COST CENTERS						
0. 00 05000 OPERATING ROOM	-301, 054	1, 082, 734				50
. 00 05300 ANESTHESI OLOGY	-433, 392	59, 345				53
. 00 05400 RADI OLOGY-DI AGNOSTI C	-110, 737	1, 273, 189				54
0. 00 06000 LABORATORY	0	1, 343, 312				60
. 00 06500 RESPI RATORY THERAPY	0	564, 969				65
. 00 06600 PHYSI CAL THERAPY	-18	766, 123				66
. 00 06700 OCCUPATI ONAL THERAPY	0	234, 597				67
. 00 06800 SPEECH PATHOLOGY	0	18, 569				68
. 00 06900 ELECTROCARDI OLOGY	-158, 471	536, 147				69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	366, 200				71
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 164, 957				72
. 00 07300 DRUGS CHARGED TO PATIENTS	0	3, 714, 917				73
. 01 03480 ONCOLOGY	0	233, 921				73
0. 00 03160 CARDI OPULMONARY	0	0				76
. 97 07697 CARDI AC REHABI LI TATI ON	0	130, 631				76
OUTPATIENT SERVICE COST CENTERS	1 074 404	1 (01 010				
. 00 09100 EMERGENCY	-1, 071, 194	1, 681, 042				91
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92
SPECIAL PURPOSE COST CENTERS		0F 0FF 407				-
8.00 SUBTOTALS (SUM OF LINES 1 through 117)	-2, 968, 962	35, 855, 437				118
NONREI MBURSABLE COST CENTERS		100				-
2.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	109, 147				192
22. 01 19201 OCCUPATI ONAL MEDI CI NE	0	75, 879				192
92. 02 19202 VACANT SPACE	0	0				192
00.00 TOTAL (SUM OF LINES 118 through 199)	-2, 968, 962	36, 040, 463				200

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

IU HEALTH TI PTON HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 15-1311 Period: Ecom 01/01/2019 Worksheet A-6

	STELCATIONS			Provider CCN:		Period: From 01/01/2019 To 12/31/2019	Worksheet Date/Time 6/29/2020	Prepare
	Cost Center	I ncreases Li ne #	Salary	Other	L			
	2.00	3.00	4.00	5.00				
2 2 2 2	A - DEPRECIATION CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00 2.00 0.00 0.00	0 0 0 0	553, 461 1, 196, 797 0 0				1. 2. 3. 4.
2 2 2 2	0	0.00 0.00 0.00 0.00		0 0 0 0 1, 750, 258				5. 6. 7. 8.
•	B - INTEREST	1.01		700,004				
))	CAP REL COSTS-BLDG & FIXT - INTERES 0	1.01 0.00	0 0	702, 804 0 702, 804				1. 2.
)	C - OTHER CAPITAL ADMINISTRATIVE & GENERAL O	5.00	0	1 <u>7, 1</u> 56 17, 156				1.
C	D - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 852, 473				1.
)))		0. 00 0. 00 0. 00	0 0 0	0 0 0				2. 3. 4.
)		0. 00 0. 00	0	0				5.
)		0.00	0	0				7.
)		0.00 0.00	0	0				8
00		0.00	0	0				10
00 00		0. 00 0. 00	0	0				11
00		0.00	0	0				13
00 00		0. 00 0. 00	0	0				14
0		0.00	0	0				16
)0)0		0. 00 0. 00	0	0				17
00		0.00	0	0				19
00 00		0. 00 0. 00	0	0				20
			0	1, 852, 473				_
C	E – CAFETERIA CAFETERIA	11.00	365, 954	327, 907				1
	0		365, 954	327, 907				_
)	F - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY	14.00	0	770, 481				1
)	LABORATORY MEDI CAL SUPPLI ES CHARGED TO PATI ENT	60.00 71.00	0 0	55 366, 200				2 3
)	IMPL. DEV. CHARGED TO PATIENTS EMPLOYEE BENEFITS DEPARTMENT	72.00 4.00	0	1, 164, 957 48				4
))	NURSING ADMINISTRATION PHYSICIANS' PRIVATE OFFICES	13.00 192.00	0	94 1, 095				6
)		0.00	0	0				8
))0		0. 00 0. 00	0	0				9
0		0.00	0	0				11
)0)0		0. 00 0. 00	0	0				12
00		0.00	0	0				14
)0)0		0. 00 0. 00	0	0				15
0	$\square _ _ _ _ _ _$	0.00	o	0				17
	O G - DRUGS		0	2, 302, 930				
)	PHARMACY	15.00	0	64, 234				1
)	DRUGS CHARGED TO PATIENTS CENTRAL SERVICES & SUPPLY	73.00 14.00	0	3, 714, 917 9				2
)	SENTIAL SEIVI VES & SUFFEI	0.00	0	0				4
))		0. 00 0. 00	0	0				5
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С		0.00	0	0				8

Heal th	Financial Systems		IU HEALTH TIPT	ON HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASS	SI FI CATI ONS			Provider (CCN: 15-1311	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 6/29/2020 8:	epared: 41 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	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
	0		0	3, 779, 160				
	H - ORTHOPEDIC CLERICAL STAFF	Ξ						
1.00	OCCUPATI ONAL THERAPY	67.00	45, 020	0				1.00
2.00	SPEECH PATHOLOGY	68.00	1, 026	0				2.00
	0		46, 046	0				
	I - VP OF NURSING							
1.00	NURSING ADMINISTRATION	13.00	76, 743	0				1.00
	0		76, 743	0				
	J - MAINTENANCE & LEASE EXPEN	VSE			_			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	190, 042				1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 820				2.00
	OPERATION OF PLANT	7.00	0	8, 152				3.00
4.00	OPERATION_OF_PLANTOFFSITE	7.01	0	35, 590				4.00
	0		0	235, 604				
	L - PROPERTY INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	48, 280				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	<u> </u>				2.00
	TOTALS		0	50, 270				
500.00	Grand Total: Increases		488, 743	11, 018, 562				500.00

Heal th	n Financial Systems		IU HEALTH TIF	TON HOSPITAL				
RECLAS	SSI FI CATI ONS			Provider (CCN: 15-1311	Perio From To		
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	·		
	6.00	7.00	8.00	9.00	10.00			
	A - DEPRECIATION							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 539, 969		9		
2.00	NURSING ADMINISTRATION	13.00	0	26, 625		9		
3.00	OPERATING ROOM	50.00	0	50, 502		0		
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	41, 624		0		
5.00	RESPI RATORY THERAPY	65.00	0	8, 305		0		
6.00	PHYSI CAL THERAPY	66.00	0	49, 870		o		
7.00	EMERGENCY	91.00	0	937		0		
B. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	32, 426	,	0		
	0		0	1, 750, 258		1		
	B - INTEREST							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	702, 326	1	1		
2.00	OPERATION OF PLANT	7.00	0	478	1	0		
	0		0	702, 804		1		
	C - OTHER CAPI TAL							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17, 156	1	3		
	0 — — — — — —		0	17, 156		7		
	D - EMPLOYEE BENEFITS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	78, 674		0		
2.00	OPERATION OF PLANT	7.00	0	47, 885	i l	0		
3.00	LAUNDRY & LINEN SERVICE	8.00	0	24, 944		0		
4.00	HOUSEKEEPI NG	9.00	0	112, 139		0		
5.00	DI ETARY	10.00	0	106, 825		0		
6.00	NURSING ADMINISTRATION	13.00	0	78, 687		0		
7.00	PHARMACY	15.00	0	94, 182		0		
3. 00	ADULTS & PEDIATRICS	30.00	0	355, 917		0		
9.00	OPERATING ROOM	50.00	0	165, 134		0		
	1				1	1		

