PART I - COST	REPORT STATUS		
Provi der	1.[X]Electronically filed cost report	Date: 5/24/2017 T	Time: 10:02 am
use only	2. [] Manually submitted cost report		
	3. [0] If this is an amended report enter the number of times the provider 4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	resubmitted this cost repo	ort
Contractor use only		D. NPR Date: L'Contractor's Vendor Code: 2. [0]If line 5, column 1 number of times reop	is 4: Enter

PART II - CERTIFICATION

MISREPRESENTATION OF 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY 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 01/01/2016 and ending 12/31/2016 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.

(Si aned)

Officer or Administrator of Provider(s)

In Lieu of Form CMS-2552-10

Worksheet S

Parts I-III

OMB NO. 0938-0050 EXPIRES 05-31-2019

Date/Time Prepared: 5/24/2017 10:02 am

PRESI DENT

Title

05/25/2017 Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-162, 820	-233, 830	1	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	-239, 894	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-402, 714	-233, 830	1	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.

HOSPITAL AND HOSPITAL HEAD HOSPITAL and HOSPITAL HEAD 1.00 Street: 1000 SOUTH M 2.00 City: TIPTON	1.00				er CCN: 1		Period: From 01/01		Part I	eet S-2	
1.00 Street: 1000 SOUTH M	1 00						To 12/31	/2016			pared:
1.00 Street: 1000 SOUTH M		2	00		3.00			4.00	5/24/20	017 9:1	0 am
		omplex Address:									
2.00 CITY: ITPION	AIN STREET	PO Box:	NI 7		4/070	0					1.00
		State: I Component Na		ip Code CCN	CBSA	Provi der	ty: TIPTON Date	Payme	nt Syst	em (P.	2.00
				umber	Number	Туре	Certi fi ed		0, or		
							5.00	V	XVIII	XIX	-
Hospital and Hospit	al-Based Componer	1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	-
3.00 Hospital		IU HEALTH TIPTON		51311	99915	1	11/12/2005	N	0	0	3.00
		HOSPI TAL									1.00
4.00 Subprovider - IPF 5.00 Subprovider - IRF											4.00
6.00 Subprovider - (Othe	r)										6.00
7.00 Swing Beds - SNF		IU HEALTH TIPTON	1	5Z311	29020		11/12/2005	N	0	N	7.00
8.00 Swing Beds - NF		HOSPI TAL									8.00
9.00 Hospital -Based SNF											9.00
10.00 Hospital -Based NF											10.00
11.00 Hospi tal -Based OLTC 12.00 Hospi tal -Based HHA											11.00
13.00 Separately Certifie	d ASC										13.00
14.00 Hospital-Based Hosp											14.00
15.00 Hospital-Based Heal 16.00 Hospital-Based Heal											15.00 16.00
17.00 Hospital-Based (CMH											17.00
18.00 Renal Dialysis											18.00
19.00 Other							From		Tc		19.00
							1.00		2.0		1
20.00 Cost Reporting Peri							01/01/2		12/31		20.00
21.00 Type of Control (se							2				21.00
22.00 Does this facility		currently receiv	/ing pavmer	nts for	di sprop	ortionate	N		N	1	22.00
share hospital adju	stment, in accord	lance with 42 CFR	§412.106?	In col	umn 1,	enter "Y"					
for yes or "N" for amendment hospital?					2.106(c)	(2) (Pi ckl	e				
22.01 Did this hospital r					s cost r	eportina	N		Ν	I	22.01
period? Enter in co	lumn 1, "Y" for y	ves or "N" for no	for the po	ortion d	of the c	ost					
reporting period oc	0.				2						
for no for the port (see instructions)	I UN UN LINE CUSE I	eporting period c				ODEL 1.					
22.02 Is this a newly mer							N		Ν	I	22. 02
determined at cost or "N" for no, for		•	,			2	S				
in column 2, "Y" fo							n				
or after October 1.	5	·				•					
22.03 Did this hospital r of the OMB standard									Ν	1	22.03
in column 1, "Y" fo											
prior to October 1.							е				
cost reporting peri hospital contain at							h				
42 CFR 412. 105)? En				Junteu i	II accor	uance wit	"				
23.00 Which method is use								3	Ν	I	23.00
1, enter 1 if date method of identifyi		J .			3						
used in the prior c											
			In-State Medicaid	In-St)ut-of		Medicai HMO dav		ther	
			paid days	Medic eligi		State edi cai d	State Medi cai d	nivio uag	·	di cai d days	
			1	unpa			eligible			j.	
			4.00	day		2.00	unpai d	F 00			-
24.00 If this provider is	an LPPS hosnital	. enter the	1.00	2.0	0	3.00	4.00	5.00	0	<u>5.00</u> 0	24.00
in-state Medicaid p				-1	Ĭ				Ĩ	0	
Medicaid eligible u											
out-of-state Medica out-of-state Medica											
4, Medicaid HMO pai											
column 5, and other	Medicaid days in	n column 6.				_	_				0.5
25.00 f this provider is			(0	0	0		0		25.00
Medicaid naid dave											
Medicaid paid days Medicaid eligible u											
Medicaid eligible u out-of-state Medica	id days in columr	13, out-of-state									
Medicaid eligible u	id days in columr npaid days in col	1 3, out-of-state umn 4, Medicaid									

	Financial Systems IU HEAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		ON HOSPITAL Provider CC		eriod:	eu of Form CMS Worksheet S-	
					rom 01/01/2016 o 12/31/2016	Date/Time Pr	
					Urban/Rural S	5/24/2017 9: Date of Geog	
5.00	Enter your standard assanabile allossification (act w		tuo at the hea	inning of the	1.00	2.00	26.0
	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. age) sta	itus at the end	l of the cost		2	27.0
5. 00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	cati on	in column 2.			D	35. C
					Begi nni ng:	Endi ng:	
00	Enter applicable beginning and ending dates of SCH st	atus S	Subseriet Line	26 for number	1.00	2.00	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	es.	·		(D	37. (
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo				N		37.
. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.</pre>						38.
					Y/N	Y/N	
9.00	Does this facility qualify for the inpatient hospital	navmer	t adjustment f	for low volume	1.00 N	2.00 N	39. (
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Ente quiremer or "N"	er in column 1 nts in accordan for no. (see i	"Y" for yes ice with 42 nstructions)			
. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. E	Enter "Y" for y		N	N N	40.
					1.0	XVIII XIX 0 2.00 3.00	
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for c	li sproporti onat	e share in ac	cordance N	N N	45.
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N N	46.
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N N N	47. 48.
. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y"	for yes N		56.
. 00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or th of th (", comp	"N" for no in his cost report blete Worksheet	i column 1. If ing period?	column 1 Enter "Y"		57.
. 00	If line 56 is yes, did this facility elect cost reimb	oursemer	nt for physicia	ins' services a	as		58.
. 00	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.	N		59.
. 00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"				N N		60.
	provider-operated criteria under 3413.03: Enter i	Y/N	I ME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	-
00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	Ν			0.00	0 0.	00 61.
. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0.00	0.0	d		61.
02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	0.0	d		61.
03	and primary care FTEs added under section 5503 of ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0.0	d		61.
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00				61.
	Enter the difference between the baseline primary		0.00	0.0	þ		61.

OSPI T	AL AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	TA	Provider CC		eriod: com 01/01/2016 o 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/24/2017 9:1	pared
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
. 06	Enter the amount of ACA §5503 aw used for cap relief and/or FTEs care or general surgery. (see in	that are nonprimary		0.00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
10		<u> </u>		1.00	2.00	3.00	4.00	
. 10	Of the FTEs in line 61.05, speci specialty, if any, and the numbe for each new program. (see instr column 1, the program name, ente program code, enter in column 3, unweighted count and enter in co FTE unweighted count.	r of FTE residents uctions) Enter in r in column 2, the the IME FTE				0.00	0.00	61.
. 20	Of the FTEs in line 61.05, speci program specialty, if any, and t residents for each expanded prog instructions) Enter in column 1, enter in column 2, the program c 3, the IME FTE unweighted count 4, direct GME FTE unweighted cou	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.
							1.00	-
	ACA Provisions Affecting the Hea							
2.00	Enter the number of FTE resident your hospital received HRSA PCRE	funding (see instruc	ctions)					62.
2. 01	01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62. during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 0.00) 62.
8. 00	Has your facility trained reside "Y" for yes or "N" for no in col	nts in nonprovider se	ettings	during this co		eriod? Enter	N	63.
					Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Base Yea							
. 00	period that begins on or after J Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trair -primar all nor מ non-pr ו columr	ned residents ry care nprovider rimary care n 3 the ratio	0.00	0.00	0. 000000	64.
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00 0.000000	1
. 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				0.00	0.00		

Heal th	Financial Systems		TH TIPTON HOSPITAL			eu of Form CMS-2	
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2016 p 12/31/2016		pared:
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider Setting	1.00 sEffective fo	2.00 pr cost report	3.00 ing periods	
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. Ty care resident 3 the ratio of	0. 00	0.00	0. 000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
(7.00	Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00	(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.0	0. 000000	
					1.0	0 2.00 3.00	
	Inpatient Psychiatric Facility P					0 2.00 3.00	
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, indi (see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii)	oproved GME teaching 004? Enter "Y" for y lity train residents (D)? Enter "Y" for y	, program in the es or "N" for r in a new teach es or "N" for r	most no. (see ni ng no.	0	70.00
	Inpatient Rehabilitation Facilit	y PPS					
75.00	Is this facility an Inpatient Re		(IRF), or does it c	ontain an IRF	N		75.00
76.00	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate which program year bega	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	mber 15, 2004? Enter new teaching program for no. Column 3: If	"Y" for yes or in accordance column 2 is Y,	"N" for with 42	0	76.00
						1.00	
00.00	Long Term Care Hospital PPS		for the little of			1	00.00
	Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers				period? Enter	N N	80.00 81.00
	Is this a new hospital under 42					N	85.00
86.00	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo			42 CFR Section	1		86.00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			(1)(B)(iv)(II)?	'Enter "Y"	N	87.00
					V	XI X	
	Title V and XIX Services				1.00	2.00	
90.00	Does this facility have title V yes or "N" for no in the applica		hospital services? E	nter "Y" for	N	Y	90.00
91.00	Is this hospital reimbursed for	title V and/or XIX th			Ν	N	91.00
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ing title XVIII SNF b	eds (dual certificat			N	92.00
93.00	instructions) Enter "Y" for yes Does this facility operate an IC			d XIX? Enter	N	N	93.00
	"Y" for yes or "N" for no in the Does title V or XIX reduce capit	applicable column.			N	N	94.00
74.00	applicable column.					IV	/ . 00

Health Financial Systems IU HEALTH TIP HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TON HOSPITAL Provider CO	1	Period: From 01/01/2 To 12/31/2	2016	u of Form Workshee Part I Date/Tim 5/24/201	et S-2 ne Pre	pared:
			V		XIX		
			1.00		2.00		05.6
 95.00 If line 94 is "Y", enter the reduction percentage in the ap 96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column. 			0. 00 N		0. 00 N)	95.00 96.00
07.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers	•	1.	0.00		0.00)	97.00
05.00 Does this hospital qualify as a critical access hospital (C 06.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		nod of payment	Y N				105.00 106.00
07.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see insti	ructions) If	N				107.00
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		Dessia	.	108.00
	Physi cal 1.00	Occupational 2.00	Speech 3.00	1	Respi ra 4.00		-
109.00 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.		N	N		N	, 	109.00
10.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (41	OA Demo)for	,	1.00 N)	110. 00
			-	1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide	2. If column 2 i ent for long ter	is "E", enter rm care (inclu	in column des	N		0	115. 0
Pub. 15-1, chapter 22, §2208. 1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu			"N" for	N N			116. 0 117. 0
no. 18.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1 i	f the policy	is	1			118. 0
		Premi ums	Losses	;	Insura	nce	
10 Othist arounts of relaractics provides and raid losses		1.00	2.00	0	3.00) 118. 0 [°]
18.01 List amounts of malpractice premiums and paid losses:		55,88		0			-
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche and amounts contained therein.			1.00 N		2.00)	118.0
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i	n column 1, "Y	' for yes or	N		Ν		119.0 120.0
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no.							
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl	ents? (see instr	ructions)	Y				121. 0
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t	ents? (see instr antable devices ? Enter "Y" for	ructions) s charged to yes or "N"	Y Y		5.03	3	
"N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	nts? (see inst antable devices P Enter "Y" for the Worksheet A	ructions) s charged to yes or "N" line number			5. 03	}	122. 0
 "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 20.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, e 	nts? (see inst antable devices ? Enter "Y" for the Worksheet A for yes and "N" enter the certif	ructions) s charged to yes or "N" line number for no. If	Y		5. 03	}	122. 0 125. 0
 "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 	nts? (see instr antable devices P Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2.	ructions) s charged to yes or "N" line number for no. If fication date cation date	Y		5. 03	3	121. 00 122. 00 125. 00 126. 00 127. 00
 "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 	nts? (see inst antable devices P Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2. ther the certifi 2. ther the certifi 2.	ructions) s charged to yes or "N" line number for no. If fication date cation date	Y N		5. 03	3	122. 0 125. 0 126. 0 127. 0 128. 0
 "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 1. 127.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1. 128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1. 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1. 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1. 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 1. 129.00 If this is a Medicare certified lung transplant center, entin column 1 and termination date, if applicable, in column 1. 	ents? (see insti- antable devices 2 Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2. ther the certifi 2. ther the certific enter the certific	ructions) s charged to yes or "N" line number for no. If fication date cation date cation date in	Y N		5. 03	3	122. 0 125. 0 126. 0
 "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant cen	ents? (see insti- antable devices P Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2. ther the certifi 2. ther the certifi 2. enter the certifi	ructions) s charged to yes or "N" line number for no. If fication date cation date cation date in tification	Y N		5. 03	3	122. 00 125. 00 126. 00 127. 00 128. 00 129. 00

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX ID	IU HEALTH TIPTO ENTIFICATION DATA	DN HOSPITAL Provider CC		In Li Period: From 01/01/201 To 12/31/201		pared:
						-
122 00 LE this is a Madisons contified athen	trananiant contar ant	on the contifi	aati an data	1.00	2.00	122.00
133.00 If this is a Medicare certified other in column 1 and termination date, if a			cation date			133.00
134.00 If this is an organ procurement organi and termination date, if applicable, i	zation (OPO), enter th		n column 1			134.00
All Providers		final in CMC		Y	1511050	140.00
140.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" f are claimed, enter in column 2 the hom	or no in column 1. If	yes, and home	office costs		15H059	140.00
1.00	2.00			3.00		
If this facility is part of a chain or				ame and address	s of the	
home office and enter the home office 141.00 Name: INDIANA UNIVERSITY HEALTH	<u>contractor name and co</u> Contractor's Name: WPS			or's Number: 08	101	141.00
142.00 Street: 340 WEST 10TH STREET	PO Box:)			101	142.00
143.00 City: INDIANAPOLIS	State: IN		Zip Code:	462	202	143.00
		2			1.00	111.00
144.00 Are provider based physicians' costs i	ncluded in Worksheet A	?			Y	144.00
				1.00	2.00	-
145.00 If costs for renal services are claime	d on Wkst. A, line 74,	are the costs	for	Y	2100	145.00
inpatient services only? Enter "Y" for no, does the dialysis facility include period? Enter "Y" for yes or "N" for	yes or "N" for no in Medicare utilization no in column 2.	column 1. If c for this cost	olumn 1 is reporting			
146.00 Has the cost allocation methodology ch Enter "Y" for yes or "N" for no in col yes, enter the approval date (mm/dd/yy	umn 1. (See CMS Pub. 1			N		146.00
					1.00	1
147.00 Was there a change in the statistical	basis? Enter "Y" for y	es or "N" for	no.		N	147.00
148.00 Was there a change in the order of all		5			N	148.00
149.00 Was there a change to the simplified c	ost finding method? En				N	149.00
	-	Part A 1.00	<u>Part B</u> 2.00	Title V 3.00	<u>Title XIX</u> 4.00	-
Does this facility contain a provider	that qualifies for an					
or charges? Enter "Y" for yes or "N" f						
155.00 Hospi tal		N	N	N	N	155.00
156.00 Subprovider - IPF		N	N	N	N	156.00
157.00 Subprovider - IRF		N	N	N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N	Ν	N	N	158.00 159.00
160.00 HOME HEALTH AGENCY		N	N	N	N	160.00
161.00 CMHC			N	N	N	161.00
					1.00	
Multicampus 165.00 s this hospital part of a Multicampus	hospital that has one	or more campu	ses in diffe	rent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State Zi	p Code CBSA	FTE/Campus	
	0	1.00		3.00 4.00	5.00	-
166.00 If line 165 is yes, for each		1.00	2.00	1.00		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						
column 5 (see instructions)						
	1					
					1.00	
Heal th Information Technology (HIT) in				t Act	V	147 00
167.00 Is this provider a meaningful user und 168.00 If this provider is a CAH (line 105 is				enter the	Y	167.00 1168.00
reasonable cost incurred for the HIT a			, , , , , , , , , , , , , , , , , , ,			
168.01 If this provider is a CAH and is not a	meaningful user, does	this provider		a hardship		168.01
exception under §413.70(a)(6)(ii)? Ent						
169.00 If this provider is a meaningful user transition factor. (see instructions)	(IINE 16/ IS "Y") and	is not a CAH (iine 105 is '	א"), enter the	0.00	169.00

Health Financial Systems IU	J HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATI	ON DATA	Provider CCN: 15-1311	Period: From 01/01/2016	Worksheet S-2 Part I	2
			To 12/31/2016		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning date period respectively (mm/dd/yyyy)	10/01/2016	12/31/2016	170.00		
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have any section 1876 Medicare cost plans reported on Wks "Y" for yes and "N" for no in column 1. If colum 1876 Medicare days in column 2. (see instruction	st. S-3, Pt. I, mn 1 is yes, en	line 2, col. 6? Enter	n	77	171.00

SPI T	Financial Systems IU HEALTH TIPTON AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	HOSPITAL Provider C	CN: 15-1311	Period: From 01/01/2016	w of Form CMS- Worksheet S-2 Part II	
				To 12/31/2016	Date/Time Pre 5/24/2017 9:1	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N fo	or all NO ro	sponsos Entr	1.00	2.00	-
	mm/dd/yyyy format.		sponses. Ente		line	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation				-	
00	Has the provider changed ownership immediately prior to the b			N		1
	reporting period? If yes, enter the date of the change in col	umn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare Pro yes, enter in column 2 the date of termination and in column		N	2.00	0.00	2
	voluntary or "I" for involuntary.	-				
00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home off	ices, drug	Y			3
	or medical supply companies) that are related to the provider officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certif	iod Public	Y	С	03/25/2016	
50	Accountant? Column 2: If yes, enter "A" for Audited, "C" for or "R" for Reviewed. Submit complete copy or enter date avail	Compiled,	Y	C	0372572016	
	column 3. (see instructions) If no, see instructions.					
00	Are the cost report total expenses and total revenues differe		N			
	those on the filed financial statements? If yes, submit recon	ciliation.		Y/N	Legal Oper.	
				1.00	2.00	+
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: I	fyes, is th	ne provider is	s N		(
	the legal operator of the program?					
00 00	Are costs claimed for Allied Health Programs? If "Y" see inst Were nursing school and/or allied health programs approved an		during the	N		8
00	cost reporting period? If yes, see instructions.	u/or renewed	a dui ring the	IN		
00	Are costs claimed for Interns and Residents in an approved gr	aduate medic	cal education	Ν		9
	program in the current cost report? If yes, see instructions.					
. 00	Was an approved Intern and Resident GME program initiated or	renewed in t	the current	N		10
00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & Teaching Program on Worksheet A? If yes, see instructions.	R in an App	proved	Ν		1
	readining fregram on workdidet A. Triges, see first detroits.				Y/N 1.00	
	Bad Debts					
00 00	Is the provider seeking reimbursement for bad debts? If yes, If line 12 is yes, did the provider's bad debt collection pol	see instruct icy change c	tions. during this co	ost reporting	Y Y	1:
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payment Bed Complement	s waived? If	°yes, see ins	structions.	Ν	14
00	Did total beds available change from the prior cost reporting		yes, see inst rt A		N T B	1!
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
00	PS&R Data	N	1			
00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Ν		N		10
00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	04/03/2017	Y	04/03/2017	1
	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		N		18
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.	Ν		N		19

Health Financial Systems

IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provi der C	1	Period: From 01/01/2016 Fo 12/31/2016	Worksheet S-2 Part II Date/Time Pre 5/24/2017 9:	2 epared:
			iption	Y/N	Y/N	
20,00	LE Line 1/ og 17 is were adjustmente mede to DCAD	(0	1.00	3.00	20.00
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	
		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	l	1		
_	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPLTALS)		1.00	
	Capital Related Cost					
	Have assets been relifed for Medicare purposes? If yes, se				Ν	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made durir	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter	ed into during	this cost repo	orting period?	Ν	24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during	the cost renor	ting period?	f ves see	Ν	25.00
	instructions.	5	N.			
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during th	/es, submit	Ν	27.00		
	copy. Interest Expense					
28.00	Were new Loans, mortgage agreements or letters of credit e	ntered into dur	ing the cost r	reporting	Ν	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (De	bt Service Res	serve Fund)	Ν	29.00
	treated as a funded depreciation account? If yes, see inst	ructions		,	N	20.00
30.00	Has existing debt been replaced prior to its scheduled mat instructions.	unity with new	debt? IT yes,	See	Ν	30.00
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? If yes,	see	Ν	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		d through cont	ractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ig to competiti	ve bidding? If		33.00
	no, see instructions. Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an a	rrangement with	provi der-base	ed physi ci ans?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	isting agreemen	ts with the pr	rovi der-based	Ν	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been p	ropared by the	home office?	Y Y		36.00 37.00
37.00	If yes, see instructions.	repared by the	nome office?	T		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			Y		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lf ves see	N		40.00
	instructions.	1				
		2.	00	-		
	Cost Report Preparer Contact Information	1	00			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
42.00	respectively. Enter the employer/company name of the cost report	I NDI ANA UNI VER	SITY HEALTH			42.00
43 00	preparer. Enter the telephone number and email address of the cost	317. 962. 1093		RUTTER@I UHEALT	H ORG	43.00
10.00	report preparer in columns 1 and 2, respectively.					

Health Financial Systems IU HEALTH	TI PTON HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1311	Period: From 01/01/2016	Worksheet S-2 Part II	
			Date/Time Pre 5/24/2017 9:1	pared: <u>0 am</u>
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	DIRECTOR OF GOVERNMENT			41.00
held by the cost report preparer in columns 1, 2, and 3	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 of the cos	st			43.00
report preparer in columns 1 and 2, respectively.				

