AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-13	From 06/01/2017	
PART I - COST	REPORT STATUS			3/24/2010 12. 13 pili
Provi der use onl y	1. [X]Electronically filed cost report 2. []Manually submitted cost report 3. [O]If this is an amended report enter the number 4. [F]Medicare Utilization. Enter "F" for full or "L		Date: 5/29/20 er resubmitted this co	
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for	or this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH FRANKFORT HOSPITAL (15-1316) for the cost reporting period beginning 06/01/2017 and ending 12/31/2017 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.

]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

Title XVIII Title V Part B Cost Center Description Part A HIT Title XIX 3.00 1.00 2.00 4.00 5.00 PART III - SETTLEMENT SUMMARY 1, 463, 331 1, 848, 348 1.00 Hospi tal 0 0 1.00 0 Subprovi der - IPF 2 00 2 00 C 0 3.00 Subprovider - IRF 0 0 0 3.00 Swing bed - SNF 0 0 5.00 465, 766 0 5.00 Swing bed - NF 0 6 00 0 6.00 HOME HEALTH AGENCY I 9.00 0 0 9.00 1, 929, 097 1, 848, 348 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.

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1316 Peri od: Worksheet S-2 From 06/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:13 pm 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 1300 SOUTH JACKSON STREET 1.00 PO Box: 1.00 2.00 City: FRANKFORT State: IN Zip Code: 46041 County: CLINTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 IU HEALTH FRANKFORT 151316 99915 01/21/2003 Ν 0 0 3.00 HOSPI TAI Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF III HEALTH FRANKFORT 157316 99915 N 7.00 01/21/2003 N 0 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14 00 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 06/01/2017 12/31/2017 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 N N 22 00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. Medi cai d Other In-State In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 25.00 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

instructions)

ealth Financial Systems		Provider C	CN: 15-1316	Peri od:	eu of Form CMS-2 Worksheet S-2	
IOST THE AND TOST THE HEALTH OAKE COMMERCE TENTITION	TTON BATA	Trovider o	GN. 13 1310	From 06/01/2017 To 12/31/2017	Part I	pared:
	Y/N	I ME	Direct GME	IME	Direct GME	
	1. 00	2. 00	3. 00	4. 00	5. 00	
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in current cost reporting period. (see instruction 1.05 Enter the difference between the baseline prim	the s).					61. C
and/or general surgery FTEs and the current ye primary care and/or general surgery FTE counts 61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is be	(line					61.0
used for cap relief and/or FTEs that are nonpr care or general surgery. (see instructions)						01.
care or general surgery. (see riistructrons)	Pi	rogram Name	Program Cod	e Unweighted IME	Unwei ghted	
				FTE Count	Direct GME FTE Count	
1 10 00 11 575 1 11 11 11 11		1. 00	2. 00	3.00	4.00	
1. 10 Of the FTEs in line 61.05, specify each new pr specialty, if any, and the number of FTE resid for each new program. (see instructions) Enter column 1, the program name. Enter in column 2, program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct FTE unweighted count.	ents in the			0.00	0.00	61. 1
20 Of the FTEs in line 61.05, specify each expand program specialty, if any, and the number of F residents for each expanded program. (see instructions) Enter in column 1, the program neture in column 2, the program code. Enter in 3, the IME FTE unweighted count. Enter in coluthe direct GME FTE unweighted count.	TE ame. col umn			0. 00	0.00	61.
					1.00	
ACA Provisions Affecting the Health Resources	and Servi ces	Admi ni strati or	ı (HRSA)		1. 00	
2.00 Enter the number of FTE residents that your ho	spital traine	ed in this cost		riod for which	0.00	62.
your hospital received HRSA PCRE funding (see 2.01 Enter the number of FTE residents that rotated during in this cost reporting period of HRSA T	from a Teach HC program. (ning Health Cen (see instructio		o your hospital	0.00	62.
Teaching Hospitals that Claim Residents in Nor B.00 Has your facility trained residents in nonprov			ost reporting	period? Enter	N	63.
"Y" for yes or "N" for no in column 1. If yes,			67. (see inst	ructi ons)		00.
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
			Nonprovi der Si te		2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Resident period that begins on or after July 1, 2009 ar			Inis base yea	ar is your cost i	reporting	
in the base year period, the number of unweigh resident FTEs attributable to rotations occurr settings. Enter in column 2 the number of unweigh resident FTEs that trained in your hospital.	facility trai ted non-prima ing in all no reighted non-p	ned residents ary care onprovider orimary care	0.	0. 00	0. 000000	64.
of (column 1 divided by (column 1 + column 2))			Upus:	House'	Doti o (! 0'	
Program Na	ame Pi	rogram Code	Unwei ghted FTEs Nonprovi der	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
			Si te			
1 00		2 00	3 00	4 00	5.00	

2.00

3. 00

4.00

5.00

1.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1316 Peri od: Worksheet S-2 From 06/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:13 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems IU HEALTH FRANKFO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	N: 15-1316	Peri od: From 06/01/2017 To 12/31/2017	u of Form CMS- Worksheet S-2 Part I Date/Time Pre	epared:
				5/29/2018 12:	13 pm
Long Term Care Hospital PPS				1.00	_
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no. TEFRA Providers			g period? Enter	N N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classi fi ed ι	ınder section		N	87. 00
1000(d)(1)(b)(vi): Littel 1 Toll yes of N Toll Ho.			V	XI X	
Title V and XIX Services			1. 00	2. 00	_
90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? Er	nter "Y" for	N	Y	90. 00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the			N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appli 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	al certificati			N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.		I XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	N	N	94. 00		
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the appl 98.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for	terns and resi	dents post	0. 00 N	0. 00 Y	97. 00 98. 00
oclumn 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the rep. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.				Y	98. 01
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	Y	98. 02
98.03 Does title V or XIX follow Medicare (title XVIII) for a critire imbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.				N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.			N	N	98. 04
98.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co column 2 for title XIX.				Y	98. 05
98.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.			N	Y	98. 06
Rural Providers					
105.00Does this hospital qualify as a CAH? $106.00lf$ this facility qualifies as a CAH, has it elected the all-i	nclusive meth	nod of paymen	t Y		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the CME climination is not made on West R. P. H. L. column	1. (see instr	ructions) If	N		107. 00
yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 s this a rural hospital qualifying for an exception to the C	·	· ·			108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	ORIVA FOE SCHEO	iui 0: 300 42	IV		100.00
	Physi cal	Occupationa	-	Respiratory	4
100 00 If this hospital qualifies as a CAH or a cost provider are	1.00	2.00	3. 00	4. 00	100.00

i or insur sour ii jos somproto mot. s 2, i ti iii	i or industrial in Job compresses intotal b 27 its in					
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	N		108. 00	
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.						
	Physi cal	Occupati onal	Speech	Respi ratory		
	1.00	2.00	3.00	4. 00		
109.00 If this hospital qualifies as a CAH or a cost provider, are	Υ	Υ	N	N	109. 00	
therapy services provided by outside supplier? Enter "Y"						
for yes or "N" for no for each therapy.						
				1.00		
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (§41	OA	N	110.00	
Demonstration) for the current cost reporting period? Enter "	'Y" for yes or	"N" for no. If	yes,			
complete Worksheet E, Part A, lines 200 through 218, and Wor	rksheet E-2, li	nes 200 through	h 215, as			
appl i cabl e.						
• • •						

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-1316	Peri od: From 06/01/ To 12/31/	/2017 I /2017 I		S-2 Prepared: 12:13 pm
		1.00		2. 00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cosmy" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is particle all that apply: "A" for Ambulance services; "B" for addition for tele-health services.	st reporting period? Ente Lumn 1 is Y, enter the ticipating in column 2.	N N			111. 0
			1.00	2. 00 3.	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" 1	If column 2 is "E", ente t for long term care (inc s) based on the definitio	rin column ludes	N N		0 115. 0
17.00 s this facility legally-required to carry malpractice insura		r "N" for	N		117. 0
18.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the polic	y is	2		118. 0
	Premi ums	Losse	S	Insuranc	е
	1.00	2.00		3. 00	
18.01 List amounts of malpractice premiums and paid losses:	16,	792	0		0 118. 0
		1. 00		2. 00	
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA §3121 and applicable amendments	ule listing cost centers Harmless provision in AC column 1, "Y" for yes or alifies for the Outpatien			N	118. 0 119. 0 120. 0
Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implan	ntable devices charged to	N			121. 0
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.				5. 00	122. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" for no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 on the sis a Medicare certified kidney transplant center, en		е			126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, ento in column 1 and termination date, if applicable, in column 2.	er the certification date				127. 0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certification date				128. 0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.	r the certification date	in			129. C
30.00 f this is a Medicare certified pancreas transplant center, and date in column 1 and termination date, if applicable, in column 1.00 f this is a Medicare certified intestinal transplant center,	umn 2.				130. C
date in column 1 and termination date, if applicable, in column 1 and termination date, if applicable, in column 32.00 f this is a Medicare certified islet transplant center, ente	umn 2.				132. 0
in column 1 and termination date, if applicable, in column 2. 33.00 f this is a Medicare certified other transplant center, ento	er the certification date				133. 0
in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the					134. 0
and termination date, if applicable, in column 2. All Providers					
40.00 Are there any related organization or home office costs as de	efined in CMS Pub. 15-1,	Y		15H059	140. 0

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1316 Period: Worksheet S-2
From 06/01/2017 Part I

HOSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DATA	Provi der C	CN: 15-1316	From C	I: 06/01/2017 12/31/2017		
4.00		0.00			2.00	5/29/2018 12:	
1.00 If this facility is part of a cha		2.00	uah 143 th	na nama an	3.00	of the	
home office and enter the home of				ie rialile ari	iu addi 633	or the	
141.00 Name: INDIANA UNIVERSITY HEALTH				actor's Nu	umber: 0810)1	141. 00
42.00 Street: 340 WEST 10TH STREET	PO Box:						142. 00
143. 00 Ci ty: I NDI ANAPOLI S	State:	I N	Zi p C	ode:	4620)2	143. 00
						1.00	-
44.00 Are provider based physicians' co	osts included in Workshee	et A?				Y	144. 00
					1. 00	2.00	
inpatient services only? Enter "\ no, does the dialysis facility ir period? Enter "Y" for yes or "N"	" for yes or "N" for no nclude Medicare utilizati for no in column 2. ngy changed from the prev	in column 1. If ion for this cost viously filed cos	column 1 i reporting t report?		Υ	09/29/2017	145. 00
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/		o. 15-2, chapter 	40, §4020) ————	If			
						1.00	
47.00 Was there a change in the statist						Y	147. 00
48.00 Was there a change in the order of				6		N	148. 0
49.00 Was there a change to the simplif	fied cost finding method				T: ±1 - \/	N T: +1 - VIV	149. 0
		Part A 1.00	Part 2.00		<u>Title V</u> 3.00	Title XIX 4.00	-
Does this facility contain a prov	vider that qualifies for						
or charges? Enter "Y" for yes or							
55.00 Hospi tal		N	N		N	N	ີ 155. C
56.00 Subprovider - IPF		N	N		N	N	156. C
57. 00 Subprovi der - IRF		N	N		N	N	157. C
58. OO SUBPROVI DER 59. OO SNF		N	N.		N	N	158. 0 159. 0
60.00 HOME HEALTH AGENCY		N N	N N		N N	N N	160. 0
61. OO CMHC		IN IN	N N		N	N	161. 0
		'				1.00	-
Multicampus			. ,.	66 1 0	DC4 0		1/5 0/
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	campus nospitai that has	one or more camp	uses in ai			N	165. 0
	Name	County	State	Zip Code		FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	0 166. 0
						1.00	
Health Information Technology (HI	T) incentive in the Amo	rican Recovery an	nd Reinvest	tment Act		1.00	
67.00 s this provider a meaningful use	er under §1886(n)? Enter	r "Y" for yes or	"N" for no).	r the	Y	167. 0 0168. 0
reasonable cost incurred for the	HIT assets (see instruct	tions)					
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	HIT assets (see instruction of a meaningful user, of the second of the s	tions) does this provide 'N" for no. (see	instructio	ns)	•	0.00	
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	HIT assets (see instruction of a meaningful user, of the second of the s	tions) does this provide 'N" for no. (see	instructio	is "N"), (enter the		
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reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi	HIT assets (see instruction of a meaningful user, of the second of the s	tions) does this provide 'N" for no. (see and is not a CAH	instructic (line 105	is "N"), o	enter the		0169.0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi 70.00 Enter in columns 1 and 2 the EHR	HIT assets (see instruction of a meaningful user, of the second of the s	tions) does this provide 'N" for no. (see and is not a CAH	instructic (line 105	is "N"), o	enter the	Endi ng 2. 00	168. 0 0169. 0 170. 0