1.00 2.00

In Lieu of Form CMS-2552-10 Worksheet A-6 Date/Time Prepared: 6/29/2020 8:41 am

4.00 MOD (LOCY-UPARADS)IC 54.00 0 41,624 0 4.00 5.00 RESPERATION THEARY 65.00 0 8307 0 5700 5.00 RESPERATION THEARY 65.00 0 32,200 0 52,200 0 57,000 7,000		ADEDATING BOOM	13.00	0	26, 625	,	2.00
5.00 PERFERINGENT INTERATY 65.00 0 4.305 0 6.00 7.00 PERFERS FERRENCE 0 7.00 PERFERS 0 7.00 8.1 MTERENT FERRENCE 0 7.00 PERFERS 0 7.00 9.1 MTERENT FERRENCE 0 7.00 7.00 PERFERS 0 7.00 1.00 MARINERSTRUTT & ACHTRAL 5.00 0 7.02 5.04 0 7.00 PERFERSTRUTT & ACHTRAL 1.00 0 7.02 5.04 7.02 0 7.02 0 7.02 0 7.02 0 7.00 0 7.02 0 7.00 0 7.00 0 7.05 1.00 7.00 1.00 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 7.00 0 <t< td=""><td></td><td>OPERATING ROOM</td><td>50.00</td><td>0</td><td>50, 502</td><td>0</td><td>3.00</td></t<>		OPERATING ROOM	50.00	0	50, 502	0	3.00
6.00 PHYSICAL THERMAPY 66.01 0 49,870 0 7.00 8.00 PHYSICAL THERMAPY 66.01 7.02				-			
7.00 PAREFIEV 91.00 937 0 7.00 0.00 PREFIEV 92.00 0 7.426 0 0 7.00 0.01 PREFIEV 0 0 7.426 0 0 7.00 0.01 PREFIEV 0 0 7.00 4.76 0 0 0.01 PREFIEV 0 0 7.00 4.78 0 0 0.01 PREFIEV 0 0 7.156 0 1.00 0 7.156 0.00 PREFIEV 0 0 7.156 1 0 7.00 4.884 0 2.00 1.00 0 7.156 0 7.177 0 4.00 2.00 <td>5.00</td> <td>RESPI RATORY THERAPY</td> <td>65.00</td> <td>0</td> <td>8, 305</td> <td>0</td> <td>5.00</td>	5.00	RESPI RATORY THERAPY	65.00	0	8, 305	0	5.00
8.00 PHYSICLAME' PRIVATE OFFICES 192.00 0 32.426 0 0 1.00 9.00 PHYSICLAME' PRIVATE OFFICES 0.00 7.22.266 1 1.00 1.00 PARATILITERTY & GENERAL 5.00 0 7.25.804 0 1.00 2.00 PERTUREST 1.00 0 7.25.804 0 1.00 2.00 PERTURE COSIS-FULDE & FIXI 1.00 0 7.1564 1 1.00 0.00 OPERTURE SERVET 5.00 0 72.674 0 2.00 0.01 OPERTURE SERVET 8.00 0 7.06 2.4944 0 3.00 0.01 DELEVEN 10.00 0 7.06 9.07 0.00 0.00 1.00 3.00	6.00	PHYSI CAL THERAPY	66.00	0	49, 870	0	6.00
8.00 PHYSICLAME' PRIVATE OFFICES 192.00 0 32.426 0 0 1.00 9.00 PHYSICLAME' PRIVATE OFFICES 0.00 7.22.266 1 1.00 1.00 PARATILITERTY & GENERAL 5.00 0 7.25.804 0 1.00 2.00 PERTUREST 1.00 0 7.25.804 0 1.00 2.00 PERTURE COSIS-FULDE & FIXI 1.00 0 7.1564 1 1.00 0.00 OPERTURE SERVET 5.00 0 72.674 0 2.00 0.01 OPERTURE SERVET 8.00 0 7.06 2.4944 0 3.00 0.01 DELEVEN 10.00 0 7.06 9.07 0.00 0.00 1.00 3.00	7.00	EMERGENCY	91.00	o	937	o	7.00
0 0 1.96 2.96 1.96 2.96 1.00 DRIM INSTRATIVE A. GENERAL 5.00 702.506 11 2.00 0 DRIM INSTRATIVE A. GENERAL 5.00 702.506 11 2.00 0 DRIM INSTRATIVE A. GENERAL 1.00 702.804 11 1.00 0 DRIM INSTRATIVE A. GENERAL 1.00 702.804 11 1.00 1.00 DRIM INSTRATIVE A. GENERAL 1.00 702.804 0 1.00 2.00 DRIM INT VE A. GENERAL 5.00 71.864 1 0 2.00 0.00 DRIM INT VE A. GENERAL 5.00 71.864 0 3.00 0.00 DRIM INT VE A. GENERAL 5.00 70.00 4.189 0 5.00 0.00 DRIM INT VE A. GENERAL 5.00 70.00 4.189 0 1.00 0.00 DRIM INT VE A. GENERAL 5.00 70.00 70.00 70.00 0.00 DRIM INT VE A. GENERAL 5.00 70.00 70.0				0		0	
B - INTEREST -	0.00					•	0.00
100 AMM IN STRATURE & GENERAL 5.00 0 702, 220 11 1.00 200 DECREMENT OR OF PLANT 2.00 0 702, 604 0 702, 604 0 1.00 CAPE 0 702, 604 0 702, 604 0 10 0.0 CAPE 0 1.00 0 17, 156 11 0 0.0 CAPE CAPE CAPE 1.00 0 17, 156 11 0 0.0 CAPE CAPE CAPE CAPE 1.00 0 10, 68, 25 0 1.00 2.00 1.00 2.00 <td< td=""><td></td><td>D INTEDEST</td><td></td><td>U</td><td>1,730,230</td><td></td><td>-</td></td<>		D INTEDEST		U	1,730,230		-
2.00 DEFENTION OF PLANT 2.00 4.7% 0 7.00 4.7% 0 7.00 0 2.00 0	1 00			a	700 00/		1 1 00
C. OTHER CAPITAL 1.00 0 17.156 18 D. OKENCESTERLICS COSTSELLOS (CS FILX) 0 17.156 18 D. OKENCESTERLICS 0 17.156 18 D. OMINISTATIVE & COSTSELLOS (SELENCE) 5.00 0 7.874 D. OMINISTATIVE & COSTSELLOS (SELENCE) 5.00 0 7.474 0 D. OMINISTATIVE & COSTSELLOS (SELENCE) 0 11.23 0 5.00 D. OMINISTATIVE & COSTSELLOS (SELENCE) 0 16.00 9.00 0 16.5134 0 D. OMINISTATICS 30.00 0 16.5134 0 10.00 D. OMINISTATICS 30.00 0 16.5134 0 11.00 D. OMINISTATICS 30.00 0 16.5134 0 11.00 D. OMINISTATICS 50.00 0 16.5134 0 12.00 D. OMINISTATICS 50.00 0 12.00 12.00 12.00 D. OMINISTATICS 15.00 0 12.00 12.00 12.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
C. OTHER CAPITAL 1.00 0 17.156 18 D. OKENCESTERLICS COSTSELLOS (CS FILX) 0 17.156 18 D. OKENCESTERLICS 0 17.156 18 D. OMINISTATIVE & COSTSELLOS (SELENCE) 5.00 0 7.874 D. OMINISTATIVE & COSTSELLOS (SELENCE) 5.00 0 7.474 0 D. OMINISTATIVE & COSTSELLOS (SELENCE) 0 11.23 0 5.00 D. OMINISTATIVE & COSTSELLOS (SELENCE) 0 16.00 9.00 0 16.5134 0 D. OMINISTATICS 30.00 0 16.5134 0 10.00 D. OMINISTATICS 30.00 0 16.5134 0 11.00 D. OMINISTATICS 30.00 0 16.5134 0 11.00 D. OMINISTATICS 50.00 0 16.5134 0 12.00 D. OMINISTATICS 50.00 0 12.00 12.00 12.00 D. OMINISTATICS 15.00 0 12.00 12.00 12.00 <td< td=""><td>2.00</td><td>OPERATION OF PLANT</td><td></td><td>0</td><td></td><td> 0</td><td>2.00</td></td<>	2.00	OPERATION OF PLANT		0		0	2.00
1.00 CAP REL OSSI S-BUDG & FLXT 1.00 0 17, 150 13 1.00 D EMPLOYE BURNETTS 0 17, 150 1 0 1.00 D EMPLOYE BURNETTS 0 0 200 0 200 0 200 0 200 0 200<		0		0	702, 804		
0 □		C – OTHER CAPITAL					
0 □	1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17, 156	13	1.00
0 - EBFLOYEE EVENTS 1.00 00 OWINNEXALIVE & SCHWRAL 7.00 0 47,855 0 2.00 2.00 DEPRATION OF FLANT 7.00 0 47,855 0 2.00 4.00 MULTERNY 0.00 0 116,823 0 4.00 4.00 MULTERNY 15.00 0 78,667 0 7.00 0.00 MULTERNY 15.00 0 78,667 0 7.00 0.00 MULTERNY 15.00 0 7.646 0 10.00 0.00 OPFATING RADUN STRATION 13.00 0 7.564 0 11.00 0.00 MULTERNY 5.00 0 14.01 12.01 12.01 13.00 12.01 13.00							
1.00 AMM NI STRATURE & GENERAL 5.00 0 78.674 0 2.00 OPERATING OF FLANT 7.00 0 44.943 0 3.00 3.00 LANDRY & LINEN SERVICE 8.00 0 24.944 0 3.00 4.00 MOUSEREEPING 9.00 0 112.139 0 5.00 5.00 DIFTARY 10.00 0 106.12.134 0 5.00 7.00 PRAMENY 10.00 0 30.517 0 8.00 8.00 ADULTS & PEDIATRICS 30.00 0 7.556 0 10.00 10.00 MARSTHESI OLGCY 53.00 0 7.556 0 10.00 10.00 RASITERSI OLGCY 53.00 0 11.00 12.01 10.00 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 12.01 <td></td> <td></td> <td></td> <td></td> <td>17,150</td> <td></td> <td>-</td>					17,150		-
2.00 DEFEATION OF FLANT 7.00 0 47.885 0 2.00 0.0 LAUNPY & LINEN SERVICE 8.00 0 47.885 0 4.00 4.00 MUSERCEPING 9.00 0 12.139 0 4.00 4.00 MUSENCALMIN INSTATION 13.00 0 72.6672 0 5.00 0.00 MUSENCALMIN STRATION 13.00 0 72.6672 0 5.00 0.00 OUFFATING ROOM 50.00 0 155.917 0 50.00 0.00 OUFFATING ROOM 50.00 0 75.56 0 11.00 0.00 MUSENTEX INERVITE 54.00 0 12.00 12.00 12.00 11.00 RADICLOCY - DATORY THEAPY 60.00 0 13.01 12.00 13.01 12.00 12.00 DETATORY THEAPY 60.00 0 58.971 0 13.00 12.00 13.00 DETATORY THEAPY 60.00 0 13.336 0	1 00			0	70 (74	0	1 00
3.00 LAUNDRY & LINEW SERVICE 8.00 0 24,944 0 4.00 0.00 DIFTARY 10.00 0 106,825 0 5.00 0.00 DIFTARY 15.00 0 9.63 7.00 9.63 7.00 PAMANCY 15.00 0 9.63 7.00 9.00 7.00 PAMANCY 15.00 0 9.63 7.00 9.00 7.00 PAMANCY 15.00 0 9.65 9.00 7.00 7.00 PAMANCY 15.00 0 9.65 9.00 9.00 10.00 ANESTRESIOLOGY 53.00 0 7.556 0 10.00 11.00 RADION-SIA KANDANGSTIC 54.00 0 13.00 12.00 13.00 14.00 12.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
4.00 MUSENEEPING 9,00 0 112,139 0 4.00 0.00 DETAY 10,00 0 112,139 0 5.00 0.00 NRESING ADMINISTRATION 13,00 0 78,687 0 6.00 0.00 PHARMACY 15,00 0 94,182 0 7.00 0.00 PHARMACY 15,00 0 125,158 0 10.00 0.00 PHARMACY 53,00 0 142,158 0 11.00 11,00 PHARMACY 55,00 0 91,341 0 12.00 12,00 RESPIRATIONAL THERAPY 66,00 0 182,918 13.00 13,00 PHYSICAL THERAPY 67,00 0 30,499 0 14.00 15,00 SPECCH PATHOLOCY 68,00 98,071 0 14.00 17,00 ONCOLOCY 68,00 90,00 17,03 0 17,00 17,00 ONCOLOCY 64,00 227,907							
5.00 DETARY 10.00 0 106.825 0 5.00 6.00 NURSING ADM IN STRATTON 13.00 0 78.687 0 6.00 7.00 PHARMACY 15.00 0 94.182 0 7.00 8.00 ADUTS A PEDI ATRICS 30.00 0 7.558 0 10.00 9.00 DETARTING ROOM 50.00 0 165.134 0 9.00 10.00 MESTENGLOCKY 165.00 0 19.341 0 12.00 11.00 DESEMENTORY THERRY 66.00 0 13.00 13.00 13.00 12.00 DESEMENTORY THERRY 67.00 0 30.499 0 14.00 13.00 CARDIAC EREARULTATION 76.77 0 15.00 15.00 16.00 DELECTROCARDIOLOGY 68.00 0 15.00 17.00 16.00 DELECTROCARDIOLOGY 10.00 27.753 0 12.00 17.00 DECARUL 70.00	3.00	LAUNDRY & LINEN SERVICE	8.00	0	24, 944	0	3.00
5.00 DETARY 10.00 0 106.825 0 5.00 6.00 NURSING ADM IN STRATTON 13.00 0 78.687 0 6.00 7.00 PHARMACY 15.00 0 94.182 0 7.00 8.00 ADUTS A PEDI ATRICS 30.00 0 7.558 0 10.00 9.00 DETARTING ROOM 50.00 0 165.134 0 9.00 10.00 MESTENGLOCKY 165.00 0 19.341 0 12.00 11.00 DESEMENTORY THERRY 66.00 0 13.00 13.00 13.00 12.00 DESEMENTORY THERRY 67.00 0 30.499 0 14.00 13.00 CARDIAC EREARULTATION 76.77 0 15.00 15.00 16.00 DELECTROCARDIOLOGY 68.00 0 15.00 17.00 16.00 DELECTROCARDIOLOGY 10.00 27.753 0 12.00 17.00 DECARUL 70.00	4.00	HOUSEKEEPING	9,00	0	112, 139	0	4.00
0.00 NURSI NG ADMIN STRATION 13.00 0 78.687 0 6.00 0.00 PARAMCY 15.00 0 94.182 0 7.00 0.00 PARAMCY 33.00 0 7.558 0 10.00 0.00 PARAMCY 83.00 0 7.558 0 10.00 1.000 ARESTRESTOLONY 83.00 0 7.558 0 12.00 1.000 ARESTRESTOLONY 83.00 0 7.558 0 12.00 1.200 RESPLATIONAL TREAPY 66.00 0 14.00 12.00 13.00 14.00 1.000 CARDATIONAL TREAPY 67.00 0 30.900 14.00 14.00 1.000 CARDATIONAL TREAPY 67.00 13.00 17.00 16.00 12.00 17.00 16.00 17.00 16.00 12.00 17.00 16.00 17.00 16.00 12.00 12.00 17.00 16.00 12.00 12.00 12.00 12.00 <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td>				0		0	
7.00 HMRMACY 15.00 0 94,182 0 7.00 9.00 00 9.00 00 9.00 00 9.00 00 9.00 00 9.00 00 9.00 00 9.00				-		0	
B. 00 ADULTS & PEDIATRICS 30. 00 0 355, 917 0 8. 00 0.00 DPRATINE ROAM 50. 00 0 165, 134 0 9. 00 1.00 AMESTHESI CLORY 53. 00 0 7, 556 0 11. 00 1.00 RADIONGY-DI ANNOSTI C 54. 00 0 97, 556 0 11. 00 1.00 RADIONGY-DI ANNOSTI C 66. 00 0 14. 20 00 13. 00 11. 00 12. 00 13. 00 13. 00 13. 00 14. 00 13. 00 14. 00 <td< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td></td<>				-			
9.00 OPERATING ROM 50.00 0 155, 134 0 9.00 10.00 RADIOLOGY-JACNOSTIC 53.00 0 7, 556 0 10.00 11.00 RADIOLOGY-JACNOSTIC 54.00 0 192, 158 0 11.00 12.00 RESPIRATION THERAPY 66.00 0 142, 918 0 13.00 13.00 PHYSICAL THERAPY 67.00 0 30.499 0 14.00 15.00 SPECH PATHORY THERAPY 67.00 0 30.499 0 14.00 15.00 SPECH PATHORY THERAPY 67.00 0 30.900 0 15.00 16.00 REDRICARTING, RUBULITATION 73.01 0 30.900 16.00 17.00 17.00 DAVELOCARTING, RUBULITATION 73.01 0 17.277 0 20.00 17.00 10.00 DOULOCARTINAL, REMAULITATION 75.07 0 17.287 0 20.00 10.00 11.00 DETARY 0 18.6934				-			
10.00 MRESTHESI CLOGY 53.00 0 7,556 0 10.00 11.00 RADIO COY-DI ASINGTI C 54.00 0 192,158 0 11.00 12.00 RESPIRATORY THERAPY 65.00 0 91.341 0 12.00 13.00 PHYSICAL THERAPY 66.00 0 14.2918 0 13.00 14.00 OCCUPATI ONAL THERAPY 67.00 0 30.499 0 14.00 15.00 SPECH PATHOLOGY 68.00 0 58.99 0 15.00 16.00 ELECTROCARDIOLOGY 69.00 0 17.703 0 18.00 17.703 0 18.00 19.00 21.00 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td>				-			
11.00 RADIOLOGY-DIAGNOSTIC 54.00 0 192,158 0 11.00 11.00 12.00 RESPRATORY THERAPY 65.00 0 142,918 0 12.00 13.00 PHYSICAL THERAPY 66.00 0 142,918 0 13.00 14.00 COURDATIONAL THERAPY 67.00 0 30.499 0 14.00 15.00 SPECH PATHOLOGY 68.00 0 580 0 15.00 15.00 CARLAR CHABLITATION 76.97 0 15.98 0 18.00 19.00 CARLAR CHABLITATION 76.97 0 17.703 0 19.00 20.00 19.00 20.00 19.00 20.00 19.00 20.00				-			
11.00 RADIOLOGY-JUAGNOSTIC 54.00 0 192,158 0 11.00 12.00 RESPRATORY THERAPY 65.00 0 142,918 0 13.00 13.00 PHYSICAL THERAPY 66.00 0 142,918 0 13.00 14.00 COURDATIONAL THERAPY 67.00 0 30.499 0 14.00 15.00 SPECH PATHOLOCY 66.00 0 580 0 15.00 16.00 RELEFRORMINGAR REHABILITATION 76.90 0 15.00 16.00 10.00 CARDELOCY 73.01 0 30.900 0 17.00 11.00 DARGELOCY 73.01 0 13.16 0 0 13.00 10.00 CARDELOCY 10.00 365.954 327.907 0 10.00 21.00 21.00 21.00 21.00 21.00 21.00 20.00 0 10.00 30.00 0 30.00 0 30.00 0 30.00 0 30.00 0 30.00 0 10.00 0 10.00 0 10.00 <td>10.00</td> <td>ANESTHESI OLOGY</td> <td>53.00</td> <td>0</td> <td>7, 556</td> <td>0</td> <td>10.00</td>	10.00	ANESTHESI OLOGY	53.00	0	7, 556	0	10.00
12.00 EESP RATORY THERAPY 65.00 0 91,341 0 12.00 13.00 PHX CAL THERAPY 66.00 0 30.499 0 13.00 14.00 OCCUPATIONAL THERAPY 66.00 0 30.499 0 13.00 15.00 SPECH PATHOLOCY 68.00 0 58.97 0 15.00 16.00 ELECTROCARUAL THERAPY 73.01 0 30.900 0 17.00 17.00 NOCLOGY 73.01 0 30.900 0 17.00 17.00 18.00 PHXSICLAKS PRIVATE OFFICES 192.00 0 27.257 0 21.00 20.00 27.257 0 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 21.00 20.00 20.00 21.00 20.00 21.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00 20.00	11.00	RADI OLOGY-DI AGNOSTI C		0		o	
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12.00 OCCUPATI ONAL THERAPY 67.00 0 373 0 12.00 13.00 ELECTROCARDI OLOGY 69.00 0 12,659 0 13.00 14.00 ONCOLOGY 73.01 0 9.290 0 14.00 15.00 CARDI AC REHABI LI TATI ON 76.97 0 937 0 15.00 16.00 EMERGENCY 91.00 0 81.482 0 16.00 17.00 OCCUPATI ONAL MEDI CI NE 192.01 0 2,124 0 0 0 0 2,302,930 0 17.00 0 3.633,091 0 17.00 0 0 0 3,633,091 0 2.00 17.00 0 3.00 17.00 0 3.00 17.00 0 3.00 17.00 0 2.02,930 17.00 0 2.00 17.00 0 2.02,930 17.00 0 2.00 17.00 0 2.00 17.00 0 3.00 1.00 0 3.00 0 1.00 0 3.00 0 1.00	3.00 4.00 5.00 6.00 7.00 8.00 9.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	9.00 10.00 15.00 30.00 50.00 53.00 54.00	0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495	0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00
13.00 ELECTROCARDI OLOGY 69.00 0 12,659 0 13.00 14.00 ONCOLOGY 73.01 0 9,290 0 14.00 15.00 CARDI AC REHABI LI TATI ON 76.97 0 937 0 15.00 16.00 EMERGENCY 91.00 0 81,482 0 16.00 17.00 OCCUPATI ONAL MEDI CI NE 192.01 0 2,124 0 0 0 - 0 2,302,930 0 17.00 0 3,633,091 0 10.00 1.00 PHARMACY 15.00 0 3,633,091 0 1.00 10.00 2.00 DI ETARY 10.00 0 83 0 2.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 15,836 0 4.00 4.00 DERATI NG ROOM 50.00 0 3.30 0 4.00 6.00 RADI OLOGY - DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 33.00 </td <td>3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00</td> <td>HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY</td> <td>9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00</td> <td>0 0 0 0 0 0</td> <td>12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284</td> <td>0 0 0 0 0 0 0</td> <td>4.00 5.00 6.00 7.00 8.00 9.00 10.00</td>	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00	0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284	0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00
14.00 ONCOLOGY 73.01 0 9,290 0 15.00 CARDIAC REHABILITATION 76.97 0 937 0 16.00 EMERGENCY 91.00 0 81,482 0 16.00 17.00 OCCUPATIONAL MEDICINE 192.01 0 2,124 0 17.00 0 C.URDATIONAL MEDICINE 192.01 0 2,302,930 0 17.00 6 DRUGS 0 3,633,091 0 1.00 10.00 83 0 2.00 2.00 DIETARY 10.00 0 83 0 2.00 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 11.611 0 3.00 4.00 OPERATING ROOM 50.00 0 5.646 0 5.00 6.00 RADIOLOGY-DIAGNOSTIC 54.00 0 56.312 0 6.00 7.00 RESPIRATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSICAL THERAPY 66.00 0 296 0 8.00	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ \end{array}$	0 0 0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340	0 0 0 0 0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
15.00 CARDI AC REHABI LI TATI ON 76.97 0 937 0 15.00 16.00 EMERGENCY 91.00 0 81.482 0 16.00 17.00 OCCUPATI ONAL MEDI CI NE 92.01 0 2.124 0 17.00 G - - 0 2.302.930 0 17.00 17.00 G - - 0 0 3.633.091 0 17.00 17.00 G - - 0 0 3.633.091 0 1.00 17.00 G - - - 0 0 3.633.091 0 1.00 2.00 DI ETARY 10.00 0 83 0 2.00 2.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 11.61 0 3.00 4.00 OPERATI NG ROOM 50.00 0 15.836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6.6312 0 7.00 <t< td=""><td>3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00</td><td>HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY</td><td>$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ \end{array}$</td><td>0 0 0 0 0 0 0 0 0</td><td>12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373</td><td>0 0 0 0 0 0 0 0 0 0 0 0</td><td>4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00</td></t<>	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ \end{array}$	0 0 0 0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373	0 0 0 0 0 0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
16.00 EMERGENCY 91.00 0 81.482 0 16.00 17.00 OCCUPATI ONAL MEDI CI NE 192.01 0 2.124 0 0 0 0 2.302.930 0 17.00 17.00 17.00 6 DRUGS 0 3.633.091 0 1.00 2.00 1.00 2.00 DI ETARY 10.00 0 83 0 2.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 11.611 0 3.00 4.00 OPERATI NG ROOM 50.00 0 15.836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6.646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 2.00 9.00 17.592 0 8.00 9.00 ELECTROCARDI OLOGY 73.01 0 3.303 0 10.00 11.00 11.00 EMERGENCY 91.00 0 23,583 0 <td>3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00</td> <td>HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY</td> <td>$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ \end{array}$</td> <td>0 0 0 0 0 0 0 0 0</td> <td>12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659</td> <td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00</td>	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ \end{array}$	0 0 0 0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
17. 00 OCCUPATI ONAL MEDI CINE 192.01 0 2,124 0 17.00 0 0 2,302,930 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 2.00 10.00 2.00 3.00 4.00 0 2.00 11,611 0 3.00 3.00 4.00 0 5.00 0 15.836 0 4.00 4.00 5.00 6.646 0 5.00 6.00 5.00 6.00 5.00 6.00 5.00 6.00 6.646 0 5.00 6.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.0	3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ \end{array}$	0 0 0 0 0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
17. 00 OCCUPATI ONAL MEDI CINE 192.01 0 2,124 0 17.00 0 0 2,302,930 0 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 2.00 10.00 2.00 3.00 4.00 0 2.00 11,611 0 3.00 3.00 4.00 0 5.00 0 15.836 0 4.00 4.00 5.00 6.646 0 5.00 6.00 5.00 6.00 5.00 6.00 5.00 6.00 6.646 0 5.00 6.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 8.00 7.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ 73.\ 01\\ \end{array}$	0 0 0 0 0 0 0 0 0 0 0 0 0	12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00
O O Q	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ 73.\ 01\\ 76.\ 97\end{array}$		$\begin{array}{c} 12,190\\ 44\\ 31,428\\ 105,353\\ 1,964,657\\ 1,418\\ 29,495\\ 27,284\\ 19,340\\ 373\\ 12,659\\ 9,290\\ 937\end{array}$		4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00
G DRUGS 1.00 PHARMACY 15.00 0 3,633,091 0 1.00 2.00 DI ETARY 10.00 0 83 0 2.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 11,611 0 3.00 4.00 OPERATI NG ROOM 50.00 0 15,836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6,646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ 73.\ 01\\ 76.\ 97\\ 91.\ 00\\ \end{array}$		$\begin{array}{c} 12,190\\ 44\\ 31,428\\ 105,353\\ 1,964,657\\ 1,418\\ 29,495\\ 27,284\\ 19,340\\ 373\\ 12,659\\ 9,290\\ 937\\ 81,482\end{array}$		$\begin{array}{c} 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
1.00 PHARMACY 15.00 0 3,633,091 0 1.00 2.00 DI ETARY 10.00 0 83 0 2.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 11,611 0 3.00 4.00 OPERATI NG ROOM 50.00 0 15,836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6,646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ 73.\ 01\\ 76.\ 97\\ 91.\ 00\\ \end{array}$		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124		$\begin{array}{c} 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
2.00 DI ETARY 10.00 0 83 0 2.00 3.00 ADULTS & PEDI ATRI CS 30.00 0 11, 611 0 3.00 4.00 OPERATI NG ROOM 50.00 0 15, 836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6, 646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56, 312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 73.01 0 3.303 0 9.00 10.00 ONCOLOGY 73.01 0 3.303 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE	$\begin{array}{c} 9.\ 00\\ 10.\ 00\\ 15.\ 00\\ 30.\ 00\\ 50.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 69.\ 00\\ 73.\ 01\\ 76.\ 97\\ 91.\ 00\\ \end{array}$		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124		$\begin{array}{c} 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ \end{array}$
3. 00 ADULTS & PEDIATRICS 30. 00 0 11, 611 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 0 15, 836 0 4. 00 5. 00 ANESTHESI OLOGY 53. 00 0 6, 646 0 5. 00 6. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 56, 312 0 6. 00 7. 00 RESPI RATORY THERAPY 65. 00 0 330 0 7. 00 8. 00 PHYSI CAL THERAPY 66. 00 0 296 0 8. 00 9. 00 ELECTROCARDI OLOGY 73. 01 0 3. 303 0 9. 00 10. 00 ONCOLOGY 73. 01 0 3. 303 0 10. 00 11. 00 EMERGENCY 91. 00 0 23, 583 0 11. 00	$\begin{array}{c} 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O C	9.00 10.00 15.00 30.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930		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
4.00 OPERATING ROOM 50.00 0 15,836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6,646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	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	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY	9.00 10.00 15.00 30.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 97 81, 482 2, 302, 930 3, 633, 091		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
4.00 OPERATING ROOM 50.00 0 15,836 0 4.00 5.00 ANESTHESI OLOGY 53.00 0 6,646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	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	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00		12, 190 44 31, 428 105, 353 1, 964, 657 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83		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
5.00 ANESTHESI OLOGY 53.00 0 6,646 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	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	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00		12, 190 44 31, 428 105, 353 1, 964, 657 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83		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
6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 56,312 0 6.00 7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83 11, 611		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 2.00 3.00
7.00 RESPI RATORY THERAPY 65.00 0 330 0 7.00 8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	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 1.00 2.00 3.00 4.00	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 50.00		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83 11, 611 15, 836		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 2.00 3.00 4.00
8.00 PHYSI CAL THERAPY 66.00 0 296 0 8.00 9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 9.00 10.00 10.00 10.00 10.00 10.00 11.00 11.00 23,583 0 11.00 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 50.00 53.00		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83 11, 611 15, 836 6, 646		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 2.00 3.00 4.00 5.00
9.00 ELECTROCARDI OLOGY 69.00 0 17,592 0 9.00 10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 50.00 53.00 54.00		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 1, 418 \\ 29, 495 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 9, 377 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ \hline \end{array}$		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 2.00 3.00 4.00 5.00 6.00
10.00 ONCOLOGY 73.01 0 3,303 0 10.00 11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 65.00 10.00 50		12, 190 44 31, 428 105, 353 1, 964, 657 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 302, 930 3, 633, 091 83 11, 611 15, 836 6, 646 56, 312 330		$\begin{array}{c} 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ \end{array}$
11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3. 00\\ 4. 00\\ 5. 00\\ 6. 00\\ 7. 00\\ 8. 00\\ 9. 00\\ 10. 00\\ 11. 00\\ 12. 00\\ 12. 00\\ 13. 00\\ 14. 00\\ 15. 00\\ 16. 00\\ 17. 00\\ \hline \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 65.00 66.00 10.00 53.00 54.00 55.00 54.00 55.00 50.00 55		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 937 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ 330 \\ 296 \\ \end{array}$		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 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
11.00 EMERGENCY 91.00 0 23,583 0 11.00	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY	$\begin{array}{c} 9.00\\ 10.00\\ 15.00\\ 30.00\\ 50.00\\ 53.00\\ 54.00\\ 65.00\\ 66.00\\ 67.00\\ 69.00\\ 73.01\\ 76.97\\ 91.00\\ 192.01\\ \hline \end{array}$		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83 11, 611 15, 836 6, 646 56, 312 330 296 17, 592		4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00 17.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.000 1.00
	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY	$\begin{array}{c} 9.00\\ 10.00\\ 15.00\\ 30.00\\ 50.00\\ 53.00\\ 54.00\\ 65.00\\ 66.00\\ 67.00\\ 69.00\\ 73.01\\ 76.97\\ 91.00\\ 192.01\\ \hline \end{array}$		12, 190 44 31, 428 105, 353 1, 964, 657 1, 418 29, 495 27, 284 19, 340 373 12, 659 9, 290 937 81, 482 2, 124 2, 302, 930 3, 633, 091 83 11, 611 15, 836 6, 646 56, 312 330 296 17, 592		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 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
MCRLE32 - 16 1 168 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \hline \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY ONCOLOGY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 66.00 69.00 73.01 75.00 10.00 30.00 50.00 53.00 53.00 54.00 66.00 69.00 53.00 53.00 53.00 54.00 53.00 54.00 66.00 67.00 69.00 53.01 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 60.00 60.00 50.00 60.00 50.00 50.00 53.00 64.00 65.00 66.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 67.00 53.00 53.00 53.00 53.00 60		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 1, 418 \\ 29, 495 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 937 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ 330 \\ 296 \\ 17, 592 \\ 3, 303 \\ \end{array}$		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 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.00
MCRLF32 - 16 1 168 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \hline \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY ONCOLOGY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 66.00 69.00 73.01 75.00 10.00 30.00 50.00 53.00 53.00 54.00 66.00 69.00 53.00 53.00 53.00 54.00 53.00 54.00 66.00 67.00 69.00 53.01 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 60.00 60.00 50.00 60.00 50.00 50.00 53.00 64.00 65.00 66.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 67.00 53.00 53.00 53.00 53.00 60		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 1, 418 \\ 29, 495 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 937 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ 330 \\ 296 \\ 17, 592 \\ 3, 303 \\ \end{array}$		4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 14.00 15.00 16.00 17.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.000 1.00
MCRLE32 - 16 1 168 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \hline \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY ONCOLOGY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 66.00 69.00 73.01 75.00 10.00 30.00 50.00 53.00 53.00 54.00 66.00 69.00 53.00 53.00 53.00 54.00 53.00 54.00 66.00 67.00 69.00 53.01 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 60.00 60.00 50.00 60.00 50.00 50.00 53.00 64.00 65.00 66.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 67.00 53.00 53.00 53.00 53.00 60		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 1, 418 \\ 29, 495 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 937 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ 330 \\ 296 \\ 17, 592 \\ 3, 303 \\ \end{array}$		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 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.00
MCREF32 - 16 1 168 0	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \hline \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY ONCOLOGY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 66.00 69.00 73.01 75.00 10.00 30.00 50.00 53.00 53.00 54.00 66.00 69.00 53.00 53.00 53.00 54.00 53.00 54.00 66.00 67.00 69.00 53.01 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 60.00 60.00 50.00 60.00 50.00 50.00 53.00 64.00 65.00 66.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 67.00 53.00 53.00 53.00 53.00 60		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 1, 418 \\ 29, 495 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 937 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ 330 \\ 296 \\ 17, 592 \\ 3, 303 \\ \end{array}$		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 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 1.00
	$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \hline \end{array}$	HOUSEKEEPI NG DI ETARY PHARMACY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY ONCOLOGY CARDI AC REHABI LI TATI ON EMERGENCY OCCUPATI ONAL MEDI CI NE O G - DRUGS PHARMACY DI ETARY ADULTS & PEDI ATRI CS OPERATI NG ROOM ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY PHYSI CAL THERAPY ELECTROCARDI OLOGY ONCOLOGY	9.00 10.00 15.00 30.00 50.00 53.00 54.00 65.00 66.00 67.00 69.00 73.01 76.97 91.00 192.01 15.00 10.00 30.00 53.00 54.00 66.00 69.00 73.01 75.00 10.00 30.00 50.00 53.00 53.00 54.00 66.00 69.00 53.00 53.00 53.00 54.00 53.00 54.00 66.00 67.00 69.00 53.01 50.00 50.00 50.00 50.00 50.00 50.00 50.00 60.00 60.00 60.00 50.00 60.00 50.00 50.00 53.00 64.00 65.00 66.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 53.00 53.00 53.00 66.00 67.00 67.00 67.00 53.00 53.00 53.00 53.00 60		$\begin{array}{c} 12, 190 \\ 44 \\ 31, 428 \\ 105, 353 \\ 1, 964, 657 \\ 1, 418 \\ 29, 495 \\ 27, 284 \\ 19, 340 \\ 373 \\ 12, 659 \\ 9, 290 \\ 937 \\ 81, 482 \\ 2, 124 \\ 2, 302, 930 \\ \hline \\ 3, 633, 091 \\ 83 \\ 11, 611 \\ 15, 836 \\ 6, 646 \\ 56, 312 \\ 330 \\ 296 \\ 17, 592 \\ 3, 303 \\ \end{array}$		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 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.