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	ΔΙ ΠΔΤΔ					
			Provider Co	CN: 15-1311	Period: From 01/01/2016 To 12/31/2016		pared:
			·			I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Avai I abl e 3. 00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00	5.00			1.00
1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00			54 50, 544. 00	0	
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		19				
8.00	INTENSIVE CARE UNIT	31.00	6	2, 1	96 10, 800. 00	0	8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)		25	9, 1	50 61, 344. 00		14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30. 00					24.10
25.00	CMHC – CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		25				27.00
28.00	Observation Bed Days					0	
29.00	Ambul ance Tri ps						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32.01	Total ancillary labor & delivery room						32.01
22 00	outpatient days (see instructions) LTCH non-covered days						33.00

10SPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1311	Pe Fr To	eriod: com 01/01/2016 0 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/24/2017 9:1	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
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, 411	4	2, 1	06	7.00	10.00	1.00
2.00	HMO and other (see instructions)	376	123					2.00
3.00	HMO I PF Subprovi der	370	123					3.00
1.00	HMO IRF Subprovider	0	0					4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	674	0		74			5.00
5.00	Hospital Adults & Peds. Swing Bed NF	071	0		12			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 085	4	2, 8				7.00
3. 00	INTENSIVE CARE UNIT	211	0	4	50			8.00
9.00	CORONARY CARE UNIT	2	0					9.00
10.00	BURN INTENSIVE CARE UNIT							10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T							11.0
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)	2, 296	4	3, 3	42	0.00	168.05	
15.00	CAH visits	0	0		0			15.00
16.00	SUBPROVIDER - IPF							16.0
7.00	SUBPROVIDER - IRF							17.0
8.00	SUBPROVI DER							18.0
9.00	SKILLED NURSING FACILITY							19.0
20.00	NURSING FACILITY							20.0
1.00	OTHER LONG TERM CARE							21.0
2.00	HOME HEALTH AGENCY							22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)							23.0
4.00	HOSPICE							24.0
4. 10	HOSPICE (non-distinct part)	0	0		0			24.1
5.00	CMHC - CMHC							25.0
26.00	RURAL HEALTH CLINIC							26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0.00	0.00	26.2
7.00	Total (sum of lines 14-26)					0.00	168.05	27.0
8.00	Observation Bed Days		48	6	70			28.0
9.00	Ambul ance Trips	0						29.0
80.00	Employee discount days (see instruction)				0			30.0
31.00	Employee discount days - IRF				0			31.0
32.00	Labor & delivery days (see instructions)	0	0		0			32.0
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0			32. 0 [.]
33.00	LTCH non-covered days	0						33.0

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/24/2017 9:1	pared:
		Full Time Equivalents	·	Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00	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		0		75 2 88 6 0	893	1.00 2.00 3.00
4.00 5.00 6.00 7.00 8.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT				0		4. 00 5. 00 6. 00 7. 00 8. 00
9.00 10.00 11.00 12.00 13.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY						9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00	0	4	75 2	893	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0.00 0.00					26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

Heal th	Financial Systems IU	HEALTH TIPTON HOSPI	I TAL		In Lie	u of Form CMS-2	2552-10
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi	ider CCN	I: 15-1311	Peri od:	Worksheet S-1	
					From 01/01/2016		
					To 12/31/2016		
						5/24/2017 9:1	0 am
						1 00	
	Uncomponented and indigent core cost computation					1.00	
1 00	Uncompensated and indigent care cost computation		l by Ling	- 202 ool umm	0)	0. 287612	1 00
1.00	Cost to charge ratio (Worksheet C, Part I line 2 Medicaid (see instructions for each line)		трутти		8)	0.28/012	1.00
2.00	Net revenue from Medicai d					777, 992	2.00
2.00	Did you receive DSH or supplemental payments fro	m Madi cai d2				111, 992	3.00
4.00	If line 3 is "yes", does line 2 include all DSH		monte fi	com Modicaid	2		4.00
5.00	If line 4 is "no", then enter DSH or supplementa				:	0	5.00
6.00	Medi cai d charges	i payments i on med	ii cai u			11, 277, 902	6.00
7.00	Medicaid cost (line 1 times line 6)					3, 243, 660	7.00
8.00	Difference between net revenue and costs for Med	icaid program (line	7 minus	s sum of lin	es 2 and 5 if	2, 465, 668	8.00
0.00	< zero then enter zero)		, / III 11 0 .	5 5011 01 1111		2,400,000	0.00
	Children's Health Insurance Program (CHIP) (see	instructions for ea	ich Line`)			
9.00	Net revenue from stand-al one CHIP			/		0	9.00
10.00	Stand-al one CHIP charges					0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)					0	11.00
12.00	Difference between net revenue and costs for sta	nd-alone CHLP (line	e 11 minu	us line 9: i	f < zero then	0	12.00
.2.00	enter zero)				2010 11011	, i i i i i i i i i i i i i i i i i i i	12:00
	Other state or local government indigent care pro	ogram (see instruct	ions for	⁻ each line)			
13.00	Net revenue from state or local indigent care pr)	0	13.00
14.00	Charges for patients covered under state or loca	l indigent care pro	ogram (No	ot included	in lines 6 or	0	14.00
	10)	0					
15.00	State or local indigent care program cost (line	1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for sta	te or local indigen	nt care p	orogram (lin	e 15 minus line	0	16.00
	13; if < zero then enter zero)	-		-			
	Uncompensated care (see instructions for each li						
17.00	5					0	
18.00	Government grants, appropriations or transfers f					0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and	state and local ind	ligent ca	are programs	(sum of lines	2, 465, 668	19.00
	8, 12 and 16)					T + + (+ 4	
				Uni nsured	Insured	Total (col. 1	
			-	patients	patients	+ col . 2)	
20,00	Charity are shares for the optime for this	o instructions)		1.00	2.00	3.00	20,00
20.00 21.00	Charity care charges for the entire facility (se Cost of patients approved for charity care (line			1, 811, 80 521, 09			
21.00							
22.00	Partial payment by patients approved for charity Cost of charity care (line 21 minus line 22)	care		58, 33 462, 76			
23.00	cost of charity care (the 21 minus the 22)			402,70	-13, 309	449, 391	23.00
						1.00	
24.00	Does the amount in line 20 column 2 include char	acc for patient day	ic hover	d a longth a	fctovlimit	1.00	24.00
24.00	imposed on patients covered by Medicaid or other				i Stay i i iii t		24.00
25.00	If line 24 is "yes," charges for patient days b			aram's Lenat	h of stav limit	0	25.00
26.00	Total bad debt expense for the entire hospital c			grain 3 rengt	in on Stuy millit	951, 460	
20.00	Medicare bad debts for the entire hospital compl					511, 660	
27.00	Non-Medicare and non-reimbursable Medicare bad d			line 27)		439, 800	
29.00	Cost of non-Medicare and non-reimbursable Medica				28)	126, 492	29.00
30.00	Cost of uncompensated care (line 23 column 3 plu				20)	575, 883	
	Total unreimbursed and uncompensated care cost (30)			3, 041, 551	

RECLAS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IU HEALTH TIPTO	Provi der CO	CN: 15-1311	Peri od:	u of Form CMS-2 Worksheet A	2002 10
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/24/2017 9:1	pared:
	Cost Center Description	Sal ari es	Other	Total (col	Reclassi fi cati	Reclassi fi ed	
		our ur roo	othor	+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1	1 007 0/1	4 997 94		500.440	1
1.00	00100 CAP REL COSTS-BLDG & FLXT		1, 387, 364			503, 113	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES 00200 CAP REL COSTS-MVBLE EQUIP		818, 811	818, 81		818, 811	1.01
2.00	00300 OTHER CAP REL COSTS		0		0 884, 251	884, 251 0	2.00
3.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	154, 677	2 420 012		0 0 9 -3	2, 594, 586	3.00
4.00 5.01	01160 COMMUNI CATI ONS	154, 677	2, 439, 912	2, 594, 58	-3 0 323, 359		4.00
5.01 5.02	00550 PATIENT ACCOUNTING	0	23, 203	23, 20		23, 203	5.01
5.02	00591 OTHER ADMINISTRATIVE AND GENERAL	-					
5.03 7.00	00700 OPERATION OF PLANT	887, 376	5,677,274			6,047,145	7.00
	00701 OPERATION OF PLANT 00701 OPERATION OF PLANT- OFFSITE	405, 201	3, 216, 544	3, 621, 74		3, 626, 554 0	
7.01 8.00		-	0 55 220				7.01
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	48, 245	55, 228			103, 473	
	01000 DI ETARY	265, 148	91, 768			321, 525	
10.00	01100 CAFETERIA	410, 686	211, 515 0			359, 807	10.00
11.00		270.047	-			262, 344	
13.00	01300 NURSI NG ADMI NI STRATI ON	379, 867	12, 314	392, 18			
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY	14,095	2, 396				
15.00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	543, 158	2, 164, 448	2, 707, 60	6 -1, 637, 924	1, 069, 682	15.00
30.00	03000 ADULTS & PEDIATRICS	1, 195, 297	130, 071	1, 325, 36	8 -75, 951	1, 249, 417	30.00
30.00	03100 INTENSIVE CARE UNIT		28, 675		-		
31.00	ANCI LLARY SERVICE COST CENTERS	717, 133	20,075	745, 80	0 -20,000	720, 275	31.00
50.00	05000 OPERATING ROOM	1, 084, 943	2, 672, 801	3, 757, 74	4 -2, 206, 071	1, 551, 673	50.00
53.00	05300 ANESTHESI OLOGY	1,084,943	308, 822	502, 51		491, 989	
54.00	05400 RADI OLOGY - DI AGNOSTI C	1, 021, 434	308, 202			1, 227, 849	
60.00	06000 LABORATORY	1, 021, 434	1, 342, 539			1, 342, 539	
64.00	06400 I NTRAVENOUS THERAPY	0	1, 342, 339		0 0	1, 342, 339	64.00
65.00	06500 RESPI RATORY THERAPY	410, 536	64, 910			452, 454	
66.00	06600 PHYSI CAL THERAPY	599, 212	59, 914	659, 12			66.00
67.00	06700 OCCUPATI ONAL THERAPY	220, 864	49,003			287, 842	
69.00	06900 ELECTROCARDI OLOGY	396, 788	61, 690	458, 47		438, 532	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,0,700	01,070		0 189, 925	189, 925	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 385, 682	1, 385, 682	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 816, 921	1, 816, 921	
73.01	03480 ONCOLOGY	178, 759	28, 503			193, 227	
76.00	03160 CARDI OPULMONARY	0	20,000		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	67, 558	18, 366			84, 837	76.97
	OUTPATIENT SERVICE COST CENTERS	0,,000	10,000	00,72	1,007	01,001	
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	1,071,335	1, 256, 381	2, 327, 71			•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	., ., ., .,	., 200, 00.	2,02,,,,	00,071	2/2/0/0/2	92.00
/2:00	SPECIAL PURPOSE COST CENTERS						1 /2:00
118.00		10, 266, 007	22, 430, 654	32, 696, 66	1 150, 841	32, 847, 502	1118 00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	19001 MARKETI NG/PUBLI C RELATI ONS	0	24, 646	24, 64		24, 646	
	19100 RESEARCH	0	2., 310		0 0		191.00
	19101 MEALS ON WHEELS	0	0		0 0		191.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	76, 337	452, 916	529, 25	3 -138, 421	390, 832	
	19201 OCCUPATI ONAL MEDI CI NE	32, 839	57, 889				
			-				194.00
194 00	107950 COMMUNETY FEENESS CENTER	())	()		0 0	11	
	07950 COMMUNITY FITNESS CENTER 07951 VACANT SPACE	0	0		0 0 0 0		194.00

RECLASSI	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1311	Peri od:	Worksheet A	
					From 01/01/2016 To 12/31/2016	Date/Time Pr 5/24/2017 9:	epared: 10 am
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8) 6.00	For Allocation 7.00				
G	ENERAL SERVICE COST CENTERS	0.00	7.00				-
	0100 CAP REL COSTS-BLDG & FIXT	832, 072	1, 335, 185				1.0
	0101 CAP REL COSTS-BLDG & FIXT - INTERES	-115, 427	703, 384				1.0
	0200 CAP REL COSTS-MVBLE EQUI P	211, 962	1, 096, 213				2.0
	0300 OTHER CAP REL COSTS	0	0				3.0
4.00 0	0400 EMPLOYEE BENEFITS DEPARTMENT	-447, 336	2, 147, 250				4.0
5.01 0	1160 COMMUNI CATI ONS	-8, 014	315, 345				5.0
5.02 0	0550 PATIENT ACCOUNTING	-55	23, 148				5.0
5.03 0	0591 OTHER ADMINISTRATIVE AND GENERAL	-436, 935	5, 610, 210				5.0
7.00 0	0700 OPERATION OF PLANT	0	3, 626, 554				7.0
	0701 OPERATION OF PLANT- OFFSITE	0	0				7.0
B. 00 0	0800 LAUNDRY & LINEN SERVICE	0	103, 473				8.0
	10900 HOUSEKEEPI NG	-20	321, 505				9.0
	1000 DI ETARY	0	359, 807				10. 0
	1100 CAFETERI A	-66, 658	195, 686				11. (
	1300 NURSI NG ADMI NI STRATI ON	-645	549, 074				13. (
	1400 CENTRAL SERVICES & SUPPLY	0	1, 066, 689				14. (
	1500 PHARMACY	-300, 628	769, 054				15. (
	NPATIENT ROUTINE SERVICE COST CENTERS	1	I				
	3000 ADULTS & PEDIATRICS	-13, 350	1, 236, 067				30.0
	3100 I NTENSI VE CARE UNI T	0	720, 275				31. (
	NCI LLARY SERVICE COST CENTERS	054 004	1 405 000				
	5000 OPERATING ROOM	-356, 391	1, 195, 282				50. (53. (
	15300 ANESTHESI OLOGY 15400 RADI OLOGY-DI AGNOSTI C	-443, 695 -150, 749	48, 294				54.0
	6000 LABORATORY	-5, 250	1, 077, 100 1, 337, 289				60.0
	6400 I NTRAVENOUS THERAPY	-5,250	1, 337, 209				64.0
	6500 RESPIRATORY THERAPY	-16, 308	436, 146				65.0
	6600 PHYSI CAL THERAPY	-8, 498	607, 739				66. (
	6700 OCCUPATI ONAL THERAPY	-2,050	285, 792				67.
	6900 ELECTROCARDI OLOGY	-17, 564	420, 968				69.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	189, 925				71.
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 385, 682				72.
	7300 DRUGS CHARGED TO PATIENTS	- 4	1, 816, 917				73.
	3480 ONCOLOGY	0	193, 227				73.
76.00 0	3160 CARDI OPULMONARY	0	0				76. (
	7697 CARDI AC REHABI LI TATI ON	0	84, 837				76.
0	UTPATIENT SERVICE COST CENTERS						
90.00 0	9000 CLI NI C	0	0				90. (
91.00 0	9100 EMERGENCY	-734, 932	1, 508, 910				91. (
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92.0
	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	-2, 080, 475	30, 767, 027				118. (
	ONREI MBURSABLE COST CENTERS						4.6.5
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. (
	9001 MARKETI NG/PUBLI C RELATI ONS	0	24, 646				190. (
	9100 RESEARCH	0	0				191.0
	9101 MEALS ON WHEELS	0	0				191.
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	390, 832				192.
	9201 OCCUPATIONAL MEDICINE	0	78, 308				192.
	7950 COMMUNITY FITNESS CENTER	0	0				194.
	17951 VACANT SPACE	0					194. (
200.00	TOTAL (SUM OF LINES 118-199)	-2, 080, 475	31, 260, 813				200. (

IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

	Financial Systems		IU HEALTH TIPTC	Provider C	CN: 15-1311	Peri od:	u of Form (Worksheet	
						From 01/01/2016 To 12/31/2016	Date/Time	Prepared
		Increases					5/24/2017	9:10 am
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - DIETARY/CAFETERIA	11.00	470 475	00.4(0				
0	<u>CAFETERI A</u>	<u>11.</u> 00	<u>173, 1</u> 75 173, 175	8 <u>9, 1</u> 69 89, 169				1.
	B - VICE PRESIDENT OF NURSING		175, 175	09, 109				
	NURSI NG ADMI NI STRATI ON	13.00	157, 800	0				1.
(0		157, 800	ū				
	C - SUPPLIES COSTS							
	CENTRAL SERVICES & SUPPLY	14.00	0	1,050,198				1.
	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	189, 925				2.
	IMPL. DEV. CHARGED TO	72.00	o	1, 385, 682				3.
	PATIENTS		-	.,,				
		0.00	0	0				4.
)		0.00	0	0				5.
)		0.00	0	0				6.
		0.00 0.00	0	0 0				8.
Ś		0.00	0	0				9.
00		0.00	0	0				10.
00		0.00	0	0				11.
0		0.00	0	0				12.
00		0.00	0	0				13.
00		0.00	0	0				14.
00		0.00 0.00	0	0 0				15.
		0.00	0	0				17.
		0.00	0	0				18.
00		0.00	0	0				19.
(0			2, 625, 805				
E	D - DRUGS COSTS							
	PHARMACY	15.00	0	117, 508				1.
) 	DRUGS CHARGED TO PATIENTS	73.00 0.00	0	1, 816, 921 0				2.
5		0.00	0	0				4.
5		0.00	0	0				5
o		0.00	0	0				6
		0.00	0	0				7.
D		0.00	0	0				8
		0.00	0	0				9
00		0.00 0.00	0	0 0				10
		0.00	0	0				12
00		0.00	0	0				13
00		0.00	0	0				14.
00		0.00	0	0				15.
00		0.00	0	0				16.
00		0.00	0	0 1,934,429				17.
	E – EQUIPMENT DEPRECIATION		0	1, 934, 429				
	CAP REL COSTS-MVBLE EQUIP	2.00	0	884, 251				1.
(0		0	884, 251				
	F - ORTHOPEDIC CLERICAL STAFF							
) (OCCUPATI ONAL THERAPY		17,975	0				1.
(O		17, 975	0				
	G - UTILITIES COSTS	5.01	0	4, 050				1.
	OPERATION OF PLANT	7.00	0	4,050				2.
		0.00	0	0, 977				3.
(<u>0</u>	15, 027				0.
	H - COMMUNICATION CLERKS	I	-1					
)	COMMUNICATIONS	5.01	<u>319, 3</u> 09	0				1.
(0		319, 309	0				
	I – SURGERY ON CALL							
		FO 001	~					
о [OPERATING ROOM	<u>50.</u> 00	<u>o</u>	_ <u>113, 786</u> 113, 786				1.

LASS	Financial Systems IFICATIONS			Provi der (CCN: 15-1311	Period: From 01/01/2016	u of Form CMS-2552 Worksheet A-6
						To 12/31/2016	Date/Time Prepar 5/24/2017 9:10 a
		Decreases				.	
	Cost Center 6.00	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00		
	A - DI ETARY/CAFETERI A	7.00	8.00	9.00	10.00		
	DI ETARY	10.00	173, 175	89, 169)	0	1
	0		173, 175	89, 169	»		
	B - VICE PRESIDENT OF NURSING				1	1	
	OTHER ADMI NI STRATI VE AND	5.03	157, 800	C)	0	1
	<u>GENERAL</u>	+	157, 800	c	<u> </u>	-	
	C - SUPPLIES COSTS		107,000		·		
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3	8	0	1
	OTHER ADMINISTRATIVE AND	5.03	0	13, 028	6	0	2
	GENERAL	7 00		/ 1//			
	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	0	6, 166 35, 391		0	3
	DI ETARY	10.00	0	45		0	5
	NURSING ADMINISTRATION	13.00	0	262		0	6
0	PHARMACY	15.00	0	5, 435		0	7
	ADULTS & PEDIATRICS	30.00	О	65, 695		o	8
	INTENSIVE CARE UNIT	31.00	0	22, 083		0	9
	OPERATING ROOM	50.00	0	2, 303, 474		0	10
	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54.00 65.00	0	26, 931		0	11
	PHYSICAL THERAPY	65.00 66.00	0	22, 769 24, 237		0	12
	ELECTROCARDI OLOGY	69.00	o	24, 237		0	13
	ONCOLOGY	73.01	0	11, 326		0	15
	CARDI AC REHABI LI TATI ON	76.97	0	1, 082		0	16
	EMERGENCY	91.00	0	64, 482		0	17
	PHYSICIANS' PRIVATE OFFICES	192.00	0	11, 062		0	18
00	OCCUPATIONAL MEDICINE	1 <u>92.</u> 01	0	<u>1, 226</u>		ol	19
			0	2, 625, 805			
	D - DRUGS COSTS OTHER ADMINISTRATIVE AND	5.03	0	26, 082	>	0	1
	GENERAL	0.00	0	20,002	-		
0	OPERATION OF PLANT	7.00	0	2		0	2
	DI ETARY	10.00	0	5		0	3
	PHARMACY	15.00	0	1, 749, 997		0	4
	ADULTS & PEDIATRICS	30.00	0	10, 256		0	5
	INTENSIVE CARE UNIT OPERATING ROOM	31.00 50.00	0	3, 450 16, 383		0	6
	ANESTHESI OLOGY	53.00	0	10, 528		0	6
	RADI OLOGY-DI AGNOSTI C	54.00	0	74, 856		0	9
00	RESPI RATORY THERAPY	65.00	0	223		0	10
	PHYSICAL THERAPY	66.00	0	48		0	11
	ELECTROCARDI OLOGY	69.00	0	8, 838		0	12
		73.01	0	2, 709		0	13
	CARDIAC REHABILITATION EMERGENCY	76. 97 91. 00	0	5 19, 392		0	14
	PHYSICIANS' PRIVATE OFFICES	192.00	0	19, 392 461		o	16
	OCCUPATI ONAL MEDI CI NE	192.00	0	11, 194		ŏ	17
	0		ŏ	1, 934, 429		1	
	E - EQUIPMENT DEPRECIATION					-	
0	CAP REL COSTS-BLDG & FIXT		0	884, 251		9	1
ļ			0	884, 251			
	F - ORTHOPEDIC CLERICAL STAFF PHYSICAL THERAPY	66.00	17, 975	C	b	0	1
Ĭ			17, 975	0		1	'
	G - UTILITIES COSTS		, , , , , , , ,				
	OTHER ADMINISTRATIVE AND	5.03	0	1, 286		0	1
	GENERAL						
	PHYSICAL THERAPY	66.00	0	629		0	2
0	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	º	1 <u>3, 1</u> 12		0	3
	H - COMMUNICATION CLERKS		U	15, 027	<u> </u>		
	OTHER ADMI NI STRATI VE AND	5.03	319, 309	C)	0	1
	GENERAL						
[0		319, 309				
ļ	I – SURGERY ON CALL						
	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	113, 786		Q	1
	TOTALS		0	113, 786			1

Hoal th	Financial Systems	IU HEALTH TIPT			Inlie	eu of Form CMS-:	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part I	pared:
				Acqui si ti ons	S		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	31, 500	0		0 0	0	1.00
2.00	Land Improvements	0	0		0 0	0	2.00
3.00	Buildings and Fixtures	30, 401, 084	0		0 0	0	3.00
4.00	Building Improvements	8, 633, 678	0		0 0	0	4.00
5.00	Fixed Equipment	12, 029, 575	0		0 0	0	5.00
6.00	Movable Equipment	17, 449, 292	185, 433		0 185, 433	276, 665	6.00
7.00	HIT designated Assets	1, 137, 296	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	69, 682, 425	185, 433		0 185, 433	276, 665	8.00
9.00	Reconciling Items	0	0		0 0	0	
10.00	Total (line 8 minus line 9)	69, 682, 425	185, 433		0 185, 433	276, 665	10.00
		Ending Balance					
		J	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	31, 500	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	30, 401, 084	2, 377, 541				3.00
4.00	Building Improvements	8, 633, 678	111, 137				4.00
5.00	Fixed Equipment	12, 029, 575	9, 459, 866				5.00
6.00	Movable Equipment	17, 358, 060	12, 263, 521				6.00
7.00	HIT designated Assets	1, 137, 296	0				7.00
8.00	Subtotal (sum of lines 1-7)	69, 591, 193	24, 212, 065				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	69, 591, 193	24, 212, 065				10.00
			,, 0000	I			

Heal th	Financial Systems	IU HEALTH TIPT	TON HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016	Worksheet A-7 Part II	
					To 12/31/2016	Date/Time Pre	
						5/24/2017 9:1	0 am
			SI	UMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
-	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	and 2		-	
1.00	CAP REL COSTS-BLDG & FIXT	1, 387, 364	C	D	0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	C	818, 81	1 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	C		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 387, 364	C	818, 81	1 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	n			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00			-	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM		1			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 387, 364				1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	818, 811				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	C				2.00
3.00	Total (sum of lines 1-2)	0	2, 206, 175	5			3.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F		Date/Time Prep 5/24/2017 9:10	
	COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00 CAP REL COSTS-BLDG & FLXT	503, 113		503, 113		0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES	818, 811		818, 811		0	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	884, 251		884, 251		0	2.00
3.00 Total (sum of lines 1-2)	2, 206, 175		2, 206, 175			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capital-Relate d Costs	cols. 5 through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	0	(1, 335, 185	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	(974, 720	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(2, 309, 905	0	3.00
		SI	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	-	(0 0	1, 335, 185	1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES	703, 384	0	0	0 0	703, 384	1.01
2.00 CAP REL COSTS-MVBLE EQUIP	121, 493	0	(0 0	1, 096, 213	2.00
3.00 Total (sum of lines 1-2)	824, 877	c	0 0	0 0	3, 134, 782	3.00

DJUST	MENTS TO EXPENSES				Period: From 01/01/2016	Worksheet A-8	
					To 12/31/2016	Date/Time Prep 5/24/2017 9:10	
				Expense Classification of To/From Which the Amount is			
					-		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1
01	COSTS-BLDG & FIXT - INTERES (chapter 2)	В	-115, 427	CAP REL COSTS-BLDG & FIXT - INTERES	1. 01	11	1
00	Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3
00	(chapter 2) Trade, quantity, and time		C		0.00	0	4
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5
	expenses (chapter 8)						
00	Rental of provider space by suppliers (chapter 8)		C		0.00		6
00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	0	7
00	Television and radio service (chapter 21)		C		0.00	0	8
00	Parking lot (chapter 21)		C		0.00		9
0. 00	Provider-based physician adjustment	A-8-2	-1, 524, 537			0	10
. 00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11
. 00	Related organization transactions (chapter 10)	A-8-1	1, 769, 488	3		0	12
	Laundry and linen service		C		0.00		
	Cafeteria-employees and guests Rental of quarters to employee	В	-66, 658 C		11.00 0.00		14 15
. 00	and others Sale of medical and surgical		C		0.00	0	16
. 00	supplies to other than patients		C		0.00	0	10
. 00	Sale of drugs to other than	А	-300, 626	PHARMACY	15.00	0	17
. 00	patients Sale of medical records and	В	-55	PATI ENT ACCOUNTI NG	5.02	0	18
. 00	abstracts Nursing school (tuition, fees,		C		0.00	0	19
	books, etc.) Vending machines		C		0.00	0	20
	Income from imposition of		C		0.00		
	interest, finance or penalty charges (chapter 21)						
2.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22
8. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23
. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24
. 00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25
. 00	(chapter 21) Depreciation - CAP REL	А	861, 010	CAP REL COSTS-BLDG & FIXT	1.00	9	26
	COSTS-BLDG & FIXT Depreciation - CAP REL			CAP REL COSTS-BLDG & FIXT -			
	COSTS-BLDG & FIXT - INTERES	•		INTERES			
	Depreciation - CAP REL COSTS-MVBLE EQUIP	A		CAP REL COSTS-MVBLE EQUIP	2.00		
	Non-physician Anesthetist Physicians' assistant		C	*** Cost Center Deleted ***	19.00 0.00		28 29
	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30
0.00	limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30