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1316	Peri od: From 06/01/2017 To 12/31/2017	Part II Date/Time Pre	epared
				Y/N	Date/Time Prep. 5/29/2018 12: 1 Date	10 51
	Conoral Instruction, Enton V for all VEC recogness. Enton N	for all NO so	onences Ent	1.00		
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all No re	sponses. Ente	er all dates in t	.ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	beginning of	the cost	Y	06/01/2017 	1.
	proporting period: IT yes, enter the date of the change IT e	oralin 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe	ffices, drug er or its f the board	Y			3.
	relationships? (see instructions))/ (N			
	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date as column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffi		1, 00	7ype 2. 00		
	Financial Data and Reports		1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues diffe	rent from	N			5.
	those on the filed financial statements? If yes, submit rec	onciliation.		V /N	1 1 0	
				Y/N 1. 00		
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	ne provider is	s N		6.
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	structions		N		7.
00 00	Were nursing school and/or allied health programs approved		during the	N N		8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	al education	N		9.
	program in the current cost report? If yes, see instruction	S.				
. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in t	the current	N		10.
. 00		& R in an App	proved	N		11.
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting		12. 13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	yes, see in	structions.	N	14.
	Bed Complement		<u> </u>			١
. 00	Did total beds available change from the prior cost reporti		yes, see ins t A			15.
		Y/N	Date	Y/N		
		1. 00	2.00	3. 00	4. 00	
. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16.
. 00	date of the PS&R Report used in columns 2 and 4 (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Υ	04/18/2018	Y	04/18/2018	17.
00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
	If line 16 or 17 is yes, were adjustments made to PS&R	N	1	N	i	19

Precords? If yes, see instructions. 1.00		Financial Systems IU HEALTH FRANK		ON 45 4044		u of Form CM	
1.00 3.00 1.00 3.00 2.00 1.00 3.00 2.00 1.00 3.00 2.00 2.00 2.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 2.00 3.00 3.00 2.00 3.00 3.00 2.00 3.00	HUSPII	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider (JCN: 15-1316	From 06/01/2017	Part II Date/Time P	repared:
20.00 If I I Ine 16 or 17 I is yes, were adjustments made to PSSR N N 20.00							
Report data for Other? Describe the other adjustments:	20.00	If line 14 or 17 is yes were adjustments made to DSOD		0			20.00
1.00	20.00				IN .	IN	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 Processes? If yes, see instructions. 1.00			Y/N	Date	Y/N	Date	
COMPLETE BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) COMPLETED BY COST RELIBRURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been roll of in the Medicare purposes? If yes, see instructions N 22.00 23.00 Have change of the yes, see instructions 16.00 Were new leaves and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions 25.00 Have there been new capital ized leases entered into during the cost reporting period? If yes, see N 25.00 Have there been new capital ized leases entered into during the cost reporting period? If yes, see N 26.00 Were nessets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit interest Expense 10.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (bebt Service Reserve Fund) N 29.00 Have casting debt been replaced prior to its schoduled amburity without issuance of new debt? If yes, see N 30.00 Have skiring debt been replaced prior to its schoduled amburity without issuance of new debt? If yes, see N 30.00 Have capital search of the provider hased Physicians of Sec. 2135.2 applied pertaining to competitive bidding? If no. see Instructions. 17.00 Have a provided the provider facility under an arrangement with the provider-based physicians? Y 34.00 Fitter asset instructions. 18.00 Have changes or new agreements of secretices for amended existing agreements with the provider-based physicians? Y 34.00 Fitter asset in the provider facility under an arrangement with provider-based physicians? Y 34.00 Fitter asset in the provider facility under an arrangement with provider-based physicians? Y 37.00 Fitter asset in the provider render serv				2.00		4. 00	
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31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00	30. 00		urity with new	debt? If yes	, see	N	30. 00
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instructions. Cost Report Preparer Contact Information Intermediate the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Line the employer/company name of the cost report in NDI ANA UNI VERSITY HEALTH preparer. Intermediate the employer/company name of the cost report in NDI ANA UNI VERSITY HEALTH preparer. Line the telephone number and email address of the cost in the cost i	40. 00		home office?	If yes, see	N		40.00
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42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00							
43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	42.00		INDIANA UNIVE	RSITY HEALTH			42. 00
		1					
report preparer in columns I and Z, respectively.	43.00		317. 962. 1093		RUTTER@I UHEALT	H. ORG	43. 00
		preport preparer in columns i and 2, respectively.	I		1		II

Heal th	Financial Systems	KFORT HOSPIT	AL	In Lie	In Lieu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provi dei	CCN: 15-1316	Peri od:	Worksheet S-2	2
					From 06/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 12:	pared: 13 pm
				3. 00			
	Cost Report Preparer Contact Information			0.00			
41. 00	Enter the first name, last name and the held by the cost report preparer in colurrespectively.		GOVERNMENT	PROGRAMS DIRECTO	OR .		41. 00
42.00	Enter the employer/company name of the co	ost report					42. 00
43. 00	preparer. Enter the telephone number and email add report preparer in columns 1 and 2, resp						43. 00

| Peri od: | Worksheet S-3 | From 06/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1316

					T	o 12/31/2017	Date/Time Pre 5/29/2018 12:	
							I/P Days / 0/P	13 piii
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	5, 350	12, 408. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	5, 350	12, 408. 00	0	7. 00
	beds) (see instructions)			_	_		_	
8.00	INTENSIVE CARE UNIT	31. 00		0	0	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00		0.5		40 400 00	0	
14.00	Total (see instructions)			25	5, 350	12, 408. 00	l e	14.00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18.00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	101 00						21. 00 22. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	30.00						24. 00 24. 10
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)	09.00		25			0	27. 00
28. 00	Observation Bed Days			25			0	28. 00
29. 00	Ambul ance Trips						0	29.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'istruction)							31.00
32. 00	Labor & delivery days (see instructions)			0	0			32.00
32. 00	Total ancillary labor & delivery room			Ü				32. 00
JZ. UI	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01
	1	l .			•		1	

Health Financial Systems IU HEALTH HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1316

				'	0 12/31/201/	5/29/2018 12:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	· · · · · · · · · · · · · · · · · · ·			Pati ents	& Residents	Payrol I	
		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)	387	5	517			1. 00
2.00	HMO and other (see instructions)	65	30				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	122	0	122			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	23			6. 00
7.00	Total Adults and Peds. (exclude observation	509	5	662			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	0	0	0			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		0	0			13. 00
14.00	Total (see instructions)	509	5	662	0.00	51. 26	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00							24. 00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			
27. 00	Total (sum of lines 14-26)				0.00	51. 26	
28. 00	Observation Bed Days		5	222			28. 00
29. 00		0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	1 1 3			0			31. 00
32.00		0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00		0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1316

					12/31/2017	5/29/2018 12:	
	·	Full Time	<u> </u>	Di sch	arges		
		Equi val ents			,		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	130	2	183	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			22	11		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
8. 00 9. 00	INTENSIVE CARE UNIT						8.00
	CORONARY CARE UNIT						9. 00 10. 00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						11.00
							12.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						13.00
14. 00		0.00	0	130	2	183	
15. 00	Total (see instructions) CAH visits	0.00	U	130	2	183	15.00
16. 00	SUBPROVIDER - IPF						16.00
17. 00	SUBPROVIDER - I FF						17.00
18. 00							18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00							20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY	0.00					22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE						24.00
24. 10							24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0, 00					26. 25
27. 00		0.00					27. 00
28. 00	,						28. 00
29. 00	1						29. 00
30. 00	· ·						30.00
31. 00	, , ,				ļ		31. 00
32. 00	1 . 3				ļ		32. 00
32. 01	Total ancillary labor & delivery room	1					32. 01
	outpatient days (see instructions)						
33.00				0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

OSPI 1	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	ovider CCN: 15-1316	Peri od:	Worksheet S-1	0	
			From 06/01/2017 To 12/31/2017	Date/Time Pre		
				5/29/2018 12:	13 pr	
				1.00		
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi- Medicaid (see instructions for each line)	ded by line 202 col	umn 8)	0. 629775	1.	
00	Net revenue from Medicaid			932, 046	2.	
00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.		
00	If line 3 is yes, does line 2 include all DSH and/or supplementa	i cai d?	Y	4.		
00	If line 4 is no, then enter DSH and/or supplemental payments fro	6, 074, 742				
.00	Medicaid charges Medicaid cost (line 1 times line 6)					
00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if					
	< zero then enter zero)			2, 893, 675		
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
00	Net revenue from stand-alone CHIP Stand-alone CHIP charges			0		
0.00	Stand-alone CHIP cost (line 1 times line 10)				1	
2. 00	Difference between net revenue and costs for stand-alone CHIP (I	ine 11 minus line 9	if < zero then	Ö	1	
	enter zero)					
	Other state or local government indigent care program (see instru				1,0	
3. 00 4. 00	Net revenue from state or local indigent care program (Not inclu Charges for patients covered under state or local indigent care			0	13.	
. 00	10)	program (Not Theraa	ed III IIIles 0 01		14.	
. 00	State or local indigent care program cost (line 1 times line 14)			0	15.	
6. 00	Difference between net revenue and costs for state or local indi	gent care program (line 15 minus line	0	16.	
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state/local in	digont care progra	ms (soo		
	instructions for each line)	and State/Tocal Til	argent care progra	1115 (566		
7. 00	Private grants, donations, or endowment income restricted to fun	9		1	17.	
3. 00	Government grants, appropriations or transfers for support of ho		omo (oum of lineo	2, 893, 675		
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care progr	dilis (Suili 01 1111eS	2, 693, 673	19.	
		Uni nsure	ed Insured	Total (col. 1		
		pati ent		+ col . 2)		
	Uncompensated Care (see instructions for each line)	1.00	2. 00	3.00		
0. 00	Charity care charges and uninsured discounts for the entire faci	lity 1,040	, 277 92, 140	1, 132, 417	20.	
	(see instructions)					
1. 00	Cost of patients approved for charity care and uninsured discoun	ts (see 655	, 140 92, 140	747, 280	21.	
2. 00	<pre>instructions) Payments received from patients for amounts previously written o</pre>	ff as	0	0	22.	
2. 00	charity care	11 43		ή	22.	
3. 00		655	, 140 92, 140	747, 280	23.	
				1 00		
L 00	Does the amount on line 20 column 2, include charges for patient	days beyond a Leng	th of stay limit	1. 00 N	24.	
	imposed on patients covered by Medicaid or other indigent care p	rogram?	•			
. 00	0 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of					
. 00	stay limit 0 Total bad debt expense for the entire hospital complex (see instructions) 1,350,115					
6. 00 7. 00						
7. 01	· · ·	,		55, 479	1	
	1			1, 294, 636	1	
	Non-Medicare bad debt expense (see instructions) 1,294,63					
8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	nse (see instructio	ns)	834, 746		
3. 00 9. 00 0. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	•	ns)	834, 746 1, 582, 026 4, 475, 701	30.	

Health Financial Systems	U HEALTH FRANKFO	ORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 06/01/2017 o 12/31/2017	Date/Time Pre	narod:
			'	0 12/31/2017	5/29/2018 12:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
· ·			+ col . 2)	ons (See A-6)	Trial Balance	
			,	, ,	(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		11, 124	11, 124		585, 633	1. 00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	(476, 231	476, 231	1. 01
1. 02 00102 CAP REL COSTS-BLDG & FIXT - MOB		0	(16, 500		1. 02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 727	14, 905			531, 784	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	504, 195	2, 038, 788			2, 188, 610	5. 00
7. 00 00700 OPERATION OF PLANT	177, 700	3, 989, 843	4, 167, 543			7. 00
7.01 00701 OPERATION OF PLANT - HOSPITAL 7.02 00702 OPERATION OF PLANT - MOB	0	0		3, 318, 849	3, 318, 849 0	7. 01 7. 02
i i	0	0		24 441		7. 02 8. 00
8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG	133, 415	121, 803	255, 218	26, 461 3 -44, 911	26, 461 210, 307	9. 00
10. 00 01000 DI ETARY	101, 424	158, 005	259, 429		86, 238	10.00
11. 00 01100 CAFETERI A	101, 424	130,003	239, 429		133, 387	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	368, 761	80, 286	١ ٠		406, 260	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	300, 701	55, 697	55, 697		255, 133	14. 00
15. 00 01500 PHARMACY	225, 463	187, 888			273, 618	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	223, 403	107, 000	413, 331		273,010	16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			ή σ	U	10.00
30. 00 03000 ADULTS & PEDIATRICS	492, 862	509, 083	1, 001, 945	-136, 981	864, 964	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	0	0	(ol	0	31. 00
43. 00 04300 NURSERY	o	0	d	ol	0	43.00
ANCILLARY SERVICE COST CENTERS	- 1			- 1		
50. 00 05000 OPERATING ROOM	182, 066	658, 812	840, 878	-165, 125	675, 753	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		o	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	348, 751	136, 734	485, 485	-93, 168	392, 317	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C	0	0	55.00
56.00 03630 ULTRA SOUND	0	0	C	0	0	56.00
57.00 05700 CT SCAN	0	0	(0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	(0	0	58. 00
60. 00 06000 LABORATORY	7, 560	377, 124			384, 534	60. 00
66. 00 06600 PHYSI CAL THERAPY	488	269, 455			265, 861	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	116, 760			116, 760	67. 00
68. 00 06800 SPEECH PATHOLOGY	40, 068	14, 908	54, 97 <i>6</i>	-11, 193	43, 783	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		18, 369	18, 369	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		11(22(0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 ONCOLOGY DRUGS	0	0		116, 326	116, 326	73.00
73. 01 07301 0NCOLOGY DRUGS 76. 00 03020 CARDI OPULMONARY	220 250	122 E10	252 070	24, 980	24, 980	73. 01
OUTPATIENT SERVICE COST CENTERS	220, 359	133, 519	353, 878	-57, 655	296, 223	76. 00
90. 00 09000 CLINIC	n	5, 000	5, 000	-5, 000	0	90. 00
91. 00 09100 EMERGENCY	538, 572	1, 622, 811	2, 161, 383			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	330, 372	1,022,011	2, 101, 300	211, 303	1, 747, 010	92. 00
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	o	0	(0	92. 01
OTHER REIMBURSABLE COST CENTERS	<u> </u>			,		72.0.
101. 00 10100 HOME HEALTH AGENCY	O	0	C	o	0	101. 00
SPECIAL PURPOSE COST CENTERS	1			'		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 349, 411	10, 502, 545	13, 851, 956	16, 500	13, 868, 456	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
191. 00 19100 RESEARCH	0	0	(o o	0	191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(o		192. 00
192. 02 19202 MOB	0	97, 787	97, 787	-16, 500		
193.00 19300 NONPALD WORKERS		0	0	이		193. 00
194. 00 07950 LEASED SPACE	0	0	(이		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	3, 349, 411	10, 600, 332	13, 949, 743	8 0	13, 949, 743	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