ECLAS	SI FI CATI ONS			Provider (CCN: 15-1311	Period: From 01/01/2019	Worksheet A-	6
						To 12/31/2019	Date/Time Pro 6/29/2020 8:4	epared: 41 am
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	<u>.</u>		
	6.00	7.00	8.00	9.00	10.00			
2.00	OCCUPATIONAL MEDICINE	192.01	0	10, 477		0		12.0
	0		0	3, 779, 160				
	H - ORTHOPEDIC CLERICAL STAFF							
. 00	PHYSI CAL THERAPY	66.00	46, 046	0		0		1.0
. 00		0.00	0	0		0		2.0
	0		46, 046	0		7		
	I - VP OF NURSING							1
. 00	ADMI NI STRATI VE & GENERAL	5.00	76, 743	0		0		1.0
		T	76, 743	0		7		
	J - MAINTENANCE & LEASE EXPEN	SE						1
. 00	PHYSI CAL THERAPY	66.00	0	124, 698	1	0		1.0
. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	110, 906		0		2.0
. 00		0.00	0	0		0		3.0
. 00		0.00	0	0		0		4.0
	0			235, 604		1		
	L - PROPERTY INSURANCE							1
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	50, 270	1	2		1.0
. 00		0.00	0	0		2		2.0
	TOTALS			50, 270		-		1
00 00	Grand Total: Decreases		488, 743	11,018,562		-		500.0

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		Inlie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS	TO HEALTH THI	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part I	
				Acquisitions		<u> 6/29/2020_8:4</u>	1 am
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	i di ondooo	bonation	rotar	Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	0	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	
4.00	Building Improvements	2, 872, 457	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	11, 559, 570	903, 511		0 903, 511	213, 241	
7.00	HIT designated Assets	964, 363	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	15, 396, 390	903, 511		0 903, 511	213, 241	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	15, 396, 390	903, 511		0 903, 511	213, 241	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	2, 872, 457	372, 370				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	12, 249, 840	6, 072, 256				6.00
7.00	HIT designated Assets	964, 363	0				7.00
8.00	Subtotal (sum of lines 1-7)	16, 086, 660	6, 444, 626				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	16, 086, 660	6, 444, 626				10.00

Health Financial Systems	IU HEALTH TIP	TON_HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	-	Period: From 01/01/2019 To 12/31/2019		pared:
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FRO	M WORKSHEET A, COLUM	AN 2, LINES 1 a	and 2	-	-	
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(0 0	0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES	0	0	(0 0	0	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1)	1			
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FRO	M WORKSHEET A, COLUM	AN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES	0	0				1.01
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	,	Provider C	F		Date/Time Prep 6/29/2020 8:4	pared:
	COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT 1.01 CAP REL COSTS-BLDG & FIXT - INTERES	3, 836, 820 0	0	3, 836, 820 C	0. 000000	0 0	1.00 1.01
2.00 CAP REL COSTS-MVBLE EQUIP	12, 249, 840	0	12, 249, 840		0	2.00
3.00 Total (sum of lines 1-2)	16, 086, 660	0	16, 086, 660		0	3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY O	F CAPI TAL	
Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 CAP REL COSTS-BLDG & FIXT 1.01 CAP REL COSTS-BLDG & FIXT - INTERES	0	0		1, 332, 646 733, 394	159, 466 0	1.00 1.01
2. 00 CAP REL COSTS-MVBLE EQUIP	0	0		1, 509, 853	Ő	2.00
3.00 Total (sum of lines 1-2)	0	0		3, 575, 893	159, 466	3.00
		SL	JMMARY OF CAPI	ΓAL		
Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
		(see instructions)	instructions)	Capi tal -Rel at ed Costs (see i nstructi ons)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		-			
1.00 CAP REL COSTS-BLDG & FIXT	0	48, 280		0	1, 523, 236	1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES	-187, 656	0		0	545, 738	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	0	1, 990		0	1, 511, 843	2.00
3.00 Total (sum of lines 1-2)	-187, 656	50, 270	-17, 156	0	3, 580, 817	3.00

In Lieu of Form CMS-2552-10

JUSTMENTS TO EXPENSES				eriod: rom 01/01/2019 o 12/31/2019	Worksheet A-8 Date/Time Prep	
			Expense Classification on	Worksheet A	6/29/2020 8: 4	1 ar
			To/From Which the Amount is	to be Adjusted		
Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00 Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1
COSTS-BLDG & FIXT (chapter 2) I nvestment income - CAP REL COSTS-BLDG & FIXT - INTERES	В		CAP REL COSTS-BLDG & FIXT - INTERES	1. 01	11	
(chapter 2) 10 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2
0 Investment income - other (chapter 2)		0		0.00	0	3
0 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4
0 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5
0 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6
0 Telephone services (pay stations excluded) (chapter		O		0.00	0	7
21) 0 Tel evision and radio service		C		0.00	0	8
(chapter 21) 0 Parking lot (chapter 21) 00 Provider-based physician	A-8-2	0 -2, 405, 913		0.00	0	
adjustment 00 Sale of scrap, waste, etc.		0		0.00		11
(chapter 23) 00 Related organization	A-8-1	3, 654, 786			0	12
transactions (chapter 10) 00 Laundry and linen service	_	0		0.00		13
00 Cafeteria-employees and guests 00 Rental of quarters to employee	В	-219, 040 0	CAFETERI A	11. 00 0. 00	0 0	
and others 00 Sale of medical and surgical supplies to other than patients		O		0.00	0	16
00 Sale of drugs to other than patients	В	-489, 175	PHARMACY	15.00	0	17
00 Sale of medical records and abstracts		0		0.00	0	18
00 Nursing and allied health education (tuition, fees, books, etc.)		O		0.00	О	19
00 Vending machines 00 Income from imposition of		0		0.00 0.00	0	
interest, finance or penalty charges (chapter 21)						
00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22
00 Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23
limitation (chapter 14) 00 Adjustment for physical therapy costs in excess of	A-8-3	O	PHYSI CAL THERAPY	66.00		24
limitation (chapter 14) 00 Utilization review - physicians' compensation		o	*** Cost Center Deleted ***	114.00		25
(chapter 21) 00 Depreciation - CAP REL	А	784, 011	CAP REL COSTS-BLDG & FIXT	1.00	9	26
COSTS-BLDG & FIXT 01 Depreciation - CAP REL		O	CAP REL COSTS-BLDG & FIXT -	1. 01	0	26
COSTS-BLDG & FIXT - INTERES 00 Depreciation - CAP REL	А	75, 455	INTERES CAP REL COSTS-MVBLE EQUIP	2.00	9	27
COSTS-MVBLE EQUIP 00 Non-physician Anesthetist			*** Cost Center Deleted ***	19.00		28
00 Physicians' assistant		0	1	0.00	0	29

	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:4	pared:
				Expense Classification or	Worksheet A	0/2//2020 0.4	
				To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	cost center bescription	(2)	Amount	Cost center		Ref.	
		1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational	A-8-3		OCCUPATI ONAL THERAPY	67.00	0100	30.00
	therapy costs in excess of		-				
	limitation (chapter 14)						
30.99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
	instructions)						
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	A	-19, 225	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
~~ ~~	Depreciation and Interest	5			5.00		
33.00	MISCELLANEOUS INCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.01	INVESTMENT FEES	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 02 33. 03	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		HOUSEKEEPI NG NURSI NG ADMI NI STRATI ON	9.00	0	
33.03	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	13.00 69.00	0	
33.04 33.05	MI SCELLANEOUS I NCOME	В		PHARMACY	15.00	0	
33.05	MEDICALD HOSPITAL ASSESSMENT	B		ADMINISTRATIVE & GENERAL	5.00	0	
55.00	FEE	D	-1,077,347		5.00	0	35.00
33.07	ASSISTED LIVING DEPRECIATION -	А	-125, 780	CAP REL COSTS-BLDG & FIXT	1.00	9	33.07
	BLDG						
33.08	ASSISTED LIVING DEPRECIATION -	А	-397	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.08
	MVBLE						
33.09	CRNA SALARY EXPENSE	А		ANESTHESI OLOGY	53.00	0	33.09
33.10	CRNA BENEFITS EXPENSE	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33. 11	PATIENT PHONES - SALARY	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.12	PATIENT PHONES - BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33.13	EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33.14	CABLE	A		OPERATION OF PLANT	7.00	0	
33.15	LEASE REVENUE	В		CAP REL COSTS-BLDG & FIXT	1.00		
33.16	ACCRUED PTO	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33. 17	LEASE DEPRECIATION - CARRY FORWARD A	A	284	CAP REL COSTS-BLDG & FIXT	1.00	9	33.17
33. 18	EQUIPMENT DEPRECIATION - CARRY	А	31 899	CAP REL COSTS-MVBLE EQUIP	2.00	9	33.18
55.10	FORWA	n	51,077		2.00	,	33.10
33, 19	TELEPHONE EQUI PMENT	А	-235	ADULTS & PEDIATRICS	30.00	0	33.19
33.20	MARKETING	A		ADMI NI STRATI VE & GENERAL	5.00		1
33.21	MARKETING	A		PHYSI CAL THERAPY	66.00	0	
33. 22	MARKETING	А		EMERGENCY	91.00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-2, 968, 962				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).

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	IU HEALTH TI	PTON HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1311	Period:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2019 To 12/31/2019		nared
				10 12/31/2017	6/29/2020 8:4	
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	2.00	3.00	4.00	5	
	1.00 A. COSTS INCURRED AND ADJUST			4.00	5.00	
	OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	RANSACTIONS WITH RELATED	URGANIZATI UNS UR	CLAIMED HOME	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	150, 803	30, 133	1.00
2.00	-	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1, 435, 720	702, 326	2.00
3.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	225, 324	0	3.00
4.00		EMPLOYEE BENEFITS DEPARTMENT		2, 539, 247	0	4.00
4.01		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5, 616, 577	5, 533, 375	4.01
4.02		OPERATION OF PLANT	HOME OFFICE ALLOCATION	0	35, 112	4.02
4.03	-			0	11, 939	4.03
4.04		ADMINISTRATIVE & GENERAL	RELATED PARTY EXPENSE	510, 237		4.04
4.05		OPERATION OF PLANT	RELATED PARTY EXPENSE	682, 774		4.05
4.06		NURSING ADMINISTRATION	RELATED PARTY EXPENSE	36, 576		4.06
4.07			RELATED PARTY EXPENSE	457, 878		4.07
4.08		OPERATING ROOM	RELATED PARTY EXPENSE	56, 515		4.08
4.09		RADI OLOGY-DI AGNOSTI C	RELATED PARTY EXPENSE	126, 652		4.09
4.10		LABORATORY	RELATED PARTY EXPENSE	1, 310, 139		4.10
4.11		ELECTROCARDI OLOGY	RELATED PARTY EXPENSE	335, 708		4.11
4.12		ONCOLOGY	RELATED PARTY EXPENSE	10, 810		4.12
4.13		EMERGENCY	RELATED PARTY EXPENSE	1, 611, 548		4.13
4.14		OCCUPATIONAL MEDICINE	RELATED PARTY EXPENSE	31, 751	31, 751	4.14
5.00	TOTALS (sum of lines 1-4).			15, 138, 259	11, 483, 473	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 part.