Heal th	Fi nan	ci al	Systems
AD.JUST	MENTS	TO F	XPENSES

IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10 Worksheet A-8

Image: Second		Financial Systems		IU HEALIH IIPI		In Lie	eu of Form CMS-2	
To 12/31/2016 Date/Time Prepared: S/24/2017 9:10 am Cost Center Description Bosis/Code (2) Amount Cost Center Line # Wist. A-7 Ref. 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 66.00 31.00 32.00 CAH HIT Adjustment for pathology costs in excess of limitation (chapter 14) A -90, 125 CAP REL CostS-MVBLE Coull P 2.00 9 32.00 33.01 ASSISTED LIVING BLDG A -146, 375 CAP REL CostS-BLDG & FIXT 1.00 9 33.00 33.01 MAF FEES A -90, 125 CAP REL CostS-BLDG & FIXT 1.00 9 33.00 33.01 CRN SALAPY A -146, 375 CAP REL CostS-BLDG & FIXT 1.00 9 33.00 33.01 KMS ALAPY A -192, 696 MISTRESID.00 Y 53.00 0 33.01 33.01 MIS SCELLANEOUS REVENUE B -2172 696 DIFER ADMIN STRATIVE AND GENERAL 5.03 0 33.00 33.03 CRN SCRALAPUE A A -49, 692 EMPLOVEE BINERTISTS DENTMIN TA<	ADJUST	MENTS TO EXPENSES					Worksheet A-8	
Cost Center Description Basi s/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 66.0 31.00 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 0 *** Cost Center Deleted *** 66.0 31.00 33.01 REXISTED LIVING BLDG A -90, 125 CAP REL COSTS-MVBLE EQUIP 2.00 92.00 33.03 REXISTED LIVING BLDG A -146, 373 CAP REL COSTS-MVBLE FOULP 33.00 33.01 33.01 HAF FEES A -112, 640 THER ADMIN ISTRATIVE AND 5.03 0 33.01 33.03 CRNA SALARY A -192, 693/MESTHESI CLOGY 5.00 0 33.03 33.04 INSCELLANEOUS REVENUE B -47.01FHR ADMIN ISTRATIVE AND 5.03 0 33.06 33.07 MISCELLANEOUS REVENUE B -43.92DHPM CHE BENEFITS DEPARTMENT 4.00 0 30.06 33.09 MISCELLANEOUS REVENUE B -47.95SERFAL </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
Cost Center Description Basi s/Code (2) Amount Cost Center Line # Next. A-7 Ref. 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 66.00 31.00 22.00 CAH TAGU STREET A-8-3 0 *** Cost Center Deleted *** 66.00 31.00 32.00 CAH HT Adjustment for Dest Street Ion and Interest 33.00 A -90,125 CAP REL COSTS-MVBLE EQUIP 2.00 9 32.00 33.01 DEST Street Ion and ELGO A -146,373 CAP REL COSTS-BLDG & FIXT 1.00 9 33.01 33.01 GRN SALARY A -193,093 ANSTHESI OLOGY 5.03 0 33.03 33.01 MSCELLANEOUS REVENUE B -4,4120 THER ADMINISTRATI VE AND GENERAL 5.03 03.03 33.04 33.04 GRN BENET TS A -490 CP2UPUPCOVE BENET SUPARTNEET 4.00 33.04 33.05 GRN SALARY A -193,093 ANSTRATI VE AND 5.03 0 33.07 33.06 MSCELLANEOUS REVENUE B								
1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0*** Cost Center Deleted *** 68.00 31.00 32.00 CAH HT Adjustment for Depercelation and Interest A -90, 125CAP REL COSTS-BLDG & FIXT 1.00 9 32.00 33.00 ASISTED LIVING BLG A -146, 373CAP REL COSTS-BLDG & FIXT 1.00 9 33.00 33.01 HAF FEES A -112, 9640THER ADMINISTRATIVE AND GENERAL 5.03 0 33.01 33.03 CRNA SALARY A -129, 696ANESTHESIOLOGY 53.00 0 33.04 33.04 CRNA BENEFITS A -49, 022EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 022EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.06 33.04 CRNA BENEFITS A -49, 022EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.07 33.05 CRNA DIOLOGY B -4730THER ADMINISTRATIVE AND 5.03 0 33.07					To/From Which the Amount is	to be Adjusted		
1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 68.00 31.00 32.00 CAH HT Adjustment for Depercelation and Interest A -90, 125 CAP REL COSTS-BLDG & FIXT 1.00 9 32.00 33.01 ASISTED LIVING BLDG A -146, 373 CAP REL COSTS-BLDG & FIXT 1.00 9 33.00 33.01 HAF FEES A -112, 964 OTHER ADMINISTRATIVE AND GENERAL 50.00 0 33.01 33.03 CRNA SALARY A -173, 965 ANTESI OLOGY 53.00 0 33.04 33.04 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS 0 33.07 33.05 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS 0 33.07								
1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 0 4.00 5.00 31.00 32.00 CAH HT Adjustment for Deperceitation and interest A -90, 125CAP REL COSTS-MUBLE EQUI P 2.00 9 32.00 33.00 ASISTED LIVING BL0G A -146, 373CAP REL COSTS-BL0G & FLXT 1.00 9 33.00 33.01 HAF FEES A -146, 373CAP REL COSTS-BL0G & FLXT 1.00 9 33.00 33.01 HAF FEES A -179, 695ANESTHESI LIVE PADHORY 53.00 0 33.01 33.03 CRNA SALARY A -179, 695ANESTHESI LIVE PERFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 602EMPLOVEE BENEFITS DEPARTMENT 4.00 0 33.06 33.04 CRNA BENEFITS A -49, 052EMPLOVEE BENEFITS DEPARTMENT 4.00 0 33.07 33.09 MI SCELLANEOUS REVENUE B -4730THER ADMINISTRATIVE ADM 5.03 0 33.07 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 68.00 31.00 32.00 CAH HT Adjustment for Depercelation and Interest A -90, 125 CAP REL COSTS-BLDG & FIXT 1.00 9 32.00 33.01 ASISTED LIVING BLDG A -146, 373 CAP REL COSTS-BLDG & FIXT 1.00 9 33.00 33.01 HAF FEES A -112, 964 OTHER ADMINISTRATIVE AND GENERAL 50.00 0 33.01 33.03 CRNA SALARY A -173, 965 ANTESI OLOGY 53.00 0 33.04 33.04 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS 0 33.07 33.05 CRNA BENEFITS A -49, 022 EMPLORYE EBENEFITS 0 33.07								
1.00 2.00 3.00 4.00 5.00 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0*** Cost Center Deleted *** 68.00 31.00 32.00 CAH HT Adjustment for Depercelation and Interest A -90, 125CAP REL COSTS-BLDG & FIXT 1.00 9 32.00 33.00 ASISTED LIVING BLG A -146, 373CAP REL COSTS-BLDG & FIXT 1.00 9 33.00 33.01 HAF FEES A -112, 9640THER ADMINISTRATIVE AND GENERAL 5.03 0 33.01 33.03 CRNA SALARY A -129, 696ANESTHESIOLOGY 53.00 0 33.04 33.04 CRNA BENEFITS A -49, 022EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 022EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.06 33.04 CRNA BENEFITS A -49, 022EMPLORYE EBENEFITS DEPARTMENT 4.00 0 33.07 33.05 CRNA DIOLOGY B -4730THER ADMINISTRATIVE AND 5.03 0 33.07		Cost Center Description	Basis/Code (2)	Amount	Cost Center	line #	Wkst A-7 Ref	
31. 00 Adjustment for speech in tation (chapter 14) A-8-3 0 *** Cost Center Deleted *** 68. 00 31. 00 32. 00 CAH HT Adjustment for Depreciation and Interest A -90, 125 CAP REL COSTS-MVBLE EQUIP 2. 00 9 32. 00 33. 00 Depreciation and Interest A -90, 125 CAP REL COSTS-MVBLE EQUIP 2. 00 9 33. 00 33. 01 HAF FEES A -146, 373 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 00 33. 01 HAF FEES A -512, 964 OTHER ADMINISTRATIVE AND 5. 03 0 33. 01 33. 03 CRNA SALARY A -193, 695 ANESTHESI OLOGY 53. 00 0 33. 01 33. 04 CRNA SENEFITS A -49, 692 EMPLOYEE DENEFITS DEPARTIMENT 4. 00 0 33. 01 33. 04 CRNA SELLANEOUS REVENUE B -43, 120 THER ADMINISTRATIVE AND 5. 03 0 33. 07 33. 04 CRNA SELLANEOUS REVENUE B -2, 050 OCCUPATI ONAL THERAPY 67. 00 0 33. 01 33. 07 MI SCELLANEOUS REVENUE <td></td> <td>cost center bescription</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		cost center bescription						
pathol ogy costs in excess of limitation (chapter 14) A -90, 125 CAP REL COSTS-MVBLE EQUIP 2.00 9 32.00 02000 CAH HIT Adjustment for Depercentation and Interest A -90, 125 CAP REL COSTS-MVBLE EQUIP 2.00 9 32.00 33.00 ASSISTED LIVING BLDG A -146, 373 CAP REL COSTS-BLDG & FIXT 1.00 9 33.00 33.01 HAF FEES A -512, 964 OTHER ADMINISTRATIVE AND GENERAL 5.03 0 33.01 33.04 CRNA SALARY A -193, 693 MRSTHESI IOLOGY 53.00 0 33.03 33.04 CRNA SALARY A -49, 692 EMPLOYED EDEPARTMENT 4.00 33.04 33.05 MI SCELLANEOUS REVENUE B -474 CHTHER ADMINISTRATIVE AND 5.03 0 33.07 33.06 MI SCELLANEOUS REVENUE B -474 CHTHER ADMINISTRATIVE AND 5.03 0 33.06 33.07 MI SCELLANEOUS REVENUE B -476 OTHER ADMINISTRATIVE AND 5.03 0 33.07 33.08 MI SCELLANEOUS REVENUE B -476 ODECUPATIONAL THERADMINISTRATIVE AND </td <td>31,00</td> <td>Adjustment for speech</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>31.00</td>	31,00	Adjustment for speech						31.00
1 0 9 32.00 9 32.00 9 32.00 9 32.00 9 32.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.00 9 33.03 CRAN SALARY A -193.0695 ARSTHESI IOLOGY 53.00 0 33.03 0 33.04 CRAN SALARY A -49.692 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.04 GENERAL 50.03 0 33.07 0 33.04 GENERAL 50.03 0 33.07 0 33.07 0 SCLLANEOUS REVENUE B -4.75 OTHER ADIN IN STRATI VE AND 5.03 0 33.07<				-				
Depreciation and Interest A -146, 373, 62P REL COSTS-BLOG & FIXT 1.00 9 33.00 33.00 ASSITED LIVIN B BLG A -512, 964 OTHER ADMINISTRATIVE AND GENERAL 5.03 0 33.01 33.01 HAF FEES A -512, 964 OTHER ADMINISTRATIVE AND GENERAL 5.03 0 33.03 33.03 CRNA SALARY A -193, 699 ANESTHESI OLOGY 53.00 0 33.04 33.04 CRNA BENEFITS A -49, 692 BME/DYEE BENEFITS DEPARTMENT 4.00 0 33.04 33.04 CRNA BENEFITS A -49, 692 BME/DYEE BENEFITS DEPARTMENT 4.00 33.04 33.04 CRNA BENEFITS A -49, 692 BME/DYEE BENEFITS DEPARTMENT 4.00 33.04 33.07 MI SCELLANEOUS REVENUE B -4,412 OTHER ADMINISTRATIVE AND 5.03 0 33.07 33.09 MI SCELLANEOUS REVENUE - B -2,050 OCCUPATIONAL THERADMINISTRATIVE AND 5.03 0 33.09 33.10 LAB B -2,050 OCCUPATIONAL THERADMINISTRATIVE AND 5.03 0		limitation (chapter 14)						
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33. 23 MI SCELLANEOUS REVENUE B -4 DRUGS CHARGED TO PATIENTS 73. 00 0 33. 23 33. 24 EMPLOYEE BENEFITS A -2 PHARMACY 15. 00 0 33. 24 33. 25 EMPLOYEE BENEFITS A -20 RADI OLOGY-DI AGNOSTIC 54. 00 0 33. 25 33. 26 EMPLOYEE BENEFITS A -10 RADI OLOGY-DI AGNOSTIC 54. 00 0 33. 26 34. 00 ACCRUED PTO EXPENSE A -11 ELECTROCARDI OLOGY 69. 00 0 34. 00 34. 01 LEASE DEPRECI ATI ON - CARRY FORWARD A -126, 018 EMPLOYEE BENEFITS DEPARTMENT 1. 00 9 34. 01 34. 02 EOUI PMENT DEPRECI ATI ON - CARRY FORWARD A 15, 476 CAP REL COSTS-MVBLE EQUI P 2. 00 9 34. 02 50. 00 TOTAL (sum of lines 1 thru 49) -2, 080, 475 50. 00 50. 00 50. 00		MI SCELLANEOUS REVENUE				65.00	0	
33. 24 EMPLOYEE BENEFITS A -2PHARMACY 15.00 0 33. 24 33. 25 EMPLOYEE BENEFITS A -20 RADI OLOGY-DI AGNOSTIC 54. 00 0 33. 25 33. 26 EMPLOYEE BENEFITS A -10 RADI OLOGY-DI AGNOSTIC 54. 00 0 33. 25 34. 00 ACCRUED PTO EXPENSE A -11 ELECTROCARDI OLOGY 69. 00 0 34. 00 34. 01 LEASE DEPRECI ATI ON - CARRY FORWARD A -126, 018 EMPLOYEE BENEFITS DEPARTMENT 1.00 9 34. 01 34. 02 EQUI PMENT DEPRECI ATI ON - CARRY FORWARD A 15, 476 CAP REL COSTS-MVBLE EQUI P 2. 00 9 34. 02 50. 00 TOTAL (sum of lines 1 thru 49) -2, 080, 475 50. 00 50. 00 50. 00								
33. 25EMPLOYEE BENEFITSA-20RADIOLOGY-DIAGNOSTIC54.00033. 2533. 26EMPLOYEE BENEFITSA-11ELECTROCARDIOLOGY69.00033. 2634. 00ACCRUED PTO EXPENSEA-126, 018EMPLOYEE BENEFITS DEPARTMENT4.00034. 0034. 01LEASE DEPRECIATION - CARRY FORWARDA30CAPREL <costs-bldg &="" fixt<="" td="">1.00934. 0134. 02EQUIPMENT DEPRECIATION - CARRY FORWARA15, 476CAPREL<costs-mvble equip<="" td="">2.00934. 0250. 00TOTAL (sum of lines 1 thru 49)-2, 080, 475-2, 080, 47550.0050.00</costs-mvble></costs-bldg>		4						
33.26EMPLOYEE BENEFITSA-11ELECTROCARDIOLOGY69.00033.2634.00ACCRUED PTO EXPENSEA-126,018EMPLOYEE BENEFITS DEPARTMENT4.00034.0034.01LEASE DEPRECIATION - CARRY FORWARDA30CAPRELCOSTS-BLDG & FIXT1.00934.0134.02EQUI PMENT DEPRECIATION - CARRY FORWARDA15,476CAPRELCOSTS-MVBLE2.00934.0250.00TOTAL (sum of lines 1 thru 49)-2,080,475-2,080,47550.0050.00					-			
34.00ACCRUED PTO EXPENSEA-126,018EMPLOYEE BENEFITS DEPARTMENT4.00034.0034.01LEASE DEPRECIATION - CARRY FORWARDA30CAP REL COSTS-BLDG & FIXT1.00934.0134.02EQUI PMENT DEPRECIATION - CARRY FORWAA15,476CAP REL COSTS-MVBLE EQUI P2.00934.0250.00TOTAL (sum of lines 1 thru 49)-2,080,475-2,080,47550.0050.00							-	
34. 01LEASE DEPRECIATION - CARRY FORWARDA30CAP REL COSTS-BLDG & FIXT1.00934. 0134. 02EQUI PMENT DEPRECIATION - CARRY FORWAA15, 476CAP REL COSTS-MVBLE EQUI P2. 00934. 0250. 00TOTAL (sum of lines 1 thru 49)-2, 080, 475-2, 080, 47550. 0050. 00		1						
FORWARD SQUI PMENT DEPRECIATION - CARRY FORWAA15,476 CAP REL COSTS-MVBLE EQUI P2.00934.0250.00TOTAL (sum of lines 1 thru 49)-2,080,47550.0050.00								
34. 02 EQUI PMENT DEPRECIATION - CARRY A 15, 476 CAP REL COSTS-MVBLE EQUI P 2.00 9 34. 02 50. 00 TOTAL (sum of lines 1 thru 49) -2, 080, 475 50. 00 50. 00 50. 00	34.01		A	30	VAP REL CUSIS-BLUG & FIXI	1.00	9	34.01
FORWA FORWA 50.00 TOTAL (sum of lines 1 thru 49) -2,080,475 50.00 50.00	34 02		Δ	15 476	CAP REL COSTS_MURLE FOLLE	2 00	0	34 02
50.00 TOTAL (sum of lines 1 thru 49) -2,080,475 50.00	J4. UZ			15,470	CALLE COSTS-WVDEL EQUIP	2.00	/ 7	34.02
	50.00			-2,080,475				50.00
(Transfer to Worksheet A,		(Transfer to Worksheet A,						
column 6, line 200.)		column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	IU HEALTH TI	PTON HOSPITAL	In Lie	eu of Form CMS-:	2552-10
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM		Peri od:	Worksheet A-8	-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		narod
				10 12/31/2016	5/24/2017 9:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:			447.405		
1.00			BUILDING DEPRECIATION (HO)	117, 405	0	1.00
2.00	-		INTEREST EXPENSE (HO)	821, 792	821, 792	2.00
3.00			EQUIPMENT DEPRECIATION (HO)	121, 493	0	3.00
4.00			EMPLOYEE BENEFITS	1, 487, 360	28, 658	4.00
4.01		OTHER ADMINISTRATIVE AND GEN		4, 929, 678		4.01
4.02			FACILITIES (SLA)	123, 424	123, 424	4.02
4.03			DI ETARY (SLA)	10, 335	10, 335	4.03
4.04		NURSING ADMINISTRATION	NURSING ADMIN (SLA)	50, 487	50, 487	4.04
4.05			MATERIALS MANAGEMENT (SLA)	14,095	14,095	4.05
4.06		OPERATING ROOM	OPERATING ROOM (SLA)	96, 126	96, 126	4.06
4.07 4.08		RADI OLOGY-DI AGNOSTI C LABORATORY	RADI OLOGY (SLA)	150, 386	150, 386	4.07
4.08 4.09			LABORATORY (SLA)	1, 312, 126	1, 312, 126 13, 728	4.08 4.09
4.09 4.10			RESP THERAPY (SLA) SLEEP LAB (SLA)	13, 728 182, 811	182, 811	4.09 4.10
4.10 4.11			EMERGENCY (SLA)	1, 184, 888	1, 184, 888	4.10
4.11			MARKETING (SLA)	24, 606	24,606	4.11
4.12			PHYSICIAN SERVICES (SLA)	191, 669	191, 669	4.12
4.13			OCCUPATIONAL HEALTH (SLA)	33, 360	33, 360	4.13
4.14	0.00	OCCUPATIONAL MEDICINE	CCOPATIONAL HEALTH (SEA)	33, 300	33, 300	4.14
4.15	0.00			0	0	4.15
4.17	0.00			0	0	4.10
4.18	0.00			0	0	4. 18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4. 20
4.20	0.00			0	0	4.20
	TOTALS (sum of lines 1-4).			10, 865, 769	9, 096, 281	5.00
5.00	Transfer column 6, line 5 to			,,	,, 0, 0, 201	0.00
	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.

			Related Organization(s) and/	or Home Office	1				
					1				
					1				
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1.00	2.00	3.00	4.00	5.00					
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFLCE:							

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

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

i ci indui					
6.00	В	IU HEALTH	100.00	0.00	6.00
7.00	В	IUH NORTH HOSP	1.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

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

Health Financial Systems	IU HEALTH TIPTON HOSPITAL		In Lieu	of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELAT	ED ORGANIZATIONS AND HOME Provider	CCN: 15-1311 Peri	od: 01/01/2016	Worksheet A-8-1
UFFICE COSTS		То	12/31/2016	Date/Time Prepared: 5/24/2017 9:10 am

		57247201	7 7. 10 am
		Wkst. A-7 Ref.	
	Adjustments		
	(col. 4 minus	S S	
	col. 5)*		
	6.00	7.00	
		RRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO		
1.00	117, 405	5 9	1.00
2.00	0	0 9	2.00
3.00	121, 493		3.00
4.00	1, 458, 702		4.00
4.01	71, 888	8 0	4.01
4.02	0	0 0	4. 02
4.03	0	0 0	4.03
4.04	0	0 0	4.04
4.05	0	0 0	4.05
4.06	0	0 0	4.06
4.07	0	0 0	4.07
4.08	0	0 0	4.08
4.09	0	0 0	4.09
4.10	0	0 0	4. 10
4.11	0	0 0	4. 11
4.12	0	0 0	4. 12
4.13	0	0 0	4.13
4.14	0	0 0	4.14
4.15	0	0 0	4.15
4.16	0	0 0	4. 16
4.17	0	o o	4.17
4.18	0	o o	4. 18
4.19	0	o o	4.19
4.20	0	o o	4. 20
4.21	0	o	4. 21
5.00	1, 769, 488	8	5.00

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

1103 1101	been posted to norkaneet A,	cordinas i and/or 2, the amount arrowable should be that eated in cordinary of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51		
	6.00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	6.00
7.00	6.00 7.00
8.00	8.00
9.00	9.00
10.00	10.00
6.00 7.00 8.00 9.00 10.00 100.00	8.00 9.00 10.00 100.00

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

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

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

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

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

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

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

Heal th	Fi nanci a	al Systems	
		DUVELCLAN	

IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10

	R BASED PHYSIC			Provider (Peri od:	Worksheet A-8	
						From 01/01/2016 To 12/31/2016	b Date/Time Pre	narod
						10 12/31/2010	5/24/2017 9:1	0 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.03	OTHER ADMINISTRATIVE AND	500	500	C	0	0	1.00
		GENERAL	10.050	10.050				
2.00		ADULTS & PEDIATRICS	13, 350	13, 350		1		2.00
3.00		OPERATI NG ROOM	356, 391	356, 391		0		3.00
4.00		ANESTHESI OLOGY	304, 133					4.00
5.00		RADI OLOGY-DI AGNOSTI C	150, 386	150, 386		i i	-	5.00
6.00			9, 488	5, 250		0	0	6.00
7.00		RESPIRATORY THERAPY	13, 728	13, 728 0			0	7.00
8.00 9.00		OCCUPATI ONAL THERAPY ELECTROCARDI OLOGY	6,000	0	-,		0	8.00 9.00
		EMERGENCY	25, 172	-	==,=		0	9.00 10.00
10. 00 200. 00	91.00	EMERGENCY	2, 021, 931	734, 932 1, 524, 537			0	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		2497, 394 Cost of	Provi der	Physician Cost	200.00
	WKSL A LINE #	I denti fi er	Limit		Memberships &		of Malpractice	
		rdentirrei			Continuing	Share of col.		
					Educati on	12	Thourance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		OTHER ADMINISTRATIVE AND	0	0			0	1.00
		GENERAL						
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	C	0	0	3.00
4.00	53.00	ANESTHESI OLOGY	0	0	C	0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	5.00
6.00		LABORATORY	0	0	C	0	0	6.00
7.00		RESPI RATORY THERAPY	0	0	C	0	0	7.00
8.00		OCCUPATIONAL THERAPY	0	0	C	0	0	8.00
9.00		ELECTROCARDI OLOGY	0	0	-	0	0	9.00
10.00	91.00	EMERGENCY	0	0	-	0	-	10.00
200.00			0	0		-	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col. 14					
	1.00	2.00	15.00	16.00	17.00	18.00	-	
1.00		OTHER ADMINISTRATIVE AND	13.00	0				1.00
1.00	0.00	GENERAL		0				1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	C	13, 350		2.00
3.00		OPERATING ROOM	0	0	C			3.00
4.00	53.00	ANESTHESI OLOGY	0	0	C	250,000		4.00
5.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	150, 386		5.00
6.00	60.00	LABORATORY	0	0	C	5, 250		6.00
7.00		RESPI RATORY THERAPY	0	0	C	13, 728		7.00
8.00	67.00	OCCUPATI ONAL THERAPY	0	0	C	0		8.00
9.00	69.00	ELECTROCARDI OLOGY	0	0	C			9.00
10.00	91.00	EMERGENCY	0	0	-			10.00
200.00			0	0	C	1, 524, 537		200.00

Heal th	Financial Systems	IU HEALTH TIP	ON HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST AL	LOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/24/2017 9:1	
			CAP	TAL RELATED C	OSTS		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	
		<u>col. 7)</u>	1.00	1.01	2.00	4.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	1, 335, 185	1, 335, 185				1.00
	00101 CAP REL COSTS-BLDG & FIXT - INTERES	703, 384	0	703, 38			1.01
	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 096, 213 2, 147, 250	11, 139	6, 98	1, 096, 213 3 9, 308	2, 174, 680	2.00 4.00
	01160 COMMUNI CATI ONS	315, 345	16, 422	10, 29		69, 254	•
	00550 PATIENT ACCOUNTING	23, 148	41, 099			07,234	1
	00591 OTHER ADMINISTRATIVE AND GENERAL	5, 610, 210	28, 806			88, 982	•
	00700 OPERATION OF PLANT	3, 626, 554	272, 793			87, 883	•
7.01	00701 OPERATION OF PLANT- OFFSITE	0	0		0 0	0	7.01
	00800 LAUNDRY & LINEN SERVICE	103, 473	20, 795	13, 03	6 17, 377	10, 464	8.00
	00900 HOUSEKEEPI NG	321, 505	11, 023	6, 91	9, 211	57, 507	9.00
	01000 DI ETARY	359, 807	32, 031	20, 08		51, 596	
	01100 CAFETERI A	195, 686	22, 278			37, 476	•
	01300 NURSI NG ADMI NI STRATI ON	549,074	29, 451			116, 613	•
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1,066,689	30, 425 10, 378			3, 057	•
	INPATIENT ROUTINE SERVICE COST CENTERS	769, 054	10, 376	6, 50	6 8, 672	117, 804	15.00
	03000 ADULTS & PEDI ATRI CS	1, 236, 067	99, 175	62, 17	4 82, 874	259, 238	30.00
	03100 I NTENSI VE CARE UNI T	720, 275	26, 084			155, 537	•
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	1, 195, 282	158, 050	99, 08	4 132, 073	235, 310	50.00
	05300 ANESTHESI OLOGY	48, 294	2, 902	1, 82		0	
	05400 RADI OLOGY-DI AGNOSTI C	1,077,100	80, 754			221, 536	•
		1, 337, 289	33, 082	20, 73	9 27,644	0	
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	436, 146	1, 935		0	0 89, 040	64.00 65.00
	06600 PHYSI CAL THERAPY	607, 739	42, 183			126, 063	
	06700 OCCUPATI ONAL THERAPY	285, 792	6, 837	4, 28		51, 801	•
	06900 ELECTROCARDI OLOGY	420, 968	19, 692	12, 34		86, 058	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	189, 925	0		0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 385, 682	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 816, 917	0		0 0	0	73.00
	03480 ONCOLOGY	193, 227	12, 829	8, 04	3 10, 720	38, 771	•
	03160 CARDI OPULMONARY	0	0		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	84, 837	14, 603	9, 15	5 12, 203	14, 652	76.97
	DUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	90.00
	09100 EMERGENCY	1, 508, 910	93, 409		· · ·		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,000,710	,0,10,	00,00	, , , , , , , , , , , , , , , , , , , ,	202,007	92.00
	SPECIAL PURPOSE COST CENTERS			1			1
118.00	SUBTOTALS (SUM OF LINES 1-117)	30, 767, 027	1, 118, 175	665, 27	4 934, 388	2, 151, 001	118.00
	NONREI MBURSABLE COST CENTERS			1	1	-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19001 MARKETI NG/PUBLI C RELATI ONS	24, 646	4, 799	3, 00	8 4, 010		190.01
	19100 RESEARCH 19101 MEALS ON WHEELS	0	0				191. 00 191. 01
	19200 PHYSICIANS' PRIVATE OFFICES	390, 832	0 179, 497	25, 42	6 149, 994		191.01
	19200 PHTSICIANS PRIVATE OFFICES	78, 308	9, 359				192.00
	07950 COMMUNITY FITNESS CENTER	70, 500	, 337 N	5,00	0 ,, 321		194.00
	07951 VACANT SPACE	0	23, 355	3, 80	9 0		194.01
200.00	Cross Foot Adjustments		_2, 500				200.00
201.00	Negative Cost Centers		0		0 C		201.00
202.00	TOTAL (sum lines 118-201)	31, 260, 813	1, 335, 185	703, 38	4 1, 096, 213	2, 174, 680	202.00