TOTAL (SUM OF LINES 118 through 199)

Provider CCN: 15-1316

Peri od: Worksheet A From 06/01/2017 To 12/31/2017 Date/Time Prepared:

200.00

5/29/2018 12:13 pm Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 51, 168 636, 801 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 106, 884 583, 115 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 1.02 1.634 18, 134 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 162, 065 4 00 693.849 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 3, 452, 081 5, 640, 691 5.00 00700 OPERATION OF PLANT 258, 001 7.00 48, 244 7.00 00701 OPERATION OF PLANT - HOSPITAL 2, 447, 651 7.01 -871, 198 7.01 00702 OPERATION OF PLANT - MOB 7.02 0 7 02 8.00 00800 LAUNDRY & LINEN SERVICE 26, 461 8.00 9 00 00900 HOUSEKEEPI NG 11, 319 221, 626 9 00 01000 DI ETARY 10.00 86, 238 10 00 11.00 01100 CAFETERI A -32, 894 100, 493 11.00 13.00 01300 NURSING ADMINISTRATION 406, 260 13.00 01400 CENTRAL SERVICES & SUPPLY 291, 203 14.00 36,070 14.00 01500 PHARMACY 247,016 520, 634 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 618, 129 30.00 30.00 -246, 835 03100 INTENSIVE CARE UNIT 31.00 Ω 31 00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM -155, 716 50.00 520, 037 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 392, 317 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 0 0 03630 ULTRA SOUND 56.00 Λ 56,00 0 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0000000 58.00 60.00 06000 LABORATORY 384, 534 60.00 06600 PHYSI CAL THERAPY 66.00 265, 861 66.00 67.00 06700 OCCUPATIONAL THERAPY 116, 760 67.00 06800 SPEECH PATHOLOGY 68.00 43, 783 68.00 69 00 06900 ELECTROCARDI OLOGY 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 18, 369 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 116, 326 73.00 07301 ONCOLOGY DRUGS 73.01 24, 980 73.01 76.00 03020 CARDI OPULMONARY 296, 223 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLINIC 0 -196, 443 91.00 09100 EMERGENCY 1, 753, 375 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 2, 613, 395 118.00 16, 481, 851 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 0 192 02 19202 MOB 0 81, 287 192 02 193. 00 19300 NONPALD WORKERS 0 193.00 194.00 07950 LEASED SPACE 194. 00

2, 613, 395

16, 563, 138

200.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 06/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/29/2018 12: 13 pm Provider CCN: 15-1316

Cost Control Cost						12/31/20	5/29/2018 12:13 pm
1.00							
1.00							
ASSET LINE A			3.00	4.00	5.00		
0	1 00		11 00	61 599	71 788		1 00
1 10	1.00	0					1.00
2.00 BIRDS CHANCED ID PATTERNIS 73.00 0 116.328 3.00 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		B - DRUGS	<u>'</u>		,,		
0000LOCY DRUSS	1.00	PHARMACY	15. 00	0	19, 732		1. 00
4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	2.00		l l	0			2. 00
1.00		ONCOLOGY DRUGS		0			· · · · · · · · · · · · · · · · · · ·
Company Comp			l l	0	-		
TOTALS			l l				
TOTALS			l l		-		
C - MEDICAL SUPPLES 14.00	7.00	TOTALS — — — —					7.00
1.00 CENTRAL SERVICES & SIRPLY 14.00 0 215,707 1.00 2.00				U U	101, 030		
MEDICAL SUPPLIES CHARGED TO	1.00		14.00	0	215. 707		1.00
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6.00 7.00 8.00 9.00 10.00 0.00 0.00 0.00 0.00 0.00				- 1			· · · · · · · · · · · · · · · · · · ·
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13.00							•
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1.00		TOTALS					
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1.00			l l	0	0		
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TOTALS			l l	0	0		•
F - OTHER CAPITAL	9.00		0.00	•	0		9. 00
1.00				0	476, 231		
CAP REL COSTS-BLDG & FIXT - 1.02 0 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000 15,000	1 00		1 00	ol	E02 222		1 00
MOB				l l			
TOTALS	2.00	1	1.02		13, 000		2.00
1.00 OPERATION OF PLANT - 7.01 0 3,318,849 HOSPITAL TOTALS 0 3,318,849 H - EMPLOYEE BENEFITS					598. 333		
1.00			,	-,			
TOTALS	1.00		7. 01	0	3, 318, 849		1. 00
H - EMPLOYEE BENEFITS							
1. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 509, 152 2. 00 2. 00 3. 00 4. 00 5. 00 0 0 0 0 4. 00 5. 00 6. 00		TOTALS		0	3, 318, 849		
2. 00 3. 00 4. 00 5. 00 6. 00 6. 00 7. 00 8. 00 9. 00 10. 00 10. 00 9. 00 11. 00 12. 00 12. 00 13. 00 14. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 12. 00 10.		H - EMPLOYEE BENEFITS		ما	500 450		1.00
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7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 10. 00 10. 00 10. 00 11. 00 12. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 0				0	-		
8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 TOTALS 1 - HOUSEKEEPING 1. 00 1.				ol			
9. 00 10. 00 11. 00 11. 00 12. 00 TOTALS - HOUSEKEEPI NG 9. 00 0 0 0 10. 00 0 0 0 - HOUSEKEEPI NG 9. 00 0 0 2. 00 3. 00 0 0 0 0 - HOUSEKEEPI NG 9. 00 0 0 3. 00 0 0 0 0 3. 00 0 0 0 3. 00 0 0 0 1. 00 0 0 3. 00 0 0 4. 00 0 0 5. 00 0 0 5. 00 0 0 5. 00 0 0 5. 00 0 6. 00 0 7. 00 0 7. 00 0 8. 00 0 9. 00 0 9. 00 0 9. 00 0 1. 00 1. 00 2. 00 3. 00 0 3. 00 9. 00 0 9. 00 9. 00 10. 00 11. 00 12. 00 3. 00 9. 00 9. 00 9. 00 10. 00 11. 00 12. 00 3. 00 9. 00 9. 00 9. 00 10. 00 11. 00 12. 00 3. 00 9. 00 9. 00 10. 00 11. 00 12. 00 3. 00 9. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 17. 00 18. 00 19. 00 19. 00 10. 00 11. 00 11. 00 12. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 10. 00				ol	-		
10. 00 11. 00 12. 00 10. 00 10. 00 10. 00 11. 00 12. 00 10. 00 10. 00 10. 00 11. 00 12. 00 12. 00 13. 00 14. 00 1509, 152 1 - HOUSEKEEPI NG 1. 00 2. 00 3. 00 0. 0				ol			
11. 00 12. 00 TOTALS 1 - HOUSEKEEPI NG 1. 00 2. 00 3. 00 0 0 0 509, 152 1 - HOUSEKEEPI NG 1. 00 2. 00 3. 00 0 0 897 1. 00 2. 00 3. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				o	0		•
TOTALS 0 509, 152 I - HOUSEKEEPING 9.00 0 897 1.00 2.00 0.00 0 0 0 2.00 3.00 0.00 0 0 3.00	11.00			o	0		
1 - HOUSEKEEPI NG	12.00		0.00	0	0		12.00
1. 00 HOUSEKEEPI NG 9. 00 0 897 1. 00 2. 00 0. 00 0 0 2. 00 3. 00 0. 00 0 0 3. 00				0	509, 152		
2.00 3.00 0.00 0 0 0 0 0 0 0 0 3.00							
3.00 0.00 0 0 3.00		HOUSEKEEPING		l l			
				- 1	-		
1 0.00 0 0 1 4.00				•			
	4.00	1 1	0.00	Ч	U		4.00

	Financial Systems SIFICATIONS			Provi der C	CCN: 15-1316	Peri od:		of Form CMS Worksheet A-	
						From 06/01/ To 12/31/		Date/Time Pr	epared.
						10 12/01/	2017	5/29/2018 12	2: 13 pm
		Increases							
	Cost Center	Li ne #	Sal ary	0ther					
	2. 00	3. 00	4.00	5. 00					
5.00		0.00	0	0					5. 00
6.00		0.00	0	0					6. 00
	TOTALS		0	897					
	J - NONCAPITAL COSTS								
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	8, 824					1. 00
	TOTALS		0	8, 824					
	K - MOB MAINTENANCE AND RENT								
1.00	CAP REL COSTS-BLDG & FIXT -	1. 02	0	1, 500					1. 00
	MOB								
	TOTALS			1, 500					