1103 110	t been posted to norkaneet A,	corunns r and/or z, the anou			4 of this purt.	
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HC	ME OFFICE:			

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

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

6.00	B	0.00IU HEALTH	100.00	6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00 G. Other (fina	inci al or			100.00
non-fi nanci al)	speci fy:			

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

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

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

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

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

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

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

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1311	Period: Worksheet A-8-1

		SERVICES INOW	RELATED ORGANIZATIONS AND HOME	FIOVICEI	CCN. 15-1511	From 01/01/2019	WUI KSHEEL A	-0-1
OFFICE	CUSTS					To 12/31/2019		
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF T	RANSACTI ONS	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOM	Ξ
	OFFICE COSTS:							
1.00	120, 670	9						1.00
2.00	733, 394	9						2.00
3.00	225, 324	9						3.00
4.00	2, 539, 247	0						4.00

4.02	-35, 112	0	4.02
4.03	-11, 939	0	4.03
4.04	0	0	4.04
4.05	0	0	4.05
4.06	0	0	4.06
4.07	0	0	4.07
4.08	0	0	4.08
4.09	0	0	4.09
4.10	0	0	4.10
4.11	0	0	4.11
4.12	0	0	4.12
4.13	0	0	4.13
4.14	0	0	4.14
5.00	3, 654, 786		5.00

4.01

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

Related Organization(s)
Noracea organization(5)
and/or Home Office
Type of Business
6.00
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	HEALTHCARE	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
7.00 8.00 9.00 10.00 100.00)	100.00

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

0

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

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

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

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

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

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

4.01

83, 202

Heal th	Financial Syste	ams	ιιι μεδι τη τι	PTON HOSPITAL		Inli	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet A-8	3-2 epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADMI NI STRATI VE & GENERAL	13, 367	13, 367	(1.00
2.00	30.00	ADULTS & PEDIATRICS	516, 264	516, 264	(ol o	0	2.00
3.00	50.00	OPERATING ROOM	301, 054	301, 054	(o o	0	3.00
4.00	53.00	ANESTHESI OLOGY	254, 167	254, 167	(0 0	0	4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	110, 737	110, 737	(0 0	0	5.00
6.00	69.00	ELECTROCARDI OLOGY	138, 929	138, 929	(0 0	0	6.00
7.00	91.00	EMERGENCY	1, 559, 527	1, 071, 395	488, 132	2 0	0	7.00
8.00	0. 00		0	0	(0 0	0	8.00
9.00	0. 00		0	0	(0 0	0	9.00
10.00	0. 00		0	0	(0 0	0	10.00
200.00			2, 894, 045	2, 405, 913	488, 132	2	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practi ce	
				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		ADMI NI STRATI VE & GENERAL	0	0	(1.00
2.00		ADULTS & PEDIATRICS	0	0		0	-	
3.00		OPERATING ROOM	0	0	(-	-	3.00
4.00		ANESTHESI OLOGY	0	0		0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0		0	0	5.00
6.00		ELECTROCARDI OLOGY	0	0	(0	0	6.00
7.00		EMERGENCY	0	0		0	0	7.00
8.00	0.00		0	0	(°	0	8.00
9.00	0.00		0	0	(0	9.00
10.00	0.00		0	0	(-	-	
200.00			0	0	(,	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	-	
1.00		ADMI NI STRATI VE & GENERAL	15.00	0	17.00			1.00
2.00		ADULTS & PEDIATRICS		0	(2.00
3.00		OPERATING ROOM		0	(3.00
4.00		ANESTHESI OLOGY		0	(4.00
4.00 5.00		RADI OLOGY-DI AGNOSTI C		0	(4.00 5.00
6.00		ELECTROCARDI OLOGY		0	(6.00
7.00		EMERGENCY		0	(7.00
8.00	0.00			0	(8.00
9.00	0.00		0	0	(°		9.00
10.00	0.00		1 0	0	(-		10.00
200.00	0.00		0	e e e e e e e e e e e e e e e e e e e		2, 405, 913		200.00
	I I				· · · · · · · · · · · · · · · · · · ·	_,, //	1	

REASON	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	IU HEALTH TIPT FURNISHED BY	ON HOSPITAL Provider CC	CN: 15-1311	In Lie Period: From 01/01/2019 To 12/31/2019 Physical Therapy	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 6/29/2020 8:4 Cost	-3 pared:
						1 00	
	PART I - GENERAL INFORMATION					1.00	
1.00 2.00 3.00 4.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapis assistant was	st was on provi			11 165 11 0	1.00 2.00 3.00 4.00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or ther apy assistants	(include only	visits made	by therapy s)) (see	0 0	5.00 6.00
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile					5.45 0.00	7.00 8.00
0100		Supervi sors	Therapi sts	Assi stants		Trai nees	0100
0.00	Total hours worked	1.00	2.00	3.00	4.00 25 0.00	5.00	9.00
9.00 10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00 0.00 0.00	0.00 0.00 0.00	62.	18 0.00	0.00	
12. 01 13. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0 0 0	0 0 0 0		0 0 0		12.00 12.01 13.00 13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0	14.00 15.00
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others)	line10)	ratory therapy	y or lines 1	4-16 for all	3, 995 3, 995 3, 995	16.00
	0 Aides (column 4, line 9 times column 4, line 10) 0 Trainees (column 5, line 9 times column 5, line 10)						
21.00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr	ainees (line 17		um of column	s 1 and 2, line 9	62.18	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					10, 260	22.00
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO					10, 260	23.00
	Standard Travel Allowance	WANCE AND TRAVE	L EXTENSE COM		KOVIDER SITE		
	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					0	
25.00 26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others)		0	
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	ry therapy or s	sum of lines	3 and 4 for all	60	27.00
28.00	Total standard travel allowance and standard 27)	travel expense	e at the provid	der site (su	m of lines 26 and	60	28.00
	Optional Travel Allowance and Optional Trave						
29.00 30.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		id 2, line 12))		0	29.00 30.00
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	all others)		0	31.00
32.00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s 1 and 2, line	e 13 for respir	ratory thera	py or sum of	0	32.00
33.00	Standard travel allowance and standard trave	I expense (line	28)			60	33.00
	Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	I expense (sum	of lines 31 ar	nd 32)	RVICES OUTSIDE PR	0 OVIDER SITE	34.00 35.00
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	37.00
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su		id 6)			0	38.00 39.00
40.00	Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.		12, line 10)			0	40.00
41.00	Assistants (column 3, line 12.01 times colum	n 3, line 10)				0	41.00
42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - 0				llowing three lin	0 0 es 44, 45, or	42.00 43.00
44 00	46, as appropriate.		•				1 4 4 4 4 4 4
	Standard travel allowance and standard trave Optional travel allowance and standard trave				,		44.00 45.00

Health Financial Systems REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS	IU HEALTH TIPTO FURNISHED BY	Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:4	-3 pared:	
				Physical Therapy	Cost		
					1.00		
46.00 Optional travel allowance and optional trave				nstructi ons) Trai nees		46.00	
	Therapists 1.00	Assistants 2.00	Ai des 3.00	4.00	Total 5.00		
PART V - OVERTIME COMPUTATION		2100	0.00		0100		
47.00 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	0 0.00	0. 00	47.00	
column of line 56) 48.00 Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00	
49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00				49.00	
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0 0.00	0.00	50.00	
<pre>line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)</pre>	0.00	0.00	0.0	0 0.00	0.00	51.00	
DETERMINATION OF OVERTIME ALLOWANCE52.00Adjusted hourly salary equivalency amount	0.00	62.18	0.0	0.00		52.00	
(see instructions) 53.00 Overtime cost limitation (line 51 times line		02.18		0 0		53.00	
52) 54.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00	
<pre>line 49 or line 53) 55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times 12)</pre>	0	0		0 0		55.00	
<pre>line 47 times line 52) 56.00 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 for all others.)</pre>	0	0		0 0	0	56.00	
					1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION 57.00 Salary equivalency amount (from line 23)	AND EXCESS COST .	ADJUSIMENI			10, 260	57 00	
 57.00 Sarary equivalency another (from rife 23) 58.00 Travel allowance and expense - provider site 59.00 Travel allowance (from column 5, line 56) 60.00 Overtime allowance (from column 5, line 56) 61.00 Equipment cost (see instructions) 62.00 Supplies (see instructions) 63.00 Total allowance (sum of lines 57-62) 64.00 Total cost of outside supplier services (from Excess over limitation (line 64 minus line 64) 65.00 Excess over Limitation (line 64 minus line 64) 	60 0 0 0 10, 320 2, 181	58.00 59.00 60.00 61.00 62.00					
	00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27						
101.00 Line 27 = line 7 times line 3 for respirator 101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02	
102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01	
13 for all others							

Heal th	Financial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
					From 01/01/2019		norod.
					Го 12/31/2019	Date/Time Pre 6/29/2020 8:4	aned: 1 am
			CAP	ITAL RELATED C	OSTS	0, 2, 7, 2020 0, 1	
	Cost Conton Decerintion	Nat Experses					
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE	
		for Cost Allocation		INTERES		BENEFI TS DEPARTMENT	
		(from Wkst A					
		col. 7)					
		0	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS	1		1	1		
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 523, 236	1, 523, 236				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	545, 738	0	545, 738			1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 511, 843			1, 511, 843		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 535, 655	6, 756			2, 551, 866	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	7,086,441	105, 493			168, 084	5.00
7.00	00700 OPERATION OF PLANT	4, 150, 849	373, 741			210, 942	7.00
7.01	00701 OPERATION OF PLANT - OFFSITE	23, 651	0		-	0	7.01
8.00 9.00	00800 LAUNDRY & LINEN SERVICE	116, 123	25, 247 15, 055			12, 149 73, 041	8.00 9.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	348, 820 178, 642	13, 348			21, 978	
11.00	01100 CAFETERI A	474, 821	51, 835			85, 363	•
13.00	01300 NURSI NG ADMI NI STRATI ON	630, 469	34, 403			134, 437	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	789, 001	32, 564				14.00
15.00	01500 PHARMACY	778, 489	11, 735			150, 831	15.00
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1 1771	11,000	1007001	10100
30.00	03000 ADULTS & PEDIATRICS	1, 991, 006	151, 327	61, 162	2 150, 610	426, 368	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 082, 734	190, 780	77, 107	7 189, 875	208, 604	50.00
53.00	05300 ANESTHESI OLOGY	59, 345	3, 600	1, 455	5 3, 583	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 273, 189	98, 378	39, 76	I 97, 912	254, 750	
60.00	06000 LABORATORY	1, 343, 312	38, 463			0	60.00
65.00	06500 RESPI RATORY THERAPY	564, 969	2, 322			118, 313	
66.00	06600 PHYSI CAL THERAPY	766, 123	48, 632			157, 624	66.00
67.00	06700 OCCUPATI ONAL THERAPY	234, 597	15, 250			51, 579	•
68.00	06800 SPEECH PATHOLOGY	18, 569	351			3, 937	68.00
69.00	06900 ELECTROCARDI OLOGY	536, 147	25, 832			116, 471	69.00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	366, 200	0			0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	1, 164, 957	0		0	0	72.00
73.00	03480 ONCOLOGY	3, 714, 917 233, 921	15, 413		15,340	45, 849	
76.00	03160 CARDI OPULMONARY	233, 921	10,413	0,230	15, 340	45, 849	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	130, 631	18, 148	7, 335	5 18,062	24, 106	•
70. 77	OUTPATIENT SERVICE COST CENTERS	130, 031	10, 140	7,000	10,002	24,100	/0. //
91.00	09100 EMERGENCY	1, 681, 042	108, 906	44, 016	5 108, 389	257, 042	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	.,					92.00
	SPECIAL PURPOSE COST CENTERS	1					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	35, 855, 437	1, 387, 579	523, 462	2 1, 381, 002	2, 521, 468	118.00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	109, 147	111, 867				192.00
	19201 OCCUPATI ONAL MEDI CI NE	75, 879	19, 598				192.01
	19202 VACANT SPACE	0	4, 192	1, 694	4 0	0	192.02
200.00			-			-	200.00
201.00		24 040 440					201.00
202.00	TOTAL (sum lines 118 through 201)	36, 040, 463	1, 523, 236	545, 738	3 1, 511, 843	2, 551, 866	202.00

	ı Financial Systems	IU HEALTH TIP				u of Form CMS-2	2552-1
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	narad
					10 12/31/2019	6/29/2020 8: 4	
	Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	OPERATION OF	LAUNDRY &	
	···· · · · · · · · · · · · · · · · · ·		E & GENERAL	PLANT	PLANT -	LINEN SERVICE	
					OFFSI TE		
		4A	5.00	7.00	7.01	8.00	
	GENERAL SERVICE COST CENTERS	1	1				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	7, 507, 647					5.00
7.00	00700 OPERATION OF PLANT	5, 240, 290					7.00
7.01	00701 OPERATION OF PLANT - OFFSITE	23, 651			29, 874	44.0.004	7.0
8.00	00800 LAUNDRY & LINEN SERVICE	188, 850		174, 293		412, 834	8.00
9.00	00900 HOUSEKEEPI NG	457, 984				0	9.00
10.00	01000 DI ETARY	232, 648				0	10.00
11.00		684, 558				0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	847, 454				0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	867, 136				0	14.00
15.00		957, 478	251, 934	81, 014	4 0	0	15.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	0 700 470	701 (0)	1 044 (0)		410 004	20.00
30.00	03000 ADULTS & PEDIATRICS	2, 780, 473	731, 606	1, 044, 680	0 0	412, 834	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	1, 749, 100	460, 228	1, 317, 03	7 0	0	50.00
53.00	05300 ANESTHESI OLOGY	67, 983				0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 763, 990				0	54.00
60.00	06000 LABORATORY	1, 435, 602				0	60.00
65.00	06500 RESPI RATORY THERAPY	688, 854				0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 025, 986		88, 922		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	318, 234				0	67.00
68.00	06800 SPEECH PATHOLOGY	23, 244		646		0	68.00
69.00	06900 ELECTROCARDI OLOGY	714, 599		178, 327		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	366, 200				0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 164, 957			0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 714, 917			0 0	0	73.00
73.01	03480 ONCOLOGY	316, 753				0	73.0
76.00	03160 CARDI OPULMONARY	0		(0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	198, 282	-			0	76.9
	OUTPATIENT SERVICE COST CENTERS	170/202	02,110	120,200	<u> </u>		
91.00	09100 EMERGENCY	2, 199, 395	578, 711	751, 825	5 0	0	91.00
92.00		0					92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	35, 536, 265	7, 374, 980	5, 898, 083	3 17, 987	412, 834	118.00
	NONREI MBURSABLE COST CENTERS			•			1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	367,089	96, 590	556, 822	2 11, 887	0	192.00
192. Oʻ	1 19201 OCCUPATI ONAL MEDI CI NE	131, 223	34, 528	135, 292	2 0	0	192. 0 ⁷
192.02	2 19202 VACANT SPACE	5, 886	1, 549	28, 94	1 0	0	192.02
200.00		0					200.00
		0	0	(o o	0	201.00
201.00							

Heal th	Financial Systems	IU HEALTH TIPTO	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
					From 01/01/2019	Part I	
					To 12/31/2019		
	Cost Center Description	HOUSEKEEPING	DIETARY	CAFETERIA	NURSI NG	6/29/2020 8:4 CENTRAL	1 am
	cost center bescription	HUUSEKEEPING	DIETART	CAFEIERIA	ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - OFFSITE						7.01
8.00	00800 LAUNDRY & LI NEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	682, 420					9,00
10.00	01000 DI ETARY	9, 176	395, 188				10.00
11.00	01100 CAFETERI A	35, 631	0,00,000	1, 258, 15	0		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	23, 649	0	65, 92			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	22, 385	0		0 1, 377, 317	1, 342, 489	14.00
15.00	01500 PHARMACY	8,067	0	73, 98	<u> </u>	18, 148	
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0,007	U	73,70	0	10, 140	15.00
30.00	03000 ADULTS & PEDIATRICS	104, 023	395, 188	299, 86	0 793, 674	53, 955	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	104, 023	390, 100	299,00	193,074	03, 900	30.00
50, 00	05000 OPERATING ROOM	131, 140	0	124, 36	3 221, 434	302, 593	50.00
53.00	05300 ANESTHESI OLOGY	2, 475	0	9, 36		302, 393 797	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	67,625	0	145, 62		15,055	54.00
60.00	06000 LABORATORY	26, 440	0	85, 87		18, 439	60.00
65.00	06500 RESPIRATORY THERAPY	1, 596	0	62,65		15, 448	
66.00	06600 PHYSI CAL THERAPY	33, 430	0	89, 62		7, 414	
67.00	06700 OCCUPATI ONAL THERAPY	10, 483	0	30, 90		208	67.00
68.00	06800 SPEECH PATHOLOGY	241	0	1, 87		208	68.00
69.00	06900 ELECTROCARDI OLOGY	17, 757	0	53, 19	-	7, 161	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	55, 17	0 0	203, 913	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	648, 686	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	048, 080	73.00
73.00	03480 ONCOLOGY	10, 595	0	25, 84	-	5, 532	73.00
76.00	03160 CARDI OPULMONARY	10, 595	0	20, 04	0 32,440	5, 532 0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	12, 475	0	13, 95	3 41, 125	617	76.97
70.97	OUTPATIENT SERVICE COST CENTERS	12,475	0	15, 90	41,120	017	10.91
91.00	09100 EMERGENCY	74, 862	0	150, 39	271, 465	43, 292	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	74,002	0	150, 39	271,403	43, 292	91.00
92.00	SPECIAL PURPOSE COST CENTERS		I				92.00
118.00		592,050	395, 188	1, 233, 42	8 1, 397, 517	1, 341, 258	110 00
110.00	NONREIMBURSABLE COST CENTERS	592,050	395, 100	1, 233, 42	.0 1, 397, 317	1, 341, 236	110.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	76, 898	0	15, 82	6 0	0	192.00
	19201 OCCUPATI ONAL MEDI CI NE	13, 472	0	8, 89			192.00
	19202 VACANT SPACE	13, 472	0	0,07	0 0		192.01
200.00		0	0			0	200.00
200.00		0	0		0	Ω	200.00
201.00	5	682, 420	395, 188	1, 258, 15	0 1, 397, 517		
202.00		502, 720	575, 100	1,200,10		1, 572, 707	-02.00

	nancial Systems CATION - GENERAL SERVICE COSTS	IU HEALTH TIPTO	Provider C	CN: 15-1311	Peri od:	Worksheet B	2552-10
					From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Prep 6/29/2020 8:4	
	Cost Center Description	PHARMACY	Subtotal	Intern &	Total	0/2//2020 011	
	·			Resi dents			
				Cost & Post	Ξ		
				Stepdown			
	-	15.00	24.00	Adjustments			
GEN	IERAL SERVICE COST CENTERS	15.00	24.00	25.00	26.00		
	00 CAP REL COSTS-BLDG & FIXT						1.00
	01 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
	200 CAP REL COSTS-MVBLE EQUIP						2.00
	OO EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 005	500 ADMINISTRATIVE & GENERAL						5.00
7.00 007	700 OPERATION OF PLANT						7.00
7.01 007	01 OPERATION OF PLANT - OFFSITE						7.01
8.00 008	300 LAUNDRY & LINEN SERVICE						8.00
9.00 009	POO HOUSEKEEPI NG						9.00
	DOO DI ETARY						10.00
	00 CAFETERI A						11.00
	800 NURSI NG ADMI NI STRATI ON						13.00
	100 CENTRAL SERVICES & SUPPLY						14.00
	500 PHARMACY	1, 390, 622					15.00
	PATIENT ROUTINE SERVICE COST CENTERS			1			
	000 ADULTS & PEDI ATRI CS	4, 272	6, 620, 565		0 6, 620, 565		30.00
	CILLARY SERVICE COST CENTERS	5, 146	4, 311, 041		0 4, 311, 041		50.00
	300 ANESTHESI OLOGY	5, 140	123, 361		0 4, 311, 041		53.00
	100 RADI OLOGY-DI AGNOSTI C	1, 328	3, 136, 914		0 3, 136, 914		54.00
	DOO LABORATORY	1, 320	2, 209, 622		0 2, 209, 622		60.00
	500 RESPIRATORY THERAPY	121	965, 953		0 965, 953		65.00
	500 PHYSI CAL THERAPY	87	1, 529, 038		0 1, 529, 038		66.00
	00 OCCUPATI ONAL THERAPY	0	475, 700		0 475,700		67.00
	300 SPEECH PATHOLOGY	0	32, 218		0 32, 218		68.00
69.00 069	200 ELECTROCARDI OLOGY	274	1, 196, 710		0 1, 196, 710		69.00
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	666, 469		0 666, 469		71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 120, 170		0 2, 120, 170		72.00
73.00 073	BOO DRUGS CHARGED TO PATIENTS	1, 366, 978	6, 059, 375		0 6, 059, 375		73.00
73.01 034	180 ONCOLOGY	1, 203	582, 126		0 582, 126		73.01
	60 CARDI OPULMONARY	0	0		0 0		76.00
	597 CARDI AC REHABI LI TATI ON	0	443, 911		0 443, 911		76.97
	PATIENT SERVICE COST CENTERS			1			
	OO EMERGENCY	8, 678	4, 078, 625		0 4, 078, 625		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	CLAL PURPOSE COST CENTERS	1 000 007	04 554 700	1	0 04 554 700		110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) IREIMBURSABLE COST CENTERS	1, 388, 087	34, 551, 798		0 34, 551, 798		118.00
	200 PHYSICIANS' PRIVATE OFFICES	0	1, 125, 112	1	0 1, 125, 112		192.00
	201 OCCUPATI ONAL MEDI CI NE	2, 535	327, 177		0 1, 123, 112		192.00
	202 VACANT SPACE	2, 535	327, 177 36, 376		0 327, 177		192.01
200.00	Cross Foot Adjustments	0	30, 370 0		0 30, 370		200.00
200.00	Negative Cost Centers	0	0		0 0		200.00