COST /	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH TIPT	Provider CCN		Period: From 01/01/2016	u of Form CMS- Worksheet B Part I	
					To 12/31/2016		
	Cost Center Description	COMMUNI CATI ONS	PATI ENT ACCOUNTI NG	Subtotal	OTHER ADMI NI STRATI VE	OPERATION OF PLANT	
		5.01	5.02	5A. 02	AND GENERAL 5. 03	7.00	
	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 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4.00 5.01	01160 COMMUNI CATI ONS	425, 039					5.01
5.02	00550 PATIENT ACCOUNTING	48, 149	172, 506				5.02
5.03	00591 OTHER ADMINISTRATIVE AND GENERAL	54, 789	0	5, 824, 91	7 5, 824, 917		5.03
7.00	00700 OPERATION OF PLANT	31, 546	0	4, 385, 96		5, 390, 359	7.00
7.01	00701 OPERATION OF PLANT- OFFSITE	0	0		0 0	322, 734	
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	165, 14		132, 328	
9.00	00900 HOUSEKEEPI NG	0	0	406, 15		70, 145	
10.00	01000 DI ETARY	4, 981	0	495, 26		203, 828	
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	3, 321 34, 866	0	291, 34 769, 14		141, 768 147, 474	
14.00	01400 CENTRAL SERVICES & SUPPLY	6, 641	0	1, 151, 31		193, 608	
15.00		8, 302	0	920, 71		66, 041	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0,002		,20,71	210,010	00/011	10100
30.00	03000 ADULTS & PEDI ATRI CS	26, 565	3, 493	1, 769, 58	405, 242	631, 103	30.00
31.00	03100 I NTENSI VE CARE UNI T	14, 943	762	955, 75	0 218, 871	165, 985	31.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	38, 187	42, 392	1, 900, 37		1, 005, 762	
53.00	05300 ANESTHESI OLOGY	0	1,471	56, 91		18, 470	
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	21, 584 21, 584	17, 236 12, 957	1, 536, 31 1, 453, 29		513, 880 210, 518	
64.00	06400 I NTRAVENOUS THERAPY	21, 304	12, 937		0 0	210, 310	
65.00	06500 RESPI RATORY THERAPY	8, 302	2, 106	540, 35	-	12, 313	
66.00	06600 PHYSI CAL THERAPY	26, 565	4, 230	868, 47		268, 432	
67.00	06700 OCCUPATI ONAL THERAPY	6, 641	1, 243	362, 31	3 82, 971	43, 507	67.00
69.00	06900 ELECTROCARDI OLOGY	23, 244	7, 445	586, 20	134, 244	125, 309	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 038	193, 96		0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	18, 946	1, 404, 62		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	18, 837	1, 835, 75		0	
73.01		9, 962	3, 164	276, 71		81, 638	
76.00 76.97	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	0	0 1, 036	136, 48	0 0 86 31, 256	0 92, 925	
70. 77	OUTPATIENT SERVICE COST CENTERS	0	1,030	130, 40	51,230	72,723	/0. //
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	19, 924	33, 150	2, 024, 36	463, 588	594, 409	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS	TT	I		-		
118.00		410, 096	172, 506	30, 311, 46	5, 607, 511	5, 042, 177	118.00
100.00	NONREIMBURSABLE COST CENTERS	3, 321	0	2 22	761	0	190.00
	19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN	4, 981	0	3, 32 41, 44			190.00
	19100 RESEARCH	4, 901	0		0 0		191.00
	1 19101 MEALS ON WHEELS	0	0		0 0		191.01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	o	762, 30	6 174, 571	258, 089	
	1 19201 OCCUPATIONAL MEDICINE	6, 641	0	115, 11			192.01
	07950 COMMUNITY FITNESS CENTER	0	0		0 0		194.00
	1 07951 VACANT SPACE	0	0	27, 16	6, 221	0	194.01
200.00					0		200.00
201 00	Negative Cost Centers	0	0		0 0		201.00
201.00 202.00	TOTAL (sum lines 118-201)	425, 039	172, 506	31, 260, 81	3 5, 824, 917	5, 390, 359	1000 00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part I Date/Time Pre 5/24/2017 9:1	epared:
Cost Center Description	OPERATION OF PLANT- OFFSITE	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
	7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00 5.01
5. 02 00550 PATIENT ACCOUNTING						5. 02
5. 03 00591 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00 00700 OPERATION OF PLANT						7.00
7.01 00701 OPERATION OF PLANT- OFFSITE	322, 734					7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	335, 292				8.00
9. 00 00900 HOUSEKEEPI NG	0	0	569, 312			9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0	0	22,007		E1E 120	10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	13, 935	0	15, 307 15, 923		515, 139 19, 226	
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	20, 904		0	1
15. 00 01500 PHARMACY	0	0			24, 689	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	46, 803			88, 968	
31. 00 03100 I NTENSI VE CARE UNI T	0	41, 584	17, 921	112, 376	39, 872	31.00
ANCI LLARY SERVI CE COST CENTERS		40.457	100 500		57.0/0	1 50 00
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0	43, 157 0			57, 360 3, 547	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	56, 406			56, 260	
60. 00 06000 LABORATORY	0	6, 291	22, 730		45, 299	
64.00 06400 INTRAVENOUS THERAPY	0	0			0	
65. 00 06500 RESPI RATORY THERAPY	0	0	1, 329	0	23, 093	65.00
66. 00 06600 PHYSI CAL THERAPY	0	22, 782			32, 706	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	4, 698		15, 785	
69. 00 06900 ELECTROCARDI OLOGY	0	44, 729			16, 105	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
73. 01 03480 ONCOLOGY	0	0	8, 814	-	9, 223	
76. 00 03160 CARDI OPULMONARY	0	0	0,011		0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	16, 681	10, 033	0	3, 334	76.97
OUTPATIENT SERVICE COST CENTERS	-		1			
90. 00 09000 CLINIC	0	0			0	
91.00 09100 EMERGENCY	0	42, 775	64, 179	0	69, 385	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	13, 935	321, 208	487, 700	834, 513	504, 852	1118 00
NONREI MBURSABLE COST CENTERS	10, 700	521,200	407,700	004, 010	504, 052	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190. 01 19001 MARKETI NG/PUBLI C RELATI ONS	0	0	3, 297	0		190. 01
191. 00 19100 RESEARCH	0	0	0	0		191.00
191.01 19101 MEALS ON WHEELS	0	0	0	0		191.01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	308, 799	14, 084				192.00
192. 01 19201 OCCUPATI ONAL MEDI CI NE	0	0	6, 430	0		192.01
194.00 07950 COMMUNITY FITNESS CENTER 194.01 07951 VACANT SPACE	0	0		0		194.00 194.01
200.00 Cross Foot Adjustments		0		0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	322, 734	335, 292	569, 312	834, 513	515, 139	202.00

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
					From 01/01/2016 To 12/31/2016	Part Date/Time Pre	pared:
						5/24/2017 9:1	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	Subtotal	Intern & Residents Cost	
		ADMINI STRATTON	SUPPLY			& Post	
			JULL			Stepdown	
						Adjustments	
	[13.00	14.00	15.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	-T	I				
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 2.00	00101 CAP REL COSTS-BLDG & FIXT - INTERES 00200 CAP REL COSTS-MVBLE EQUIP						1.01 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	01160 COMMUNI CATI ONS						5.01
5.02	00550 PATIENT ACCOUNTING						5.02
5.03	00591 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT- OFFSITE						7.01
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
9.00 10.00	01000 DI ETARY						10.00
	01100 CAFETERIA						11.00
	01300 NURSI NG ADMI NI STRATI ON	1, 141, 838					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 629, 477				14.00
15.00	01500 PHARMACY	0	3, 627	1, 233, 05	1		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	T					
30.00	03000 ADULTS & PEDIATRICS	295, 227	40, 065		0 4, 067, 272	0	30.00
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	132, 338	13, 239		0 1, 697, 936	0	31.00
50, 00	05000 OPERATING ROOM	190, 326	459, 273		0 4, 200, 043	0	50.00
53.00	05300 ANESTHESI OLOGY	11, 772	0		0 105, 728	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	186, 744	15, 531		0 2, 772, 445	0	54.00
60.00	06000 LABORATORY	0	28, 398		0 2, 099, 341	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	14, 180		0 715, 018	0	65.00
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	14, 900 0		0 1, 435, 162 0 509, 274	0	66.00
67.00 69.00	06900 ELECTROCARDI OLOGY	53, 438	6, 918		0 509, 274 0 980, 480	0	67.00 69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	118, 279		0 356, 660	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	862, 958		0 2, 589, 251	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 233, 05	1 3, 489, 200	0	73.00
73.01	03480 ONCOLOGY	30, 601	7, 025		0 477, 386	0	73.01
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	11, 081	674		0 302, 470	0	76.97
90, 00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	230, 311	36, 883		0 3, 525, 897	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				-,,	0	
	SPECIAL PURPOSE COST CENTERS						
118.00		1, 141, 838	1, 621, 950	1, 233, 05	1 29, 323, 563	0	118.00
	NONREI MBURSABLE COST CENTERS	-1	-			-	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 4, 082		190.00
	19001 MARKETI NG/PUBLI C RELATI ONS 19100 RESEARCH	0	0		0 84,769 0 0		190. 01 191. 00
	19101 MEALS ON WHEELS	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	6, 857		0 1, 603, 473		192.00
	19201 OCCUPATI ONAL MEDI CI NE	0	670		0 211, 541		192.01
	07950 COMMUNITY FITNESS CENTER	0	О		0 0		194.00
	07951 VACANT SPACE	0	0		0 33, 385		194.01
200.00					0		200.00
201.00 202.00		1 1/1 020	0 1 620 1	1 222 05	U 0		201. 00 202. 00
202.00	I TOTAL (Sum TITLES TIO-201)	1, 141, 838	1, 629, 477	1, 233, 05	31, 260, 813	0	1202. UU

USI ALLUCATIO	ON - GENERAL SERVICE COSTS		Provider CCN: 15-1311		Worksheet B Part I
				To 12/31/2016	Date/Time Prepare 5/24/2017 9:10 an
C	ost Center Description	Total			
OFNEDAL		26.00			
	SERVICE COST CENTERS				
1 1	AP REL COSTS-BLDG & FIXT				1
	AP REL COSTS-BLDG & FIXT - INTERES				1
1 1	AP REL COSTS-MVBLE EQUIP				2
1 1	MPLOYEE BENEFITS DEPARTMENT				4
	OMMUNI CATI ONS ATI ENT ACCOUNTI NG				5
	THER ADMINISTRATIVE AND GENERAL				5
1 1	PERATION OF PLANT				7
	PERATION OF PLANT- OFFSITE				7
	AUNDRY & LINEN SERVICE				8
	OUSEKEEPING				9
D. 00 01000 D					10
	AFETERIA				10
	URSI NG ADMI NI STRATI ON				13
	ENTRAL SERVICES & SUPPLY				14
5. 00 01500 P					15
	NT ROUTINE SERVICE COST CENTERS				10
	DULTS & PEDIATRICS	4,067,272			30
	NTENSI VE CARE UNI T	1, 697, 936			31
	RY SERVICE COST CENTERS	1,077,700			
	PERATI NG ROOM	4, 200, 043			50
	NESTHESI OLOGY	105, 728			53
	ADI OLOGY-DI AGNOSTI C	2, 772, 445			54
	ABORATORY	2,099,341			60
	NTRAVENOUS THERAPY	0			64
	ESPI RATORY THERAPY	715, 018			65
	HYSI CAL THERAPY	1, 435, 162			66
	CCUPATIONAL THERAPY	509, 274			67
	LECTROCARDI OLOGY	980, 480			69
1 1	EDICAL SUPPLIES CHARGED TO PATIENT	356, 660			71
	MPL. DEV. CHARGED TO PATIENTS	2, 589, 251			72
3. 00 07300 D	RUGS CHARGED TO PATIENTS	3, 489, 200			73
3. 01 03480 0	NCOLOGY	477, 386			73
. 00 03160 C	ARDI OPULMONARY	0			76
5.97 07697 C	ARDI AC REHABI LI TATI ON	302, 470			76
OUTPATI	ENT SERVICE COST CENTERS				
). 00 09000 C	LINIC	0			90
.00 09100 E	MERGENCY	3, 525, 897			91
2.00 09200 0	BSERVATION BEDS (NON-DISTINCT PART				92
SPECI AL	. PURPOSE COST CENTERS				
	UBTOTALS (SUM OF LINES 1-117)	29, 323, 563			118
	BURSABLE COST CENTERS				
	IFT, FLOWER, COFFEE SHOP & CANTEEN	4, 082			190
	ARKETING/PUBLIC RELATIONS	84, 769			190
91. 00 19100 R		0			191
	EALS ON WHEELS	0			191
	HYSICIANS' PRIVATE OFFICES	1, 603, 473			192
	CCUPATIONAL MEDICINE	211, 541			192
	OMMUNITY FITNESS CENTER	0			194
94. 01 07951 V		33, 385			194
	ross Foot Adjustments	0			200
	egative Cost Centers	0			201
02.00 T	OTAL (sum lines 118-201)	31, 260, 813			202

Heal th	Financial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2016	Worksheet B	
					To 12/31/2016		
			CAP	I TAL RELATED (COSTS	5/24/2017 9:1	0 am
	Cost Center Description	Directly Assigned New	BLDG & FIXT	BLDG & FIXT - INTERES	- MVBLE EQUIP	Subtotal	
		Capital		TINTERES			
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1.00	1.01	2.00	2A	
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 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATI ONS	0	11, 139 16, 422	6, 98 10, 29		27, 430 40, 440	4.00 5.01
5.01	00550 PATIENT ACCOUNTING	0	41, 099			101, 209	5.01
5.03	00591 OTHER ADMINISTRATIVE AND GENERAL	0	28, 806			70, 936	5.03
7.00	00700 OPERATION OF PLANT	0	272, 793			639, 978	7.00
7.01 8.00	00701 OPERATION OF PLANT- OFFSITE 00800 LAUNDRY & LINEN SERVICE	0	0 20, 795		0 0 6 17, 377	0 E1 200	7.01 8.00
8.00 9.00	00900 HOUSEKEEPING	0	11, 023			51, 208 27, 144	9.00
10.00	01000 DI ETARY	0	32, 031	20, 08		78, 877	10.00
11.00	01100 CAFETERI A	0	22, 278			54, 862	
13.00	01300 NURSING ADMINISTRATION	0	29, 451	14, 52		68, 590	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	30, 425 10, 378			74, 923 25, 556	
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		10, 370	0,30	0,072	23, 330	10.00
30.00	03000 ADULTS & PEDI ATRI CS	0	99, 175			244, 223	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	26, 084	16, 35	2 21, 797	64, 233	31.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	158, 050	99, 08	4 132, 073	389, 207	50.00
53.00	05300 ANESTHESI OLOGY	0	2, 902			7, 147	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	80, 754			198, 861	54.00
60.00	06000 LABORATORY	0	33, 082	20, 73		81, 465	60.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0 1, 935		0 0 3 1,617	0 4, 765	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	0	42, 183			103, 878	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	6, 837	4, 28		16, 836	67.00
69.00	06900 ELECTROCARDI OLOGY	0	19, 692			48, 492	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0 0 0	0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73.01	03480 ONCOLOGY	0	12, 829	8, 04	3 10, 720	31, 592	73.01
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	14, 603	9, 15	5 12, 203	35, 961	76.97
90, 00	09000 CLINIC	0	0		0 0	0	90.00
	09100 EMERGENCY	0	93, 409		-	230, 024	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	0	1, 118, 175	665, 27	4 934, 388	2, 717, 837	110 00
116.00	NONREIMBURSABLE COST CENTERS	0	1, 110, 173	005,27	4 934, 300	2, 111, 031	116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19001 MARKETING/PUBLIC RELATIONS	0	4, 799			11, 817	
	19100 RESEARCH	0	0		0 0		191.00
	19101 MEALS ON WHEELS 19200 PHYSICIANS' PRIVATE OFFICES	0	179, 497	25, 42	6 149, 994	354, 917	191.01 192.00
	19201 OCCUPATI ONAL MEDI CI NE	0	9, 359			23, 047	
	07950 COMMUNITY FITNESS CENTER	0	0		0 0		194.00
	07951 VACANT SPACE	0	23, 355	3, 80	9 0		194.01
200.00 201.00			Λ		0		200. 00 201. 00
201.00		0	1, 335, 185	703, 38	4 1, 096, 213	3, 134, 782	
							•

	Financial Systems	IU HEALTH TIP				u of Form CMS-	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	1	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre	epared:
					071150	5/24/2017 9:1	0 am
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	PATI ENT ACCOUNTI NG	OTHER ADMI NI STRATI VE AND GENERAL	OPERATION OF PLANT	
		4.00	5.01	5.02	5. 03	7.00	
	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	07.400					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS	27,430					4.00
5.01 5.02	00550 PATIENT ACCOUNTING	874		105, 88	0		5.01
5.02 5.03	00591 OTHER ADMINISTRATIVE AND GENERAL	1, 122	.,		9 0 77, 383		5.02
7.00	00700 OPERATI ON OF PLANT	1, 109			0 13, 350	657, 503	
7.00	00701 OPERATION OF PLANT- OFFSITE	0			0 0	39, 366	
8.00	00800 LAUNDRY & LINEN SERVICE	132			0 502	16, 141	
9.00	00900 HOUSEKEEPI NG	725			0 1, 236	8, 556	
10.00	01000 DI ETARY	651			0 1, 507	24, 862	
11.00	01100 CAFETERIA	473			0 886	17, 293	
13.00	01300 NURSING ADMINISTRATION	1, 471			0 2, 340	17, 988	
14.00	01400 CENTRAL SERVICES & SUPPLY	39			0 3, 502	23, 616	
15.00	01500 PHARMACY	1, 486	807		2, 801	8, 056	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	3, 267	2, 582	2, 14	3 5, 383	76, 980	30.00
31.00	03100 I NTENSI VE CARE UNI T	1, 962	1, 452	46	7 2, 907	20, 246	31.00
	ANCI LLARY SERVICE COST CENTERS		-				
50.00	05000 OPERATING ROOM	2, 968	3, 712	26, 06		122, 680	
53.00	05300 ANESTHESI OLOGY	0	0	90	-	2, 253	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 795		10, 57		62, 682	
60.00	06000 LABORATORY	0		7, 95		25, 679	
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	
65.00	06500 RESPI RATORY THERAPY	1, 123		1, 29		1, 502	
66.00	06600 PHYSI CAL THERAPY	1, 590		2, 59		32, 743	
67.00		653		76		5, 307	
69.00	06900 ELECTROCARDI OLOGY	1,086		4, 56		15, 285	1
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	-	2, 47 11, 62		0	
72.00	07300 DRUGS CHARGED TO PATIENTS		-	11, 55		0	
73.00	03480 ONCOLOGY	489		1, 94		9, 958	
76.00	03160 CARDI OPULMONARY	407			0 0	2, 300 0	
76.97	07697 CARDI AC REHABI LI TATI ON	185	-	63		11, 335	
	OUTPATIENT SERVICE COST CENTERS	100				11,000	
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	2, 931	1, 937	20, 33	9 6, 158	72, 505	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00		27, 131	39, 861	105, 88	9 74, 495	615, 033	118.00
	NONREI MBURSABLE COST CENTERS		-				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0 10		190.00
	19001 MARKETING/PUBLIC RELATIONS	0			0 126		190. 01
191.00	19100 RESEARCH	0			0 0		191.00
	19101 MEALS ON WHEELS	0			0 0		191.01
	19200 PHYSI CI ANS' PRI VATE OFFI CES	209			0 2, 319		192.00
	19201 OCCUPATI ONAL MEDI CI NE	90	646		0 350		192.01
	07950 COMMUNITY FITNESS CENTER	0	0		0 0		194.00
	07951 VACANT SPACE	0	0		0 83	0	194.01
					1		200.00
200.00		_				~	
	Negative Cost Centers	0 27, 430	0 41, 314	105, 88	0 0 9 77, 383		201.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2016 o 12/31/2016	Worksheet B Part II Date/Time Pre 5/24/2017 9:1	epared: 0 am
Cost Center Description	OPERATI ON OF PLANT- OFFSI TE	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERIA	
	7.01	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 01 01160 COMMUNI CATI ONS						4.00
5. 02 00550 PATIENT ACCOUNTING						5.02
5. 03 00591 OTHER ADMINISTRATIVE AND GENERAL						5.03
7.00 00700 OPERATION OF PLANT						7.00
7.01 00701 OPERATION OF PLANT- OFFSITE	39, 366					7.01
8.00 00800 LAUNDRY & LINEN SERVICE	0	67, 983				8.00
9.00 00900 HOUSEKEEPI NG	0	0				9.00
10. 00 01000 DI ETARY	0	0	1,100	107, 837	74.050	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0 1, 700	0	1, 013 1, 053	0	74, 850 2, 794	
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0		0	2, 794	
15. 00 01500 PHARMACY	0	0		0	3, 587	
INPATIENT ROUTINE SERVICE COST CENTERS	-1 -1		,	-	.,	
30. 00 03000 ADULTS & PEDI ATRI CS	0	9, 490	4, 508	93, 316	12, 928	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	8, 431	1, 186	14, 521	5, 793	31.00
ANCI LLARY SERVICE COST CENTERS	TT					
50. 00 O5000 OPERATING ROOM	0	8, 750		0	8, 334	1
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	11 427		0	515 8, 175	
60. 00 06000 LABORATORY	0	11, 437 1, 276		0	6, 582	
64. 00 06400 I NTRAVENOUS THERAPY	0	1, 2,0		0	0, 302	
65. 00 06500 RESPI RATORY THERAPY	0	0		0	3, 355	
66. 00 06600 PHYSI CAL THERAPY	0	4, 619	1, 917	0	4, 752	
67.00 06700 OCCUPATI ONAL THERAPY	0	0	311	0	2, 294	67.00
69.00 06900 ELECTROCARDI OLOGY	0	9, 069		0	2, 340	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01 03480 0NC0L0GY	0	0	583	0	1, 340	
76. 00 03160 CARDI OPULMONARY	0	0	0	0	1, 340	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	3, 382		0	484	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	
91.00 09100 EMERGENCY	0	8, 673	4, 246	0	10, 082	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117)	1,700	65, 127	32, 263	107, 837	72 255	118.00
NONREI MBURSABLE COST CENTERS	1,700	03, 127	32, 203	107, 037	73, 300	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190. 01 19001 MARKETI NG/PUBLIC RELATIONS	0	0	218	0		190.01
191. 00 19100 RESEARCH	0	0	0	0		191.00
191.01 19101 MEALS ON WHEELS	0	0	0	0		191.01
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	37, 666	2, 856		0		192.00
192. 01 19201 OCCUPATI ONAL MEDI CI NE	0	0	425	0		192.01
194. 00 07950 COMMUNITY FITNESS CENTER	0	0	0	0		194.00
194.0107951VACANT SPACE200.00Cross Foot Adjustments	0	0	0	0	0	194. 01 200. 00
201.00 Negative Cost Centers	0	Ω	0	0	Ω	200.00
202.00 TOTAL (sum lines 118-201)	39, 366	67, 983	37, 661	107, 837		202.00
	0.,000	0., 700	0.,001	,	, 500	1

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1311	Period: From 01/01/2016	Worksheet B Part II	
					To 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	Subtotal	5/24/2017 9:1	0 am
		ADMI NI STRATI ON	SERVICES &			Residents Cost	
			SUPPLY			& Post	
						Stepdown	
		13.00	14.00	15.00	24.00	Adjustments 25.00	
	GENERAL SERVICE COST CENTERS	10100	11100	101.00	21100	20100	
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 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNICATIONS						4.00 5.01
5.02	00550 PATIENT ACCOUNTING						5.02
5.03	00591 OTHER ADMINISTRATIVE AND GENERAL						5.03
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 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	99, 325					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	104, 109				14.00
15.00	01500 PHARMACY	0	232	42, 99	7		15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	25 (01	2.5/0		402.0/1		20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	25, 681 11, 512	2, 560 846		0 483, 061 0 133, 556	0	30.00 31.00
51.00	ANCI LLARY SERVICE COST CENTERS	11, 312	040		0 133, 330	0	31.00
50.00	05000 OPERATI NG ROOM	16, 556	29, 343		0 620, 574	0	50.00
53.00	05300 ANESTHESI OLOGY	1, 024	0		0 12, 146	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 244	992		0 322, 202	0	54.00
60.00 64.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	1, 814 0		0 132, 789 0 0	0	60.00 64.00
65.00	06500 RESPI RATORY THERAPY	0	906		0 15, 482	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	952		0 158, 270	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 27, 911	0	67.00
69.00	06900 ELECTROCARDI OLOGY	4, 648	442		0 90, 867	0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	7, 557		0 10, 624 0 71, 032	0	71.00 72.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	55, 135 0	42, 99	,	0	73.00
73.01	03480 ONCOLOGY	2,662	449		0 50, 824	0	73.01
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	964	43		0 54, 069	0	76.97
00.00	OUTPATI ENT SERVICE COST CENTERS		0		0 0	0	
90.00 91.00	09100 EMERGENCY	0 20, 034	0 2, 357		0 0 0 379, 286	0	90.00 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	20,034	2, 337		577,200	0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		99, 325	103, 628	42, 99	7 2, 622, 831	0	118.00
100.00	NONREI MBURSABLE COST CENTERS				0 222		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 MARKETING/PUBLIC RELATIONS	0	0		0 333 0 16, 370		190. 00 190. 01
	19100 RESEARCH	0	0		0 10, 370		190.01
	19101 MEALS ON WHEELS	0	0		0 0		191.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	438		0 435, 641	0	192.00
	19201 OCCUPATI ONAL MEDI CI NE	0	43		0 32, 360		192.01
	07950 COMMUNITY FITNESS CENTER 07951 VACANT SPACE	0	0		0 0 0 27, 247		194. 00 194. 01
200.00		0	0		ر 21,241 ۱		200.00
200.00		0	о		0 0		201.00
202.00		99, 325	104, 109	42, 99	7 3, 134, 782		202.00

Heal th Financi	al Syste	ems	
ALLOCATION OF	CAPI TAL	RELATED	COSTS

IU HEALTH TIPTON HOSPITAL In Provider CCN: 15-1311 Period:

In Lieu of Form CMS-2552-10 Worksheet B

ALLOUA	ITTON OF CAPITAL RELATED COSTS		From 01/01/2016 Pa To 12/31/2016 Da	art II ate/Time Prepared: /24/2017 9:10 am
	Cost Center Description	Total	 	2472017 7.10 dill
		26.00	 	
1 00	GENERAL SERVICE COST CENTERS	I I		
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 EQUI P			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.01	01160 COMMUNI CATI ONS			5. 01
5.02	00550 PATIENT ACCOUNTING			5.02
5.03	00591 OTHER ADMINISTRATIVE AND GENERAL			5.03
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 HOUSEKEEPING			9.00
10.00	01000 DI ETARY			10.00
11.00				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY			14.00
15.00	01500 PHARMACY			15.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	402.0/1		
30.00	03000 ADULTS & PEDIATRICS	483,061		30.00
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	133, 556		31.00
50, 00	05000 OPERATING ROOM	620, 574		50.00
53.00	05300 ANESTHESI OLOGY	12, 146		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	322, 202		54.00
54.00 60.00	06000 LABORATORY	132, 202		60. 00
64.00	06400 I NTRAVENOUS THERAPY	132, 789		64.00
64.00 65.00	06500 RESPIRATORY THERAPY			65.00
66.00	06600 PHYSI CAL THERAPY	15, 482 158, 270		66.00
67.00	06700 OCCUPATI ONAL THERAPY	27, 911		67.00
69.00	06900 ELECTROCARDI OLOGY	90, 867		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 624		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	71,032		71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	60, 138		73.00
	03480 ONCOLOGY	50, 824		73.00
76.00	03160 CARDI OPULMONARY	0		76.00
	07697 CARDI AC REHABI LI TATI ON	54,069		76.97
70.77	OUTPATIENT SERVICE COST CENTERS	54,007		10. 11
90.00	09000 CLINIC	0		90.00
	09100 EMERGENCY	379, 286		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0111200		92.00
,2,00	SPECIAL PURPOSE COST CENTERS	II		
118.00		2, 622, 831		118.00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	333		190.00
	19001 MARKETI NG/PUBLIC RELATIONS	16, 370		190.01
191.00	19100 RESEARCH	0		191.00
	19101 MEALS ON WHEELS	0		191.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	435, 641		192.00
	19201 OCCUPATIONAL MEDICINE	32, 360		192.01
	07950 COMMUNITY FITNESS CENTER	0		194.00
	07951 VACANT SPACE	27, 247		194.01
200.00		0		200.00
201.00	5	0		201.00
202.00	5	3, 134, 782		202.00
	· · · ·			

alth Financial Systems ST ALLOCATION - STATISTICAL BASIS	TO HEALTH T	PTON HOSPITAL Provider C	CN: 15-1311	Period:	wof Form CMS- Worksheet B-1	
			F	rom 01/01/2016		
			1	Го 12/31/2016	Date/Time Pre 5/24/2017 9:1	
	CA	PITAL RELATED CO	OSTS			Ī
Cost Center Description	BLDG & FIXT (SQUARE FEET		MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFI TS	COMMUNI CATI ONS	
		(SQUARE FEET)		DEPARTMENT	(NON-PATIEN T	
				(GROSS	TELEPHON)	
				SALARI ES)		
	1.00	1.01	2.00	4.00	5. 01	-
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT	207,00	16	1			1.
00101 CAP REL COSTS-BLDG & FIXT		0 173, 951				
00 00200 CAP REL COSTS-MVBLE EQUIP			203, 385	5		
00400 EMPLOYEE BENEFITS DEPARTME	NT 1, 72	1, 727				
01160 COMMUNI CATI ONS	2, 54	6 2, 546	2, 546	319, 309	256	1
00550 PATIENT ACCOUNTING	6, 37				29	
00591 OTHER ADMINISTRATIVE AND G					33	
00700 OPERATION OF PLANT	42, 29				19	
01 00701 OPERATION OF PLANT- OFFSIT 00 00800 LAUNDRY & LINEN SERVICE	3, 22	0 0 24 3, 224			0	
00900 HOUSEKEEPING	1, 70				0	
00 01000 DI ETARY	4, 96				3	1
00 01100 CAFETERIA	3, 45				2	1
00 01300 NURSING ADMINISTRATION	4, 56				21	1
. 00 01400 CENTRAL SERVICES & SUPPLY	4, 71	7 4, 717	4, 71	7 14, 095	4	1
. 00 01500 PHARMACY	1,60	1, 609	1,609	9 543, 158	5	1!
INPATIENT ROUTINE SERVICE COST (45.07	1 105 007		
00 03000 ADULTS & PEDIATRICS	15, 37				16	
00 03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	4,04	4 4, 044	4, 044	4 717, 133	9	3
00 05000 OPERATING ROOM	24, 50	24, 504	24, 504	1, 084, 943	23	50
00 05300 ANESTHESI OLOGY	45				0	5
00 05400 RADI OLOGY-DI AGNOSTI C	12, 52				13	
00 06000 LABORATORY	5, 12				13	6
00 06400 INTRAVENOUS THERAPY		0 0		0 0	0	64
00 06500 RESPI RATORY THERAPY	30				5	6
00 06600 PHYSI CAL THERAPY	6, 54				16	
00 06700 OCCUPATI ONAL THERAPY	1, 06					6
00 06900 ELECTROCARDI OLOGY 00 07100 MEDI CAL SUPPLI ES CHARGED T	0. PATLENT	3 3, 053			14 0	6º
00 07200 IMPL. DEV. CHARGED TO PATI				°	0	7
00 07300 DRUGS CHARGED TO PATIENTS		0 0		0 0	0	7
01 03480 ONCOLOGY	1, 98	1, 989	1, 989	178, 759		7
00 03160 CARDI OPULMONARY		0 0	(0 0	0	70
. 97 07697 CARDI AC REHABI LI TATI ON	2,26	2, 264	2, 264	4 67, 558	0	70
OUTPATIENT SERVICE COST CENTERS	I			-1 -	-	1
. 00 09000 CLINIC	1.1.15	0 0				
.00 09100 EMERGENCY .00 09200 OBSERVATION BEDS (NON-DIST	14, 48	32 14, 482	14, 482	2 1, 071, 335	12	9
SPECIAL PURPOSE COST CENTERS	INCI PARI					9.
B. 00 SUBTOTALS (SUM OF LINES 1-	117) 173, 36	1 164, 526	173, 36	9, 917, 635	247	1118
NONREI MBURSABLE COST CENTERS		101/020	110,00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1
D. 00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN	0 0	(0 0	2	190
D. 01 19001 MARKETI NG/PUBLIC RELATIONS	74	4 744	744	4 O		190
1.00 19100 RESEARCH		0 0	(0 0		19
I. 01 19101 MEALS ON WHEELS	c					19
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CE						19: 19:
2.01 19201 OCCUPATIONAL MEDICINE 4.00 07950 COMMUNITY FITNESS CENTER	1, 45	51 1, 451	1, 45	1 32, 839		19.
4. 01 07951 VACANT SPACE	3, 62	21 942				194
0.00 Cross Foot Adjustments	5,02	742				200
1.00 Negative Cost Centers						20
2.00 Cost to be allocated (per	Wkst. B, 1, 335, 18	703, 384	1, 096, 213	2, 174, 680	425, 039	
Part I)						
3.00 Unit cost multiplier (Wkst		4. 043575	5. 389842			
4.00 Cost to be allocated (per	Wkst. B,			27, 430	41, 314	204
Part II)	D. Dont			0.00070/	1/1 202012	00
5.00 Unit cost multiplier (Wkst	. в, Рагт			0.002736	161. 382813	120

OST /	ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2016	Worksheet B-1	
					o 12/31/2016	Date/Time Pre 5/24/2017 9:1	
	Cost Center Description	PATI ENT	Reconci I i ati on		OPERATION OF	OPERATION OF	
		ACCOUNTING (GROSS CHAR		ADMI NI STRATI VE AND GENERAL	PLANT (SQUARE FEET)	PLANT- OFFSITE	
		GES)		(ACCUM. COST)		(SQUARE FEET)	
		5.02	5A. 03	5.03	7.00	7.01	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 1.0
. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
. 01 . 02	01160 COMMUNI CATI ONS 00550 PATI ENT ACCOUNTI NG	100, 713, 921					5. 5.
. 02	00591 OTHER ADMINISTRATIVE AND GENERAL	100, 713, 92		25, 435, 896			5.
. 00	00700 OPERATION OF PLANT	C	0	4, 385, 961			7.
. 01	00701 OPERATION OF PLANT- OFFSITE	C	0	C		22, 512	7.
. 00	00800 LAUNDRY & LINEN SERVICE	(0	165, 145		0	
. 00 0. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	(406, 156		0	9. 10.
1.00	01100 CAFETERIA			495, 261 291, 345		0	10.
3.00	01300 NURSI NG ADMI NI STRATI ON	(0	769, 143		972	13.
4.00	01400 CENTRAL SERVICES & SUPPLY	(0	1, 151, 310		0	14.
5.00		(0	920, 716	1, 609	0	15.
0 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 020 025	·	1 7(0 50(15, 376	0	1 20
0.00 1.00		2, 039, 035 444, 712				0	30. 31.
1.00	ANCI LLARY SERVICE COST CENTERS	, , , , , , , , , , , , , , , , , , , ,		755,750	1,011	0	51.
0. 00	05000 OPERATI NG ROOM	24, 757, 883	8 0	1, 900, 378	24, 504	0	50.
3.00	05300 ANESTHESI OLOGY	858, 511				0	53.
4.00	05400 RADI OLOGY-DI AGNOSTI C	10, 061, 785		1, 536, 317		0	54.
0.00 4.00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	7, 564, 193	0	1, 453, 295	5, 129 0	0	60. 64.
4.00 5.00	06500 RESPI RATORY THERAPY	1, 229, 177		540, 359	-	0	65.
6.00		2, 469, 366		868, 475		0	66.
7.00	06700 OCCUPATI ONAL THERAPY	725, 453	0	362, 313	1, 060	0	67.
9.00		4, 345, 908		586, 207		0	69.
1.00		2, 357, 173		193, 963		0	71.
2.00 3.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	11, 060, 297 10, 996, 226		1, 404, 628 1, 835, 754		0	72.
3.00	03480 ONCOLOGY	1, 847, 026		276, 716		0	73.
6.00		(0	C		0	76.
6. 97	07697 CARDI AC REHABI LI TATI ON	605, 068	8 0	136, 486	2, 264	0	76.
	OUTPATIENT SERVICE COST CENTERS					0	
0.00 1.00	09000 CLINIC 09100 EMERGENCY) 19, 352, 108	-		-	0	90. 91.
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 332, 100		2, 024, 307	14, 402	0	92.
	SPECIAL PURPOSE COST CENTERS		1	1			
18.00		100, 713, 921	-5, 824, 917	24, 486, 543	122, 846	972	118.
~ ~	NONREI MBURSABLE COST CENTERS			2.201		0	1100
	D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 19001 MARKETI NG/PUBLI C RELATI ONS	(3, 321 41, 444			190. 190.
	D19100 RESEARCH	(41, 444	0		191.
	1 19101 MEALS ON WHEELS	(0	C	0		191.
92.00	0 19200 PHYSI CLANS' PRI VATE OFFI CES	C	0	762, 306	6, 288	21, 540	192.
	1 19201 OCCUPATI ONAL MEDI CI NE	C	0	115, 118	1, 451		192.
	007950 COMMUNITY FITNESS CENTER	(0		0		194.
74.0° 00.00	1 07951 VACANT SPACE Cross Foot Adjustments	(0	27, 164	0	0	194. 200.
00.00 01.00	5						200.
02.00	S.	172, 506		5, 824, 917	5, 390, 359	322, 734	
	Part I)						
03.00		0.001713		0. 229004		14. 336087	
04.00		105, 889		77, 383	657, 503	39, 366	204.
05.00	Part II) D Unit cost multiplier (Wkst. B, Part	0. 001051		0.003042	5. 006533	1. 748667	205
JJ. U	II)	0.00105		0.003042		1. / 4000 /	200.

	Financial Systems	IU HEALTH TIP				u of Form CMS-	
CUST A	LLOCATION - STATISTICAL BASIS		Provider C	F	Period: From 01/01/2016 Fo 12/31/2016		pared:
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	5/24/2017 9:1 NURSI NG	0 am
		LINEN SERVICE (POUNDS OF LAUNDRY)	(SQUARE FEET)	(MEALS SERVED)) (FTE' S)	ADMI NI STRATI ON (DI RECT NUR	
						SING HOURS)	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5.01	01160 COMMUNI CATI ONS						5. 01
5.02	00550 PATIENT ACCOUNTING						5.02
5.03 7.00	00591 OTHER ADMINISTRATIVE AND GENERAL 00700 OPERATION OF PLANT						5.03
7.01	00701 OPERATION OF PLANT- OFFSITE						7.01
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	14, 070 0	128, 466				8.00 9.00
9.00 10.00	01000 DI ETARY	0	4, 966		5		10.00
	01100 CAFETERI A	0	3, 454	0	14, 522		11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	3, 593 4, 717			201, 753 0	
	01500 PHARMACY	0	1, 609			0	
	INPATIENT ROUTINE SERVICE COST CENTERS						1
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	1, 964 1, 745	15, 376 4, 044			52, 164 23, 383	
51.00	ANCI LLARY SERVICE COST CENTERS	1,743	4, 044	1,07	1, 124	23, 303	51.00
50.00	05000 OPERATING ROOM	1, 811	24, 504			33, 629	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 2, 367	450 12, 520			2, 080 32, 996	
60.00	06000 LABORATORY	264	5, 129			0	
64.00	06400 I NTRAVENOUS THERAPY	0	0		-	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 956	300 6, 540		0 651 0 922	0	
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 060			0	
	06900 ELECTROCARDI OLOGY	1, 877	3, 053		454	9, 442	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	
	07300 DRUGS CHARGED TO PATIENTS	0	0		-	0	
	03480 ONCOLOGY	0	1, 989			5, 407	
76.00 76.97	03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON	0 700	0 2, 264	-		0 1, 958	
/0. //	OUTPATIENT SERVICE COST CENTERS	/00	2,204			1, 750	/0. //
		0	0			0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 795	14, 482	0	1, 956	40, 694	91.00
, 2, 00	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	13, 479	110, 050	14, 065	5 14, 232	201, 753	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0	0	190.00
190.01	19001 MARKETI NG/PUBLIC RELATIONS	0	744	(0 0		190. 01
	19100 RESEARCH	0	0	(191.00
	19101 MEALS ON WHEELS 19200 PHYSI CLANS' PRI VATE OFFI CES	591	16, 221		0 0 0 194		191.01 192.00
192.01	19201 OCCUPATIONAL MEDICINE	0	1, 451		96	0	192.01
	07950 COMMUNITY FITNESS CENTER	0	0	(0		194.00
200.00	07951 VACANT SPACE Cross Foot Adjustments	0	0		0	0	194. 01 200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	335, 292	569, 312	834, 513	3 515, 139	1, 141, 838	202.00
203.00		23. 830277	4. 431616	59. 332599	35. 473006	5. 659584	203.00
204.00	Cost to be allocated (per Wkst. B,	67, 983	37, 661				204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	4. 831770	0. 293159	7.667046	5. 154249	0. 492310	205.00
			0.2/010/		5.101277	3. 172010	