61, 599

50.00

1. 00

500.00

5, 000 5, 000 5, 412, 149

1. 00 OPERATING ROOM
TOTALS

500. 00 Grand Total: Increases

RECLASSI FI CATIONS

Provider CCN: 15-1316

Period: Worksheet A-6 From 06/01/2017

12/31/2017 Date/Time Prepared: 5/29/2018 12:13 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 61, 599 71, 788 0 1.00 61, 599 71, 788 B - DRUGS 1.00 PHARMACY 15.00 131, 450 0 1.00 ADULTS & PEDIATRICS 2, 777 0 2.00 30.00 0 2.00 3.00 OPERATING ROOM 50.00 ol 217 0 3.00 0 4.00 RADI OLOGY-DI AGNOSTI C 54.00 0 10, 303 4.00 5.00 PHYSICAL THERAPY 66.00 0 94 0 5.00 CARDI OPULMONARY 974 6.00 76.00 0 0 6.00 7 00 EMERGENCY 91.00 0 15, 223 0 7 00 0 **TOTALS** 161, 038 C - MEDICAL SUPPLIES 1.00 ADMINISTRATIVE & GENERAL 5.00 0 54 0 1.00 OPERATION OF PLANT 7.00 0 206 0 2 00 2 00 HOUSEKEEPI NG 0 3.00 9.00 0 3, 412 3.00 4.00 DI ETARY 10.00 o 10 0 4.00 0 5.00 PHARMACY 15.00 0 4, 559 5.00 0 0 6.00 ADULTS & PEDIATRICS 30.00 34, 165 6.00 7.00 OPERATING ROOM 50.00 0 56, 372 0 7.00 RADI OLOGY-DI AGNOSTI C o 0 8.00 54.00 14,067 8.00 0 LABORATORY 60.00 0 9.00 9.00 150 10.00 PHYSICAL THERAPY 66.00 0 3,677 0 10.00 SPEECH PATHOLOGY 68.00 0 0 11.00 3, 202 11.00 12.00 CARDI OPULMONARY 76.00 0 6, 979 0 12.00 13.00 EMERGENCY 91.00 0 107, 223 0 13.00 **TOTALS** 234, 076 D - LAUNDRY CENTRAL SERVICES & SUPPLY 0 16, 271 0 1.00 14. 00 1.00 2 00 ADULTS & PEDLATRICS 30.00 0 4.220 0 2 00 3.00 OPERATING ROOM 50.00 0 458 0 3.00 4.00 EMERGENCY 91.00 5, 512 0 4.00 Ō TOTALS 26, 461 E - DEPRECIATION 5.00 1.00 ADMINISTRATIVE & GENERAL 0 323, 120 9 1.00 OPERATION OF PLANT 2.00 7.00 0 9, 384 0 2.00 10.00 0 0 3.00 DI FTARY 2.425 3.00 ADULTS & PEDIATRICS 0 4.00 30.00 13, 950 4.00 5.00 OPERATING ROOM 50.00 0 78, 744 0 5.00 0 0 6.00 RADI OLOGY-DI AGNOSTI C 54.00 20, 101 6.00 0 7.00 PHYSICAL THERAPY 66.00 0 105 7.00 8.00 CARDI OPULMONARY 76.00 0 26, 847 0 8.00 EMERGENCY 9.00 91.00 1,555 0 9.00 TOTALS ō 476, 231 F - OTHER CAPITAL 1.00 OPERATION OF PLANT 7. 00 0 583, 333 10 1.00 2.00 MOB 192.02 0 15,000 13 2.00 TOTALS 598, 333 G - OPERATION OF PLANT 1.00 OPERATION OF PLANT 7. 00 0 3, 318, 849 0 1.00 TOTALS 3, 318, 849 H - EMPLOYEE BENEFITS 1.00 ADMINISTRATIVE & GENERAL 5.00 0 40, 023 0 1.00 OPERATION OF PLANT 2.00 7.00 0 46,014 0 2.00 HOUSEKEEPI NG 9.00 0 0 3 00 42, 396 3 00 4.00 DI ETARY 10.00 0 37, 313 0 4.00 5.00 NURSING ADMINISTRATION 13.00 o 42, 787 0 5.00 0 6.00 PHARMACY 15.00 0 23, 165 6.00 ADULTS & PEDIATRICS 0 81, 808 0 7.00 30.00 7 00 8.00 OPERATING ROOM 50.00 0 34, 127 0 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 48, 621 0 9.00 SPEECH PATHOLOGY 68.00 0 7, 991 0 10.00 10.00 CARDI OPULMONARY 76.00 0 22, 855 0 11.00 11.00 12.00 **EMERGENCY** 91.00 82, 052 0 12.00 ō 509, 152 **TOTALS** I - HOUSEKEEPING 1.00 DI FTARY 10.00 0 56 0 1 00 2. 00 2.00 PHARMACY 15.00 0 291 0 0 0 3.00 ADULTS & PEDIATRICS 30.00 61 3.00

0

0

0

207

76

206

897

0

0

0

4.00

5.00

6.00

50.00

54.00

66.00

TOTALS

4.00

5.00

6.00

OPERATING ROOM

PHYSI CAL THERAPY

RADI OLOGY-DI AGNOSTI C

Heal th	Financial Systems		IU HEALTH FRAN	KFORT HOSPITAL		In Lie	u of Form CMS-	-2552-10
RECLASS	SIFICATIONS			Provi der (Peri od:	Worksheet A-	5
						From 06/01/2017 To 12/31/2017	Date/Time Pro 5/29/2018 12	epared:
		Decreases						
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7. 00	8. 00	9. 00	10.00			
	J - NONCAPITAL COSTS							
1.00	CAP REL COSTS-BLDG & FIXT	100	0	8, 824	1:	2		1. 00
	TOTALS		0	8, 824				
	K - MOB MAINTENANCE AND RENT							
1.00	MOB	192. 02	0	1, 500	1	0		1. 00
	TOTALS		0	1, 500				
	L - ONCOLOGY							
1.00	CLINIC	90.00	0	5, 000)	0		1. 00
	TOTALS		0	5, 000				
500.00	Grand Total: Decreases		61, 599	5, 412, 149	1			500.00
			·			,		•

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1316

				1	o 12/31/2017	Date/Time Pre 5/29/2018 12:	pared: 13 pm
				Acqui si ti ons		072772010 12.	ТО РІП
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	0	0	(0	0	1. 00
2.00	Land Improvements	0	0	(0	0	2. 00
3.00	Buildings and Fixtures	0	0	(0	0	3. 00
4.00	Building Improvements	0	1, 980, 094	(1, 980, 094	0	4. 00
5.00	Fi xed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	0	3, 372, 166	(3, 372, 166	0	6. 00
7. 00	HIT designated Assets	0	0	(0	0	7. 00
8. 00	Subtotal (sum of lines 1-7)	0	5, 352, 260	(5, 352, 260	0	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	0	5, 352, 260	(5, 352, 260	0	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	_1				
1.00	Land	0	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	1, 980, 094	0				4.00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	3, 372, 166	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	5, 352, 260	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	5, 352, 260	0				10. 00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 06/01/2017 To 12/31/2017	Worksheet A-7 Part II Date/Time Pre 5/29/2018 12:	pared:
		S	UMMARY OF CAPI	TAL		
Cost Center Description	Depreci ati on	Lease	Interest	Insurance (see instructions)		
	9. 00	10.00	11.00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COLUM	N 2, LINES 1 a	and 2			

			30	JIVIIVIARY OF CAPI	IAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(11, 124	0	1.00
1.01	CAP REL COSTS-BLDG & FLXT - HOSPITAL	0	0	(0	0	1. 01
1.02	CAP REL COSTS-BLDG & FLXT - MOB	0	0	(0	0	1. 02
3.00	Total (sum of lines 1-2)	0	0	(11, 124	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	45.00				
	DART II. DECONOLILIATION OF MICHIES FROM WORK	14.00	15.00	L			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	CSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FLXT	0	11, 124				1. 00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	1			1. 01
1. 02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	1			1. 02
3. 00	Total (sum of lines 1-2)	0	11, 124				3. 00

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	F	Period: From 06/01/2017 Fo 12/31/2017	Worksheet A-7 Part III Date/Time Prep 5/29/2018 12:	
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(0	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	5, 315, 770		5, 315, 770		0	1. 01
1.02	CAP REL COSTS-BLDG & FLXT - MOB	36, 490		36, 490		0	1. 02
3.00	Total (sum of lines 1-2)	5, 352, 260		5, 352, 260			3. 00
		ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		<u> </u>			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(0	583, 333	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	(513, 566	0	1. 01
1.02	CAP REL COSTS-BLDG & FLXT - MOB	0	0	(1, 634	1, 500	1. 02
3.00	Total (sum of lines 1-2)	0	0	(515, 200	584, 833	3.00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	,	instructions)	Capi tal -Rel ate d Costs (see instructions)	through 14)	
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	51, 168		•	-	636, 801	1. 00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	69, 549	0		,	583, 115	1. 01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	15, 000		18, 134	1. 02
3. 00	Total (sum of lines 1-2)	120, 717	2, 300	15, 000	0	1, 238, 050	3. 00

					To 12/31/2017		
				Expense Classification or To/From Which the Amount is		5/29/2018 12:	13 pm
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2. 00 1. 282	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 11	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL			CAP REL COSTS-BLDG & FIXT - HOSPITAL	1. 01		
1. 02	(chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - MOB			CAP REL COSTS-BLDG & FIXT - MOB	1. 02	O	1. 02
2. 00	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	*** Cost Center Deleted ***	2.00	0	2. 00
3. 00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	О	7. 00
8. 00	21) Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00		1
10. 00	Provider-based physician adjustment	A-8-2	-483, 148			0	
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	7, 973, 913			0	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -35, 751	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	O	16. 00
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	O	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20.00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	O	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	O	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	*** Cost Center Deleted ***	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25. 00	llimitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FLXT	1.00	0	26. 00
26. 01	COSTS-BLDG & FLXT Depreciation - CAP REL	А	25, 956	CAP REL COSTS-BLDG & FIXT -	1. 01	9	26. 01
26. 02	COSTS-BLDG & FIXT - HOSPITAL Depreciation - CAP REL	A		HOSPITAL CAP REL COSTS-BLDG & FIXT -	1. 02	9	26. 02
27. 00	COSTS-BLDG & FIXT - MOB Depreciation - CAP REL			MOB *** Cost Center Deleted ***	2.00	0	27. 00
28. 00 29. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00		28. 00 29. 00

377, 996 ADMINI STRATI VE & GENERAL

11.379 CAP REL COSTS-BLDG & FIXT -

-928, 651 OPERATION OF PLANT -

HOSPI TAL

HOSPI TAL

2, 613, 395

5.00

7.01

1.01

33. 10

33.11

33. 12

50.00

Α

Α

Α

TOTAL (sum of lines 1 thru 49)

AMORTIZED START UP COSTS

CAPITALIZED ASSETS PREVIOUSLY

DEPRECIATION ON CAPITALIZED

(Transfer to Worksheet A, column 6, line 200.)

OFFSET)

ASSETS

33.10

33. 11

33. 12

50.00

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.

Worksheet A-8-1

From 06/01/2017 OFFICE COSTS 12/31/2017 Date/Time Prepared:

					5/29/2018 12:	13 pm
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00			HOME OFFICE	23, 133	0	1. 00
2.00			HOME OFFICE	38, 566	0	2. 00
3.00	1		HOME OFFICE	622, 829	0	3. 00
3. 01			HOME OFFICE	4, 072, 072	966, 377	3. 01
3.02			START UP COSTS	3, 239, 968	0	3. 02
3.03	1.00	CAP REL COSTS-BLDG & FIXT	RELATED PARTY	26, 753	0	3. 03
4.00			RELATED PARTY	30, 983	0	4.00
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	51, 887	0	4. 02
4.03	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	347, 073	0	4. 03
4.04	7. 00	OPERATION OF PLANT	RELATED PARTY	61, 940	0	4.04
4.05	7. 01	OPERATION OF PLANT - HOSPITA	RELATED PARTY	57, 453	0	4.05
4.06	9. 00	HOUSEKEEPI NG	RELATED PARTY	11, 319	0	4.06
4.07	11.00	CAFETERI A	RELATED PARTY	2, 857	o	4. 07
4.08	14.00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	36, 070	o	4. 08
4.09	15. 00	PHARMACY	RELATED PARTY	247, 016	o	4. 09
4.10	30.00	ADULTS & PEDIATRICS	RELATED PARTY	268, 075	257, 455	4. 10
4. 11	50.00	OPERATING ROOM	RELATED PARTY	204, 789	174, 288	4. 11
4. 12	60.00	LABORATORY	RELATED PARTY	364, 666	364, 666	4. 12
4. 13	91.00	EMERGENCY	RELATED PARTY	29, 250	0	4. 13
5.00	TOTALS (sum of lines 1-4).			9, 736, 699	1, 762, 786	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

1100 110	as not both postor to not kender if our amount of the amount of the partition								
				Related Organization(s) and/	or Home Office				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2.00	3. 00	4. 00	5. 00				
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

6.00	В	IU HEALTH	100.00	0. 00	6. 00
7.00	В	IUH ARNETT	1.00	0.00	7. 00
8.00			0.00	0.00	8. 00
9.00			0.00	0.00	9. 00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				ĺ

- (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
- 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.

	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6. 00	7. 00		
			IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	4
	HOME OFFICE COS	STS:		
1.00	23, 133	11		1.00
2.00	38, 566	11		2. 00
3.00	622, 829	0		3. 00
3.01	3, 105, 695	0		3. 01
3.02	3, 239, 968	0		3. 02
3.03	26, 753	11		3. 03
4.00	30, 983	11		4. 00
4.02	51, 887	0		4. 02
4.03	347, 073	0		4. 03
4.04	61, 940	0		4. 04
4.05	57, 453	0		4. 05
4.06	11, 319	0		4. 06
4.07	2, 857	0		4. 07
4.08	36, 070	0		4. 08
4.09	247, 016	0		4. 09
4.10	10, 620	0		4. 10
4. 11	30, 501	0		4. 11
4. 12	l o	0		4. 12
4. 13	29, 250	0		4. 13
5.00	7, 973, 913			5.00
* +		44611		

* 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		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	6. 00 7. 00 8. 00 9. 00 10. 00 100. 00
7.00	7.00
8. 00	8.00
9. 00	9.00
10. 00	10.00
100.00	100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider. B. Corporation, partnership, or other organization has financial interest in provider.
- 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.

| Peri od: | Worksheet A-8-2 | From 06/01/2017 | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1316