Health Fin	ancial Systems	IU HEALTH TIP	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	N OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/29/2020 8:4	epared:
	· ·		CAP	I TAL RELATED	COSTS	0/29/2020 8.4	
			0.11				
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	BLDG & FIXT INTERES	- MVBLE EQUIP	Subtotal	
		Related Costs					
		0	1.00	1.01	2.00	2A	
GENI	ERAL SERVICE COST CENTERS						
1.00 001	00 CAP REL COSTS-BLDG & FIXT						1.00
1.01 001	01 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00 002	00 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 004	00 EMPLOYEE BENEFITS DEPARTMENT	0	6, 756	2,73	6, 724	16, 211	4.00
5.00 005	00 ADMI NI STRATI VE & GENERAL	0	105, 493	42, 63	7 104, 992	253, 122	5.00
7.00 007	00 OPERATION OF PLANT	0	373, 741	132, 78	5 371, 973	878, 499	7.00
7.01 007	01 OPERATION OF PLANT - OFFSITE	0	0		0 0	C	1
	00 LAUNDRY & LINEN SERVICE	0	25, 247	10, 20	4 25, 127	60, 578	8.00
	00 HOUSEKEEPI NG	0	15,055			36, 123	
	00 DI ETARY	0	13, 348			32, 028	1
	00 CAFETERIA	0	51, 835			124, 374	1
	00 NURSI NG ADMI NI STRATI ON	0	34, 403				
	00 CENTRAL SERVICES & SUPPLY	0	32, 564				1
	00 PHARMACY	0	11, 735				1
	ATIENT ROUTINE SERVICE COST CENTERS	0	11,755	4,74	5 11,000	20, 150	13.00
	00 ADULTS & PEDIATRICS	0	151, 327	61, 16	2 150, 610	363, 099	30,00
	I LLARY SERVICE COST CENTERS	0	101, 027	01,10	130,010	303, 077	30.00
	00 OPERATING ROOM	0	190, 780	77,10	189, 875	457, 762	50.00
	00 ANESTHESI OLOGY	0	3, 600			8, 638	1
	00 RADI OLOGY-DI AGNOSTI C	0	98, 378			236, 051	
	00 LABORATORY	0	38, 463			92, 290	
	00 RESPIRATORY THERAPY	0	2, 322			5, 572	1
	00 PHYSI CAL THERAPY	0	48, 632			102, 239	1
	00 OCCUPATIONAL THERAPY	0	48, 032			32, 058	
	00 SPEECH PATHOLOGY	0	351		8 349	738	1
	00 ELECTROCARDI OLOGY	0					1
		0	25, 832			61, 981	
	00 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	C	
	00 I MPL. DEV. CHARGED TO PATIENTS	-	0		0 0	C	
	00 DRUGS CHARGED TO PATIENTS	0	0		0 0	C	
	80 ONCOLOGY	0	15, 413			36, 983	1
	60 CARDI OPULMONARY	0	0		0 0	C	
	97 CARDI AC REHABI LI TATI ON	0	18, 148	7,33	5 18, 062	43, 545	76.97
	PATIENT SERVICE COST CENTERS	-					
	00 EMERGENCY	0	108, 906	44, 01	6 108, 389	261, 311	1
	00 OBSERVATION BEDS (NON-DISTINCT PART					C	92.00
	CIAL PURPOSE COST CENTERS	1		1			-
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 387, 579	523, 46	2 1, 381, 002	3, 292, 043	118.00
	REIMBURSABLE COST CENTERS	1		1	1		
	00 PHYSI CLANS' PRI VATE OFFI CES	0	111, 867				192.00
	01 OCCUPATIONAL MEDICINE	0	19, 598				192.01
	02 VACANT SPACE	0	4, 192	1, 69	4 0		192.02
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)	0	1, 523, 236	545, 73	8 1, 511, 843	3, 580, 817	202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CON: 15-1311 Provider CON: 15-1311 Portid: From 0/07/2010 Dirt 11 Date/Time Cost Center Description EMPLOYEE RENETIS ADMINISTRATIV E & GENERAL OPENATION OF PLANT OPENATION PLANT	Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		Inlie	u of Form CMS-2	2552-10	
From 01/07/2019 Pert I.11 Pert I.11 <th c<="" td=""><td></td><td></td><td></td><td>CN: 15-1311</td><td></td><td></td><td></td></th>	<td></td> <td></td> <td></td> <td>CN: 15-1311</td> <td></td> <td></td> <td></td>				CN: 15-1311			
ID 10 12/31/2019 Date/Time Prepared: C2/2/2020 Date/Time Prepared: C2/2/2020 Date/Time Prepared: C2/2/2020 C2/2/2020 C2/2/2020 <thc2 2="" 2020<="" th=""> <thc2 2="" 2020<="" th=""> <thc2 2="" 2020<="" <="" td=""><td>REPORTION OF OWNER REPUED COOLD</td><td></td><td>in our der of</td><td></td><td></td><td></td><td></td></thc2></thc2></thc2>	REPORTION OF OWNER REPUED COOLD		in our der of					
Cost Center Description EMPLAYE BENEFITS ADMINISTRATU E & GENERAL OPERATION OF PLANT DEPARTMENT LANNERY & LINEN SERVICE 0 00100 CAP REL COSTS-CENTERS - - - - - - 0 - 0						Date/Time Pre		
BENEFITS E & GENERAL PLANT PLANT PLANT LINEN SERVICE 00100 CAP REL COSTS-BLDG & FIXT 1.00 7.01 8.00 1.00 COTOD CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.00 0.000 COP REL COSTS-BLDG & FIXT 1.01 1.01 1.01 1.01 0.0100 CAP REL COSTS-MUBLE EQUIP 1.01 0.00 COSCOD ADMINI STRATIVE & GENERAL 1.068 254,190 7.01 8.00 0.00 COSCOD ADMINI STRATIVE & GENERAL 1.064 211 0 7.01 0.00 COSCOD ADMINI STRATIVE & GENERAL 1.044 244,397 0 66,734 0.00 COSCOD ADMINI STRATIVE & GENERAL 1.62 24,397 0 66,734 0.00 COSCOD ADMINI STRATIVE & GENERAL 542 6.099 50.089 0 0 10.00 1.00 DIADMINESING ADMINI STRATION B54 7.550 33.244 0 0 13.00 1.00 DIADMINE SERVICE COST CENTERS 1.1440 0 66,6734 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><u>1 am</u></td>							<u>1 am</u>	
DEPARTMENT 0 OFFSITE 0 4.00 5.00 7.00 7.01 8.00 1.01 OCIOR REL COSTS-BLDG & FIXT 1 1.01 1.01 1.01 0.0101 CAP REL COSTS-BLDG & FIXT 1.01 1.01 1.01 0.0200 2.00 0.0200 CPR RL COSTS-BLDG & FIXT 1.01 0.00 0.0000 CPR RL COSTS-BLDG & FIXT 1.01 2.00 2.00 1.00 0.0000 CPR RL COSTS-BLDG & FIXT 1.062 2.54,190 2.00 0.00000 CPR RL COSTS-BLDG & FIXT 1.068 2.54,190 5.00 5.00 1.010 0.00000 CPRAITION OF PLANT 1.340 0.211 0 7.01 0.00000 CPRAITION OF PLANT 1.422 2.093 1.350 0.0 1.000 1.100 1.000 D1000 D1000 D1000 D1400 1.458 0 0 1.100 1.000 D1400 D1400 D14100 D14100 D14100 D14100 D14100 D	Cost Center Description							
CENERAL SERVICE COST CENTERS 4.00 5.00 7.00 7.01 8.00 1.00 COTOD CAP REL COST-BLOG & FIXT - INTRES			E & GENERAL	PLANT		LINEN SERVICE		
CENERAL SERVICE COST CATTERS 1.00 1.00 00100 CAP REL COST S-BLD & FIXT 1.00 1.01 00101 CAP REL COSTS-WBLE COUP 2.00 2.00 00200 CAP REL COSTS-WBLE COUP 2.00 0.00 00000 CAP REL COSTS-WBLE COUP 5.00 0.00 00000 CAP REL COST CAPREL COST CAPREL 1.6211 0.00 000000 OPERATION OF PLANT - OFFSITE 0 211 0 1.00 01000 OUSEKEEPING 464 464 4.080 14.545 0 0 9.00 1.00 01000 OUSEKEEPING 542 6.099 5.089 0 0 10.00 1.00 01000 CERTERAL SERVICE COST CENTERS 958 8.33 11.340 0 0 13.00 1.00 01000 CERTERAL SERVICE COST CENTERS 958 8.33 144,354 0 55.00 0.00 050000 OFARTIN								
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 1.01 00100 CAP REL COSTS-BLDG & FLXT 1.01 2.00 00200 CAP REL COSTS-MURE FOUP 4.00 0.00 00400 CMRL0YEE BERFITS DEPARTMENT 16.211 2.00 0.00 00400 OPERATION OF PLANT 1.380 46.679 920.518 7.00 7.01 00701 OPERATION OF PLANT 1.380 46.679 920.518 7.00 7.01 00701 OPERATION OF PLANT 1.380 46.679 920.518 7.00 7.00 00700 OUND (AUNDRY & LINEN SERVICE 7.71 1.682 24.977 0 66.734 8.00 9.00 000000 (DITARY 14.00 2.073 12.899 0 11.00 0 13.00 01100 CAPEREI A SUVICES & SUPLY 0 7.25 31.467 0 11.00 15.00 01400 CENTRAL SERVICES & SUPLY 0 7.25 31.467 0 15.00 16.00 01400 CENTRAL SERVICE COST CENTERS 0 8.530 11.340 0 15.00 </td <td></td> <td>4.00</td> <td>5.00</td> <td>7.00</td> <td>7.01</td> <td>8.00</td> <td></td>		4.00	5.00	7.00	7.01	8.00		
1. 01 00101 (AP REL COSTS -BUDG & FLXT - INTERES 1. 01 2. 00 00200 (AP REL COSTS -WBLE E OUP P 1. 00 0. 00 0000 (AP ML OVSEE BENEFITS DEPARTMENT 16, 211 0 0. 00 0000 (APM IN STEAMULE 2 GENREAL 1, 068 254, 190 7. 00 0. 00 0000 (DERATION OF PLANT - OFFSITE 0 211 0 7. 00 0. 00 00000 (MUSEKEEPIN 6 464 4, 080 14, 545 0 0 9, 00 0. 00 00000 (MUSEKEEPIN 6 464 4, 080 14, 545 0 0 9, 00 0 <td></td> <td></td> <td>1</td> <td>1</td> <td></td> <td></td> <td></td>			1	1				
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	Financial Systems	IU HEALTH TIPTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/29/2020 8:4	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
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 - OFFSITE						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	55, 215					9.00
10.00	01000 DI ETARY	742	47, 882				10.00
11.00	01100 CAFETERI A	2, 883	0	183, 98	7		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 913	0	9, 64	1 135, 750		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 811	0		0 0	119, 138	14.00
15.00	01500 PHARMACY	653	0	10, 81	9 0	1, 611	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDIATRICS	8, 417	47, 882	43, 85	0 77, 095	4, 788	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10, 611	0	18, 18		26, 853	50.00
53.00	05300 ANESTHESI OLOGY	200	0	1, 36		71	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 472	0	21, 29		1, 336	54.00
60.00	06000 LABORATORY	2, 139	0	12, 55		1,636	60.00
65.00	06500 RESPIRATORY THERAPY	129	0	9, 16		1, 371	65.00
66.00	06600 PHYSI CAL THERAPY	2,705	0	13, 10		658	66.00
67.00	06700 OCCUPATIONAL THERAPY	848	0	4, 51		18	67.00
68.00	06800 SPEECH PATHOLOGY	20	0	27-		0	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 437	0	7, 77		635	69.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			18, 096 57, 568	71.00
72.00	07300 DRUGS CHARGED TO PATIENTS	0	0			57,508	73.00
73.00	03480 ONCOLOGY	857	0	3, 78	-	491	73.00
76.00	03160 CARDI OPULMONARY	0	0	3,70	3, 132	471	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	1,009	0	2,04	3, 995	55	
/0. //	OUTPATIENT SERVICE COST CENTERS	1,007		2,01	0, 770		/0. //
91.00	09100 EMERGENCY	6, 057	0	21, 99	4 26, 369	3, 842	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	-,	-	,		-,	92.00
	SPECIAL PURPOSE COST CENTERS	I	I				
118.00		47, 903	47, 882	180, 37	2 135, 750	119, 029	118.00
102 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CLANS' PRI VATE OFFI CES	6, 222	0	2, 31	4 0		192.00
	19201 OCCUPATI ONAL MEDI CI NE	0, 222 1, 090	0	2, 31			192.00
	19201 OCCUPATIONAL MEDICINE	1,090	0				192.01
200.00		0	0			0	200.00
200.00		0	0		0	0	200.00
201.00	5	55, 215	47, 882	183, 98	0	119, 138	
202.00		00,210	, 002	, ,0		, 100	

	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/29/2020 8:4	
	Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
		15.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00 7.01	00700 OPERATI ON OF PLANT 00701 OPERATI ON OF PLANT - OFFSI TE						7.00 7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
8.00 9.00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	62,069					15.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	02,007					15.00
30.00	03000 ADULTS & PEDI ATRI CS	191	805, 765		0 805, 765		30.00
50.00	ANCI LLARY SERVICE COST CENTERS		000,700		0 000,700		00.00
50.00	05000 OPERATI NG ROOM	230	736, 413		0 736, 413		50.00
53.00	05300 ANESTHESI OLOGY	0	14, 363		0 14, 363		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	59	376, 611		0 376, 611		54.00
60.00	06000 LABORATORY	o	158, 580		0 158, 580		60.00
65.00	06500 RESPI RATORY THERAPY	5	25, 372		0 25, 372		65.00
66.00	06600 PHYSI CAL THERAPY	4	141, 397		0 141, 397		66.00
67.00	06700 OCCUPATI ONAL THERAPY	O	44, 536		0 44, 536		67.00
68.00	06800 SPEECH PATHOLOGY	o	1, 355	1	0 1, 355		68.00
69.00	06900 ELECTROCARDI OLOGY	12	107, 541		0 107, 541		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	21, 358		0 21, 358		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	67, 947		0 67, 947		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	61, 014	94, 110		0 94, 110		73.00
	03480 ONCOLOGY	54	63, 324		0 63, 324		73.0
76.00	03160 CARDI OPULMONARY	0	0		0 0		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	70, 100		0 70, 100		76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	387	446, 424		0 446, 424		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
440 2-	SPECIAL PURPOSE COST CENTERS	(A. 05-1	0.475.45		0 0 175 151		110 0
118.00		61, 956	3, 175, 196		0 3, 175, 196		118.00
100 00	NONREI MBURSABLE COST CENTERS		005 005		0 005 005		100 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	325, 835		0 325, 835		192.00
	19201 OCCUPATI ONAL MEDI CI NE	113	69, 797		0 69, 797		192.01
102 02	19202 VACANT SPACE	0	9, 989		0 9, 989		192.02
	Conner Frank Additional States						
200. 00 201. 00		0	0		0 0 0 0		200.00 201.00

<u>Health Finar</u>	icial Systems	IU HEALTH TIP	TON_HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epared:
		CAP	TAL RELATED CO	OSTS		6/29/2020 8:4	1 am
	Cost Center Description	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	EMPLOYEE	Reconciliatio	
		(SQUARE FEET)	I NTERES (SQUARE FEET)	(SQUARE FEET)	BENEFI TS DEPARTMENT (GROSS SALARI ES)	n	
		1.00	1.01	2.00	4.00	5A	
	AL SERVICE COST CENTERS	105 470	1				1 1 00
	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT - INTERES	195, 479 0	173, 282				1.00
	CAP REL COSTS-MVBLE EQUIP		110,202	194, 94	1		2.00
	EMPLOYEE BENEFITS DEPARTMENT	867	867	86			4.00
	ADMI NI STRATI VE & GENERAL	13, 538	13, 538				5.00
	OPERATION OF PLANT OPERATION OF PLANT - OFFSITE	47,963	42, 162	47,96	3 904, 318 0 0	0	
	LAUNDRY & LINEN SERVICE	3, 240	3, 240	3, 24		0	1
	HOUSEKEEPI NG	1, 932	1, 932	1, 93	2 313, 132	0	9.00
	DI ETARY	1, 713	1, 713	1, 71		0	10.00
		6, 652	6, 652	6, 65		0	11.00 13.00
	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY	4, 415 4, 179	4, 415 4, 179	4, 41 4, 17		0	1
	PHARMACY	1, 506	1, 506	1, 50		0	1
	IENT ROUTINE SERVICE COST CENTERS						1
	ADULTS & PEDIATRICS	19, 420	19, 420	19, 42	0 1, 827, 857	0	30.00
	LARY SERVICE COST CENTERS	24, 483	24, 483	24, 48	3 894, 294	0	50.00
	ANESTHESI OLOGY	462	462	46		0	53.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	12, 625	12, 625	12, 62	5 1, 092, 126	0	54.00
	LABORATORY	4, 936	4, 936	4, 93		0	60.00
		298	298	29		0	
	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	6, 241 1, 957	1, 653 518	6, 24 1, 95		0	66.00 67.00
	SPEECH PATHOLOGY	45	12	4		0	68.00
	ELECTROCARDI OLOGY	3, 315	3, 315	3, 31		0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	DRUGS CHARGED TO PATIENTS ONCOLOGY	1, 978	1, 978	1, 97	0	0	73.00 73.01
	CARDI OPULMONARY	0	0		0 0	0	1
	CARDI AC REHABI LI TATI ON	2, 329	2, 329	2, 32	9 103, 344	0	76.97
	TIENT SERVICE COST CENTERS	10.07/	10.07/	10.07	/ 1 101 051		1 01 00
	EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	13, 976	13, 976	13, 97	6 1, 101, 951	0	91.00 92.00
	AL PURPOSE COST CENTERS	470.070	4.(470.07	0 40 000 (47	7 507 (47	110.00
118.00 NONRE	SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	178,070	166, 209	178, 07	0 10, 809, 647	-7, 507, 647	118.00
	PHYSICIANS' PRIVATE OFFICES	14, 356	4, 020	14, 35	6 94, 651	0	192.00
	OCCUPATIONAL MEDICINE	2, 515	2, 515		5 35, 669		192.01
	VACANT SPACE	538	538		0 0	0	192.02
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 523, 236	545, 738	1, 511, 84	3 2, 551, 866		201.00
202100	Part I)	1,020,200		.,	2,001,000		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 792326	3. 149421	7. 75538			203.00
204.00	Cost to be allocated (per Wkst. B,				16, 211		204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part				0. 001482		205.00
206.00	II) NAHE adjustment amount to be allocated						206.00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207.00
207.00	Parts III and IV)						