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		1	n Lieu of Form C	MS-2552-10
	LLOCATION - STATISTICAL BASIS		Provider CCN:	15-1311	Period: From 01/01	Worksheet	
						/2016 Date/Time 5/24/2017	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S.)			1 3/24/2011	7. 10 dm
		14.00	15.00				
	GENERAL SERVICE COST CENTERS	1					
1.00 1.01 2.00 4.00 5.01 5.02 5.03	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - INTERES 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 01160 COMMUNI CATIONS 00550 PATIENT ACCOUNTING 00591 OTHER ADMINISTRATIVE AND GENERAL						$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 5.\ 03\end{array}$
7.00 7.01 8.00	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT- OFFSITE 00800 LAUNDRY & LINEN SERVICE						7.00 7.01 8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DI ETARY						9.00 10.00
							11.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	2, 616, 509					13.00 14.00
	01500 PHARMACY	5, 824	100				15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	64, 334	0				30.00
	03100 I NTENSI VE CARE UNI T	21, 259	0				31.00
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	737, 471	0				50.00 53.00
53.00 54.00	05400 RADI OLOGY-DI AGNOSTI C	24, 939	0				53.00
	06000 LABORATORY	45, 599	0				60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	22, 769 23, 926	0				65.00 66.00
	06700 OCCUPATIONAL THERAPY	0	0				67.00
69.00	06900 ELECTROCARDI OLOGY	11, 108	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	189, 925 1, 385, 682	0				71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 303, 002	100				73.00
	03480 ONCOLOGY	11, 280	0				73.01
	03160 CARDI OPULMONARY	0	0				76.00
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	1,082	0				76. 97
	09000 CLI NI C	0	0				90.00
	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	59, 225	0				91.00 92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		2, 604, 423	100				118.00
100.00	NONREI MBURSABLE COST CENTERS		0				100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 MARKETING/PUBLIC RELATIONS	0	0				190. 00 190. 01
191.00	19100 RESEARCH	0	0				191.00
	19101 MEALS ON WHEELS	0	0				191.01
	19200 PHYSICIANS' PRIVATE OFFICES 19201 OCCUPATIONAL MEDICINE	11,010	0				192. 00 192. 01
	07950 COMMUNITY FITNESS CENTER	0	0				194.00
	07951 VACANT_SPACE	0	0				194.01
200.00 201.00							200. 00 201. 00
201.00	0	1, 629, 477	1, 233, 051				202.00
203.00 204.00	Cost to be allocated (per Wkst. B,	0. 622768 104, 109					203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)	0. 039789	429. 970000				205. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CON: 15-1311 Period: From 01/01/2016 To 12/31/2016 Worksheet C Date/Time Prepared: 5/24/2017 9:10 am 5/24/2017 0:10 am 5/24/2017 0:10 am 5/24/2017 0:10 am 5/24/2017 0:10 am 5/2	Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Total Cost (from Wkst: B, Part I, col. 26) Therapy Limit Adj. Therapy Limit Adj. Total Costs Total Costs Total Costs 30.00 03000 ADULTS & PEDIATRICS 4,067,272 0 <t< td=""><td>COMPUTATION OF RATIO OF COSTS TO CHARGES</td><td></td><td></td><td></td><td>From 01/01/2016 To 12/31/2016</td><td>Part I Date/Time Pre</td><td></td></t<>	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2016 To 12/31/2016	Part I Date/Time Pre	
Cost Center Description Total Cost (from Wkst. B) 26) Therapy Lim it Adj. Total Costs Adj. RCE Disal I owance Total Costs RCE 1000 200 3.00 4.00 5.00 1000 3000 ADULTS & PEDIATRICS 4.067, 272 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1,697, 936 1 0 30.00 31.00 31.00 0.00 03000 ADULTS & PEDIATRICS 4.067, 272 0 0 30.00 31.00 0.00 05000 (OPERATIN RO ROM 4.200, 043 4.200, 043 0 50.00 0.00 05000 (OPERATING ROM 4.200, 043 0 50.00 53.00 0.00 05000 (OPERATING ROM 2.099, 341 0 0 54.00 0.00 06000 LABORATORY 2.099, 341 2.099, 341 0 66.00 0.00 06000 RADEINCRY THERAPY 0 0 0 66.00 0.00 0.00 0 0 0 66.00 67.00 0.00 0		_	Title	XVIII	Hospi tal	Cost	
Impart Entropy (from Wkst. B, Part I, col. 26) Adj. Disal I owance 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDIATRICS 4,067,272 0 0 30.00 31.00 DITENSIVE CARE UNIT 1.677,936 1.97,936 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05300 ANESTHESIOLOGY 105,728 0 0 53.00 53.00 05400 PERATING ROOM 4,200,043 4,200,043 0 0 53.00 54.00 05400 RADIOLOGY 105,728 0 0 54.00 54.00 54.00 54.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
Part I, col. 26 3 3 4 3 4 3 4 3 4 3 4 3 <	Cost Center Description		Therapy Limit	Total Costs		Total Costs	
26) 0 0 0 1.00 2.00 3.00 4.00 5.00 30.00 03000 ADULTS & PEDIATRICS 4.067.272 4.067.272 0 0 30.00 31.00 03000 ADULTS & PEDIATRICS 4.067.272 4.067.272 0 0 30.00 31.00 03000 INTENSIVE CARE UNI T 1.697.936 0 0 31.00 50.00 05500 OPERATING ROOM 4.200.043 4.200.043 0 0 53.00 51.00 05300 ANESTHESI OLOGY 105.728 0 0 53.00 54.00 05400 RADI OLOGY OI AGNOSTI C 2.772.445 2.772.445 0 64.00 60.00 06400 INTRAVENOUS THERAPY 0 0 0 66.00 65.00 06500 RESPI RATORY THERAPY 1435.162 0 1.435.162 0 66.00 60.00 667.00 00 0 66.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00		N	Adj.		Di sal I owance		
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 3000 AULTS & PEDI ATRI CS 4,067,272 0 0 30.00 31.00 03000 ADULTS & PEDI ATRI CS 4,067,272 0 0 0 30.00 31.00 03000 ADULTS & PEDI ATRI CS 4,067,272 0 0 0 31.00 31.00 03000 INTENSI VE CARE UNI T 1,697,936 1,697,936 0 0 31.00 30.00 05000 OPERATI NG ROOM 4,200,043 4,200,043 0 50.00 53.00 05300 ANESTHESI OLGY 105,728 0 0 53.00 54.00 05600 LERAPY 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 67.00 66.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 4, 067, 272 0 0 30. 00 31. 00 03000 ADULTS & PEDIATRICS 4, 067, 272 00							
30.00 03000 ADULTS & PEDIATRICS 4,067,272 4,067,272 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1,697,936 0 0 31.00 ANCILLARY SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
31.00 O3100 INTENSIVE CARE UNIT 1, 697, 936 0 0 31.00 ANCI LLARY SERVICE COST CENTERS				1			-
ANCILLARY SERVICE COST CENTERS 50:00 05000 OPERATI NG ROM 4, 200, 043 4, 200, 043 0 0 53. 00 54:00 05400 ANESTHESI OLOGY 105, 728 0 0 53. 00 54:00 05400 RADI OLOGY – DI AGNOSTI C 2, 772, 445 2, 772, 445 0 0 60. 00 60:00 LABORATORY 2, 099, 341 0 0 60. 00 64. 00 64.00 0 0 0 64. 00 64.00 66.00 0 0 64. 00 66.00 65.00 06500 RESPI RATORY THERAPY 715, 018 0 715, 018 0 65.00 66.00 66.00 66.00 66.00 66.00 66.00 67. 00 66000 200 colupational therapy 509, 274 0 509, 274 0 66.00 67. 00 66.00 0 71.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></td<>							
50.00 05000 0PERATI NG R00M 4, 200, 043 4, 200, 043 0 0 50.00 53.00 05300 ANESTHESI 0LOGY 105, 728 0 0 53.00 54.00 05400 RADIOLOGY-DIAGNOSTI C 2, 772, 445 0 0 54.00 60.00 06000 LABORATORY 2, 099, 341 0 0 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 715, 018 0 715, 018 0 65.00 66.00 06600 PLYSI CAL THERAPY 1, 435, 162 0 1, 435, 162 0 66.00 67.00 06700 OCUPATI IONAL THERAPY 509, 274 0 509, 274 0 67.00 69.00 ELECTROCARDI OLOGY 980, 480 980, 480 0 0 67.00 72.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2,589, 251 2,589, 251 0 72.00 73.01 03480 0NCOLOGY 477, 386 477, 386 0		1, 697, 936		1, 697, 93	36 0	0	31.00
53.00 05300 ANESTHESI OLOGY 105,728 105,728 0 53.00 54.00 RADI OLOGY-DI AGNOSTI C 2,772,445 2,772,445 0 54.00 60.00 LABORATORY 2,099,341 0 0 60.00 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 715,018 0 715,018 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,435,162 0 1,435,162 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 509,274 0 599,274 0 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 0 69.00 69.00 69.00 69.00 71.00 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00		1			1		
54.00 05400 RADI OLOGY - DI AGNOSTI C 2,772,445 0 0 54.00 60.00 06000 LABORATORY 2,099,341 0						-	
60.00 06000 LABORATORY 2,099,341 2,099,341 0						0	
64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 715,018 0 715,018 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,435,162 0 1,435,162 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 1,435,162 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 980,480 980,480 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 356,660 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2,589,251 2,589,251 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 3,489,200 3,489,200 0 73.00 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 76.00 76.00 76.00 76.00 76.97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 0 92.00 90.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>0</td><td></td></t<>						0	
65.00 06500 RESPI RATORY THERAPY 715,018 0 715,018 0 66.00 66.00 06600 PHYSI CAL THERAPY 1,435,162 0 1,435,162 0 66.00 67.00 0COUPATI ONAL THERAPY 509,274 0 509,274 0 67.00 69.00 06900 ELECTROCARDIOLOGY 980,480 980,480 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 356,660 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,589,251 2,589,251 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,489,200 3,489,200 0 73.00 73.01 03480 ONCOLOGY 477,386 477,386 0 0 73.01 76.07 07697 CARDI AC REHABILITATION 302,470 302,470 0 76.97 0UTPATIENT SERVICE COST CENTERS 0 0 0 786,888 786,888 0 92.00 90.00 092000 DELENRGENCY 3,525,897 0 <td></td> <td>2,099,341</td> <td></td> <td>2, 099, 3</td> <td>41 0</td> <td>0</td> <td></td>		2,099,341		2, 099, 3	41 0	0	
66.00 06600 PHYSI CAL THERAPY 1,435,162 0 1,435,162 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 509,274 0 509,274 0 67.00 69.00 06900 ELECTROCARDI OLOGY 980,480 980,480 980,480 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 356,660 356,660 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2,589,251 2,589,251 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 3,489,200 3,489,200 0 0 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 73.01 76.00 03160 CARDI AC REHABI LI TATI ON 302,470 302,470 0 0 76.97 00 09000 CLINIC 0 0 0 0 0 90.00 91.00 91.00 92.00 <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td>0</td> <td></td>		0			0 0	0	
67.00 06700 0CCUPATI ONAL THERAPY 509, 274 0 509, 274 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 980, 480 980, 480 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 356, 660 356, 660 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 589, 251 2, 589, 251 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 2, 589, 251 2, 589, 251 0 0 73.00 73.01 03480 0NCOLOGY 477, 386 477, 386 0 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 0 76.00 76.97 OR697 CARDI AC REHABI LI TATI ON 302, 470 302, 470 0 0 76.97 0 09000 CLI NI C 0 0 0 0 90.00 91.00 91.00 91.00 92.00 0 92.00 92.00 92.00 92.00 92.00 92.00 92.00		715, 018	0	715, 0	18 0	0	65.00
69.00 06900 ELECTROCARDIOLOGY 980,480 980,480 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 356,660 356,660 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2,589,251 2,589,251 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,489,200 3,489,200 0 73.00 73.01 03480 ONCOLOGY 477,386 477,386 0 0 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 73.01 76.97 OR697 CARDI AC REHABILITATION 302,470 302,470 0 0 76.00 76.97 OR697 CARDI AC REHABILITATION 302,470 0 0 76.97 00.00 09000 CLINIC 0 0 0 90.00 91.00 91.00 92.00 09SERVATI ON BEDS (NON-DI STINCT PART 786,888 786,888 0 9		1, 435, 162	0	1, 435, 1	62 0	0	66.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 356, 660 356, 660 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 2, 589, 251 2, 589, 251 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 3, 489, 200 3, 489, 200 0 0 73.00 73.01 03480 ONCOLOGY 477, 386 477, 386 0 0 73.01 76.00 03160 CARDI AC REHABI LI TATI ON 0 0 0 76.00 76.97 OAGOT CARDI AC REHABI LI TATI ON 302, 470 0 0 76.97 0 09000 CLI NI C 0 0 90.00 90.00 91.00 90.00 091000 DBERGENCY 3, 525, 897 3, 525, 897 0 91.00 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART 786, 888 786, 888 0 92.00 200.00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200.00 201.00 Less Observati on Beds 786, 888 786, 888		509, 274	0	509, 2	74 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 2,589,251 2,589,251 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 3,489,200 3,489,200 0 0 73.00 73.01 03480 ONCOLOGY 477,386 477,386 0 0 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 0 76.00 76.97 07677 CARDI AC REHABI LI TATI ON 302,470 0 0 76.97 0 09000 CLI NI C 0 0 0 0 90.00 90.00 09000 CLI NI C 0 0 90.00 90.00 90.00 91.00 09000 DBERGENCY 3,525,897 0 0 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00		980, 480		980, 48	30 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS 3, 489, 200 3, 489, 200 0 73.00 73.01 03480 ONCOLOGY 477, 386 0 0 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 0 76.00 76.97 07697 CARDI AC REHABILITATION 302, 470 0 0 76.97 00 09000 CLINIC 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 90.00 90.00 91.00 09000 DBSERVATION BEDS (NON-DI STINCT PART 786, 888 786, 888 0 92.00 200.00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200.00 201.00 Less Observation Beds 786, 888 786, 888 0 201.00		356, 660		356, 6	60 0	0	
73. 01 03480 0NCOLOGY 477, 386 0 0 73. 01 76. 00 03160 CARDI OPULMONARY 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 302, 470 302, 470 0 0 76. 97 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 0 90. 00 90. 00 09000 CLI NI C 0 0 0 90. 00 90. 00 91. 00 09100 EMERGENCY 3, 525, 897 3, 525, 897 0 0 92. 00 92.00 09SERVATI ON BEDS (NON-DI STI NCT PART 786, 888 786, 888 0 92. 00 200. 00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200. 00 201. 00 Less Observati on Beds 786, 888 786, 888 0 201. 00		2, 589, 251		2, 589, 2	51 0	0	
76.00 03160 CARDI OPULMONARY 0 0 0 76.00 70.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 91.00 90.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00		3, 489, 200		3, 489, 20	0 00	0	
76.97 CARDI AC_REHABI LI TATI ON 302,470 302,470 0 76.97 OUTPATI ENT_SERVICE_COST_CENTERS	73. 01 03480 ONCOLOGY	477, 386		477, 3	36 0	0	73.01
OUTPATI ENT_SERVICE_COST_CENTERS 90.00 09000 CLINIC 0 0 90.00 91.00 09100 EMERGENCY 3, 525, 897 3, 525, 897 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 786, 888 786, 888 0 92.00 200.00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200.00 201.00 Less Observation Beds 786, 888 786, 888 0 201.00	76.00 03160 CARDI OPULMONARY	0			0 0	0	76.00
90. 00 09000 CLINIC 0 0 0 90. 00 91. 00 09100 EMERGENCY 3, 525, 897 3, 525, 897 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 786, 888 786, 888 0 92. 00 200. 00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200. 00 201. 00 Less Observation Beds 786, 888 786, 888 0 201. 00	76. 97 07697 CARDIAC REHABILITATION	302, 470		302, 4	70 0	0	76.97
91.00 09100 EMERGENCY 3, 525, 897 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 786, 888 786, 888 0 92.00 200.00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200.00 201.00 Less Observation Beds 786, 888 786, 888 0 201.00	OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 786, 888 786, 888 0 92.00 200.00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200.00 201.00 Less Observation Beds 786, 888 786, 888 0 201.00	90. 00 09000 CLINIC	0			0 0	0	90.00
200.00 Subtotal (see instructions) 30, 110, 451 0 30, 110, 451 0 200.00 201.00 Less Observation Beds 786, 888 786, 888 0 201.00	91.00 09100 EMERGENCY	3, 525, 897		3, 525, 8	97 0	0	91.00
201.00 Less Observation Beds 786,888 786,888 0 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	786, 888		786, 8	38	0	92.00
201.00 Less Observation Beds 786, 888 786, 888 0 201.00	200.00 Subtotal (see instructions)	30, 110, 451	0	30, 110, 4	51 0	0	200.00
202. 00 Total (see instructions) 29, 323, 563 0 29, 323, 563 0 0 202. 00	201.00 Less Observation Beds	786, 888		786, 8	38	0	201.00
	202.00 Total (see instructions)	29, 323, 563	0	29, 323, 5	63 0	0	202.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/24/2017 9:1	
	-		XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9,00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2,039,035		2,039,03	5		30.00
31. 00 03100 I NTENSI VE CARE UNI T	444, 712		444, 71	2		31.00
ANCI LLARY SERVI CE COST CENTERS						1
50. 00 05000 OPERATI NG ROOM	7,831,344	16, 926, 539	24, 757, 88	3 0. 169645	0.000000	50.00
53.00 05300 ANESTHESI OLOGY	355, 658	502, 853	858, 51	0. 123153	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	497, 033	9, 582, 518	10, 079, 55	0. 275056	0.000000	54.00
60. 00 06000 LABORATORY	1, 415, 020	6, 149, 173	7, 564, 19	3 0. 277537	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0. 000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	512, 157	720, 283	1, 232, 44	0. 580165	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	869, 765	1, 599, 600	2, 469, 36	5 0. 581187	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	383, 757	341, 697			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	276, 069	4, 069, 839	4, 345, 90	B 0. 225610	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 487, 805	869, 368	2, 357, 17	3 0. 151308	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 361, 912	1, 698, 385	11, 060, 29		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 075, 184	7, 921, 042	10, 996, 22		0.00000	
73. 01 03480 ONCOLOGY	0	1, 847, 026	1, 847, 02	6 0. 258462	0.00000	73.01
76. 00 03160 CARDI OPULMONARY	0	0		0. 000000	0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	606, 731	606, 73	0. 498524	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0. 000000	0.000000	
91.00 09100 EMERGENCY	543, 088	18, 809, 020			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 371	1, 202, 271			0.000000	
200.00 Subtotal (see instructions)	29, 108, 910	72, 846, 345	101, 955, 25	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	29, 108, 910	72, 846, 345	101, 955, 25	5		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 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/24/2017 9:1	epared: 0 am
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1 1				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 I NTENSI VE CARE UNI T					31.00
ANCI LLARY SERVI CE COST CENTERS					-
50. 00 05000 OPERATI NG 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
64.00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
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
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	r				
90. 00 09000 CLI NI C	0.000000				90.00
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	FON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1311	Period: From 01/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)				5.00	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 0 (7 070		4.0(7.0		4 0/7 070	
30. 00 03000 ADULTS & PEDI ATRI CS	4,067,272		4,067,2		.,	
31.00 03100 I NTENSI VE CARE UNI T	1, 697, 936		1, 697, 93	6 0	1, 697, 936	31.00
ANCI LLARY SERVI CE COST CENTERS	4 200 042		4 200 0		4 200 042	50.00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	4, 200, 043		4, 200, 04		4, 200, 043 105, 728	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	105, 728 2, 772, 445		105, 72 2, 772, 44			
60. 00 06000 LABORATORY	2, 772, 445 2, 099, 341		2, 772, 44		2, 772, 445 2, 099, 341	
64. 00 06400 INTRAVENOUS THERAPY	2,099,341		2, 099, 34	0 0	2, 099, 341	
65. 00 06500 RESPIRATORY THERAPY	715, 018	0	715, 0		715, 018	
66. 00 06600 PHYSI CAL THERAPY	1, 435, 162		1, 435, 10		1, 435, 162	
67. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	509, 274		509, 2		509, 274	
69. 00 106900 ELECTROCARDI OLOGY	980, 480		980, 48		980, 480	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	356, 660		356, 60		356, 660	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 589, 251		2, 589, 2		2, 589, 251	
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 489, 200		3, 489, 20		3, 489, 200	
73. 01 03480 ONCOLOGY	477, 386		477, 38		477, 386	
76. 00 03160 CARDI OPULMONARY	477, 300		477, 50		477, 300	
76. 97 07697 CARDI AC REHABI LI TATI ON	302, 470		302, 4	0 0 10 0	302, 470	
OUTPATIENT SERVICE COST CENTERS	002,110		002, 1	0 0	002, 170	/0. //
90. 00 09000 CLINIC	0			0 0	0	90.00
91. 00 09100 EMERGENCY	3, 525, 897		3, 525, 89		3, 525, 897	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	786, 888		786, 88		786, 888	
200.00 Subtotal (see instructions)	30, 110, 451	0				
201.00 Less Observation Beds	786, 888	-	786, 88		786, 888	
202.00 Total (see instructions)	29, 323, 563					
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Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/24/2017 9:1	
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	-l l		•			
30. 00 03000 ADULTS & PEDI ATRI CS	2, 039, 035		2, 039, 03	5		30.00
31. 00 03100 I NTENSI VE CARE UNI T	444, 712		444, 71	2		31.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	7, 831, 344	16, 926, 539	24, 757, 88	3 0. 169645	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	355, 658	502, 853	858, 51	0. 123153	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	497, 033	9, 582, 518	10, 079, 55	0. 275056	0.000000	54.00
60. 00 06000 LABORATORY	1, 415, 020	6, 149, 173	7, 564, 19	3 0. 277537	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0. 000000	0.000000	
65. 00 06500 RESPI RATORY THERAPY	512, 157	720, 283	1, 232, 44	0. 580165	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	869, 765	1, 599, 600			0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	383, 757	341, 697			0.000000	
69. 00 06900 ELECTROCARDI OLOGY	276, 069	4, 069, 839	4, 345, 90	B 0. 225610	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 487, 805	869, 368	2, 357, 17	3 0. 151308	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 361, 912	1, 698, 385	11, 060, 29	7 0. 234103	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 075, 184	7, 921, 042	10, 996, 22		0.000000	
73. 01 03480 ONCOLOGY	0	1, 847, 026	1, 847, 02	6 0. 258462	0.000000	73.01
76. 00 03160 CARDI OPULMONARY	0	0		0. 000000	0.000000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	606, 731	606, 73	0. 498524	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0. 000000	0.000000	
91. 00 09100 EMERGENCY	543, 088	18, 809, 020			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 371	1, 202, 271			0.000000	
200.00 Subtotal (see instructions)	29, 108, 910	72, 846, 345	101, 955, 25	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	29, 108, 910	72, 846, 345	101, 955, 25	5		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1311 Period: From 01/01/2016 To 12/31/2016 Worksheet C Part I Date/Time Prepared: 5/24/2017 9:10 am Cost Center Description PPS Inpatient Ratio 11.00 Title XIX Hospital Cost INPATIENT ROUTINE SERVICE COST CENTERS 0 03000 ADULTS & PEDIATRICS 31.00 30.00 30.00 30.00 31.00 ANCILLARY SERVICE COST CENTERS 0 <t< th=""><th>Health Financial System</th><th>tems</th><th>IU HEALTH TIPTON</th><th>HOSPI TAL</th><th>In Lie</th><th>u of Form CMS-</th><th>2552-10</th></t<>	Health Financial System	tems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description PPS Inpatient Ratio 11.00 30.00 03000 ADULTS & PEDIATRICS 31.00 30.00 31.00 03100 INTENSI VE CARE UNIT ANCILLARY SERVICE COST CENTERS 30.00				Provider CCN: 15-1311	From 01/01/2016	Part I Date/Time Pre	pared: 0 am
Ratio Ratio 30.00 30.00 ADULTS & PEDIATRICS 30.00 30.00 31.00 <td></td> <td></td> <td></td> <td>Title XIX</td> <td>Hospi tal</td> <td>Cost</td> <td></td>				Title XIX	Hospi tal	Cost	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 30.00 31.00 03100 I NTENSI VE CARE UNI T 30.00 31.00	Cost Center	nter Description					
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 30. 00 31. 00 03100 I NTENSI VE CARE UNI T 31. 00 ANCI LLARY SERVI CE COST CENTERS 31. 00							
30. 00 03000 ADULTS & PEDIATRICS 30. 00 31. 00 03100 INTENSIVE CARE UNIT 31. 00 ANCILLARY SERVICE COST CENTERS 31. 00			11.00				
31.00 03100 INTENSIVE CARE UNIT 31.00 ANCILLARY SERVICE COST CENTERS			1				
ANCI LLARY SERVICE COST CENTERS							
							31.00
			I				
	50.00 05000 OPERATI NG F		0. 000000				50.00
							53.00
							54.00
60. 00 06000 LABORATORY 0. 000000 60. 00							
64. 00 06400 I NTRAVENOUS THERAPY 0. 000000 64. 00							
							65.00
66. 00 06600 PHYSI CAL THERAPY 0. 000000 66. 00							
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 67. 00							
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00							
							71.00
							72.00
							73.00
73. 01 03480 0NC0L0GY 0. 000000 73. 01							
							76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 76. 97			0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS		RVICE COST CENTERS	1				
							90.00
91.00 09100 EMERGENCY 0.000000 91.00							
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 000000 92. 00			0. 000000				
200.00 Subtotal (see instructions) 200.00							
201.00 Less Observation Beds 201.00							
202.00 Total (see instructions)	202.00 Total (see	see instructions)					202.00

Health Financial Systems	IU HEALTH TIP	TON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/24/2017 9:1	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		1 ·	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	T	I	1			
50.00 05000 OPERATING ROOM	620, 574					
53. 00 05300 ANESTHESI OLOGY	12, 146				2, 662	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	322, 202					
60. 00 06000 LABORATORY	132, 789	7, 564, 193			13, 223	
64.00 06400 INTRAVENOUS THERAPY	0	,	0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY	15, 482	1, 232, 440	0. 01256	228, 354	2, 869	65.00
66. 00 06600 PHYSI CAL THERAPY	158, 270	2, 469, 365	0.06409			66.00
67.00 06700 OCCUPATI ONAL THERAPY	27, 911	725, 454			7,487	67.00
69. 00 06900 ELECTROCARDI OLOGY	90, 867	4, 345, 908	0. 02090	160, 567	3, 357	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 624	2, 357, 173	0. 00450	796, 195	3, 588	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	71, 032	11, 060, 297	0. 00642	5, 329, 722	34, 227	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 138	10, 996, 226	0. 00546	9 1, 460, 050	7, 985	73.00
73. 01 03480 ONCOLOGY	50, 824	1, 847, 026	0. 02751	7 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	54,069	606, 731	0. 08911	5 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
91.00 09100 EMERGENCY	379, 286	19, 352, 108	0. 01959	6, 336	124	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	93, 457	1, 218, 642	0. 07668		43	92.00
200.00 Total (lines 50-199)	2, 099, 671	99, 471, 508		13, 926, 461	212, 642	200.00

APPORTI ONMENT OF I NPATI ENT/OUTPATI ENT ANCI LLARY SERVI CE OTHER PASS THROUGH COSTS Provi der CCN: 15-1311 Peri od: From 01/01/2016 To 12/31/2016 Worksheet D Pate/Time Prepared: 5/24/2017 9: 10 am
Thirdood roosts To 12/31/2016 Date/Time Prepared: 5/24/2017 9:10 am Cost Center Description Non Physician Anesthetist Cost Nursing School Allied Health All Ober Cost Sono ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 Sono 05300 OPERATING ROOM 0 0 0 0 50.00 53.00 05300 ARSTHESI OLOGY 0 0 0 0 53.00 54.00 06000 LABORATORY 0 0 0 0 0 54.00 60.00 06400 INTRAVENOUS THERAPY 0<
Anci LLARY SERVICE COST CENTERS O <t< td=""></t<>
Cost Center Description Non Physician Anesthetist Cost Nursing School Allied Health Health All Other Medical (sum of col 1 through col. 4) ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 0 0 0 0 50.00 5.00 50.00 05300 OPERATING ROOM 0 0 0 0 50.00 54.00 05400 RABIOLOGY - DI AGNOSTIC 0 0 0 0 54.00 54.00 54.00 60.00 0 0 0 0 60.00
Anestheti st Cost Medical Feducation Cost (sum of col 1 through col. 4) 1.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 0 0 0 0 50.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54.00 60.00 06000 LABORATORY 0 0 0 0 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0
ANCI LLARY SERVICE COST CENTERS Cost Educati on Cost through col. 4) 1.00 2.00 3.00 4.00 5.00 50.00 05000 OPERATI NG ROOM 0 0 0 50.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 54.00 60.00 06000 LABORATORY 0 0 0 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 60.00 64.00
ANCI LLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 50.00 05000 0PERATI NG ROOM 0 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 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 64.00
I.00 2.00 3.00 4.00 5.00 ANCI LLARY SERVICE COST CENTERS Image: control of the service
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM 0 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 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64. 00
50.00 05000 OPERATING ROOM 0 0 0 0 0 0 50.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0 0 0 0 60.00 64.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64.00
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 64.00 06400 I NTRAVENOUS THERAPY 0 0 0 0 64.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54. 00 60. 00 06000 LABORATORY 0 0 0 0 0 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 64. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 60. 00 60. 00 64. 00 64. 00 0 0 0 0 0 0 64. 00 64. 00 0 0 0 0 0 64. 00
64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 0 0 64. 00
66.00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00
69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 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
90. 00 09000 CLINIC 0 0 0 0 0 90. 00
91. 00 09100 EMERGENCY 0 0 0 0 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 0 0 0 92.00
200.00 Total (lines 50-199) 0 0 0 0 0 200.00

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUG	H COSTS				From 01/01/2016		norod.
					To 12/31/2016	Date/Time Pre 5/24/2017 9:1	
			Title	XVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	·	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7.00	8.00	9.00	10.00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	24, 757, 883				•
53.00	05300 ANESTHESI OLOGY	0	858, 511	0.00000		188, 136	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 079, 551	0.00000		207, 673	•
60.00	06000 LABORATORY	0	7, 564, 193	0.00000	0. 000000	753, 257	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.00000	0. 000000	0	64.00
65.00	06500 RESPI RATORY THERAPY	0	1, 232, 440	0.00000	0. 000000	228, 354	65.00
66.00	06600 PHYSI CAL THERAPY	0	2, 469, 365	0.00000	0. 000000	387, 153	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	725, 454	0.00000	0. 000000	194, 599	67.00
69.00	06900 ELECTROCARDI OLOGY	0	4, 345, 908	0.00000	0. 000000	160, 567	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 357, 173	0.00000	0. 000000	796, 195	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 060, 297	0.00000	0. 000000	5, 329, 722	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10, 996, 226	0.00000	0. 000000	1, 460, 050	73.00
73.01	03480 ONCOLOGY	0	1, 847, 026	0.00000	0. 000000	0	73.01
76.00	03160 CARDI OPULMONARY	0	0	0.00000	0. 000000	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	606, 731	0.00000	0. 000000	0	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.00000	0. 000000	0	90.00
91.00	09100 EMERGENCY	0	19, 352, 108	0. 00000	0. 000000	6, 336	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 218, 642	0. 00000	0. 000000	561	92.00
200.00	Total (lines 50-199)	0	99, 471, 508			13, 926, 461	200.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1311	Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016 To 12/31/2016		narod
				10 12/31/2010	5/24/2017 9:1	lo am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	1 1		1			
50. 00 05000 OPERATI NG ROOM	0	C		0		50.00
53. 00 05300 ANESTHESI OLOGY	0	C		0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
60. 00 06000 LABORATORY	0	C		0		60.00
64.00 06400 INTRAVENOUS THERAPY	0	C		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
73. 01 03480 ONCOLOGY	0	C		0		73.01
76. 00 03160 CARDI OPULMONARY	0	C		0		76.00
76. 97 07697 CARDIAC REHABILITATION	0	C		0		76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0		90.00
91. 00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
200.00 Total (lines 50-199)	0	0		0		200. 00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCI NE COST	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre	pared:
					5/24/2017 9:1	0 am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0. 169645		4, 745, 66		0	1 00.0
3. 00 05300 ANESTHESI OLOGY	0. 123153		111, 77		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 275056		3, 422, 98	37 0	0	
0. 00 06000 LABORATORY	0. 277537	0	2, 014, 76	09 0	0	60. (
4.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. (
5. 00 06500 RESPI RATORY THERAPY	0. 580165	0	316, 76	0 0	0	65.0
6. 00 06600 PHYSI CAL THERAPY	0. 581187	0	644, 22	9 0	0	66. (
7.00 06700 OCCUPATI ONAL THERAPY	0. 702007	0	115, 96	06 0	0	67.0
9. 00 06900 ELECTROCARDI OLOGY	0. 225610	0	1, 800, 60	03 0	0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 151308	0	191, 64		0	71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234103	0	384, 49	02 0	0	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 317309	0	3, 545, 07	3 1, 802	0	73.0
3. 01 03480 ONCOLOGY	0. 258462		999, 86		0	73.0
6. 00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 498524	0	357, 09	04 0	0	76.
OUTPATIENT SERVICE COST CENTERS	-	•				1
0. 00 09000 CLINIC	0. 000000	0		0 0	0	90. (
1.00 09100 EMERGENCY	0. 182197		6, 324, 46	5 0	0	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 645709		508, 54		0	
00.00 Subtotal (see instructions)		0	25, 483, 92		0	200. 0
01.00 Less PBP Clinic Lab. Services-Program	1			0 0	-	201. (
Only Charges						
02.00 Net Charges (line 200 +/- line 201)		0	25, 483, 92	1, 802	0	202. (

Health Financial Systems	IU HEALTH TIP	TON_HOSPITAL		In Lie	u of Form CMS-	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Peri od: From 01/01/2016 To 12/31/2016	5/24/2017 9: 1	
			XVIII	Hospi tal	Cost	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.					
	(see inst.)	(see inst.)				
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00				
50. 00 05000 OPERATING ROOM	805, 077	0				50.00
53. 00 05300 OPERATING ROOM	13, 766	-				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	941, 513	0				54.0
60. 00 06000 LABORATORY	559, 173	0				60.00
64. 00 06400 I NTRAVENOUS THERAPY	557,173	0				64.00
65. 00 06500 RESPIRATORY THERAPY	183, 773	0				65.00
66. 00 06600 PHYSI CAL THERAPY	374, 418	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	81, 409	0				67.0
69. 00 06900 ELECTROCARDI OLOGY	406, 234	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 997	0				71.0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	90, 011	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 124, 884	572				73.0
73. 01 03480 ONCOLOGY	258, 427	0				73.0
76. 00 03160 CARDI OPULMONARY	230, 427	0				76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	178, 020	0				76.9
OUTPATIENT SERVICE COST CENTERS	170,020	0				_ /0. /
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	1, 152, 299	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	328, 373	0				92.00
200.00 Subtotal (see instructions)	6, 526, 374	572				200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 020, 0,4	572				201.0
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	6, 526, 374	572				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	CN: 15-1311	Peri od:	Worksheet D	
		Component	CCN: 15-Z311	From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
		component	UCIN: 15-2311	10 12/31/2010	5/24/2017 9:1	
		Title	e XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	-					
50.00 05000 OPERATI NG ROOM	0. 169645			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 123153			0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 275056			0 0	0	
60. 00 06000 LABORATORY	0. 277537	0		0 0	0	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 580165	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 581187	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 702007	0		0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 225610	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 151308	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234103	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 317309	0		0 0	0	73.00
73.01 03480 ONCOLOGY	0. 258462	0		0 0	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. 498524	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			•			
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 182197	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.645709	0		0 0	0	92.00
200.00 Subtotal (see instructions)		l o		0 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		0 0	0	202.00

lealth Financial Systems	IU HEALTH TIP			In Lie	u of Form CMS-	2552-
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CCN: 15 Component CCN: 1		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	
					5/24/2017 9: 1	10 am
			<u> </u>	Swing Beds - SNF	Cost	
		sts				
Cost Center Description	Cost Reimbursed	Cost Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50.0
3. 00 05300 ANESTHESI OLOGY	0	o				53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
0. 00 06000 LABORATORY	0	0				60.0
4. 00 06400 I NTRAVENOUS THERAPY	0	0				64.0
5. 00 06500 RESPI RATORY THERAPY	0	0				65.0
6. 00 06600 PHYSI CAL THERAPY	0	0				66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.0
9. 00 06900 ELECTROCARDI OLOGY	0	0				69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.
3. 01 03480 ONCOLOGY	0	0				73.
6. 00 03160 CARDI OPULMONARY	0	0				76.
6. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.
OUTPATIENT SERVICE COST CENTERS	T					
0. 00 09000 CLINIC	0	0				90.
1.00 09100 EMERGENCY	0	0				91.
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.
200.00 Subtotal (see instructions)	0	0				200.
201.00 Less PBP Clinic Lab. Services-Program	0					201.
Only Charges						202
202.00 Net Charges (line 200 +/- line 201)	0	0				202.

ealth Financial Systems APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN		TON HOSPITAL Provider C		Period: From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/24/2017 9:1	o am
		Ti tl	e XIX	Hospi tal	Cost	0 4
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 169645		182, 59		0	00.0
53. 00 05300 ANESTHESI OLOGY	0. 123153		14, 23		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 275056		67, 80		0	
0.00 06000 LABORATORY	0. 277537		61, 77	0 0	0	
64.00 06400 INTRAVENOUS THERAPY	0. 000000			0 0	0	
5. 00 06500 RESPI RATORY THERAPY	0. 580165		99		0	
6. 00 06600 PHYSI CAL THERAPY	0. 581187		3, 18	31 0	0	
57. 00 06700 OCCUPATI ONAL THERAPY	0. 702007			0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	0. 225610	0	13, 61	17 0	0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 151308		7, 09	95 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 234103			0 0	0	1
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 317309		43, 64		0	1
3. 01 03480 ONCOLOGY	0. 258462		8, 89	94 0	0	1
6. 00 03160 CARDI OPULMONARY	0. 000000			0 0	0	1
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 498524	0		0 0	0	76.9
OUTPATIENT SERVICE COST CENTERS	- P		1			
0. 00 09000 CLINIC	0. 000000			0 0	0	90.0
1.00 09100 EMERGENCY	0. 182197		382, 04		0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 645709	0	2, 04		0	
200.00 Subtotal (see instructions)		0	787, 92	24 0	0	200. 0
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.0
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	787, 92	24 0	0	202.0