Wikst. A Line F Cost Center/Physician Identifier Component Redunderation Provider Component Component Redunderation Provider Component Redunderation Redunderation							-	To 12/31/2017	Date/Time Pre 5/29/2018 12:	
1.00		Wkst. A Line #	Cost Center/Physician	Total	Profess	i onal	Provi der	RCE Amount		
1.00			Identifier	Remuneration	Compo	nent	Component		ider Component	
1.00										
2.00										
3.00										
A DO				257, 455	5 2					
S				0)	-	_	1	_	
Continuing Con				0)	0	C	0	0	1
7.00				0		0	C	0	0	
8.00				0		0	C	0	0	
9,00				0	2	0	0	0	0	
1.00				0)	0	0		0	
1, 200, 00 1, 343, 028 483, 148 859, 880 Provider Cost Center/Physician Identifier Unadjusted RCE Limit Provider Continuing Education 12 100 13,000 14,000 100				0	2	0	0		0	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Unadjusted RCE Limit Component Component Component Component Cost of Malpractic Cost of Ma		0.00		4 040 000	2	0 440	050.000		0	
Identifier		WI+ A I : //	C+ C+ (Db							
1.00		WKST. A LINE #								
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1.00		1 00	2 00	8 00	9.0	10			14 00	
2. 00	1. 00			0.00	, , ,					1. 00
4.00				0		0	C	0	0	
S. 00	3.00	0.00		0	ol	0	C	0	0	3. 00
6. 00	4.00	0.00		0		0	C	0	0	4. 00
7. 00	5.00	0.00		0		0	C	0	0	5. 00
8.00	6.00	0.00		0	ol	0	C	0	0	6. 00
9.00	7.00	0.00		0		0	C	0	0	7. 00
10.00	8.00	0. 00		0)	0	C	0	0	8. 00
Number Cost Center/Physician Identifier Component Share of col. 14	9.00			0		0	C	0	0	9. 00
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14		0. 00		0		0	C	0	0	
Identifier Component Share of col. Li mi t Di sal I owance	200.00			0)	0			0	200. 00
1.00 2.00 15.00 16.00 17.00 18.00		Wkst. A Line #			, ,			Adjustment		
14			I denti fi er		Lim	i t	Di sal I owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 91.00 EMERGENCY 0 0 0 225, 693 1.00 2.00 30.00 ADULTS & PEDIATRICS 0 0 0 257, 455 2.00 3.00 0.00 0 0 0 0 0 3.00 4.00 0.00 0 0 0 0 0 4.00 5.00 0.00 0 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 0 0 6.00 0 0 0 6.00 0 0 0 6.00 0										
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REASON	Financial Systems I ABLE COST DETERMINATION FOR THERAPY SERVICES SUPPLIERS	U HEALTH FRANKF FURNI SHED BY	ORT HOSPITAL Provider CC		Period: From 06/01/2017	u of Form CMS-2 Worksheet A-8- Parts I-VI	-3
					To 12/31/2017	Date/Time Prep 5/29/2018 12:1	
				ı	Physical Therapy	Cost	p
	DADT I OFFICE INFORMATION					1. 00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	c) (coo instruct	i one)			28	1.00
2. 00	Line 1 multiplied by 15 hours per week	s) (see mistruct	1 0115)			420	
3. 00	Number of unduplicated days in which supervis	sor or therapist	was on provi	der site (see	instructions)	173	1
4. 00	Number of unduplicated days in which therapy					124	1
	nor therapist was on provider site (see instr	ructions)	•		'		
5.00	Number of unduplicated offsite visits - super					0	
6. 00	Number of unduplicated offsite visits - there					0	6. 00
	assistant and on which supervisor and/or ther instructions)	apıst was not p	resent during	tne visit(s)) (see		
7. 00	Standard travel expense rate					5. 35	7.00
8. 00	Optional travel expense rate per mile					0.00	
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
		1.00	2.00	3. 00	4. 00	5. 00	
9.00	Total hours worked	0. 00	2, 356. 03	874. 0		0.00	
	AHSEA (see instructions)	0.00	81.04	60. 7		0. 00	1
11. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	40. 52	40. 52	30. 3	9		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	О	0		o		12.00
	Number of travel hours (offsite)	0	0		0		12. 01
	Number of miles driven (provider site)	0	0		0		13. 00
13. 01	Number of miles driven (offsite)	0	0		0		13. 01
					-	1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
	Supervisors (column 1, line 9 times column 1,					0	
	Therapists (column 2, line 9 times column 2,					190, 933	1
16.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar		atami thamani	on Lines 14	1/ for all	53, 124 244, 057	1
17.00	others)	id is for respir	атогу глегару	or rines 14-	10 101 411	244, 037	17.00
18. 00	Aides (column 4, line 9 times column 4, line	10)				13, 746	18.00
19.00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19. 00
20. 00	Total allowance amount (sum of lines 17-19 fo					257, 803	20. 00
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		o entries on l	lines 21 and	22 and enter on	line 23	
21. 00	Weighted average rate excluding aides and tra		divided by su	m of columns	1 and 2 line 9	0.00	21. 00
21.00	for respiratory therapy or columns 1 thru 3,			iii or coruinis	r and 2, Time /	0.00	21.00
22. 00	Weighted allowance excluding aides and traine					0	22. 00
23. 00	Total salary equivalency (see instructions)					257, 803	23. 00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMP	UTATION - PRO	VIDER SITE		1
24.00	Standard Travel Allowance					7.010	24.00
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					7, 010 3, 768	1
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for a	ll others)		3, 768 10, 778	1
							1
	Standard travel expense (line 7 times line 3	for respiratory	therapy or s	um of lines 3	and 4 for all I	1, 5891	1 27.00
	Standard travel expense (line 7 times line 3 others)	for respiratory	therapy or s	um of lines 3	and 4 for all	1, 589	27. 00
						1, 589 12, 367	

	others)		
18. 00	Aides (column 4, line 9 times column 4, line 10)	13, 746	18.0
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19. (
	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	257, 803	
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech path		20.
	occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on		
		TITIE 23	
1 00	the amount from line 20. Otherwise complete lines 21-23.	0.00	21 /
1.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	0. 00	21. (
	for respiratory therapy or columns 1 thru 3, line 9 for all others)		
	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	
	Total salary equivalency (see instructions)	257, 803	23.0
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
. 00	Therapists (line 3 times column 2, line 11)	7, 010	24. (
. 00	Assistants (line 4 times column 3, line 11)	3, 768	25. 0
	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	10, 778	26.0
	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	1, 589	
	others)	1,007	
00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and	12, 367	28. (
. 00	27)	12, 307	20. \
	Optional Travel Allowance and Optional Travel Expense		1
00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29. (
		- 1	
	Assistants (column 3, line 10 times column 3, line 12)	0	
	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	
. 00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32.
	columns 1-3, line 13 for all others)		
	Standard travel allowance and standard travel expense (line 28)	12, 367	33.
. 00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.
. 00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	VI DER SI TE	Ī
	Standard Travel Expense	·	İ
00	Therapists (line 5 times column 2, line 11)	0	36. (
	Assistants (line 6 times column 3, line 11)	ő	•
	Subtotal (sum of lines 36 and 37)	0	1
		-	
. 00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.
	Optional Travel Allowance and Optional Travel Expense	_	
	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	•
	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.
00	Subtotal (sum of lines 40 and 41)	0	42.
00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	es 44, 45,	
	or 46, as appropriate.		
. 00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44.
	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		45. (
	openion trans. Communication of the standard traver expenses (sum of files of and 12 of this detrois)	۱	1 10.

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provi der CC		Period: From 06/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 12:	pared
					Physical Therapy	/ Cost	
						1.00	
. 00	Optional travel allowance and optional travel						46. 0
	•	Therapists 1.00	Assistants 2.00	3. 00	Trai nees 4.00	Total 5. 00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0.00	0.00	47. (
3. 00	Overtime rate (see instructions)	0. 00	0.00	O. C	0.00		48.
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49.
). 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	O. C	0.00	0.00	50.
. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	O. C	0.00	0.00	51.
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	81. 04	60. 78	22. 8	0.00		52.
3. 00	(see instructions) Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.
1. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	O		0 0		54.
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.
0. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56.
						1. 00	
. 00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST A	ADJUSTMENT			257, 803	 57.
. 00	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			12, 367	
. 00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46))		0	1
. 00	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					0	
. 00	Supplies (see instructions)					0	1 .
	Total allowance (sum of lines 57-62)					270, 170	
00	Total cost of outside supplier services (from		+			257, 519	
. 00	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	- IT negative,	enter zero)			0	65.
0. 00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for al	I others		10, 778	100.
00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27						1, 589 12, 367	
1. 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 ar	nd 4 for all	others	1, 589	101.
1. 01	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION					0 1, 589	101. 101.
2. 00	Line 31 = line 29 for respiratory therapy or				mnc 1 2 line		102. 102.
	Line 32 = line 8 times columns 1 and 2, line	13 TOP resouran	ory merany or				

JU131 D	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CCN: 15-1316	Peri od: From 06/01/2017 To 12/31/2017	Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2018 12:	pared:
				Occupati onal Therapy	Cost	13 piii
					1. 00	
1. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	c) (see instruct	i onc)		28	1. 00
2. 00	Line 1 multiplied by 15 hours per week	s) (See Histiacti	10115)		420	
3. 00	Number of unduplicated days in which supervis				113	
. 00	Number of unduplicated days in which therapy		n provider site but nei	ther supervisor	141	4.0
. 00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super		pists (see instructions		0	5.0
. 00	Number of unduplicated offsite visits - thera	apy assistants (i	include only visits made	by therapy	0	6.0
	assistant and on which supervisor and/or ther instructions)	apist was not p	resent during the visit	(s)) (see		
7. 00	Standard travel expense rate				5. 35	7.0
3. 00	Optional travel expense rate per mile	Cuparyi cara	Thomasi ata Assi atan	Ai dag	0.00	8.0
		Supervi sors 1.00	Therapists Assistant 2.00 3.00	Ai des 4.00	Trai nees 5.00	
9. 00	Total hours worked	0. 00	845. 63 80-	1. 40 307. 44	0.00	
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 38. 41		7. 62 22. 84 3. 81	0. 00	10.00
11.00	one-half of column 2, line 10; column 3,	30. 41	30. 41	5. 61		11.0
10.00	one-half of column 3, line 10)					40.0
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0	0		12. 0 12. 0
	Number of miles driven (provider site)	Ö	Ö	0		13. 0
13. 01	Number of miles driven (offsite)	0	0	0		13. 0
					1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					
4. 00 5. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,				64, 961	14. 0 15. 0
6. 00	Assistants (column 3, line 9 times column 3,				46, 350	
17. 00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respira	atory therapy or lines '	4-16 for all	111, 311	17. 0
18. 00	others) Aides (column 4, line 9 times column 4, line	10)			7, 022	18. 0
19. 00	Trainees (column 5, line 9 times column 5, li	ne 10)			· ·	19. 0
20. 00	Total allowance amount (sum of lines 17-19 for the sum of columns 1 and 2 for respiratory				118, 333	20.0
	occupational therapy, line 9, is greater than					
	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by sum of column	so 1 and 2 line 0	0.00	21. 0
21. 00	for respiratory therapy or columns 1 thru 3,			is I aliu 2, Title 9	0.00	21.00
	Weighted allowance excluding aides and traine	ees (line 2 times	s line 21)		0	
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	FXPENSE COMPUTATION - F	PROVIDER SLTE	118, 333	23.00
	Standard Travel Allowance					
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)				4, 340 4, 062	
26. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for all others)		8, 402	
27. 00	Standard travel expense (line 7 times line 3	for respiratory	therapy or sum of lines	3 and 4 for all	1, 359	27. 0
28. 00	others) Total standard travel allowance and standard	travel expense :	at the provider site (s	m of lines 26 and	9, 761	28 00
	27)	·			.,	
29. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		2 line 12)		0	29. 0
30. 00	Assistants (column 3, line 10 times column 3,		2, 11110 12)		0	30.0
31. 00	Subtotal (line 29 for respiratory therapy or				0	31.0
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s I and Z, II ne	is for respiratory there	apy or sum or	0	32.00
33. 00	Standard travel allowance and standard travel				9, 761	
	Optional travel allowance and standard travel Optional travel allowance and optional travel	,			0	1
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA			RVICES OUTSIDE PRO		33.0
						26.00
35. 00	Standard Travel Expense				0	
35. 00 36. 00	Therapists (line 5 times column 2, line 11)				0	37.0
34. 00 35. 00 36. 00 37. 00 38. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)				0	38. 0
35. 00 36. 00 37. 00 38. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum		6)			38. 0
35. 00 36. 00 37. 00 38. 00 39. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel	Expense			0	38. 0 39. 0
35. 00 36. 00 37. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	Expense O1 times column :			0 0	39. 00 40. 00 41. 00
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	Expense 01 times column : n 3, line 10)	2, line 10)		0 0	38. 0 39. 0 40. 0 41. 0 42. 0
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	Expense Of times column : of 3, line 10) of columns 1-3	2, line 10) , line 13.01)	ollowing three line	0 0 0 0 0	38. 0 39. 0 40. 0 41. 0