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1311 P	eriod:	Worksheet B-1	
					rom 01/01/2019 0 12/31/2019	Date/Time Pre	pared.
						6/29/2020 8:4	
	Cost Center Description	ADMI NI STRATI V		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL	PLANT	PLANT -	LINEN SERVICE	(SQUARE FEET)	
		(ACCUM. COST)	(SQUARE FEET)		(TOTAL		
		5.00	7.00	7.01	PATIENT DAYS) 8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	7.00	7.01	0.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	28, 532, 816					5.00
7.00	00700 OPERATION OF PLANT	5, 240, 290					7.00
7.01	00701 OPERATION OF PLANT - OFFSITE	23, 651					7.01
8.00	00800 LAUNDRY & LINEN SERVICE	188, 850		1			8.00
9.00	00900 HOUSEKEEPI NG	457, 984		1		127, 401	9.00
	01000 DI ETARY	232, 648		1	0	1, 713	•
		684, 558			0	6, 652	•
	01300 NURSI NG ADMI NI STRATI ON	847, 454			0	4,415	
	01400 CENTRAL SERVICES & SUPPLY	867, 136			0	4, 179	•
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	957, 478	1, 506	0 0	0	1, 506	15.00
30.00	03000 ADULTS & PEDIATRICS	2, 780, 473	19, 420	0	2, 100	19, 420	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	2,700,473	17,420		2,100	17,420	30.00
50.00	05000 OPERATING ROOM	1, 749, 100	24, 483	0	0	24, 483	50.00
	05300 ANESTHESI OLOGY	67, 983				462	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 763, 990				12, 625	•
	06000 LABORATORY	1, 435, 602				4, 936	
	06500 RESPI RATORY THERAPY	688, 854				298	•
66.00	06600 PHYSI CAL THERAPY	1, 025, 986	1, 653	4, 588	0	6, 241	66.00
67.00	06700 OCCUPATI ONAL THERAPY	318, 234	518	1, 439	0	1, 957	67.00
68.00	06800 SPEECH PATHOLOGY	23, 244			0	45	68.00
	06900 ELECTROCARDI OLOGY	714, 599		0	0	3, 315	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	366, 200		-	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 164, 957		°	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 714, 917			0	0	73.00
	03480 ONCOLOGY	316, 753		1	0	1, 978	
	03160 CARDI OPULMONARY	0		0		0	76.00
76.97		198, 282	2, 329	0	0	2, 329	76.97
91.00	OUTPATIENT SERVICE COST CENTERS	2, 199, 395	13, 976	0	0	13, 976	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 177, 373	13, 770		0	13, 770	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		28, 028, 618	109, 642	6,060	2, 100	110, 530	118 00
	NONREI MBURSABLE COST CENTERS		,		2,.00		
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	367, 089	10, 351	4, 005	0	14, 356	192.00
	19201 OCCUPATI ONAL MEDI CI NE	131, 223					192.01
192.02	19202 VACANT SPACE	5, 886	538	0	0	0	192.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00		7, 507, 647	6, 619, 138	29, 874	412, 834	682, 420	202.00
	Part I)						
203.00		0. 263123					
204.00		254, 190	926, 518	211	86, 734	55, 215	204.00
205 00	Part II)	0,000000	7 500054	0.000074	41 201005	0 400005	205 00
205.00		0. 008909	7. 529851	0. 020964	41. 301905	0. 433395	205.00
206.00	NAHE adjustment amount to be allocated						206.00
200.00	(per Wkst. B-2)						200.00
207.00							207.00
	Parts III and IV)						

	Financial Systems LOCATION - STATISTICAL BASIS	IU HEALTH TIPT	Provi der C	CN: 15-1311	Peri od:	u of Form CMS- Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI N (DI RECT NURSI NG HOURS)	SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	
		10.00	11.00	13.00	14.00	15.00	-
	GENERAL SERVICE COST CENTERS						1 1.
	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
. 00 0	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
. 00 0	00500 ADMI NI STRATI VE & GENERAL						5.
	00700 OPERATION OF PLANT						7.
. 01 0	00701 OPERATION OF PLANT - OFFSITE						7.
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPI NG						9.
	D1000 DI ETARY	6, 870					10.
		0	13, 435				11
	01300 NURSI NG ADMI NI STRATI ON	0	704				13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	0 790		0 2, 410, 934 0 32, 592	3, 779, 171	14
-	NPATIENT ROUTINE SERVICE COST CENTERS	0	/90	/	0 32, 392	3, 779, 171	1 15.
	03000 ADULTS & PEDIATRICS	6, 870	3, 202	59,44	41 96, 896	11, 611	30.
	NCI LLARY SERVICE COST CENTERS	0,0,0	0,202	0,,,,	,,,,,,,		
	05000 OPERATI NG ROOM	0	1, 328	16, 58	543, 416	13, 986	50
3.00	05300 ANESTHESI OLOGY	0	100		0 1,432	0	53
4.00 0	05400 RADI OLOGY-DI AGNOSTI C	0	1, 555		0 27,037	3, 608	54
0.00	06000 LABORATORY	0	917	,	0 33, 114	0	60
5.00 0	06500 RESPI RATORY THERAPY	0	669		0 27,742	330	65
	06600 PHYSI CAL THERAPY	0	957		0 13, 314	236	
	06700 OCCUPATI ONAL THERAPY	0	330		0 373	0	
	06800 SPEECH PATHOLOGY	0	20		0 0	0	
		0	568			744	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 366, 200	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 164, 957	0	
	03480 ONCOLOGY	0	0 276		0 0 30 9,935	3, 714, 917 3, 268	
	03480 ONCOLOGI 03160 CARDI OPULMONARY	0	2/0		0 7, 733	3, 208	
	07697 CARDI AC REHABI LI TATI ON	0	149		1, 108	0	
	DUTPATIENT SERVICE COST CENTERS			0,00	1,100		1 / 0
	09100 EMERGENCY	0	1, 606	20, 33	31 77, 747	23, 583	91
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	SPECIAL PURPOSE COST CENTERS						
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	6, 870	13, 171	104, 66	2, 408, 723	3, 772, 283	118.
	NONREI MBURSABLE COST CENTERS	0	169	J		0	100
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 OCCUPATI ONAL MEDI CLNE	0	95		0	6, 888	192
	19201 OCCOPATIONAL MEDICINE	0	95		0 2,211		192
92.02	Cross Foot Adjustments	0	U	1		0	200.
01.00	Negative Cost Centers						200.
02.00	Cost to be allocated (per Wkst. B,	395, 188	1, 258, 150	1, 397, 51	1, 342, 489	1, 390, 622	
	Part I)	,	,, ,00		, =, .0,	, , 522	
03.00	Unit cost multiplier (Wkst. B, Part I)	57. 523726	93.647190	13. 35228	0. 556834	0. 367970	203.
04.00	Cost to be allocated (per Wkst. B,	47, 882	183, 987			62,069	
	Part II)						
05.00	Unit cost multiplier (Wkst. B, Part	6. 969723	13. 694604	1. 29699	0. 049416	0. 016424	205
06.00	NAHE adjustment amount to be allocated						206.
	(per Wkst. B-2)						
07.00	NAHE unit cost multiplier (Wkst. D,						207.

Health Financial Systems	IU HEALTH TIP	TON 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		pared: 1 am
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				_		
30. 00 03000 ADULTS & PEDIATRICS	6, 620, 565		6, 620, 56	05 0	0	30.00
ANCI LLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	4, 311, 041		4, 311, 04		0	
53. 00 05300 ANESTHESI OLOGY	123, 361		123, 36		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	3, 136, 914		3, 136, 91		0	
60. 00 06000 LABORATORY	2, 209, 622		2, 209, 62		0	60.00
65. 00 06500 RESPI RATORY THERAPY	965, 953		965, 95		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 529, 038		1, 529, 03		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	475, 700		475, 70		0	67.00
68.00 06800 SPEECH PATHOLOGY	32, 218		32, 21		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 196, 710		1, 196, 71		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	666, 469		666, 46		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 120, 170		2, 120, 17		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 059, 375		6, 059, 37		0	73.00
73.01 03480 ONCOLOGY	582, 126		582, 12	.6 0	0	73.01
76.00 03160 CARDI OPULMONARY	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	443, 911		443, 91	1 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1					
91.00 09100 EMERGENCY	4, 078, 625		4, 078, 62		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 382, 674		1, 382, 67		0	
200.00 Subtotal (see instructions)	35, 934, 472		00, 00 1, 1,			200.00
201.00 Less Observation Beds	1, 382, 674		1, 382, 67			201.00
202.00 Total (see instructions)	34, 551, 798	0	34, 551, 79	08	0	202.00

Health Financial Systems	IU HEALTH TIPT	ON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period:	Worksheet C	
				From 01/01/2019 To 12/31/2019		pared.
				10 12/01/2017	6/29/2020 8:4	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4 4 (2 5 (2		4 4/0 5/			
30. 00 03000 ADULTS & PEDIATRICS	4, 463, 569		4, 463, 56	9		30.00
ANCI LLARY SERVICE COST CENTERS	F (() 707	1/ 107 154	21 700 00	1 0 107027	0.00000	
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	5, 663, 727	16, 127, 154				
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	275, 320	661, 152				
60. 00 06000 LABORATORY	305, 323 658, 450	8, 987, 419 4, 291, 658				
65. 00 06500 RESPIRATORY THERAPY	361, 718	4, 291, 038 828, 767				
66. 00 06600 PHYSI CAL THERAPY	583, 981	1, 813, 916				
67. 00 06700 OCCUPATI ONAL THERAPY	268, 076	549, 688				
68. 00 06800 SPEECH PATHOLOGY	200,070	34, 779				
69. 00 06900 ELECTROCARDI OLOGY	216, 254	4, 606, 425				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 252, 930	2, 476, 705				
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 267, 925	6, 086, 119				
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 777, 845	14, 555, 727				
73. 01 03480 ONCOLOGY	2, 748	1, 787, 309				
76.00 03160 CARDI OPULMONARY	0	0		0 0.000000		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	696, 450	696, 45		0.000000	
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	440, 303	12, 644, 561	13, 084, 86	4 0. 311706	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 527	2, 956, 544	2, 972, 07	1 0. 465222	0.000000	92.00
200.00 Subtotal (see instructions)	23, 577, 793	79, 104, 373	102, 682, 16	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	23, 577, 793	79, 104, 373	102, 682, 16	6		202.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019		
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS					30.00
ANCI LLARY SERVI CE COST CENTERS	0.000000				
50. 00 05000 OPERATING ROOM	0. 000000				50.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	0. 000000				60.00
65.00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 000000				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				72.00 73.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 03480 ONCOLOGY	0.000000				73.00
73. 01 03480 0NC0L0GY 76. 00 03160 CARDI OPULMONARY	0.000000				76.00
	0.000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0.000000				10.91
91. 00 09100 EMERGENCY	0.000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
200.00 Subtotal (see instructions)	0.000000				200.00
201.00 Less Observation Beds					200.00
202.00 Total (see instructions)					201.00
	I I				-02.00

Health Financial Systems	IU HEALTH TIP	FON 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		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	<u>col. 26)</u>	0.00	2.00	1.00	F 00	
UNDATIONE DOUTINE CEDVICE COST CENTEDS	1.00	2.00	3.00	4.00	5.00	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	6, 620, 565		6, 620, 56	5 0	6, 620, 565	30,00
ANCI LLARY SERVICE COST CENTERS	0, 020, 303		0, 020, 30	<u>)</u> U	0, 020, 303	30.00
50. 00 05000 OPERATING ROOM	4, 311, 041		4, 311, 04	1 0	4, 311, 041	50.00
53. 00 05300 ANESTHESI OLOGY	123, 361		123, 36		123, 361	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 136, 914		3, 136, 91		3, 136, 914	
60. 00 06000 LABORATORY	2, 209, 622		2, 209, 62		2, 209, 622	
65. 00 06500 RESPI RATORY THERAPY	965, 953		965, 95		965, 953	
66. 00 06600 PHYSI CAL THERAPY	1, 529, 038		1, 529, 03		1, 529, 038	
67.00 06700 OCCUPATI ONAL THERAPY	475, 700		475, 70		475, 700	•
68.00 06800 SPEECH PATHOLOGY	32, 218	0	32, 21	8 0	32, 218	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 196, 710		1, 196, 71	0 0	1, 196, 710	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	666, 469		666, 46	9 0	666, 469	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 120, 170		2, 120, 17	0 0	2, 120, 170	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 059, 375		6, 059, 37	5 0	6, 059, 375	73.00
73. 01 03480 ONCOLOGY	582, 126		582, 12	6 0	582, 126	
76. 00 03160 CARDI OPULMONARY	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	443, 911		443, 91	1 0	443, 911	76.97
OUTPATIENT SERVICE COST CENTERS				-		
91.00 09100 EMERGENCY	4,078,625		4, 078, 62		4,078,625	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 382, 674		1, 382, 67		1, 382, 674	
200.00 Subtotal (see instructions)	35, 934, 472		001701717		35, 934, 472	
201.00 Less Observation Beds	1, 382, 674		1, 382, 67		1, 382, 674	•
202.00 Total (see instructions)	34, 551, 798	0	34, 551, 79	8 0	34, 551, 798	202.00

Health Financial Systems	IU HEALTH TIPT	ON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019		pared:
					6/29/2020 8:4	
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	6.00	7.00	0.00	9.00	Rati o 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	4, 463, 569		4, 463, 56	0		30.00
ANCI LLARY SERVICE COST CENTERS	4,403,309		4, 403, 30	7		30.00
50. 00 05000 OPERATING ROOM	5, 663, 727	16, 127, 154	21, 790, 88	1 0. 197837	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	275, 320	661, 152				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	305, 323	8, 987, 419				
60. 00 06000 LABORATORY	658, 450	4, 291, 658				
65. 00 06500 RESPIRATORY THERAPY	361, 718	828, 767				65.00
66. 00 06600 PHYSI CAL THERAPY	583, 981	1, 813, 916	2, 397, 89	7 0. 637658	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	268, 076	549, 688		4 0. 581708	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	24, 097	34, 779	58, 87	6 0. 547218	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	216, 254	4, 606, 425	4, 822, 67	9 0. 248142	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 252, 930	2, 476, 705	3, 729, 63	5 0. 178696	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 267, 925	6, 086, 119	13, 354, 04			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 777, 845	14, 555, 727				
73.01 03480 ONCOLOGY	2, 748	1, 787, 309	1, 790, 05			
76.00 03160 CARDI OPULMONARY	0	0		0 0. 000000		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	696, 450	696, 45	0 0. 637391	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS				1		
91.00 09100 EMERGENCY	440, 303	12, 644, 561				1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	15, 527	2, 956, 544			0.000000	
200.00 Subtotal (see instructions)	23, 577, 793	79, 104, 373	102, 682, 16	6		200.00
201.00 Less Observation Beds	00 577 700	70 404 070	100 (00 1)	,		201.00
202.00 Total (see instructions)	23, 577, 793	79, 104, 373	102, 682, 16	6		202.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 8:4	
		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					30.00
ANCI LLARY SERVI CE COST CENTERS					_
50.00 O5000 OPERATING ROOM	0. 000000				50.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65.00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73. 01 03480 ONCOLOGY	0. 000000				73.01
76. 00 03160 CARDI OPULMONARY	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS					_
91.00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH TIP			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019		pared: 1 am
			XVIII	Hospi tal	Cost	
Cost Center Description		Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	736, 413					
53. 00 05300 ANESTHESI OLOGY	14, 363					•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	376, 611					•
60. 00 06000 LABORATORY	158, 580					
65. 00 06500 RESPI RATORY THERAPY	25, 372	1, 190, 485	0. 02131	2 178, 946		
66. 00 06600 PHYSI CAL THERAPY	141, 397	2, 397, 897	0. 05896	293, 243	17, 292	66.00
67.00 06700 OCCUPATI ONAL THERAPY	44, 536	817, 764	0. 05446	135, 691	7, 390	67.00
68.00 06800 SPEECH PATHOLOGY	1, 355	58, 876	0. 02301	4 13, 352	307	68.00
69.00 06900 ELECTROCARDI OLOGY	107, 541	4, 822, 679	0. 02229	9 127, 640	2, 846	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 358	3, 729, 635	0.00572	587, 060	3, 362	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	67, 947	13, 354, 044	0. 00508	4, 057, 619	20, 645	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	94, 110	16, 333, 572	0.00576	930, 893	5, 364	73.00
73.01 03480 ONCOLOGY	63, 324	1, 790, 057	0. 03537	5 0	0	73.01
76.00 03160 CARDI OPULMONARY	0	0	0. 00000	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	70, 100	696, 450	0. 10065	0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
91.00 09100 EMERGENCY	446, 424	13, 084, 864	0. 03411	8 11, 802	403	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	168, 280	2, 972, 071	0. 05662	0 0	0	92.00
200.00 Total (lines 50 through 199)	2, 537, 711	98, 218, 597		9, 638, 110	170, 730	200 00

Health Financial Systems	IU HEALTH TIP	TON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS		CCN: 15-1311		Date/Time Pre 6/29/2020 8:4	pared: 1 am
			e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physi ci an		Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0	(0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	(0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(0 0	0	54.00
60. 00 06000 LABORATORY	0	(0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	(0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	(0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	(0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	(0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	(0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	73.00
73.01 03480 ONCOLOGY	0	(0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0	(0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	(0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	(0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	(0 0	0	200.00
			•			•

Health Financial Systems	IU HEALTH TIP	TON HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	6/29/2020 8:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
	4.00	F 00	(00	7.00	instructions)	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	6.00	7.00	8.00	
50. 00 05000 OPERATING ROOM	0	0		21, 790, 881	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		936, 472		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			9, 292, 742		
60. 00 06000 LABORATORY	0			4, 950, 108		60.00
65. 00 06500 RESPIRATORY THERAPY	0	0		1, 190, 485		
66. 00 06600 PHYSI CAL THERAPY	0	0		2, 397, 897		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		817,764		
68.00 06800 SPEECH PATHOLOGY	0	0		58, 876		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		4, 822, 679	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		3, 729, 635	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		13, 354, 044	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 16, 333, 572	0.00000	73.00
73. 01 03480 ONCOLOGY	0	0		0 1, 790, 057		
76. 00 03160 CARDI OPULMONARY	0	0		0 0	0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 696, 450	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS	-	-	1			
91.00 09100 EMERGENCY	0	0		0 13, 084, 864		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		2, 972, 071		
200.00 Total (lines 50 through 199)	0	0	I	98, 218, 597		200.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provider C		Period: From 01/01/2019	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2019		nared
				10 12/31/2019	6/29/2020 8: 4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS	· · · · ·				-	
50.00 05000 OPERATING ROOM	0. 000000	2, 726, 476		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	127, 434		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	101, 499		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	346, 455		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	178, 946		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	293, 243		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	135, 691		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	13, 352		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	127, 640		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	587, 060		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 057, 619		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	930, 893		0 0	0	73.00
73. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 000000	11, 802		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)		9, 638, 110		0 0	0	200.00