Heal th Financi	ial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/24/2017 9:1	
				e XIX	Hospi tal	Cost	
			sts				
C	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ARY SERVICE COST CENTERS	00.077					
	DPERATING ROOM	30, 977					50.00
	ANESTHESI OLOGY	1, 753					53.00
	RADI OLOGY-DI AGNOSTI C	18, 649					54.00
	_ABORATORY	17, 145					60.00
	NTRAVENOUS THERAPY	0	-				64.00
	RESPI RATORY THERAPY	574					65.00
	PHYSI CAL THERAPY	1, 849					66.00
	OCCUPATIONAL THERAPY	0	-				67.00
	ELECTROCARDI OLOGY	3, 072					69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	1,074	0				71.00
	MPL. DEV. CHARGED TO PATIENTS	0	-				72.00
	DRUGS CHARGED TO PATIENTS	13, 848					73.00
73.01 03480 0	DNCOLOGY	2, 299	0				73.01
76.00 03160 C	CARDI OPULMONARY	0	0				76.00
	CARDI AC REHABI LI TATI ON	0	0				76.97
	IENT SERVICE COST CENTERS						
90.00 09000 0		0	0				90.00
	EMERGENCY	69, 608					91.00
92.00 09200 0	DBSERVATION BEDS (NON-DISTINCT PART	1, 322	0				92.00
200.00 S	Subtotal (see instructions)	162, 170	0				200.00
201.00 L	Less PBP Clinic Lab. Services-Program	0					201.00
C	Only Charges						
202.00 N	Net Charges (line 200 +/- line 201)	162, 170	0				202.00

)MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Prep	
		Title XVIII	Hospi tal	5/24/2017 9:10 Cost	0 am
	Cost Center Description		- Hospi tui		
	PART I - ALL PROVIDER COMPONENTS			1.00	
~~	INPATIENT DAYS			0.5(0	
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			3, 562 2, 776	
00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		2, 106	4
00	Total swing-bed SNF type inpatient days (including private roc		er 31 of the cost	674	
00	reporting period Total swing-bed SNF type inpatient days (including private roc	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5.			
00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	r 31 of the cost	112	7
00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	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 to	the Program (excluding	a swina-bed and	1, 411	9
	newborn days)	5			
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruct		room days)	674	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	(only (including prive	to room days)	0	13
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this li	ne)	0	
	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)			0	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through December 21	of the cost		 17
. 00	reporting period	es thi ough beceiliber 31 (of the cost		
. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	137.32	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 Swing-bed cost applicable to SNF type services through Decembe		ting period (line	4, 067, 272 0	
	5 x line 17)	·	51		
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (iine 6	0	23
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost report	ng period (line	15, 380	24
. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	g period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			806, 966	26
	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		3, 260, 306	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and observation bed cl	pardes)	0	28
	Private room charges (excluding swing-bed charges)		lai yes)	0	29
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 29)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)	- 1111e 20)		0.000000	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 min		ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x lin Private room cost differential adjustment (line 3 x line 35)	ie 31)		0.00 0	35
	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 260, 306	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 174. 46	
. 00					
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	-		1, 657, 163 0	

MPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1311	Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	5/24/2017 9:1 Cost	U ani
Cost Center Description	Total Inpatient CostI	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	<u> </u>
.00 NURSERY (title V & XIX only)						42.
Intensive Care Type Inpatient Hospital Uni		450	0 770	10 011	70/ 1/2	1 42
. 00 INTENSIVE CARE UNIT . 00 CORONARY CARE UNIT	1, 697, 936	450	3, 773.	19 211	796, 143	43
. 00 BURN INTENSIVE CARE UNIT						44
. 00 SURGICAL INTENSIVE CARE UNIT						46.
. 00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
.00 Program inpatient ancillary service cost (line 200)			3, 367, 514	48.
.00 Total Program inpatient costs (sum of line			ns)		5, 820, 820	
PASS THROUGH COST ADJUSTMENTS						
.00 Pass through costs applicable to Program i	npatient routine s	ervices (from	Wkst. D, sur	n of Parts I and	0	50.
III) .00 Pass through costs applicable to Program i	nnatient ancillary	services (fr	om Wkst D 4	sum of Parts II	о	51
and IV)	inputrient unerriary	361 11 663 (11	om more b, c		0	
.00 Total Program excludable cost (sum of line					0	
.00 Total Program inpatient operating cost exe medical education costs (line 49 minus lin		ated, non-phy	sician anesth	netist, and	0	53
TARGET AMOUNT AND LIMIT COMPUTATION	ie 52)					
. 00 Program di scharges					0	54
.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)				1: 52)	0	
 .00 Difference between adjusted inpatient oper .00 Bonus payment (see instructions) 	ating cost and tar	get amount (i	ine 56 minus	Tine 53)	0	
.00 Lesser of lines 53/54 or 55 from the cost	reporting period e	nding 1996, u	pdated and co	ompounded by the		
market basket		0				
.00 Lesser of lines 53/54 or 55 from prior yea				Ale	0.00	
.00 If line 53/54 is less than the lower of li which operating costs (line 53) are less t					0	61
amount (line 56), otherwise enter zero (se				the target		
.00 Relief payment (see instructions)					0	
. 00 Allowable Inpatient cost plus incentive pa	ayment (see instruc	tions)			0	63
.00 PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine of	costs through Decem	ber 31 of the	cost reporti	na period (See	791, 586	64
instructions) (title XVIII only)	in ough booon		0001 10001 1		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
.00 Medicare swing-bed SNF inpatient routine of	costs after Decembe	er 31 of the c	ost reportino	g period (See	0	65
instructions)(title XVIII only) .00 Total Medicare swing-bed SNF inpatient rou	itino coste (lino 4	A pluc line 6	E) (+; + ~ V)/		791, 586	6
.00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions)		¹⁴ prus rifie o	5)(title xvii	i oniy). Toi	791, 300	
.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 o	f the cost re	eporting period	0	67
(line 12 x line 19)						
.00 Title V or XIX swing-bed NF inpatient rout	tine costs after De	cember 31 of	the cost repo	orting period	0	68
(line 13 x line 20) .00 Total title V or XIX swing-bed NF inpatier	nt routine costs (I	ine 67 + line	68)		0	69
PART III - SKILLED NURSING FACILITY, OTHER						
.00 Skilled nursing facility/other nursing fac	J)		70
.00 Adjusted general inpatient routine service .00 Program routine service cost (line 9 x lin		ne 70 ÷ line	2)			71
.00 Program routine service cost (line 9 x lir .00 Medically necessary private room cost appl	,	(line 14 x li	ne 35)			73
.00 Total Program general inpatient routine se						74
.00 Capital-related cost allocated to inpatier	nt routine service	costs (from W	orksheet B, A	Part II, column		75
26, line 45)	Line 2					-,
.00 Per diem capital-related costs (line 75 ÷ .00 Program capital-related costs (line 9 x li						76
.00 Inpatient routine service cost (line 74 mi	,					78
.00 Aggregate charges to beneficiaries for exc	cess costs (from pr					79
.00 Total Program routine service costs for co	•	st limitation	(line 78 mir	nus line 79)		80
.00 Inpatient routine service cost per diem li .00 Inpatient routine service cost limitation						81
.00 Reasonable inpatient routine service cost film tation	• • •					82
.00 Program inpatient ancillary services (see	•	,				84
.00 Utilization review - physician compensatio	on (see instruction					85
. 00 Total Program inpatient operating costs (s		ough 85)				86
.00 PART IV - COMPUTATION OF OBSERVATION BED F Total observation bed days (see instruction					670	87
. 00 Adjusted general inpatient routine cost pe		line 2)			1, 174. 46	
					,	1

Health Financial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	483, 061	4, 067, 272	0. 11876	8 786, 888	93, 457	90.00
91.00 Nursing School cost	0	4, 067, 272	0.00000	0 786, 888	0	91.00
92.00 Allied health cost	0	4, 067, 272	0.00000	0 786, 888	0	92.00
93.00 All other Medical Education	0	4, 067, 272	0.00000	0 786, 888	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2016 To 12/31/2016	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/24/2017 9:10 Cost	<u>0 am</u>
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vc oveluding nowhern)		3, 562	1 1.
. 00	Inpatient days (including private room days, excluding swing-bed day Inpatient days (including private room days, excluding swing-			2,776	
. 00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ned days)		2, 106	4.
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	674	
00	reporting period	an dava) often December	21 of the east	0	
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	bom days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	112	7.
00	reporting period Total swing-bed NF type inpatient days (including private roc	om davs) after December	31 of the cost	0	8.
00	reporting period (if calendar year, enter 0 on this line)	Jin days) arter becember		0	0.
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	4	9
0. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room days)	0	10
	through December 31 of the cost reporting period (see instruc				
. 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		te room days)	0	12
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including prive	to room dovo)	0	13
. 00	after December 31 of the cost reporting period (if calendar y			0	13
	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		I		
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31	of the cost] 17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructior	26)		4,067,272	21
	Swing-bed cost applicable to SNF type services through Decemb		ting period (line	4,007,272	
~~	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reportin	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
. 00	x line 20)			0	20
	Total swing-bed cost (see instructions)	(line 21 minus line 2()		794, 592	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 MITHUS TTHE 20)		3, 272, 680	27
	General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	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		,	0.00	35
	Private room cost differential adjustment (line 3 x line 35)	and private ream eact -	fforontial (1)	2 272 490	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost d	interential (line	3, 272, 680	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see		I	1, 178. 92	38
	Program general inpatient routine service cost (line 9 x line	-		4, 716	
. 00	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	40
. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		4, 716	41

OMPUT	TATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1311	Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	epare
			T: +1	e XIX	Hospi tal	5/24/2017 9:1 Cost	10 an
	Cost Center Description	Total	Total	Average Pe		Program Cost	
	·	Inpatient Cost	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	<u>4)</u> 5.00	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42
	Intensive Care Type Inpatient Hospital Units						
00	INTENSI VE CARE UNI T	1, 697, 936	450	3, 773.	19 0	0	
. 00 . 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00							45
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			<u> </u>	3 48
. 00				ins)		14, 594	
	PASS THROUGH COST ADJUSTMENTS	······································					
. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from	n Wkst. D, su	m of Parts I and	0	50
. 00) Pass through costs applicable to Program inp	ationt ancillary	sorvicos (fr	om Wkst D	sum of Parts II	o	51
. 00	and IV)	actencianci i al g	301 11 1005 (11	UN WASL. D,	Juni UI FAILS II		1 31
. 00	Total Program excludable cost (sum of lines	,				0	
. 00	Total Program inpatient operating cost exclu		ated, non-phy	sician anest	hetist, and	0	53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
. 00						0	54
. 00	- J					0.00	55
. 00	5					0	
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	line 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	eportina period e	ndina 1996. u	updated and c	ompounded by the	0.00	
	market basket	.p					
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	
. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61
	amount (line 56), otherwise enter zero (see		(11163 54 X	00), 01 1/00	i the target		
. 00	Relief payment (see instructions)					0	
. 00		ent (see instruc	tions)			0) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	sts through Decem	ber 31 of the	cost report	ing period (See	0	64
	instructions) (title XVIII only)	i i i i i i i i i i i i i i i i i i i		0000 i opoi i	ing porrou (coo		
. 00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	r 31 of the c	ost reportin	g period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no coste (lino 6	A plus lino 6	5) (+i +l o X)/I	II only) For	o	66
. 00	CAH (see instructions)	The COStS (TTHE O	4 prus rifle o	5)(11118 XVI	TT OILY). TOI	0	
. 00		ne costs through	December 31 c	of the cost r	eporting period	0	67
	(line 12 x line 19)	- D-		****			
. 00	Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	ie costs after De	Cemper 31 OT	the cost rep	orting period	0	68
. 00	· · · · · · · · · · · · · · · · · · ·	routine costs (I	ine 67 + line	68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N	•					
. 00	Skilled nursing facility/other nursing facil	2		•)		70
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	2)			71
. 00	Medically necessary private room cost applic		(line 14 x li	ne 35)			73
. 00	Total Program general inpatient routine serv						74
. 00		routine service	costs (from W	lorksheet B,	Part II, column		75
. 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	Inpatient routine service cost (line 74 minu	is line 77)					78
00	55 5 5						79
00 00	5		st limitation	i (line /8 mi	nus line /9)		80
00	Inpatient routine service cost per drem film						82
00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in	istructions)					84
. 00							85
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 85)				86
. 00	Total observation bed days (see instructions					670	87
3.00	Adjusted general inpatient routine cost per		line 2)			1, 178. 92	
. 00	Observation bed cost (line 87 x line 88) (se					789, 876	

Health Financial Systems	IU HEALTH TIP	TON HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		pared: 0 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	483, 061	4, 067, 272	0. 11876	8 789, 876	93, 812	90.00
91.00 Nursing School cost	0	4, 067, 272	0.00000	0 789, 876	0	91.00
92.00 Allied health cost	0	4, 067, 272	0.00000	0 789, 876	0	92.00
93.00 All other Medical Education	0	4, 067, 272	0. 00000	0 789, 876	0	93.00

31.00 03100 INTENSIVE CARE UNIT 291, 166 31. ANCILLARY SERVICE COST CENTERS 0.169645 4, 213, 858 714, 860 50. 50.00 05000 OPERATING ROOM 0.123153 188, 136 23, 170 53. 54.00 05300 ANESTHESI OLOGY 0.275056 207, 673 57, 122 54. 60.00 06400 INTRAVENOUS THERAPY 0.0000000 0 64. 65.00 06500 RESPIRATORY THERAPY 0.580165 228, 354 132, 438 65. 66.00 06600 PHYSI CAL THERAPY 0.580165 228, 354 132, 438 65. 66.00 06700 OCUPATI ONAL THERAPY 0.581187 387, 153 225, 008 66. 67.00 06700 OCUPATI ONAL THERAPY 0.225610 160, 567 36, 226 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.151308 79, 195 120, 471 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.317309 1, 460, 050 463, 287 73. 73.01 03480 ON	Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-	2552-10
Title XVIII Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges Inpatient Program Charges 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03100 INTENSIVE CARE UNIT 291, 166 31. AUDITENSIVE CARE UNIT 0.169645 4, 213, 858 714, 860 50. 50.00 05000 OPERATING ROOM 0.169645 4, 213, 858 714, 860 50. 51.00 05000 OPERATING ROOM 0.169645 4, 213, 858 714, 860 50. 52.00 05000 OPERATING ROOM 0.169645 4, 213, 858 714, 860 50. 53.00 05300 ANESTHESI OLOGY 0.275556 207, 673 57, 122 54. 64.00 06400 INTRAVENDUS THERAPY 0.275537 753, 257 209, 057 60. 65.00 06600 RESPI RATORY THERAPY 0.580165 228, 354 132, 483 65. 66.00 06600 RESPI RATORY THERAPY 0.580165 228, 354 <	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-1311	From 01/01/2016	Date/Time Pre	epared:
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 31.00 03000 ADULTS & PEDIATRICS 1.015,825 30. 31.00 03000 OPERATING ROOM 0.169645 4,213,858 714,860 50.00 053000 ADETATING ROOM 0.123153 188,136 23,170 53. 50.00 053000 ADIGTRATING ROOM 0.275056 207,673 57,122 54. 60.00 06400 LABORATORY 0.275056 207,673 57,122 54. 60.00 06400 LABORATORY 0.580165 228,354 132,483 65. 61.00 06400 PHYSICAL THERAPY 0.580165 228,354 132,483 65. 62.00 06500 RESPI RATORY THERAPY 0.581187 387,153 225,008 66. 63.00 06700 OCUPATI ONAL THERAPY 0.581187 36,226 69. 67. 69.00 06900 ELECTROCARDI DLOGY 0.225610 160,567 36,226			Title	XVIII	Hospi tal		
Inpart ENT ROUTINE SERVICE COST CENTERS To Charges Program (Costs (col 1 x col 2)) 30.00 03000 ADULTS & PEDI ATRI CS 1.00 2.00 3.00 31.00 03000 (INTENSI VE CARE UNI T 291.166 31. 31. 50.00 05000 (PERATI NG ROM 0.169645 4.213.858 714.860 50. 50.00 05000 (DEPERATI NG ROM 0.169645 4.213.858 714.860 50. 51.00 05000 (DEPERATI NG ROM 0.169645 4.213.858 714.860 50. 52.00 05400 (RABI OLOGY - DI AGNOSTI C 0.275056 207.673 57.122 54. 60.00 06400 (INTENVENOUS THERAPY 0.000000 0 0 64. 60.00 06500 (RESPI RATORY THERAPY 0.580165 228.354 132.483 65. 61.00 06600 (LECTROCARDI OLOGY 0.275056 207.673 57.122 54. 62.00 06500 RESPI RATORY THERAPY 0.580165 228.354 132.483 65. 63.00 06500 RESPI RATORY THERAPY 0.255110 160.567 <	Cost Center Description						
INPATI ENT ROUTI NE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 3.00 3.00 31.00 03000 INTENSI VE CARE UNIT 291, 166 31. ANCILLARY SERVICE COST CENTERS 291, 166 31. 31. 50.00 05000 OPERATI NG ROOM 0. 169645 4, 213, 858 714, 860 50. 51.00 05000 OPERATI NG ROOM 0. 123153 188, 136 23, 170 53. 52.00 05000 OPERATI NG ROOM 0. 275056 207, 673 57, 122 54. 60.00 06000 LABORATORY 0. 277537 753, 257 209, 057 60. 64.00 06400 INTRAVENOUS THERAPY 0. 580165 228, 354 132, 483 65. 65.00 06500 RSPI RATORY THERAPY 0. 581187 387, 153 225, 008 66. 67.00 06700 0CUPATI ONAL THERAPY 0. 2581187 387, 153 226, 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED							
I. 00 2. 00 3. 00 INPATI ENT ROUTI NE SERVI CE COST CENTERS 3. 00					Charges	(col. 1 x col.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 1, 015, 825 30. 31. 00 03100 INTENSI VE CARE UNI T 291, 166 31. ANCI LLARY SERVI CE COST CENTERS 0. 169645 4, 213, 858 714, 860 50. 50. 00 05000 OPERATI NG ROM 0. 123153 188, 136 23, 170 53. 53. 00 05400 RADI OLOGY – DI AGNOSTI C 0. 275056 207, 673 57, 122 54. 60. 00 06400 INTRAVENOUS THERAPY 0. 27537 753, 257 209, 057 60. 64. 00 06400 INTRAVENOUS THERAPY 0. 580165 228, 354 132, 483 65. 65. 00 06500 RESPI RATORY THERAPY 0. 580165 228, 354 132, 483 65. 66. 00 06600 PHYSI CAL THERAPY 0. 580165 228, 354 132, 483 65. 67. 00 06700 OCCUPATI ONAL THERAPY 0. 581187 387, 153 225, 008 66. 67. 00 06700 OCCUPATI ONAL THERAPY					5	2)	
30.00 O3000 ADULTS & PEDIATRICS 1,015,825 291,166 30. 31.00 O3100 INTENSIVE CARE UNIT 291,166 31. ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROM 0.169645 4,213,858 714,860 50. 53.00 05300 ANESTHESI OLOGY 0.123153 188,136 23,170 53. 54.00 O5400 RADI OLOGY-DI AGNOSTI C 0.275056 207,673 57,122 54. 60.00 O6000 LABORATORY 0.277537 753,257 209,057 64. 64.00 0.66000 RESPI RATORY THERAPY 0.000000 0 64. 60.00 O66000 RESPI RATORY THERAPY 0.580165 228,354 132,483 65. 67.00 O6700 OCCUPATI ONAL THERAPY 0.702007 194,599 136, 610 67. 69.00 O6900 ELECTROCARDI OLOGY 0.7225610 160,567 36, 226 69. 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.231403 5,329,722 1,247,704 73. 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.317309 1,460,050 463,287 73.				1.00	2.00	3.00	
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50.00 05000 0PERATI NG ROOM 0.169645 4, 213, 858 714, 860 50. 53.00 05300 ARESTHESI OLOGY 0.123153 188, 136 23, 170 53. 54.00 05400 RADI OLOGY – DI AGNOSTI C 0.275056 207, 673 57, 122 54. 60.00 06000 LABORATORY 0.277537 753, 257 209, 057 60. 64.00 D6400 INTRAVENOUS THERAPY 0.000000 0 0.44 65.00 06500 RESPI RATORY THERAPY 0.580165 228, 354 132, 483 65. 66.00 06600 PHYSI CAL THERAPY 0.580165 228, 354 132, 483 65. 67.00 06700 OCUPATI ONAL THERAPY 0.702007 194, 599 136, 610 67. 69.00 06900 ELECTROCARDI OLOGY 0.225610 160, 567 36, 226 69. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.151308 796, 195 120, 471 71. 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0.234103 5, 329, 722 1, 247, 704	31. 00 03100 I NTENSI VE CARE UNI T				291, 166		31.00
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71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.151308 796, 195 120, 471 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.234103 5, 329, 722 1, 247, 704 72. 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.317309 1, 460, 050 463, 287 73. 73.01 03480 ONCOLOGY 0.258462 0 0 73. 76.00 03160 CARDI AC REHABI LI TATI ON 0.498524 0 0 76. 76.07 07697 CARDI AC REHABI LI TATI ON 0.498524 0 0 76. 70.00 09000 CLI NI C 0.000000 0 0 76. 90.00 090000 CLI NI C 0.000000 0 0 90. 91.00 09100 EMERGENCY 0.182197 6, 336 1, 154 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.645709 561 362 92.							
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73. 00 07300 DRUGS CHARGED TO PATIENTS 0.317309 1,460,050 463,287 73. 73. 01 03480 ONCOLOGY 0.258462 0 0 73. 76. 00 03160 CARDI AC REHABILITATION 0.000000 0 76. 0010000 CARDI AC REHABILITATION 0.498524 0 0 76. 0010000 CLINIC 0.000000 0 0 76. 090.00 CLINIC 0.000000 0 0 76. 91. 00 09100 EMERGENCY 0.182197 6,336 1,154 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.645709 561 362 92.							
73. 01 03480 ONCOLOGY 0.258462 0 0 73. 76. 00 03160 CARDI OPULMONARY 0.000000 0 76. 76. 07 0767 CARDI AC REHABI LI TATI ON 0 76. 00TPATI ENT SERVI CE COST CENTERS 0 0 76. 90. 0 90. 00 09000 CLI NI C 0 0.000000 0 90. 91. 00 091001 EMERGENCY 0.182197 6, 336 1, 154 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.645709 561 362 92.							
76.00 03160 CARDI OPULMONARY 0.00000 0 76. 76. 77.						463, 287	
76.97 O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVICE COST CENTERS 0 0 76.97 90.00 09000 CLI NI C 0.000000 0 0 90.00 91.00 09100 EMERGENCY 0.182197 6,336 1,154 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.645709 561 362 92.						C	
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0 0 90. 91.00 09100 EMERGENCY 0.182197 6,336 1,154 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.645709 561 362 92.						-	
90. 00 09000 CLINIC 0.000000 0 90. 91. 00 09100 EMERGENCY 0.182197 6, 336 1, 154 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 645709 561 362 92.				0. 4985	24 0	C	76.97
91. 00 09100 EMERGENCY 0. 182197 6, 336 1, 154 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 645709 561 362 92.							
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0. 645709 561 362 92.						-	
				0. 64570			
200.00 Total (sum of lines 50-94 and 96-98) 13, 926, 461 3, 367, 514 200.					13, 926, 461	3, 367, 514	
		ogram only charges	(line 61)		-		201.00
202.00 Net Charges (line 200 minus line 201) 13,926,461 202.	202.00 Net Charges (line 200 minus line 201)				13, 926, 461		202.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Period:	Worksheet D-3	
		Component (From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
		component	JUN. 15-Z311	10 12/31/2010	5/24/2017 9:1	
		Title	XVIII	Swing Beds - SNF		
Cost Center Description			Ratio of Cost		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS				0		30.00
31. 00 03100 NTENSI VE CARE UNI T				0		30.00
ANCI LLARY SERVICE COST CENTERS				0		51.00
50. 00 05000 OPERATING ROOM			0. 16964	5 2,650	450	50.00
53. 00 05300 ANESTHESI OLOGY			0. 12315		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C			0. 27505		10, 959	54.00
60. 00 06000 LABORATORY			0. 27753	7 197, 595	54, 840	60.00
64.00 06400 INTRAVENOUS THERAPY			0. 00000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY			0. 58016	5 116, 113	67, 365	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 58118	7 178, 936	103, 995	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 70200		59, 579	
69. 00 06900 ELECTROCARDI OLOGY			0. 22561			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 15130			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 23410		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 31730			
73.01 03480 ONCOLOGY			0. 25846		0	
76.00 03160 CARDI OPULMONARY			0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 49852	4 0	0	76.97
OUTPATIENT SERVICE COST CENTERS			0.00000		0	
			0.00000		-	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 18219 0. 64570		0	91.00 92.00
200.00 Total (sum of lines 50-94 and 96-98)			0. 64570	1,037,015	-	
201.00 Less PBP Clinic Laboratory Services-P	Program only charges	(line 61)		1,037,015	427, 133	200.00
202.00 Net Charges (line 200 minus line 201)		(The OI)		1, 037, 015		201.00
202.00 million ges (The 200 millios The 201)			I	1,037,013	1	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-1311 Period: From 01/01/2016 To 01/231/2016 Worksheet D-3 bate/Time Prepared: 5/24/2017 9:10 am 5/24/2017 9:	Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
Title XIX Hospital Cost Cost Center Description Ratio of Cost To Charges Inpatient Program Costs (col. 1 x col. 2) Inpatient Program Costs (col. 1 x col. 2) 30.00 03000 ADULTS & PEDIATRICS 3.044 3.004 31.00 05000 (PERATI NG ROOM ANCILLARY SERVICE COST CENTERS 30.00 31.00 ANCILLARY SERVICE COST CENTERS 0 31.00 31.00 ANCILLARY SERVICE COST CENTERS 0 31.00 50.00 05000 (PERATI NG ROOM S000 (ABUGTARDAY 0.169645 25.251 4.284 50.00 05000 (ABROSTHES) 0.123153 702 86 53.00 54.00 05400 (PABOLOCY - DIAGNOSTI C 0.275556 4.462 1.227 54.00 64.00 06600 (ABRORARY 0.580165 0 66.00 66.00 690 00 6000 CUPABORARY THERAPY 0.581187 0 65.00 66.00 70.00 FLOC CUPATI ONAL THERAPY 0.581187 0 67.00 66.00 70.00 OTOO MEDI CAL SUPPLIES CHARGED TO PATIENT 0.317.00 72.00 73.01 73.00 73.00	I NPATI ENT ANCI LLARY SERVI CE COST APPORTI ONMENT		Provider CO	CN: 15-1311	From 01/01/2016	Date/Time Pre	pared:
Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program (Cost Sci) Inpatient Program (Cost Sci Sci) Inpatient Program (Cost Sci Sci) Inpatient Sci Sci Sci Sci Sci Sci Sci Sci Sci Sci			Ti †I	e XIX	Hospi tal		
Invariant To Charges Program Costs (col. 1 x col. 2) 1.00 2.00 3.00 30.00 03000 ADULTS & PEDIATRICS 3.04 30.00 03100 INTENSIVE CARE UNIT 0 ANCILLARY SERVICE COST CENTERS 30.00 50.00 05000 (PERATING ROOM 0.169645 50.00 05000 (PERATING ROOM 0.123153 50.00 05400 RADIOLOGY -DI AGNOSTIC 0.275056 64.00 0.00000 LABORATORY 0.27555 60.00 06500 RESPI RATORY THERAPY 0.580165 60.00 06700 COUPATIONAL THERAPY 0.580165 61.00 06700 COUPATIONAL THERAPY 0.580165 62.00 06700 COUPATIONAL THERAPY 0.580165 63.00 0.6700 COUPATIONAL THERAPY 0.580165 64.00 0.6700 COUPATIONAL THERAPY 0.580165 65.00 0.6700 COUPATIONAL THERAPY 0.580165 60.00 0.6700 COUPATIONAL THERAPY 0.720007 71.00 0.7100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.151308 72.00 0.7200 INPL. DEV, CHARGED TO PATIENT	Cost Center Description						
INPATI ENT ROUTI NE SERVI CE COST CENTERS 3.00 0.00 03000 ADULTS & PEDI ATRI CS 3.044 31.00 0.00 03000 INTENSI VE CARE UNI T 0 31.00 31.00 ANCI LLARY SERVI CE COST CENTERS 0 3.044 31.00 0.00 05000 (DPERATI NG ROM 0.169645 25.251 4.284 50.00 50.00 05000 (DECONDO (DERATI NG ROM 0.123153 702 86 53.00 54.00 05400 RADI OLGY-DI AGNOSTI C 0.275537 2.547 777 60.00 60.00 06000 LABORATORY 0.277537 2.547 707 60.00 66.00 60.00 06500 PHYSI CAL THERAPY 0.580165 0 0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00<							
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50.00 05000 OPERATING ROOM 0.169645 25, 251 4, 284 50.00 53.00 05300 AMESTHESI OLOGY 0.123153 702 86 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.275056 4, 462 1, 227 54.00 60.00 06000 LABORATORY 0.277537 2, 547 707 60.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.580165 0 0 65.00 66.00 06600 PLYSI CAL THERAPY 0.580165 0 0 66.00 67.00 06700 0CUPATI ONAL THERAPY 0.702007 0 0 67.00 69.00 0C900 CLUPATI ONAL THERAPY 0.225610 0 68.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.234103 0 72.00 73.01 74.00 OLSTORY 0.0317309 2,921 927 7	31.00 03100 I NTENSI VE CARE UNI T				0		31.00
53.00 05300 ANESTHESI OLOGY 0.123153 702 86 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.275056 4,462 1,227 54.00 60.00 LABORATORY 0.277537 2,547 707 60.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.580165 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.581187 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.702007 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0.225610 0 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.151308 687 104 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.2354103 0 72.00 73.01 74.00 03460 ONCOLOCY 0.258462 0 0 73.00 73.01 03480 ONCOLOCY 0.258462 0 0 73.01	ANCI LLARY SERVI CE COST CENTERS						
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60.00 06000 LABORATORY 0.277537 2,547 707 60.00 64.00 06400 INTRAVENUUS THERAPY 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.580165 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.581187 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.702007 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0.225610 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.151308 687 104 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.317309 2, 921 927 73.00 73.01 03480 ONCOLOGY 0.258462 0 73.01 73.01 76.97 CARDI AC REHABI LI TATI ON 0.498524 0 0 76.97 70.40 09000 CLI NI C 0 0.000000 0 76.97 70.00 09000 CLI NI C 0.000000 0 <td< td=""><td>53. 00 05300 ANESTHESI OLOGY</td><td></td><td></td><td>0. 1231</td><td>53 702</td><td>86</td><td>53.00</td></td<>	53. 00 05300 ANESTHESI OLOGY			0. 1231	53 702	86	53.00
64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 65.00 06500 RESPI RATORY THERAPY 0.580165 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.581187 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.702007 0 67.00 69.00 69.00 06900 ELECTROCARDI OLOGY 0.225610 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.151308 687 10.4 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.234103 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.317309 2,921 927 73.00 73.01 03480 ONCOLOGY 0.00000 0 0 76.00 76.70 07697 CARDI AC REHABILITATION 0.498524 0 0 76.90 79.00 09000 CLINIC 0.182197 13,960 2,643 91.00 90.00 090000 OBSERVATION BEDS (NON-DI STIN	54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 2750	6 4, 462	1, 227	54.00
65.00 06500 RESPI RATORY THERAPY 0.580165 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.581187 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.702007 0 0 67.00 69.00 06900 ELECTROCARDI OLOGY 0.225610 0 0 69.00 71.00 NTIO MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.151308 687 104 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.234103 0 0 72.00 73.01 03480 ONCOLOGY 0.258462 0 0 73.01 74.00 03160 CARDI OPULMONARY 0.498524 0 0 76.00 76.97 O7697 CARDI AC REHABI LI TATI ON 0.498524 0 0 76.97 000 09000 CLI NI C 0.000000 0 0 90.00 91.00 09100 EMERGENCY 0.182197 13,960 2,543 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PA	60. 00 06000 LABORATORY			0. 27753	37 2, 547	707	60.00
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201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				0. 64570		-	
					50, 530		
202.00 Net Charges (line 200 minus line 201) 50, 530 202.00		ogram only charges	(line 61)		0		
	202.00 Net Charges (line 200 minus line 201)				50, 530		202.00