REASON	Financial Systems I ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	U HEALTH FRANK FURNI SHED BY		CN: 15-1316	Peri od: From 06/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 12:	-3 pared:
					Occupati onal Therapy	Cost	
						1.00	
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 ar	nd 42 - see ir	nstructions)	0	45. 00
46. 00	Optional travel allowance and optional travel					0	46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	0. (0.00	0.00	47. 00
48. 00	Overtime rate (see instructions)	0. 00	0. 00	0. (0.00)	48. 00
49. 00	Total overtime (including base and overtime	0. 00	0. 00	0.0	0.00)	49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0. 00	0.0	0. 00	0.00	50.00
51. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	0. (0.00	0.00	51. 00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount (see instructions)	76. 82	57. 62				52.00
53. 00 54. 00	Overtime cost limitation (line 51 times line 52) Maximum overtime cost (enter the lesser of	0	C		0 0		53. 00 54. 00
55. 00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55. 00
33. 00	hourly computation at the AHSEA (multiply line 47 times line 52)	0					33.00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	О	C		0 0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00	
	Salary equivalency amount (from line 23)					118, 333	
	Travel allowance and expense - provider site					9, 761	58.00
59. 00 60. 00	Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56)	ces (from lines	44, 45, OF 46)		0 0	59. 00 60. 00
	Equipment cost (see instructions)					0	61.00
	Supplies (see instructions)					0	62.00
63. 00	Total allowance (sum of lines 57-62)					128, 094	63.00
		-				116, 760	1
65. 00	Excess over limitation (line 64 minus line 63	3 - if negative	e, enter zero)			0	65. 00
100 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others		8 402	100. 00
	Line 27 = line 7 times line 3 for respiratory				others		100. 01
	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					•	100. 02
101. 00	Line 27 = line 7 times line 3 for respiratory	/ therapy or su	m of lines 3 a	and 4 for all	others	1, 359	101. 00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	9 and 30 for a	all others			101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3. line		102. 00 102. 01
	13 for all others Line 35 = sum of lines 31 and 32		J FJ .	2. 2. 23.	.,		102. 02

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1316

				To	o 12/31/2017	Date/Time Pre 5/29/2018 12:	pared:
			CAP	ITAL RELATED CC	STS	3/24/2010 12.	13 pili
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT -		EMPLOYEE	
		for Cost		HOSPI TAL	MOB	BENEFI TS	
		Allocation				DEPARTMENT	
		(from Wkst A					
		col. 7) 0	1.00	1. 01	1. 02	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	1.01	1. 02	1. 00	
	00100 CAP REL COSTS-BLDG & FIXT	636, 801	636, 801				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	583, 115	0	583, 115			1. 01
	00102 CAP REL COSTS-BLDG & FLXT - MOB	18, 134	0	0	18, 134		1. 02
	00400 EMPLOYEE BENEFITS DEPARTMENT	693, 849	0	0	0	693, 849	4. 00
	00500 ADMINISTRATIVE & GENERAL	5, 640, 691	63, 283		0	104, 689	5. 00
1	00700 OPERATION OF PLANT	258, 001	7, 992			36, 897	7.00
	00701 OPERATION OF PLANT - HOSPITAL	2, 447, 651	114, 850		0	0	7. 01
	00702 OPERATION OF PLANT - MOB 00800 LAUNDRY & LINEN SERVICE	26, 461	0	0	0	0	7. 02 8. 00
	00900 HOUSEKEEPI NG	221, 626	18, 014		0	27, 702	9. 00
	01000 DI ETARY	86, 238	11, 978		0	8, 269	•
	01100 CAFETERI A	100, 493	18, 530			12, 790	1
13.00	01300 NURSING ADMINISTRATION	406, 260	1, 223		0	76, 568	1
14.00	01400 CENTRAL SERVICES & SUPPLY	291, 203	6, 686	8, 296	0	0	14.00
15. 00	01500 PHARMACY	520, 634	9, 362	11, 616	0	46, 814	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	618, 129	92, 689			102, 335	1
	03100 INTENSIVE CARE UNIT	0	0			0	31.00
	04300 NURSERY NOCILLARY SERVICE COST CENTERS	l O	U	0	U	U	43. 00
	D5000 OPERATING ROOM	520, 037	10, 119	12, 555	0	37, 803	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	020,007	0,117	0		0	52. 00
	05400 RADI OLOGY-DI AGNOSTI C	392, 317	22, 042	27, 349	0	72, 413	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	03630 ULTRA SOUND	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	57. 00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
	06000 LABORATORY	384, 534	18, 590		0	1, 570	1
	06600 PHYSI CAL THERAPY	265, 861 114 740	12, 011			101 0	66.00
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	116, 760 43, 783	5, 708 2, 990			8, 320	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	43, 763	2, 990	3, 710	0	0, 320	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 369	0	o o	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ō	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	116, 326	0	0	0	0	73. 00
	07301 ONCOLOGY DRUGS	24, 980	0	_	0	0	73. 01
	03020 CARDI OPULMONARY	296, 223	11, 088	13, 758	0	45, 754	76. 00
	OUTPATIENT SERVICE COST CENTERS			1 -	ام		
	09000 CLINIC 09100 EMERGENCY	1 752 275	0			0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 753, 375	20, 459	25, 385	0	111, 824	91. 00 92. 00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	0	0	O _I	0	72.01
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS				-,		
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	16, 481, 851	447, 614	555, 394	0	693, 849	118. 00
V	IONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	01 207	0	0	10 104		192. 00
	19202 MOB	81, 287	166, 845	0	18, 134		192. 02
	19300 NONPALD WORKERS 07950 LEASED SPACE		22, 342	27, 721	0		193. 00 194. 00
200.00	Cross Foot Adjustments		22, 342	21, 121			200. 00
201.00	Negative Cost Centers		n	n	n		201. 00
202. 00	TOTAL (sum lines 118 through 201)	16, 563, 138	636, 801	583, 115	18, 134		
- (, ,				,		

Provider CCN: 15-1316

				1	0 12/31/201/	5/29/2018 12:	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	, o p
			& GENERAL	PLANT	PLANT -	PLANT - MOB	
					HOSPI TAL		
		4A	5.00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 887, 184	5, 887, 184				5. 00
7. 00	00700 OPERATION OF PLANT	312, 806					7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	2, 705, 007	1, 491, 662		4, 295, 227		7. 01
7. 02	00702 OPERATION OF PLANT - MOB	0	1, 1, 1, 1, 002	0	0	0	1
8.00	00800 LAUNDRY & LINEN SERVICE	26, 461	14, 592	1 0	0	0	
9. 00	00900 HOUSEKEEPI NG	289, 693			272, 602	0	
10. 00	01000 DI ETARY	121, 348			,	0	
11. 00	01100 CAFETERI A	154, 805	1		280, 423	0	
13. 00	01300 NURSING ADMINISTRATION	485, 568	l ·			0	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	306, 185	l .			0	1
15. 00	01500 PHARMACY	588, 426	l .			0	1
		300, 420		0,034	141, 076	0	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	<u> </u>	0	l U	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	020 140	F11 007	70 540	1 402 (72		20.00
30.00		928, 160				0	1
31. 00	03100 NTENSIVE CARE UNIT	0		0	_	0	
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
FO 00	ANCILLARY SERVICE COST CENTERS	F00 F14	220 120	0 (02	152 120		
50.00	05000 OPERATING ROOM	580, 514	320, 120	8, 683	153, 129	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	544.404	000 500	10.015	000.540	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	514, 121	283, 508	18, 915	333, 560	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	1
56.00	03630 ULTRA SOUND	0	0	0	0	0	
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	
60. 00	06000 LABORATORY	427, 761				0	
66. 00	06600 PHYSI CAL THERAPY	292, 876			181, 758	0	
67. 00	06700 OCCUPATI ONAL THERAPY	129, 550				0	
68. 00	06800 SPEECH PATHOLOGY	58, 803	32, 427	2, 566	45, 247	0	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 369	10, 129	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	116, 326	64, 147	0	0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	24, 980	13, 775	0	0	0	
76. 00	03020 CARDI OPULMONARY	366, 823	202, 282	9, 515	167, 793	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	1, 911, 043	1, 053, 831	17, 557	309, 610	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		16, 246, 809	5, 712, 746	322, 951	3, 957, 128	0	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	D 19100 RESEARCH	0	0	0	0	0	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	O		192. 00
192. 02	2 19202 MOB	266, 266	146, 831	143, 178	o		192. 02
193.00	19300 NONPALD WORKERS	0	0	0	o		193. 00
	07950 LEASED SPACE	50, 063	27, 607	19, 172	338, 099	0	194. 00
200.00		0					200. 00
201.00		0	0	0	o	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	16, 563, 138	5, 887, 184	485, 301	4, 295, 227	0	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1316

Peri od: Worksheet B From 06/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/29/2018 12:13 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG ADMI NI STRATI ON LINEN SERVICE 9.00 10.00 11.00 13.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 00702 OPERATION OF PLANT - MOB 7.02 7 02 8.00 00800 LAUNDRY & LINEN SERVICE 41,053 8.00 9.00 00900 HOUSEKEEPI NG 0 737, 502 9 00 01000 DI ETARY 24, 656 10.00 404, 469 10 00 0 11.00 01100 CAFETERI A 0 38, 143 574, 639 11.00 13.00 01300 NURSING ADMINISTRATION 0 2, 517 0 60, 440 835, 841 13.00 01400 CENTRAL SERVICES & SUPPLY 0 13, 762 14.00 0 14.00 0 01500 PHARMACY 0 0 33. 288 15.00 19, 271 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 190, 788 117, 505 375, 432 30.00 41,053 404, 469 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 04300 NURSERY 0 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 20, 828 73, 100 50.00 0 44,026 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 45, 370 0 74,860 0 54.00 00000000000 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 03630 ULTRA SOUND 0 56.00 C 0 Λ 56.00 0 57.00 05700 CT SCAN C 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 60.00 06000 LABORATORY 38, 266 0 60.00 58.599 0 06600 PHYSI CAL THERAPY 0 66.00 24, 722 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 11, 749 0 67.00 06800 SPEECH PATHOLOGY 68.00 6, 154 0 6, 596 0 68.00 69 00 06900 ELECTROCARDI OLOGY 0 0 69 00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 0 07301 ONCOLOGY DRUGS 0 73.01 Λ 73.01 76.00 03020 CARDI OPULMONARY 22, 823 0 46,634 519 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 90.00 91.00 09100 EMERGENCY 0 42, 113 0 132, 691 386, 790 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 92.01 0 0 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 41, 053 404, 469 574, 639 835, 841 118. 00 118.00 501, 162 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 191. 00 19100 RESEARCH 0 0 191. 00 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 00 0 192 02 19202 MOB 0 190, 352 0 0 192 02 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 45, 988 0 0 0 194. 00 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 737, 502 404, 469 574, 639 835, 841 202. 00 41,053

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1316 Peri od: Worksheet B From 06/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:13 pm Intern & Cost Center Description CENTRAL PHARMACY MEDI CAL Subtotal SERVICES & RECORDS & Residents Cost **SUPPLY** LI BRARY & Post Stepdown Adjustments 14.00 15.00 16.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 7.02 00702 OPERATION OF PLANT - MOB 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 595, 706 14.00 01500 PHARMACY 15.00 11, 788 1, 126, 968 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 0 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 82, 478 19, 434 0 4, 153, 358 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 04300 NURSERY 0 43.00 43.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 116, 931 1, 295 0 1, 318, 626 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54 00 35.585 10, 063 1, 315, 982 54 00 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 55.00 03630 ULTRA SOUND 0 0 0 56.00 0 56.00 05700 CT SCAN 0 57.00 57.00 0 0 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 Ω 0 0 58.00 60.00 06000 LABORATORY 388 0 0 1, 058, 183 0 60.00 06600 PHYSI CAL THERAPY 66.00 9,507 680, 674 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 304, 011 0 67.00 0 06800 SPEECH PATHOLOGY 68 00 8.279 C 160, 072 0 68 00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 47, 495 C 75, 993 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 C 0 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 814, 061 994, 534 0 73.00 73.01 07301 ONCOLOGY DRUGS 174, 813 0 213, 568 0 73.01 03020 CARDI OPULMONARY 17, 882 770 0 0 76.00 76.00 835, 041 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 265, 373 106, 532 0 4, 225, 540 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
09201 OBSERVATION BEDS (DISTINCT PART) 92.00 92.00 0 92.01 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS

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480, 929

16, 563, 138

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0 192. 00

0 192. 02

0 193.00

0 194.00

0 200. 00

0 201. 00

0 202, 00

SUBTOTALS (SUM OF LINES 1 through 117)

NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

191. 00 19100 RESEARCH

MCRI F32 - 14. 2. 164. 1

193. 00 19300 NONPALD WORKERS

194.00|07950|LEASED SPACE

192. 02 19202 MOB

200.00

201.00

202.00

| Peri od: | Worksheet B | From 06/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/201 Provider CCN: 15-1316