Health Financial Systems	IU HEALTH TIP	TON 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		pared: 1 am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATING ROOM	0. 197837		3, 829, 30	0 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0. 131730	0	124, 91	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 337566	0	2, 722, 35	9 0	0	54.00
60. 00 06000 LABORATORY	0. 446379	0	1, 434, 22	7 0	0	60.00
65.00 06500 RESPI RATORY THERAPY	0. 811395	0	366, 04	9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 637658	0	649, 76	4 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 581708	0	160, 50	4 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 547218	0	18, 30	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 248142	0	1, 729, 43	7 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 178696	0	514, 31	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 158766	0	1, 237, 60	9 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 370977	l o	7, 368, 03	5 4, 574	0	73.00
73. 01 03480 ONCOLOGY	0. 325200	0	1,002,32		0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 637391	0	295, 55	8 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			·	1
91. 00 09100 EMERGENCY	0. 311706	0	3, 852, 00	8 709	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 465222		1, 102, 48			
200.00 Subtotal (see instructions)		0	26, 407, 17			200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0	0	201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	26, 407, 17	4 5, 353	0	202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider CO		Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pr 6/29/2020 8:	
			XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To				
		Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	757, 577	0				50.00
53. 00 05300 ANESTHESI OLOGY	16, 454					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	918, 976					54.00
60. 00 06000 LABORATORY	640, 209					60.00
65. 00 06500 RESPIRATORY THERAPY	297, 010					65.00
66. 00 06600 PHYSI CAL THERAPY	414, 327					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	93, 366					67.00
68. 00 06800 SPEECH PATHOLOGY	10, 014					68.00
69. 00 06900 ELECTROCARDI OLOGY	429, 146					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	91, 905					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	196, 490					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 733, 372					73.00
73.01 03480 ONCOLOGY	325, 955					73.01
76.00 03160 CARDI OPULMONARY	0	0				76.00
76. 97 07697 CARDI AC REHABILI TATI ON	188, 386	0				76.97
OUTPATIENT SERVICE COST CENTERS	· · · ·	•				
91.00 09100 EMERGENCY	1, 200, 694	221				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	512, 899	33				92.00
200.00 Subtotal (see instructions)	8, 826, 780	1, 951				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	8, 826, 780	1, 951				202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	VACCINE COST	Provider C	CN: 15-1311	Period:	Worksheet D	
		Component		From 01/01/2019 To 12/31/2019		nared
		component	56N. 15 2511	10 12/31/2017	6/29/2020 8:4	
		Title	XVIII	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.107007					
50. 00 05000 OPERATI NG ROOM	0. 197837			0 0	0	00.00
53. 00 05300 ANESTHESI OLOGY	0. 131730			0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 337566			0 0	0	
60. 00 06000 LABORATORY	0. 446379			0 0	0	00.00
65. 00 06500 RESPI RATORY THERAPY	0. 811395			0 0	0	00.00
66. 00 06600 PHYSI CAL THERAPY	0. 637658			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 581708			0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 547218			0 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 248142			0 0	0	0,100
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0. 178696			0 0	0	1 / 11 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 158766			0 0	0	1 / 2 / 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 370977			0 0	0	1 101 00
73. 01 03480 ONCOLOGY	0. 325200			0 0	0	1 / 0/ 0/
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	1 1 01 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 637391	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	0.01170/					
91.00 09100 EMERGENCY	0. 311706			0 0	0	1 / 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 465222	0		0 0	0	1 2.00
200.00 Subtotal (see instructions)		0		0		200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges					0	202.00
202.00 Net Charges (line 200 - line 201)	1	0	I	0 0	0	202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1311	Period:	Worksheet D	
		Component (CCN: 15-Z311	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	nared
		oomponent v	0011. 10 2011	10 12/01/2017	6/29/2020 8:4	
			XVIII	Swing Beds - SNF	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.) 6.00	(see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATI NG ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0					60.00
65. 00 06500 RESPIRATORY THERAPY	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0					68.00
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0					71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
73. 01 03480 ONCOLOGY	0	0				73.01
76. 00 03160 CARDI OPULMONARY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS	-	-	1			
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 TIP	TON 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	Worksheet D Part V Date/Time Pre 6/29/2020 8:4	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS				-		
50.00 OPERATING ROOM	0. 197837		249, 81		0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 131730		29,67		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 337566		69, 21		0	54.00
60. 00 06000 LABORATORY	0. 446379		155, 26		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 811395		94	7 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 637658		5, 27		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 581708	0	83	8 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 547218	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 248142	0	27,80	5 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 178696	0	2,00	0 8	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 158766	0	4, 01	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 370977	0	61, 49	3 0	0	73.00
73.01 03480 ONCOLOGY	0. 325200	0	8, 66	1 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	0	1	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 637391	0	18, 68	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 311706	0	174, 56	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 465222	0	34, 99	5 0	0	92.00
200.00 Subtotal (see instructions)		0	843, 25	8 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	843, 25	8 0	0	202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider CO		Period: From 01/01/2019 To 12/31/2019	6/29/2020 8:4	
	-		e XIX	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed Services	Reimbursed 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	49, 423	0				50.00
53.00 05300 ANESTHESI OLOGY	3,909	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	23, 366	0	1			54.00
60. 00 06000 LABORATORY	69, 308	0				60.00
65. 00 06500 RESPI RATORY THERAPY	768	0				65.00
66. 00 06600 PHYSI CAL THERAPY	3, 362	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	487	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	6, 900	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	359	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	638					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 812					73.00
73. 01 03480 ONCOLOGY	2, 817					73.01
76. 00 03160 CARDI OPULMONARY	0	, s				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	11, 909	0				76.97
OUTPATIENT SERVICE COST CENTERS		-	1			
91.00 09100 EMERGENCY	54, 412					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 280					92.00
200.00 Subtotal (see instructions)	266, 750	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	244 750					202.00
202.00 Net Charges (line 200 - line 201)	266, 750	0				202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2019	Worksheet D-1	
		Title XVIII	To 12/31/2019 Hospi tal	Date/Time Pre 6/29/2020 8:4 Cost	epare 1 am
	Cost Center Description		nospi tai	1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS			1.00	
00	Inpatient days (including private room days and swing-bed day			2, 892	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days,	2, 702 0	
	do not complete this line. Semi-private room days (excluding swing-bed and observation b	5, 5, 5,		2 100	
00 00	Total swing-bed SNF type inpatient days (including private ro	5 /	er 31 of the cost	2, 100 180	
00	reporting period Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	10	7
00	reporting period Total swing-bed NF type inpatient days (including private roo	om days) after December	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable 1			1, 217	9
	newborn days) (see instructions)				
00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruct	ctions)	5 1	180	10
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e		room days) after	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period		te room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ac through December 21	of the cost		17
	reporting period	Ũ			
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	118.90	19
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting pariod (line	6, 620, 565 0	
	5 x line 17)		0 1		
. 00	Swing-bed cost applicable to SNF type services after December x line 18) $$	31 of the cost report	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost report	ing period (line	1, 189	24
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			414, 613	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TThe 21 minus TThe 26)		6, 205, 952	27
00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	
00	Semi -private room charges (excluding swing bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33) (see instru	ctions)	0.00 0.00	
00	Average per diem private room cost differential (line 34 x li		51101137	0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0.00	
00	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see	instructions)		2, 296. 80	38
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		2, 290, 00 2, 795, 206 0	39

	ncial Systems	IU HEALTH TIPT			In Lie	u of Form CMS-	2552-10
COMPUTATI ON	I OF INPATIENT OPERATING COST		Provider C	CN: 15-1311	Period: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
	Cost Center Description	Total	Ti tl e Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpati ent Cost	I npati ent	Diem (col. ÷ col. 2)		(col. 3 x col. 4)	
		1.00	Days 2.00	3.00	4.00	5.00	
	ERY (title V & XIX only) nsive Care Type Inpatient Hospital Units						42.00
43.00 INTE	NSIVE CARE UNIT						43.00
	NARY CARE UNIT INTENSIVE CARE UNIT						44.00
46.00 SURG	ICAL INTENSIVE CARE UNIT						46.00
47.00 OTHE	R SPECIAL CARE (SPECIFY) Cost Center Description						47.00
40.00	•					1.00	
	ram inpatient ancillary service cost (Wk I Program inpatient costs (sum of lines			ons)		2, 293, 331 5, 088, 537	
PASS	THROUGH COST ADJUSTMENTS						
50.00 Pass	through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
	through costs applicable to Program inp	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52.00 Tota	Program excludable cost (sum of lines					0	52.00
	l Program inpatient operating cost exclu cal education costs (line 49 minus line		lated, non-ph	ysician anest	hetist, and	0	53.00
TARG	ET AMOUNT AND LIMIT COMPUTATION						
5	ram discharges et amount per discharge					0 0.00	
56.00 Targ	et amount (line 54 x line 55)					0	56.00
	.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
	s payment (see instructions) er of lines 53/54 or 55 from the cost re	porting period	ending 1996,	updated and c	ompounded by the	0 0.00	
mark	et basket		0		. ,		
	er of lines 53/54 or 55 from prior year ine 53/54 is less than the lower of line					0. 00 0	
	h operating costs (line 53) are less tha		s (lines 54 x	: 60), or 1% o	f the target		
	nt (line 56), otherwise enter zero (see ef payment (see instructions)	Instructions)				o	62.00
63.00 Allo	wable Inpatient cost plus incentive paym	nent (see instru	ctions)			0	
	RAM INPATIENT ROUTINE SWING BED COST care swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of th	e cost report	ing period (See	413, 424	64.00
	ructions)(title XVIII only) care swing-bed SNF inpatient routine cos	te after Decemb	or 21 of the	cost roportin	a pariod (Soo	0	45 00
inst	ructions)(title XVIII only)			·	51 (0	65.00
	I Medicare swing-bed SNF inpatient routi (see instructions)	ne costs (line	64 plus line	65)(title XVI	ll only). For	413, 424	66.00
67.00 Ti tl	e V or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost r	eporting period	0	67.00
	e 12 x line 19) e V or XIX swing-bed NF inpatient routir	ne costs after D	ecember 31 of	the cost rep	orting period	0	68.00
	e 13 x line 20) I title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.00
PART	III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY	`	-	
1	led nursing facility/other nursing facil sted general inpatient routine service c	2)		70.00
, ,	ram routine service cost (line 9 x line			~ 2)			72.00
	cally necessary private room cost applic						73.00
75.00 Capi	l Program general inpatient routine serv tal-related cost allocated to inpatient				Part II, column		74.00 75.00
	line 45) diem capital-related costs (line 75 ÷ li	ne 2)					76.00
Ŭ	ram capital-related costs (line 9 x line						77.00
	tient routine service cost (line 74 minu egate charges to beneficiaries for exces		rovi der recor	ds)			78.00
55	I Program routine service costs for comp				nus line 79)		80.00
	tient routine service cost per diem limi		、		-		81.00
	tient routine service cost limitation (l onable inpatient routine service costs (82.00 83.00
	ram inpatient ancillary services (see in		3)				83.00
	ization review - physician compensation		ns)				85.00
	I Program inpatient operating costs (sum		rough 85)				86.00
	IV - COMPUTATION OF OBSERVATION BED PAS I observation bed days (see instructions					602	87.00
	sted general inpatient routine cost per		line 2)			2, 296. 80	
001 00 17.00 0	rvation bed cost (line 87 x line 88) (se						89.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		pared: 1 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	805, 765	6, 620, 565	0. 12170	6 1, 382, 674	168, 280	90.00
91.00 Nursing School cost	0	6, 620, 565	0.00000	0 1, 382, 674	0	91.00
92.00 Allied health cost	0	6, 620, 565	0.00000	0 1, 382, 674	0	92.00
93.00 All other Medical Education	0	6, 620, 565	0.00000	0 1, 382, 674	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 6/29/2020 8:4	pare
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s. excluding newborn)		2, 892	1.
00	Inpatient days (including private room days, excluding swing-b	bed and newborn days)		2, 702	2.
00	Private room days (excluding swing-bed and observation bed day	/s). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	d days)		2, 100	4.
00	Total swing-bed SNF type inpatient days (including private roc		er 31 of the cost		
	reporting period				
00	Total swing-bed SNF type inpatient days (including private roc 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 room	n days) through Decembe	r 31 of the cost	10	7
	reporting period				
00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December	31 of the cost	0	8.
00	Total inpatient days including private room days applicable to	o the Program (excludin	g swing-bed and	13	9.
	newborn days) (see instructions)	-			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, en				
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	(only (including priva	te room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	(onlv (including priva	te room davs)	0	13
	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this li	ne)		
	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15 16
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31	of the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 o	f the cost	118.90	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions			6, 620, 565	
. 00	Swing-bed cost applicable to SNF type services through Decembe 5 x line 17)	er 31 of the cost repor	ting period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporti	ng period (line 6	0	23
00	x line 18)	- 01 -£ the cost moved		1 100	
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost report	ing period (line	1, 189	24
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reportin	g period (line 8	0	25
00	x line 20) Tatal awing had east (ass instructions)			414 (12	24
-	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		414, 613 6, 205, 952	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29 30
. 00	General inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00 0.00	
	Average per diem private room cost differential (line 32 min			0.00	35
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost d	ifferential (line	6, 205, 952	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
]	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				1
	Adjusted general inpatient routine service cost per diem (see	-		2, 296. 80	
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra			29, 858 0	39 40
. 00					

Heal th	Financial Systems	IU HEALTH TIPT	ON_HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider (CCN: 15-1311	Period: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
				le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col.		Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units			1			
43.00 44.00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00
	BURN I NTENSI VE CARE UNI T						45.00
	SURGI CAL I NTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (We Total Program inpatient costs (sum of lines			ons)		29, 617 59, 475	
47.00	PASS THROUGH COST ADJUSTMENTS		see matrueti	0113)		37,473	47.00
50.00	Pass through costs applicable to Program inp	oatient routine	services (fro	om Wkst. D, su	m of Parts I and	0	50.00
51.00	III) Pass through costs applicable to Program ing	oatient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
50.00	and IV)	50 1 51	5				
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated. non-nh	ivsician anest	hetist. and	0	
	medical education costs (line 49 minus line						
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)	ing eact and to	ract emount ((line E(minus	Line E2)	0	
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	inget allount (TTHE 53)	0	
59.00	Lesser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996,	updated and c	ompounded by the		
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by the	market basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line	es 55, 59 or 60	enter the les	sser of 50% of	the amount by	0.00	
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 >	< 60), or 1% c	f the target		
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payr	nent (see instru	ctions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of th	ne cost report	ing period (See	0	64.00
(5.00	instructions)(title XVIII only)					0	1 15 00
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost r	eporting period	0	67.00
07.00	(line 12 x line 19)		becchiber of		opor tring porrou	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	ne costs after D	ecember 31 of	f the cost rep	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lir	ne 68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N				``		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	2		•)		70.00
72.00	Program routine service cost (line 9 x line	71)					72.00
73.00 74.00	Medically necessary private room cost applic Total Program general inpatient routine serv						73.00
75.00	Capital-related cost allocated to inpatient				Part II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minu			ade)			78.00
79.00 80.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp	• •			nus line 79)		79.00
81.00	Inpatient routine service cost per diem limi	tation					81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00 83.00
83.00 84.00	Program inpatient ancillary services (see in	•	<i>)</i>				83.00
85.00	Utilization review - physician compensation	(see instructio					85.00
86.00	Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86.00
87.00	Total observation bed days (see instructions					602	87.00
88.00	Adjusted general inpatient routine cost per	•				2, 296. 80	
07. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 382, 674	07.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	805, 765	6, 620, 565	0. 12170	6 1, 382, 674	168, 280	90.00
91.00 Nursing School cost	0	6, 620, 565	0.00000	0 1, 382, 674	0	91.00
92.00 Allied health cost	0	6, 620, 565	0.00000	0 1, 382, 674	0	92.00
93.00 All other Medical Education	0	6, 620, 565	0.00000	0 1, 382, 674	0	93.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1311	Peri od:	Worksheet D-3	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
				10 12/01/2017	6/29/2020 8:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
			1.00	2.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS				2, 536, 399		30.00
ANCI LLARY SERVICE COST CENTERS				2, 550, 577		30.00
50. 00 05000 OPERATING ROOM			0, 1978	37 2, 726, 476	539, 398	50.00
53. 00 05300 ANESTHESI OLOGY			0, 1317			•
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 3375			
60. 00 06000 LABORATORY			0. 4463	79 346, 455	154, 650	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 8113	95 178, 946	145, 196	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 6376	58 293, 243	186, 989	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 58170	08 135, 691	78, 933	67.00
68.00 06800 SPEECH PATHOLOGY			0. 5472	18 13, 352		
69. 00 06900 ELECTROCARDI OLOGY			0. 2481			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 1786			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS			0. 1587			•
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 3709			•
73. 01 03480 ONCOLOGY			0. 3252		0	
76.00 03160 CARDI OPULMONARY			0.0000		0	10.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 6373	91 0	0	76.97
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY			0. 3117	06 11, 802	2 670	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 4652		3,0/9	
200.00 Total (sum of lines 50 through 94 and	96 through 98)		0.4052	9, 638, 110	e e e e e e e e e e e e e e e e e e e	•
201.00 Less PBP Clinic Laboratory Services-Pr		(line 61)		, 030, 110	2, 2, 5, 551	200.00
202.00 Net charges (line 200 minus line 201)	sg. all only ond gos			9, 638, 110		202.00
			1	1 1 2 2 2 1 2 2 2	1	

Health Financial Systems	IU HEALTH TIPTON HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (Period:	Worksheet D-3	3
	Component		From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
	component	0011. 10 2011	10 12/31/2017	6/29/2020 8: 4	
	Titl		Swing Beds - SNF	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x	
		1.00	0.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
ANCI LLARY SERVICE COST CENTERS			0		30.00
50. 00 05000 OPERATING ROOM		0. 19783	7 8, 741	1, 729	50.00
53. 00 05300 ANESTHESI OLOGY		0. 13173		0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33756		2, 709	
60. 00 06000 LABORATORY		0. 44637		8, 362	
65. 00 06500 RESPI RATORY THERAPY		0. 81139	5 20, 748	16, 835	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 63765	8 63, 096	40, 234	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0.58170	8 36, 723	21, 362	67.00
68.00 06800 SPEECH PATHOLOGY		0. 54721			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 24814		217	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 17869		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 15876	· · ·	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 37097		16, 910	
73. 01 03480 ONCOLOGY		0. 32520		894	
76.00 03160 CARDI OPULMONARY		0.00000		0	10100
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 63739	1 0	0	76.97
91.00 OUTPATI ENT_SERVI CE_COST_CENTERS		0.31170	(0	91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 31170	· ·	0	
200.00 Total (sum of lines 50 through 94 and	04 through 00	0. 40522	207,405	-	
200.00 [Total (sull of Thes 50 through 94 and 201.00 [Less PBP Clinic Laboratory Services-Pr			207,405	110, 420	200.00
202.00 Net charges (line 200 minus line 201)	ogram only charges (inte of)		207, 405		201.00
202.00 mot ond gos (Trite 200 minus Trite 201)		1	207,403		1202.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1311	Peri od:	Worksheet D-3	3
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
				10 12/31/2019	6/29/2020 8: 4	
		Ti tl	e 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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				04.047		1 00 00
30. 00 03000 ADULTS & PEDIATRICS				24, 247		30.00
ANCI LLARY SERVI CE COST CENTERS			0. 1978:	37 35, 797	7, 082	50.00
53. 00 05300 ANESTHESI OLOGY			0. 1978.			1
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 33756			
60, 00 06000 LABORATORY			0. 4463		1, 697	
65. 00 06500 RESPIRATORY THERAPY			0. 81139		774	1
66. 00 06600 PHYSI CAL THERAPY			0. 6376			
67. 00 06700 OCCUPATI ONAL THERAPY			0. 58170		405	1
68.00 06800 SPEECH PATHOLOGY			0. 5472		0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0. 24814	438	109	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 1786	96 975	174	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 15876	6 22, 578	3, 585	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 3709	77 15, 650	5, 806	73.00
73. 01 03480 ONCOLOGY			0. 32520	0 0	0	73.01
76. 00 03160 CARDI OPULMONARY			0.0000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 63739	91 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY			0. 31170			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 46522		0	1 2.00
200.00 Total (sum of lines 50 through 94 and				111, 034	29, 617	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges	(II ne 61)		111 024		201.00
202.00 Net charges (line 200 minus line 201)			I	111, 034		202.00