CALCUL	I Financial Systems IU HEALTH TIPTON HOS LATION OF REIMBURSEMENT SETTLEMENT Pro	vider CCN: 15-1311	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2016 To 12/31/2016	Part B Date/Time Prep 5/24/2017 9:10	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	- >		6, 526, 946	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions PPS payments	5)		0	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instruction	ns)		0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, o	col. 13, line 200		0	9.00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			6, 526, 946	11.00
	Reasonabl e charges				
	Ancillary service charges				12.00
13.00 14.00	5 1 5 1	69)		0	13.00 14.00
14.00	Customary charges			0	14.00
15.00		ent for services on	a charge basis	0	15.00
16.00		yment for services o	n a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
	. , , , , , , , , , , , , , , , , , , ,			0.000000	18.00
19.00	Excess of customary charges over reasonable cost (complete only it	fline 18 exceeds li	ne 11) (see	0	19.00
20.00	instructions)	Elina 11 avaaada li	na 10) (ana	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete only if instructions)	F ITNE IT exceeds IT	ne 18) (see	0	20. 00
21.00		structions)		6, 592, 215	
22.00				0	22.00
23.00 24.00		ions)		0	23.00 24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00				38, 785	25.00
26.00	5			4, 701, 316	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus instructions)	the sum of lines 22	and 23] (see	1, 852, 114	27.00
28.00		50)		0	28.00
				0	29.00
30.00 31.00	5 ,			1, 852, 114 314	
	51515			1, 851, 800	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11)				33.00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			735, 525 478, 091	
36.00	, , , , , , , , , , , , , , , , , , ,	i ons)		687, 127	36.00
37.00		,		2, 329, 891	37.00
38.00				0	38.00
39.00 39.50				0	39.00 39.50
39.98		devices (see instruc	tions)	0	39.98
39. 99	•			0	39.99
40.00				2, 329, 891	40.00
40. 01 41. 00	Sequestration adjustment (see instructions) Interim payments			46, 598 2, 517, 123	
	1.5			2, 517, 125	42.00
43.00				-233, 830	
44.00		with CMS Pub. 15-2,	chapter 1,	193, 192	44.00
	§115.2 TO BE COMPLETED BY CONTRACTOR				
90.00				0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	93.00 94.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1311	Period: From 01/01/2016 To 12/31/2016		pared
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	⁻t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		5, 503, 13	39 0	2, 517, 123 0	1. (2. (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	3. (
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
99	3. 50-3. 98)			0	0	3.
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)		5, 503, 13	39	2, 517, 123	4.
	TO BE COMPLÉTED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5
50	Provider to Program TENTATIVE TO PROGRAM			0	0	5
50 51	ILIVIAIIVE IU PRUURAIN			0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		162, 82		233, 830	6
00	Total Medicare program liability (see instructions)		5, 340, 31		2, 283, 293	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1,00	2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1311 CCN: 15-Z311	Period: From 01/01/2010 To 12/31/2010		
		component c	CN. 13-2311	10 12/31/2010	5/24/2017 9:1	o am
			XVIII	Swing Beds - SN		
		Inpatien	t Part A	Pa	nrt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		1, 323, 9	22	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)					
. 01	Program to Provider ADJUSTMENTS TO PROVIDER	07/20/2016	103, 8	00	0	3.0
01	ADJUSTMENTS TO PROVIDER	0772072010	103, 6	0	0	
02				0	0	
04				0	0	
05				0	0	3.
	Provider to Program				1	
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	
5∠ 53				0	0	
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		103, 8	00	0	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 427, 7	22	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	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)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
01	TENTATIVE TO PROVIDER			0	0	
03				0	0	
	Provider to Program					
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	
99	5. 50-5. 98)			0	0	5.
00	Determined net settlement amount (balance due) based on					6.
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER			0	0	
02	SETTLEMENT TO PROGRAM		239, 8		0	
00	Total Medicare program liability (see instructions)		1, 187, 8		0	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1, 00	2.00	-

Heal th	Financial Systems IU HEALTH TIPTO	N HOSPITAL	In Lie	u of Form CMS-2	2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1311	Period: From 01/01/2016	Worksheet E-1 Part II			
	To 12/31/2016 Date/Time Prepa						
	5/24/2017 9:10						
	Title XVIII Hospital Cost						
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			893	1.00		
	1.00Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 142.00Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
2.00	1, 622	2.00					
3.00	376 2, 556	3.00 4.00					
	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12						
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			101, 955, 255			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			1, 920, 424			
7.00	CAH only - The reasonable cost incurred for the purchase of o	certified HIT technology	Wkst. S-2, Pt. I	1	7.00		
0.00	line 168				0.00		
8.00	Calculation of the HIT incentive payment (see instructions)			1	8.00		
9.00	Sequestration adjustment amount (see instructions)			0	9.00 10.00		
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)						
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			0	20.00		
	Initial/interim HIT payment adjustment (see instructions)			Ű	30.00		
	Other Adjustment (specify)	ing 21) (and instruction		0	31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	15)	11	32.00		

Heal th	Financial Systems IU HEALTH TIPT	ON HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1311 Component CCN: 15-Z311	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Pre	
		•	10 12/31/2010	5/24/2017 9:1	0 am
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES	-)	700 500	0	1 00
1.00	Inpatient routine services - swing bed-SNF (see instructions	·	799, 502	0	1.00
2.00 3.00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Pa		431, 404	0	2.00 3.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see i		431, 404	0	3.00
4.00	Per diem cost for interns and residents not in approved tead			0.00	4.00
4.00	instructions)			0.00	4.00
5.00	Program days		674	0	5.00
6.00	Interns and residents not in approved teaching program (see	instructions)		0	6.00
7.00	Utilization review - physician compensation - SNF optional m		0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	<u> </u>	1, 230, 906	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9.00
10.00	Subtotal (line 8 minus line 9)		1, 230, 906	0	10.00
11.00	Deductibles billed to program patients (exclude amounts appl	icable to physician	0	0	11.00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		1, 230, 906	0	12.00
13.00	Coinsurance billed to program patients (from provider record for physician professional services)	ds) (exclude coinsurance	18, 837	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	1 11 00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line	e 14)	1, 212, 069	0	
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_	0	0	
16.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)	0	0	
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		0	0	
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)	0	0	
19.00	Total (see instructions)		1, 212, 069	0	19.00
19.01	Sequestration adjustment (see instructions)		24, 241	0	19.01 20.00
20. 00 21. 00	Interim payments Tentative settlement (for contractor use only)		1, 427, 722	0	20.00
21.00	Balance due provider/program (line 19 minus lines 19.01, 20,	and (21)	-239, 894	0	21.00
22.00	Protested amounts (nonallowable cost report items) in accord		-239, 894 14, 641	0	22.00
23.00	chapter 1, §115.2	aance withi two Pub. 15-2,	14, 041	0	23.00

		TON HOSPITAL		u of Form CMS-2		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1311	Peri od:	Worksheet E-3		
			From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	nared	
			10 12/31/2010	5/24/2017 9:1		
		Title XVIII	Hospi tal	Cost		
			DELUDUDOENENT	1.00		
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	RE PART A SERVICES - COST	RETMBURSEMENT	E 000 000	1 1 00	
1.00	Inpatient services	+:>		5, 820, 820	1.00	
2.00	Nursing and Allied Health Managed Care payment (see instruc	0	2.00			
3.00 4.00	Organ acquisition Subtotal (sum of lines 1 through 3)	5, 820, 820	3.00 4.00			
4.00 5.00	Primary payer payments			5, 820, 820	5.00	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 879, 028		
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			5, 077, 020	0.00	
	Reasonable charges				1	
7.00	Routi ne servi ce charges			0	7.00	
8.00	Ancillary service charges			0	8.00	
9.00	Organ acquisition charges, net of revenue			0	9.00	
10.00	Total reasonable charges			0	10.00	
	Customary charges					
11.00	Aggregate amount actually collected from patients liable for			0	•	
12.00	Amounts that would have been realized from patients liable		on a charge basis	0	12.00	
	had such payment been made in accordance with 42 CFR 413.13	3(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000				
14.00	Total customary charges (see instructions)	0				
15.00	Excess of customary charges over reasonable cost (complete instructions)	only if line 14 exceeds li	ne 6) (see	0	15.00	
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	a 14) (see	0	16.00	
10.00	instructions)	only if the o exceeds iff	16 14) (366	0	10.00	
17.00						
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00	
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	18.00	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5, 879, 028	19.00	
20.00	Deductibles (exclude professional component)			462, 970	20.00	
21.00	Excess reasonable cost (from line 16)			0		
22.00	Subtotal (line 19 minus line 20 and 21)			5, 416, 058		
23.00	Coinsurance			322		
24.00	Subtotal (line 22 minus line 23)			5, 415, 736		
25.00	Allowable bad debts (exclude bad debts for professional ser	51, 644				
26.00	Adjusted reimbursable bad debts (see instructions)	33, 569				
27.00	Allowable bad debts for dual eligible beneficiaries (see in	49, 168 5 440 205				
28.00 29.00	Subtotal (sum of lines 24 and 25, or line 26)			5, 449, 305 0	28.00 29.00	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructi	005)		0	29.0	
29.50 29.99	Recovery of Accel erated Depreciation	01157		0		
30.00	Subtotal (see instructions)	5, 449, 305				
30.00	Sequestration adjustment (see instructions)	108, 986				
	Interim payments	5, 503, 139				
32.00	Tentative settlement (for contractor use only)			0, 303, 137		
33.00	Balance due provider/program (line 30 minus lines 30.01, 31	l, and 32)		-162, 820		
34.00	Protested amounts (nonallowable cost report items) in accor		chapter 1,	203, 599		
	§115. 2					

MCRI F32 - 10. 5. 160. 2

	Financial Systems IU HEALTH TIPT E SHEET (If you are nonproprietary and do not maintain	Provider C	CN: 15-1311 P	Period:	u of Form CMS-2 Worksheet G	_
ınd-t ıly)	ype accounting records, complete the General Fund column			rom 01/01/2016 o 12/31/2016		
57		General Fund		Endowment Fund	5/24/2017 9:10 Plant Fund	10 a
		1.00	Purpose Fund 2.00	3.00	4.00	-
	CURRENT ASSETS	1.00	2.00	5.00	4.00	
00	Cash on hand in banks	22, 150, 622		-	0	
00	Temporary investments	0		-	0	
00	Notes recei vabl e Accounts recei vabl e		0	0	0	
00 00	Other receivable	4, 995, 864 -347, 784		0	0	
00	Allowances for uncollectible notes and accounts receivable	-347,784		0	0	
00	Inventory	658, 239	Ö	0	0	
00	Prepaid expenses	192, 331	0	0	0	
00	Other current assets	33, 265		, O	0	
. 00	Due from other funds	0	0	-	0	
. 00	Total current assets (sum of lines 1-10)	27, 682, 537	0	00	0) 1 [.]
. 00	FI XED ASSETS Land	0	0	ol	0	1:
. 00	Land improvements	0	-	-	0	
	Accumulated depreciation	0	0	0	0	
. 00	Buildings	0	0	0	0	1!
	Accumulated depreciation	0	0) O	0	
	Leasehold improvements	2, 116, 905		, O	0	
	Accumulated depreciation	-863, 145		-	0	
	Fixed equipment	0		-	0	
	Accumulated depreciation Automobiles and trucks	0		-	0	
	Accumulated depreciation		0	-	0	
	Major movable equipment	11, 505, 643		0	0	
	Accumul ated depreciation	-8, 735, 982		0	0	
	Minor equipment depreciable	0	0	0	0	2
	Accumulated depreciation	0	0	0	0	20
	HIT designated Assets	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
	Minor equipment-nondepreciable	0 4 000 401	0 0	-	0	
. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	4, 023, 421	0	0	0	1 3
. 00	Investments	0	0	0	0	3
. 00	Deposits on leases	0	0 0	0 0	0	
. 00	Due from owners/officers	0	0	0	0	3:
	Other assets	23, 345, 607		, O	0	
	Total other assets (sum of lines 31-34)	23, 345, 607			0	
. 00	Total assets (sum of lines 11, 30, and 35)	55, 051, 565	0	0 0	0) 30
00	CURRENT LI ABI LI TI ES	1, 560, 242	0	ol	0	1 2.
	Accounts payable Salaries, wages, and fees payable	978, 683		-	0	
	Payroll taxes payable	978,083		-	0	
	Notes and Loans payable (short term)	800, 000	-	0	0	
	Deferred income	0	0	0	0	
2. 00	Accelerated payments	0	1			42
	Due to other funds	0	0	-	0	
	Other current liabilities	3, 749, 037		-	0	
5. 00	Total current liabilities (sum of lines 37 thru 44)	7, 087, 962	0	0 0	0	4
00	LONG TERM LIABILITIES	0	0		0	
o. 00 7. 00	Mortgage payable Notes payable	16, 905, 428	-	0	0	
	Unsecured Loans	10, 700, 420			0	
	Other long term liabilities	42, 335	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	16, 947, 763		0	0	
	Total liabilities (sum of lines 45 and 50)	24, 035, 725		0	0	<u>5</u>
	CAPI TAL ACCOUNTS					
	General fund balance	31, 015, 840				5
	Specific purpose fund		0			5
. 00	Donor created - endowment fund balance - restricted			0		5
	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		5
	Plant fund balance - invested in plant			0	0	
					0	
. 00	Plant fund balance - reserve for plant improvement					
. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	
. 00		31, 015, 840	0	0 0	0	59

Health Financial Systems STATEMENT OF CHANGES IN FUND BALANCES		IU HEALTH TIPTON HOSPITAL Provider CCN: 15-131		N. 1E 1011			eu of Form CMS-2552-10 Worksheet G-1	
STATEN	IENT OF CHANGES IN FUND BALANCES		Provi der Co	JN: 15-1311	Fro To	om 01/01/2016 12/31/2016	Date/Time Pre 5/24/2017 9:1	pared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
1.00	Fund balances at beginning of period	1.00	19, 486, 530	3.00	-	4.00	5.00	1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,006,212			Ű		2.00
3.00	Total (sum of line 1 and line 2)		28, 492, 742			0		3.00
4.00	ADDI TI ON TO UNRESTRI CTED	2, 807, 970	20, 172, 712		0	J	0	
5.00	ADDI TI ON TO PERMANENTLY RESTRI CTED	134,061			0		0	
6.00	ROUNDING	101,001			õ		0	
7.00		0			õ		0	
8.00		0			õ		0	
9.00		0			0		0	
10.00	Total additions (sum of line 4-9)	Ŭ	2, 942, 032		0	o	0	10.00
11.00	Subtotal (line 3 plus line 10)		31, 434, 774			0		11.00
12.00	REDUCTION IN TEMPORARILY RESTRICTED	418, 934	31, 434, 774		0	0	o	
12.00	REDUCTION IN TEMPORARIET RESTRICTED	410, 734			0		0	
14.00		0			0		0	
14.00		0			0		0	
		0			Ŭ			
16.00		0			0		0	
17.00		0	440.004		0		0	
18.00	Total deductions (sum of lines 12-17)		418, 934			0		18.00
19.00	Fund balance at end of period per balance		31, 015, 840			0		19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		(00	7.00	0.00				
1.00	Fund balances at beginning of period	6.00	7.00	8.00	-			1.00
1.00					()			
2 00		0			0			2 00
2.00	Net income (loss) (from Wkst. G-3, line 29)				-			2.00
3.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	0		0			3.00
3.00 4.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED		0		-			3. 00 4. 00
3.00 4.00 5.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED		0		-			3.00 4.00 5.00
3.00 4.00 5.00 6.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED		0 0 0		-			3.00 4.00 5.00 6.00
3.00 4.00 5.00 6.00 7.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED		0 0 0 0		-			3. 00 4. 00 5. 00 6. 00 7. 00
3.00 4.00 5.00 6.00 7.00 8.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED				-			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
3.00 4.00 5.00 6.00 7.00 8.00 9.00	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING		0 0 0 0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00 \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9)		0 0 0 0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9)		0 0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0		0			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0		0			3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00 \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0		0			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
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 0 0 0		0			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
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) REDUCTION IN TEMPORARILY RESTRICTED	0	0 0 0 0		0			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
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	Net income (loss) (from WKst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) REDUCTION IN TEMPORARILY RESTRICTED Total deductions (sum of lines 12-17)		0 0 0 0		000000000000000000000000000000000000000			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
$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADDITION TO UNRESTRICTED ADDITION TO PERMANENTLY RESTRICTED ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) REDUCTION IN TEMPORARILY RESTRICTED	0	0 0 0 0		0			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

	Health Financial Systems IU HEALTH TIPTON HOSPIT.		ON 45 4044			u of Form CMS-2552	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		То	01/01/2016 12/31/2016	Worksheet G-2 Parts I & II Date/Time Pre 5/24/2017 9:1	epared:
	Cost Center Description		Inpati ent	Ou	tpati ent	Total	
	PART I - PATIENT REVENUES		1.00		2.00	3.00	
	General Inpatient Routine Services						-
1.00	Hospi tal		2, 039, 0	35		2, 039, 035	1.00
2.00	SUBPROVIDER - IPF		2,007,0			2,007,000	2.00
3.00	SUBPROVIDER - IRF						3.00
4.00	SUBPROVI DER						4.00
5.00	Swing bed - SNF			0		C	5.00
6.00	Swing bed - NF			0		C	6.00
7.00	SKILLED NURSING FACILITY						7.00
8.00	NURSING FACILITY						8.00
9.00	OTHER LONG TERM CARE						9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 039, 0	35		2, 039, 035	10.00
44 00	Intensive Care Type Inpatient Hospital Services		444 7	10		444 740	1 1 1 00
11.00			444, 7	12		444, 712	
12.00 13.00	CORONARY CARE UNIT						12.00
13.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						13.00
14.00	OTHER SPECIAL CARE (SPECIFY)						14.00
16.00	Total intensive care type inpatient hospital services (sum o	flines	444, 7	12		444, 712	
10.00	11-15)	1 111163	444,7	12		444,712	10.00
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	2, 483, 7	47		2, 483, 747	17.00
18.00	Ancillary services	- /	26, 065, 7		52, 812, 363	78, 878, 067	
19.00	Outpatient services		559, 4		20, 011, 291	20, 570, 750	
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	C	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	СМНС						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27.00	PHYSI CI AN REVENUE	0 +- WI+	20, 100, 0	0	2, 540, 276	2, 540, 276	
28.00	Total patient revenues (sum of lines 17-27)(transfer column G-3, line 1)	3 LO WKSL.	29, 108, 9	10	75, 363, 930	104, 472, 840	28.00
	PART II - OPERATING EXPENSES				I		1
29.00	Operating expenses (per Wkst. A, column 3, line 200)				33, 341, 288		29.00
30.00	ADD (SPECIFY)			0	00,011,200		30.00
31.00				0			31.00
32.00				0			32.00
33.00			1	0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0 0			40.00
41.00 42.00	Total deductions (sum of lines 37-41)			U	0		41.00
42.00	Total operating expenses (sum of lines 29 and 36 minus line -	12)(transfor			33, 341, 288		42.00
							1 40.00

Heal th	Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-1311	Peri od:	Worksheet G-3	
				From 01/01/2016 To 12/31/2016	Date/Time Pre	narod
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Par				104, 472, 840	1.00
2.00	Less contractual allowances and discounts of	63, 504, 947	2.00			
3.00	Net patient revenues (line 1 minus line 2)	40, 967, 893	3.00			
4.00	Less total operating expenses (from Wkst. (33, 341, 288	4.00		
5.00	Net income from service to patients (line 3		7, 626, 605	5.00		
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				222, 750	6.00
7.00	Income from investments				286, 937	7.00
8.00	Revenues from telephone and other miscellar	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 gu	uests			66, 658	
	Revenue from rental of living quarters				0	
	Revenue from sale of medical and surgical s		an patients		0	16.00
	Revenue from sale of drugs to other than pa				0	17.00
	Revenue from sale of medical records and al				0	18.00
	Tuition (fees, sale of textbooks, uniforms,				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				85, 612	
23.00	Governmental appropriations				26, 492	
	MI SCELLANEOUS I NCOME				691, 158	
	Total other income (sum of lines 6-24)				1, 379, 607	
	Total (line 5 plus line 25)				9, 006, 212	
	OTHER EXPENSES (SPECIFY)				0	27.00
	Total other expenses (sum of line 27 and su				0	28.00
29.00	Net income (or loss) for the period (line 2	26 minus line 28)			9, 006, 212	29.00