			To 12/31/2017 Date/Time Pre	
	Cost Center Description	Total	3/27/2010 12.	13 piii
		26.00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FLXT			1.00
1.01	OO101 CAP REL COSTS-BLDG & FIXT - HOSPITAL			1. 01
1.02	00102 CAP REL COSTS-BLDG & FLXT - MOB			1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL			5. 00
7.00	00700 OPERATION OF PLANT			7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL			7. 01
7.02	00702 OPERATION OF PLANT - MOB			7. 02
8.00	00800 LAUNDRY & LINEN SERVICE			8. 00
9. 00	00900 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10. 00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY			16. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	4, 153, 358		30.00
31. 00	03100 INTENSIVE CARE UNIT	0		31.00
43. 00	04300 NURSERY	0		43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	1 210 (2)		FO 00
50.00	05000 OPERATING ROOM	1, 318, 626		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1 215 002		52.00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	1, 315, 982		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C 03630 ULTRA SOUND	0		55.00
56.00	05700 CT SCAN	0		56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		57. 00 58. 00
60.00	06000 LABORATORY	1, 058, 183		60.00
66. 00	06600 PHYSI CAL THERAPY	680, 674		66.00
67. 00	06700 OCCUPATIONAL THERAPY	304, 011		67.00
68. 00	06800 SPEECH PATHOLOGY	160, 072		68. 00
69. 00	06900 ELECTROCARDI OLOGY	100, 072		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	75, 993		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	73, 773		72.00
	07300 DRUGS CHARGED TO PATIENTS	994, 534		73.00
73. 00	07301 ONCOLOGY DRUGS	213, 568		73. 00
76. 00	03020 CARDI OPULMONARY	835, 041		76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	033, 041		70.00
90.00	09000 CLINIC	0		90.00
	09100 EMERGENCY	4, 225, 540		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	., ===, =		92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		92. 01
	OTHER REIMBURSABLE COST CENTERS	- 1		
101.00	10100 HOME HEALTH AGENCY	0		101. 00
	SPECIAL PURPOSE COST CENTERS			
118.00		15, 335, 582		118. 00
	NONREI MBURSABLE COST CENTERS			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19100 RESEARCH	0		191. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0		192. 00
	19202 MOB	746, 627		192. 02
	19300 NONPALD WORKERS	0		193. 00
	07950 LEASED SPACE	480, 929		194. 00
200.00		0		200. 00
201.00		0		201. 00
202.00	TOTAL (sum lines 118 through 201)	16, 563, 138		202. 00

| Period: | Worksheet B | From 06/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1316

				T	o 12/31/2017	Date/Time Pre 5/29/2018 12:	pared:
			CAP	TAL RELATED CO	STS	5/29/2018 12:	13 piii
	Cost Center Description	Directly Assigned New	BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXI - MOB	Subtotal	
		Capi tal		HOSHTAL	WOD		
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	2A	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	(2, 202	70 521	0	141 004	4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	63, 283 7, 992		0	141, 804 17, 908	5. 00 7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	o	114, 850		o	257, 356	1
7. 02	00702 OPERATION OF PLANT - MOB	0	0		0	0	7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	18, 014		0	40, 365	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	11, 978 18, 530		0	26, 841 41, 522	1
13. 00	01300 NURSING ADMINISTRATION	o	1, 223		o	2, 740	1
14.00	01400 CENTRAL SERVICES & SUPPLY	O	6, 686		O	14, 982	1
15. 00	01500 PHARMACY	0	9, 362		0	20, 978	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	92, 689	115, 007	ol	207, 696	30.00
31. 00	03100 INTENSIVE CARE UNIT	o	72,007		o	207, 070	31.00
43.00	04300 NURSERY	0	0	•	0	0	•
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	10, 119		0	22, 674	1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	22, 042		0	0 49, 391	52. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	ő	0		o	0	55. 00
56.00	03630 ULTRA SOUND	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	
58. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 06000 LABORATORY	0	0 18, 590	_	0	0 41 457	58. 00 60. 00
66.00	06600 PHYSI CAL THERAPY	0	12, 011		0	41, 657 26, 914	•
67. 00	06700 OCCUPATI ONAL THERAPY	Ö	5, 708		Ö	12, 790	1
68. 00	06800 SPEECH PATHOLOGY	0	2, 990	3, 710	0	6, 700	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01	07301 ONCOLOGY DRUGS	Ö	0	Ö	Ö	0	73. 01
76. 00	03020 CARDI OPULMONARY	0	11, 088	13, 758	0	24, 846	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	٥			٥	-	00.00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	0	20, 459		0	0 45, 844	90. 00 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		20, 437	25, 365	١	45, 044	1
	09201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	O	447, 614	555, 394	ol	1, 003, 008	118 00
110.00	NONREI MBURSABLE COST CENTERS	ı	777,017	333, 374	9	1,005,000	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	144 045	0	10 124		192. 00
	2 19202 MOB 0 19300 NONPALD WORKERS		166, 845 0		18, 134 0	184, 979 0	192. 02
	07950 LEASED SPACE	Ö	22, 342	27, 721	0	50, 063	194. 00
200.00						0	200. 00
201.00			(2) 001	_	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	l Ol	636, 801	583, 115	18, 134	1, 238, 050	J2U2. UU

Provider CCN: 15-1316

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 06/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 12: 13 pm

						5/29/2018 12:	13 pm
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
		4. 00	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL					I	1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB					I	1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	C				I	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	C	141, 804			I	5. 00
7.00	00700 OPERATION OF PLANT	C	4, 155	22, 063		I	7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	C	35, 926	4, 481	297, 763	I	7. 01
7.02	00702 OPERATION OF PLANT - MOB	C	0	0	o	0	7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	C	351	0	o	0	8. 00
9.00	00900 HOUSEKEEPI NG	C	3, 848	703	18, 898	0	9. 00
10.00	01000 DI ETARY	C	1, 612	467	12, 566	0	10.00
11. 00	01100 CAFETERI A	C	2, 056	723	19, 440	0	11. 00
13.00	01300 NURSING ADMINISTRATION	C	6, 450	48	1, 283	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	C	4, 067	261	7, 014	0	14. 00
15.00	01500 PHARMACY	C	7, 816	365	9, 822	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	C	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	C	12, 329	3, 616	97, 239	0	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	C	l .		0	0	
43.00	04300 NURSERY	C	0	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	C	7, 711	395	10, 616	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	0	0	0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	C	6, 829	860	23, 124	0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0	0	0	0	55. 00
56. 00	03630 ULTRA SOUND	C	0	0	0	0	
57. 00	05700 CT SCAN	C	0	0	0	0	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	0	0	0	0	
60. 00	06000 LABORATORY	C	5, 682	725	19, 503	0	60. 00
66. 00	06600 PHYSI CAL THERAPY	C	3, 890		12, 600	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	C	1, 721	223	5, 988	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	781	117	3, 137	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	244	0	0	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	1, 545		0	0	
73. 01	07301 ONCOLOGY DRUGS	C	1		11 (20	0	
76. 00	03020 CARDI OPULMONARY	C	4, 873	433	11, 632	0	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	C	1 0		O		00.00
90. 00 91. 00	09100 EMERGENCY	C		0 798	21, 463	0	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	23, 304	/90	21, 403	l	92.00
92.00	09201 OBSERVATION BEDS (NON-DISTINCT PART)	C	0	0	o	0	1
92.01	OTHER REIMBURSABLE COST CENTERS	C	<u> </u>	U	υĮ	0	92.01
101 00	10100 HOME HEALTH AGENCY	C	0	0	O	0	101. 00
101.00	SPECIAL PURPOSE COST CENTERS	C	<u> </u>	U	υĮ	0	1101.00
118.00		C	137, 602	14, 684	274, 325	0	118. 00
110.00	NONREI MBURSABLE COST CENTERS		137,002	14, 004	274, 323	0	1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1	0	٥	0	190. 00
	19100 RESEARCH	C			0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	C	1		٥		192. 00
	19202 MOB	C		6, 507	0		192. 02
	19300 NONPALD WORKERS	C		0, 307	o O		193. 00
	07950 LEASED SPACE	,	665	872	23, 438		194. 00
200.00			. 303		25, 450	ı	200. 00
201.00		C	0	n	n	0	201. 00
202.00		C		22, 063	297, 763		202. 00
			•				

Provider CCN: 15-1316

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 06/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 12: 13 pm

						5/29/2018 12:	13 pm_
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE				ADMI NI STRATI ON	
		8.00	9. 00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 00	1						7. 00
	00701 OPERATION OF PLANT - HOSPITAL						
7. 02	00702 OPERATION OF PLANT - MOB	054					7. 02
8.00	00800 LAUNDRY & LINEN SERVICE	351					8. 00
9.00	00900 HOUSEKEEPI NG	0	63, 814				9. 00
10. 00	01000 DI ETARY	0	2, 133	43, 619			10. 00
11. 00	01100 CAFETERI A	0	3, 300	0	67, 041		11. 00
13.00	01300 NURSING ADMINISTRATION	0	218	0	7, 051	17, 790	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 191	0	0	0	14.00
15. 00	01500 PHARMACY	0	1, 667	0	3, 884	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0		0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			- 1			
30. 00	03000 ADULTS & PEDI ATRI CS	351	16, 508	43, 619	13, 709	7, 991	30. 00
31. 00	03100 NTENSI VE CARE UNI T	0	0, 300	43, 017	13, 707	1 7,771	31. 00
43. 00	1 1	0	1	0	0		43. 00
43.00	04300 NURSERY	0	U	U	U	l 0	43.00
F0 00	ANCI LLARY SERVI CE COST CENTERS		4 000		F 40/	4 55/	F0 00
50. 00	05000 OPERATI NG ROOM	0	1, 802	0	5, 136	1	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	3, 926	0	8, 734	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	03630 ULTRA SOUND	0	0	0	0	0	56. 00
57.00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
60.00	06000 LABORATORY	0	3, 311	0	6, 837	0	60.00
66.00	06600 PHYSI CAL THERAPY	0	2, 139	0	. 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 017	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	533	0	770		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	,,,	٥	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	71. 00
		0	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0	0	0	0	73. 01
76. 00	03020 CARDI OPULMONARY	0	1, 975	0	5, 441	11	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	3, 644	0	15, 479	8, 232	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0	o	0	0	0	92. 01
	OTHER REIMBURSABLE COST CENTERS					<u>'</u>	
101 00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS		<u>۳</u>	<u> </u>			
118.00		351	43, 364	43, 619	67, 041	17, 790	118 00
110.00		331	13, 301	43,017	07,041	17,770	110.00
100.00	NONREI MBURSABLE COST CENTERS	0	0	0	0		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-	1	-	-		190. 00
	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	⁰	0	0		192. 00
	19202 MOB	0	16, 471	0	0		192. 02
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 LEASED SPACE	0	3, 979	0	0	0	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	o	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	351	63, 814	43, 619	67, 041	17, 790	202. 00
		•				•	•

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1316 Peri od: Worksheet B From 06/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/29/2018 12:13 pm Intern & Cost Center Description CENTRAL PHARMACY MEDI CAL Subtotal SERVICES & RECORDS & Residents Cost **SUPPLY** LI BRARY & Post Stepdown Adjustments 14.00 15.00 16.00 24.00 25.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7. 00 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 7.02 00702 OPERATION OF PLANT - MOB 7.02 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 27, 515 14.00 01500 PHARMACY 15.00 544 45,076 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 0 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 810 777 0 407, 645 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 04300 NURSERY 0 43.00 43.00 0 0 C 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 52 0 50.00 5.401 0 55.343 0 52.00 05200 DELIVERY ROOM & LABOR ROOM C 0 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 54 00 403 94, 911 54 00 1,644 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 C 0 55.00 03630 ULTRA SOUND 0 0 0 0 0 56.00 56.00 05700 CT SCAN 0 57.00 57.00 0 0 0 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 58.00 0 0 58.00 60.00 06000 LABORATORY 18 0 0 77, 733 0 60.00 06600 PHYSI CAL THERAPY 66.00 439 46, 451 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 21, 739 0 67.00 0 0 06800 SPEECH PATHOLOGY 68 00 382 Ω 12, 420 0 68 00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 2, 194 Ω 2, 438 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 0 C 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 32, 560 34, 105 0 73.00 6, 992 73.01 07301 ONCOLOGY DRUGS 0 0 7, 324 0 73.01 03020 CARDI OPULMONARY 31 0 50, 068 0 76.00 76.00 826 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 12, 257 4, 261 0 137, 362 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
09201 OBSERVATION BEDS (DISTINCT PART) 92.00 92.00 0 0 92.01 0 92.01 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 27, 515 45, 076 0 947, 539 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 0 0 0 0 191.00 191. 00 19100 RESEARCH C 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192. 00 192. 02 19202 MOB 0 0 192. 02 0 0 211, 494

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45,076

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79,017

1, 238, 050

0 193.00

0 194.00

0 200. 00

0 201. 00

0 202, 00

193. 00 19300 NONPALD WORKERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

194.00|07950|LEASED SPACE

200.00

201.00

202.00

| Peri od: | Worksheet B | From 06/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1316