	Financial Systems IU HEALTH TIPTON			u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019		pared:
		Title XVIII	Hospi tal	6/29/2020 8:4 Cost	
			nospi tui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			8, 828, 731	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instruct OPPS payments	i ons)		0	
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)	ti ana)		0.000	4.01
5.00 6.00	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	(TOHS)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	
10.00	Organ acqui si ti ons	V, col. 13, trile 200		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			8, 828, 731	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12.00	Ancillary service charges			0	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0	
14.00	Customary charges				14.00
15.00	Aggregate amount actually collected from patients liable for p			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e		n a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0. 000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete onl	vifling 18 exceeds li	no 11) (soo	0	
19.00	instructions)	y IT THE TO EXCEEds IT	ne 11) (see		19.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			8, 917, 018	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	-		29, 989	
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			4, 961, 240 3, 925, 789	
	instructions)				
28.00 29.00	Direct graduate medical education payments (from Wkst. E-4, li ESRD direct medical education costs (from Wkst. E-4, line 36)	ne 50)		0	28.00 29.00
30.00	Subtotal (sum of lines 27 through 29)			3, 925, 789	
31.00	Primary payer payments			952	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	ES)		3, 924, 837	32.00
	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)			616, 583 400, 779	
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		341, 414	
37.00	Subtotal (see instructions)			4, 325, 616	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructions	.)			39.50
39.97	Demonstration payment adjustment amount before sequestration	ad daviana (ana inatru	+:	0	
39. 98 39. 99	Partial or full credits received from manufacturers for replac RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see institut	trons)	0	39.98 39.99
40.00	Subtotal (see instructions)			4, 325, 616	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			86, 512	1
40.02	Sequestration adjustment-PARHM pass-throughs				40.02
	Interim payments			3, 813, 811	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			425, 293	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordan §115.2	ce with CMS Pub. 15-2,	chapter 1,	0	
00.00	TO BE COMPLETED BY CONTRACTOR			^	
90.00 91.00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00
00				. 0	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C	CN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Pre 6/29/2020 8:4	pared:
		Title	XVIII	Hospi tal	Cost	1 am
		Inpatien			't B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each		4, 246, 04	18 0	3, 041, 011 0	1.00 2.00 3.00
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	08/14/2019	114, 90	0 08/14/2019	772, 800	3.0
3.01	ADJUSTWENTS TO PROVIDER	06/14/2019	114, 90	0 08/14/2019	112,800	3.02
3.03				0	Ő	3.03
3.04				0	0	3.04
3.05				0	0	3.05
	Provider to Program		[-		
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	
3.51				0	0	3.5
3.52				0	0	
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		114, 90	00	772, 800	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4, 360, 94	18	3, 813, 811	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5.0
5.02 5.03				0	0	
5.05	Provider to Program			<u> </u>	0	3.0
5.50	TENTATI VE TO PROGRAM			0	0	5.5
5.51				0	0	
5.52				0	0	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
5.00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5. 01	SETTLEMENT TO PROVIDER		367, 54	14	425, 293	6.0
5. 02	SETTLEMENT TO PROGRAM		307, 32	0	423, 273	6.0
7.00	Total Medicare program liability (see instructions)		4, 728, 49	92	4, 239, 104	
				Contractor Number	NPR Date (Mo/Day/Yr)	
)	1.00	2.00	

IALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1311 CCN: 15-Z311	Period: From 01/01/201 To 12/31/201		
					6/29/2020 8:4	
				Swing Beds - SN		
		I npati en	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	1100	449, 7		0	1.0
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program			- 1	1	
50	ADJUSTMENTS TO PROGRAM			0	0	-
51				0	0	-
52				0	0	-
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	
//	3, 50-3, 98)			0	0	.
00	Total interim payments (sum of lines 1, 2, and 3.99)		449, 7	75	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
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					
01	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program			- 1		
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
77	5. 50-5. 98)			0	0	5
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
D1	SETTLEMENT TO PROVIDER		61, 64	95	0	6
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		511, 4		0	7
				Contractor	NPR Date	
			`	Number	(Mo/Day/Yr)	
		()	1.00	2.00	1

Heal th	Financial Systems IU HEALTH TIPTO	N HOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part II Date/Time Pre 6/29/2020 8:4	pared:	
		Title XVIII	Hospi tal	Cost		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			1	
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00						
3.00	3.00 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,	8-12			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	line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of 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	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00	

ALCULATI	nancial Systems IU HEALTH TIPTON HO ON OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pr	rovider CCN: 15-1311	Peri od:	u of Form CMS-2 Worksheet E-2	
	Ca	omponent CCN: 15-Z311	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:4	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
0			1.00	2.00	
	MPUTATION OF NET COST OF COVERED SERVICES patient routine services - swing bed-SNF (see instructions)		417, 558	0	1.0
	patient routine services - swing bed-SNF (see instructions)		417, 556	0	2.0
	cillary services (from Wkst. D-3, col. 3, line 200, for Part /	A and sum of Wkst D	111, 524	0	3.0
	rt V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-			0	5.0
	structions)	bed pass through, se			
1	rsing and allied health payment-PARHM (see instructions)				3.0
.00 Pe	r diem cost for interns and residents not in approved teaching	g program (see		0.00	4.0
in	structions)				
	ogram days		180	0	
	terns and residents not in approved teaching program (see ins			0	
	ilization review - physician compensation - SNF optional metho	od only	0	-	7.0
	btotal (sum of lines 1 through 3 plus lines 6 and 7)		529, 082	0	
	imary payer payments (see instructions)		E20,002	0	9.0 10.0
	btotal (line 8 minus line 9) ductibles billed to program patients (exclude amounts applical	alo to physician	529, 082	0	11.0
	ofessional services)	bre to physiciali	0	0	
	btotal (line 10 minus line 11)		529, 082	0	12.0
	insurance billed to program patients (from provider records)	(exclude coinsurance	8, 014	0	
	r physician professional services)		0,011		
	% of Part B costs (line 12 x 80%)			0	14.0
5.00 Su	btotal (see instructions)		521, 068	0	15.0
6.00 OT	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.0
6.50 Pi	oneer ACO demonstration payment adjustment (see instructions)				16.5
	ral community hospital demonstration project (§410A Demonstra	tion) payment	0		16.5
	justment (see instructions)			-	
	monstration payment adjustment amount before sequestration		0	0	
	lowable bad debts (see instructions)		1, 292	0	17.0
	justed reimbursable bad debts (see instructions)	stions)	840 0	0	
	lowable bad debts for dual eligible beneficiaries (see instructal (see instructions)	Strons)	521, 908	0	
	questration adjustment (see instructions)		10, 438	0	
	monstration payment adjustment amount after sequestration)		10, 430	0	
	questration adjustment-PARHM pass-throughs		0	0	19.0
1	terim payments		449, 775	0	
	terim payments-PARHM				20.0
1.00 Te	ntative settlement (for contractor use only)		0	0	21.0
1.01 Te	ntative settlement-PARHM (for contractor use only)				21.0
1	lance due provider/program (line 19 minus lines 19.01, 20, and	d 21)	61, 695	0	
	lance due provider/program-PARHM (see instructions)				22.0
	otested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23.0
	apter 1, §115.2				-
	ral Community Hospital Demonstration Project (§410A Demonstrat this the first year of the current 5-year demonstration perio				200.0
	ntury Cures Act? Enter "Y" for yes or "N" for no.	bu under the 213t			200.0
	st Reimbursement				
	dicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201.0
66	(title XVIII hospital))				
02.00 Me	dicare swing-bed SNF inpatient ancillary service costs (from \	Wkst. D-3, col. 3, li	ne		202.0
	0 (title XVIII swing-bed SNF))				
1	tal (sum of lines 201 and 202)				203.0
	dicare swing-bed SNF discharges (see instructions)				204.0
	mputation of Demonstration Target Amount Limitation (N/A in fi riod)	rst year of the curre	ent 5-year demons	tration	
	dicare swing-bed SNF target amount				205.0
1	dicare swing bed SNF inpatient routine cost cap (line 205 time	es line 204)			206.0
	ustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursen				1
	ogram reimbursement under the §410A Demonstration (see instruc				207.0
	dicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		208.0
	d 3)				
1	justment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209.0
10.00 Re	served for future use	·			210.0
	mparision of PPS versus Cost Reimbursement				
1E 00 To	tal adjustment to Medicare swing-bed SNF PPS payment (line 20	9 plus line 210) (see			215.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Period: From 01/01/2019 To 12/31/2019		pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	E PART A SERVICES - COS		1.00	
00	Inpatient services		T RETWOORSEWENT	5, 088, 537	1 1
00	Nursing and Allied Health Managed Care payment (see instructi	ions)		0,000,007	
00	Organ acquisition			0	
00	Subtotal (sum of lines 1 through 3)			5, 088, 537	
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 139, 422	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				1
00	Routine service charges			0	7
00	Ancillary service charges			0	8
00	Organ acquisition charges, net of revenue			0	9
0. 00	Total reasonable charges			0] 10
	Customary charges				
I. 00	Aggregate amount actually collected from patients liable for	1 5	9	0	
2.00	Amounts that would have been realized from patients liable for		on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13(e	e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
. 00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (complete or	nly if line 14 exceeds l	ine 6) (see	0	15
<i>(</i> 00	instructions)			0	
6.00	Excess of reasonable cost over customary charges (complete or	niy if line 6 exceeds li	ne 14) (see	0	16
7.00	instructions) Cost of physicians' services in a teaching hospital (see ins	tructions)		0	17
7.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ''
B. 00	Direct graduate medical education payments (from Worksheet E-	-4 line 49)		0	1 18
7.00 7.00	Cost of covered services (sum of lines 6, 17 and 18)	-, iffic +7)		5, 139, 422	
). 00	Deductibles (exclude professional component)			336, 788	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			4, 802, 634	
3.00	Coinsurance			12, 958	
1.00	Subtotal (line 22 minus line 23)			4, 789, 676	24
5.00	Allowable bad debts (exclude bad debts for professional servi	ices) (see instructions)		54, 332	25
5.00	Adjusted reimbursable bad debts (see instructions)			35, 316	26
7.00	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		21, 680	27
3.00	Subtotal (sum of lines 24 and 25, or line 26)			4, 824, 992	28
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
9.50	Pioneer ACO demonstration payment adjustment (see instruction			0	
9.99	Demonstration payment adjustment amount before sequestration			0	1
0. 00	Subtotal (see instructions)			4, 824, 992	
). 01	Sequestration adjustment (see instructions)			96, 500	
0. 02	Demonstration payment adjustment amount after sequestration			0	30
). 03	Sequestration adjustment-PARHM				30
. 00	Interim payments			4, 360, 948	
	Interim payments-PARHM			_	31
2.00	Tentative settlement (for contractor use only)			0	
2.01	Tentative settlement-PARHM (for contractor use only)			0/7 511	32
3.00	Balance due provider/program (line 30 minus lines 30.01, 30.0			367, 544	
3. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, r Protested amounts (nonallowable cost report items) in accorda			0	33
1.00					

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2019	Worksheet G	2552-
ly)			То	0 12/31/2019	6/29/2020 8:4	
		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	29, 110, 122	0	0	0	1.
00	Temporary investments	0	0	0	0	2.
00 00	Notes receivable Accounts receivable	0 2, 931, 921	0	0	0	3. 4.
00	Other receivable	-1, 133, 802	0	0	0	4. 5.
00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.
00	Inventory	720, 147	0	0	0	7.
00	Prepaid expenses	211, 789	0	0	0	8.
00	Other current assets	0	0	0	0	9.
	Due from other funds	0	0	0	0	10
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	31, 840, 177	0	0	0	11
. 00	Land	0	0	0	0	12
	Land improvements	0	0	0	0	13.
	Accumulated depreciation	0	0	0	0	14
. 00	Buildings	7, 712, 716	0	0	0	15
	Accumulated depreciation	0	0	0	0	16
	Leasehold improvements	2, 872, 457	0	0	0	17
	Accumulated depreciation	-1, 274, 332		0	0	18
	Fixed equipment Accumulated depreciation	0	0	0	0	19 20
	Accumulated deplectation Automobiles and trucks		0	0	0	20
	Accumulated depreciation	0	0	0	0	22
	Major movable equipment	13, 208, 367	0	0	0	23
	Accumulated depreciation	-10, 347, 252	0	0	0	24
	Minor equipment depreciable	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
	Minor equipment-nondepreciable	10 171 054	0	0	0	29
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	12, 171, 956	0	0	0	30
	Investments	886, 098	0	0	0	31
	Deposits on leases	0	0	0	0	32
. 00	Due from owners/officers	0	0	0	0	33
	Other assets	14, 567, 903		0	0	34
	Total other assets (sum of lines 31-34)	15, 454, 001	0	0	0	35
	Total assets (sum of lines 11, 30, and 35)	59, 466, 134	0	0	0	36
	CURRENT LIABILITIES Accounts payable	1, 485, 000	0	0	0	37
	Salaries, wages, and fees payable	1, 125, 939	-	0	0	38
	Payrol taxes payable	0	0	0	0	39
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	41
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	
	Other current liabilities	2, 572, 695		0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	5, 183, 634	0	0	0	45
. 00	Mortgage payable	0	0	0	0	46
	Notes payable	13, 855, 002	0	0	0	40
	Unsecured Loans	13, 033, 002	0	0	0	48
	Other long term liabilities	740, 614	0	0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	14, 595, 616	0	0	0	50
00	Total liabilities (sum of lines 45 and 50)	19, 779, 250	0	0	0	51
	CAPI TAL ACCOUNTS					
	General fund balance	39, 686, 884				52
	Specific purpose fund		0			53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55 56
	Plant fund balance - invested in plant			0	0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	39, 686, 884	0	0	0	59

	Financial Systems	IU HEALTH TIPTO				u of Form CMS-	
STATE	IENT OF CHANGES IN FUND BALANCES		Provider C	CN: 15-1311	Period: From 01/01/2019 To 12/31/2019		epared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) UNRESTRICTED FUND BALANCE PERM RESTRICTED TEMP RESTRICTED	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	36, 848, 709 4, 147, 226 40, 995, 935 40, 995, 935 0 40, 995, 935				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 deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 Endowment Fund	1, 309, 051 39, 686, 884 Pl ant	Fund	0 0 0) 17.00 18.00 19.00
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		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) UNRESTRICTED FUND BALANCE PERM RESTRICTED TEMP RESTRICTED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

Heal th	Fir	nanc	i al	Syst	ems	
STATEM		OF	DAT		DEVENILIES	

In Lieu of Form CMS-2552-10

STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1311	Period: From 01/01/20 To 12/31/20		epared:
	Cost Center Description		I npati ent	Outpati ent		
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					-
	General Inpatient Routine Services					
1.00	Hospi tal		4, 301, 4	99	4, 301, 499	1
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF		162, 0	/0	162, 070	1
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		4 4/0 5	(0)		9.00
10.00	Total general inpatient care services (sum of lines 1-9)		4, 463, 50	69	4, 463, 569	10.00
11 00	Intensive Care Type Inpatient Hospital Services		1			111 00
						11.00
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT					12.00
	SURGICAL INTENSIVE CARE UNIT					13.00
						14.00
	OTHER SPECIAL CARE (SPECIFY) Total intensive care type inpatient hospital services (sum c	flines		0	0	1
	11-15)					
	Total inpatient routine care services (sum of lines 10 and 1	6)	4, 463, 5		4, 463, 569	1
	Ancillary services		18, 658, 3			
	Outpatient services		455, 83			1
	RURAL HEALTH CLINIC			0	0 0	
	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	
	HOME HEALTH AGENCY					22.00
	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
	AMBULATORY SURGICAL CENTER (D. P.)					25.00
	HOSPI CE			0 540 /		26.00
	PHYSI CI AN REVENUE	0 1 1 111 1	00 577 7	0 2, 512, 6		
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	3 to wkst.	23, 577, 79	93 81, 617, 0	31 105, 194, 824	28.00
	PART II - OPERATING EXPENSES		1	1	- 1	
	Operating expenses (per Wkst. A, column 3, line 200)			39,009,4	25	29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)				0	36.00
	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00	Tatal deductions (our of lines 27 (1)			0		41.00
42.00	Total deductions (sum of lines 37-41)	(1) (transfer		20,000,4	0	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42) (transfer		39, 009, 4	20	43.00
	to Wkst. G-3, line 4)		I	I	I	I

Heal th	Financial Systems	J HEALTH TIPTON	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES		Provider CCN: 1	15-1311	Period:	Worksheet G-3	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
					10 12/31/2017	6/29/2020 8: 4	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I,					105, 194, 824	1.00
2.00	Less contractual allowances and discounts on pa	atients' accoun [.]	ts			64, 424, 936	2.00
3.00	Net patient revenues (line 1 minus line 2)					40, 769, 888	3.00
4.00	Less total operating expenses (from Wkst. G-2,		43)			39, 009, 425	4.00
5.00	Net income from service to patients (line 3 min	nus line 4)				1, 760, 463	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	s communication	servi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
	Purchase di scounts					0	10.00
	Rebates and refunds of expenses					0	11.00
	Parking lot receipts					0	12.00
	Revenue from laundry and linen service					0	13.00
	Revenue from meals sold to employees and guests	S				0	14.00
	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical suppl		nan patrents			0	16.00
	Revenue from sale of drugs to other than patien					0	
	Revenue from sale of medical records and abstra					0	
	Tuition (fees, sale of textbooks, uniforms, etc					0	19.00
	Revenue from gifts, flowers, coffee shops, and	canteen				0	20.00
	Rental of vending machines					0	21.00
	Rental of hospital space					0	22.00
	Governmental appropriations					0	23.00
	MI SCELLANEOUS I NCOME					2, 386, 763	
	Total other income (sum of lines 6-24)					2, 386, 763	
	Total (line 5 plus line 25)					4, 147, 226	
	OTHER EXPENSES (SPECIFY)					0	27.00
	Total other expenses (sum of line 27 and subsci					0	28.00
29.00	Net income (or loss) for the period (line 26 mi	inus line 28)				4, 147, 226	29.00