			To 12/31/2017	Date/Time Prepared: 5/29/2018 12:13 pm
	Cost Center Description	Total		372472016 12. 13 pili
		26.00		
	GENERAL SERVICE COST CENTERS			
1. 00	00100 CAP REL COSTS-BLDG & FLXT			1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL			1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - MOB			1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00	00700 OPERATION OF PLANT			7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL			7. 01
7. 02	00702 OPERATION OF PLANT - MOB			7. 02
8.00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
11.00	01100 CAFETERI A			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON			13.00
14.00	01400 CENTRAL SERVI CES & SUPPLY			14. 00
15. 00	01500 PHARMACY			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS			16. 00
30. 00	03000 ADULTS & PEDIATRICS	407, 645		30.00
31. 00	03100 INTENSIVE CARE UNIT	407, 645		31. 00
	04300 NURSERY	Ö		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		43.00
50. 00	05000 OPERATING ROOM	55, 343		50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	94, 911		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0		55. 00
56. 00	03630 ULTRA SOUND	o		56.00
57.00	05700 CT SCAN	o		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O		58.00
60.00	06000 LABORATORY	77, 733		60.00
66.00	06600 PHYSI CAL THERAPY	46, 451		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	21, 739		67. 00
68.00	06800 SPEECH PATHOLOGY	12, 420		68. 00
69.00	06900 ELECTROCARDI OLOGY	O		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 438		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	34, 105		73. 00
73. 01	07301 ONCOLOGY DRUGS	7, 324		73. 01
76.00	03020 CARDI OPULMONARY	50, 068		76. 00
	OUTPATIENT SERVICE COST CENTERS			
	09000 CLI NI C	0		90.00
91. 00	09100 EMERGENCY	137, 362		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	_		92. 00
92. 01	09201 OBSERVATION BEDS (DISTINCT PART)	0		92. 01
101 00	OTHER REIMBURSABLE COST CENTERS			101.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0		101. 00
118. 00		947, 539		118. 00
110.00	NONREI MBURSABLE COST CENTERS	747,337		110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19100 RESEARCH	Ö		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	o o		192. 00
	19202 MOB	211, 494		192. 02
193.00	19300 NONPALD WORKERS	, ., ,		193. 00
	07950 LEASED SPACE	79, 017		194. 00
200.00		77,017		200. 00
201.00		o		201. 00
202.00		1, 238, 050		202. 00
				1

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316 Peri od: Worksheet B-1 From 06/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 12:13 pm CAPITAL RELATED COSTS BLDG & FIXT BLDG & FIXT -BLDG & FIXT -**EMPLOYEE** Reconciliation Cost Center Description (SQUARE FEET) HOSPI TAL MOB **BENEFITS** (SQUARE FEET) (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 1. 01 1. 02 5A 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 138 011 1 00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 101, 851 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 36, 160 1.02 1.02 0 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 3, 341, 684 4 00 0 0 5.00 00500 ADMINISTRATIVE & GENERAL 13, 715 13, 715 0 504, 195 -5, 887, 184 5.00 7.00 00700 OPERATION OF PLANT 1,732 1, 732 0 177, 700 0 7.00 00701 OPERATION OF PLANT - HOSPITAL 24, 891 7.01 24, 891 0 7.01 0 0 00702 OPERATION OF PLANT - MOB 0 7 02 7 02 0 0 8.00 00800 LAUNDRY & LINEN SERVICE 0 0 8.00 00900 HOUSEKEEPI NG 3, 904 3, 904 9.00 133, 415 9.00 01000 DI ETARY 2, 596 39, 825 10.00 10.00 2.596 0 4, 016 0 61, 599 11.00 01100 CAFETERI A 4,016 0 11.00 13.00 01300 NURSING ADMINISTRATION 265 265 0 368, 761 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,449 1, 449 14.00 01500 PHARMACY 2, 029 2, 029 0 225, 463 0 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 20, 088 20, 088 0 492, 862 0 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 31.00 0 43.00 04300 NURSERY 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 193 2, 193 182, 066 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 4,777 4,777 348, 751 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 03630 ULTRA SOUND 0 0 0 0 56.00 0 05700 CT SCAN 0 57.00 0 C 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58.00 60.00 06000 LABORATORY 4,029 4, 029 0 7.560 0 60.00 06600 PHYSI CAL THERAPY 0 66,00 2,603 2,603 488 Λ 66,00 06700 OCCUPATI ONAL THERAPY 1, 237 67.00 1, 237 0 67.00 06800 SPEECH PATHOLOGY 68.00 648 648 40, 068 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 C 0 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 07301 ONCOLOGY DRUGS 0 73 01 0 73 01 03020 CARDI OPULMONARY 76.00 2, 403 2, 403 0 220, 359 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09100 EMERGENCY 0 538, 572 91 00 4, 434 91 00 4.434 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 0 92.01 0 0 OTHER REIMBURSABLE COST CENTERS 0 101.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) -5, 887, 184 118. 00 97,009 97,009 0 3, 341, 684 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 191. 00 19100 RESEARCH 0 0 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 0 192. 02 19202 MOB 0 0 192 02 36, 160 C 36, 160 193. 00 19300 NONPALD WORKERS 0 0 193.00 194.00 07950 LEASED SPACE 0 0 194.00 4,842 4.842 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 636, 801 583, 115 18, 134 693, 849 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4.614132 5. 725177 0.501493 0.207635 203.00 204.00 Cost to be allocated (per Wkst. B, 204 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207 00

207 00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316

				T	o 12/31/2017	Date/Time Pre 5/29/2018 12:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	13 piii
		& GENERAL	PLANT	PLANT -	PLANT - MOB	LINEN SERVICE	
		(ACCUM. COST)	(SQUARE FEET)	HOSPITAL (SQUARE FEET)	(SQUARE FEET)	(PATIENT DAYS)	
		5. 00	7. 00	7. 01	7. 02	8. 00	
	IERAL SERVICE COST CENTERS						
	OO CAP REL COSTS-BLDG & FIXT						1.00
	O1						1. 01 1. 02
4	100 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
	500 ADMINISTRATIVE & GENERAL	10, 675, 954					5. 00
	700 OPERATION OF PLANT	312, 806	122, 564				7. 00
	701 OPERATION OF PLANT - HOSPITAL	2, 705, 007	24, 891				7. 01
1	702 OPERATION OF PLANT - MOB 300 LAUNDRY & LINEN SERVICE	26, 461	0			662	7. 02 8. 00
1	POO HOUSEKEEPING	289, 693	ľ			002	9.00
1	000 DI ETARY	121, 348	1			ő	10.00
11. 00 011	100 CAFETERI A	154, 805	l			0	11. 00
	NURSING ADMINISTRATION	485, 568	l e			· ·	13. 00
	100 CENTRAL SERVICES & SUPPLY	306, 185				0	14.00
	500 PHARMACY 500 MEDICAL RECORDS & LIBRARY	588, 426 0	l			0	15. 00 16. 00
	PATIENT ROUTINE SERVICE COST CENTERS						10.00
	000 ADULTS & PEDIATRICS	928, 160	20, 088	20, 088	0	662	30. 00
	100 INTENSIVE CARE UNIT	0	0				31. 00
	NURSERY	0	0	0	0	0	43. 00
	CILLARY SERVICE COST CENTERS OOO OPERATING ROOM	580, 514	2, 193	2, 193	0	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0	2, 173	2,173		l	52. 00
54. 00 054	100 RADI OLOGY-DI AGNOSTI C	514, 121	4, 777	4, 777	0	0	54. 00
	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
1	530 ULTRA SOUND	0	0	0	_	0	56.00
1	700 CT SCAN BOO MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	_	0	57. 00 58. 00
4	DOO LABORATORY	427, 761	4, 029	_	_	0	60.00
4	500 PHYSI CAL THERAPY	292, 876	1			Ö	66. 00
	700 OCCUPATIONAL THERAPY	129, 550	l			0	67. 00
4	300 SPEECH PATHOLOGY	58, 803	648			0	68. 00
1	POO ELECTROCARDIOLOGY OO MEDICAL SUPPLIES CHARGED TO PATIENTS	18, 369	0	0	-	0	69. 00 71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS	10, 309	0	0	0	0	71.00
	BOO DRUGS CHARGED TO PATIENTS	116, 326	Ö	Ö	Ō	Ö	73. 00
	01 ONCOLOGY DRUGS	24, 980	0	0	_		73. 01
	020 CARDI OPULMONARY	366, 823	2, 403	2, 403	0	0	76. 00
	TPATIENT SERVICE COST CENTERS OOO CLINIC	Ι ο		0	0	0	90.00
	100 EMERGENCY	1, 911, 043	4, 434				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)	1,,	.,	.,	_		92. 00
	201 OBSERVATION BEDS (DISTINCT PART)	0	0	0	0	0	92. 01
	IER REI MBURSABLE COST CENTERS						104 00
	OO HOME HEALTH AGENCY CLIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	10, 359, 625	81, 562	56, 671	0	662	118. 00
	IREI MBURSABLE COST CENTERS		,		_		
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		l e	190. 00
	100 RESEARCH	0	0		_	l e	191. 00
192. 00 192 192. 02 192	200 PHYSICIANS' PRIVATE OFFICES	0	0	0		l e	192. 00 192. 02
4	800 NONPALD WORKERS	266, 266	36, 160	0	36, 160 0		192. 02
	950 LEASED SPACE	50, 063	4, 842	4, 842	0		194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers				_		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	5, 887, 184	485, 301	4, 295, 227	0	41, 053	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 551443	3. 959572	69. 826329	0. 000000	62. 013595	203 00
204. 00	Cost to be allocated (per Wkst. B,	141, 804	l			1	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 013283	0. 180012	4. 840652	0. 000000	0. 530211	205. 00
206. 00		1					206. 00
200.00	(per Wkst. B-2)						200.00
207. 00	NAHE unit cost multiplier (Wkst. D,	1					207. 00
	Parts III and IV)	1					

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316 Peri od: Worksheet B-1 From 06/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 12:13 pm Cost Center Description HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG CENTRAL (SQUARE FEET) (PATIENT DAYS) SERVICES & (FTE'S) ADMI NI STRATI ON **SUPPLY** (DI RECT (COSTED NURSING HOURS) REQUIS.) 9.00 10.00 11.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7 00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 7.02 00702 OPERATION OF PLANT - MOB 7.02 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 77,651 9.00 10.00 01000 DI ETARY 2,596 662 10.00 11.00 01100 CAFETERI A 4,016 C 3,746 11.00 01300 NURSING ADMINISTRATION 32, 233 13 00 394 13 00 265 Ω 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 449 0 0 230, 395 14.00 01500 PHARMACY 15.00 2,029 C 217 0 4, 559 15.00 01600 MEDICAL RECORDS & LIBRARY 16 00 0 16.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 20, 088 14, 478 31, 899 30.00 662 766 03100 INTENSIVE CARE UNIT 31.00 31.00 0 C 0 04300 NURSERY 0 43.00 0 Ω 43 00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 287 2, 819 45, 224 50.00 2.193 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 C 0 05400 RADI OLOGY-DI AGNOSTI C 4.777 488 13, 763 54.00 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 55.00 C 03630 ULTRA SOUND 0 0 56.00 0 0 56.00 0 05700 CT SCAN 57.00 0 0 0 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0 0 0 58 00 60.00 06000 LABORATORY 4,029 382 0 0 0 150 60.00 06600 PHYSI CAL THERAPY 66.00 2,603 C 3,677 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 237 0 0 67.00 0 06800 SPEECH PATHOLOGY 68 00 648 43 3, 202 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 18, 369 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 Ω 0 0 73.00 73.01 07301 ONCOLOGY DRUGS C 73.01 03020 CARDI OPULMONARY 6, <u>916</u> 76.00 2.403 304 20 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 91.00 09100 EMERGENCY 4, 434 865 14, 916 102, 636 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART) 92.00 92.00 92.01 0 0 92.01 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 52, 767 662 3,746 32, 233 230, 395 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 C 0 191.00 191. 00 19100 RESEARCH 0 C 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 192. 02 19202 MOB 0 20,042 0 0 192. 02 o 193. 00 19300 NONPALD WORKERS 0 0 193.00 Ω 194.00 07950 LEASED SPACE 4,842 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 737, 502 404, 469 574, 639 835, 841 595, 706 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 9. 497650 610. 980363 153.400694 25. 931220 2. 585586 203. 00 204.00 Cost to be allocated (per Wkst. B, 63,814 43, 619 67,041 17, 790 27, 515 204. 00 Part II) 0.821805 65.889728 17. 896690 0.551919 0. 119425 205. 00 205 00 Unit cost multiplier (Wkst. B, Part II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

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

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316

					10	ate/lime Prepared: /29/2018 12:13 pm
		Cost Center Description	PHARMACY	MEDI CAL		 27/2010 12:10 p
		·	(COSTED	RECORDS &		
			REQUI S.)	LI BRARY		
			45.00	(TIME SPENT)		
	CENED	AL SERVICE COST CENTERS	15. 00	16. 00		
1.00		CAP REL COSTS-BLDG & FLXT				1.00
1. 01		CAP REL COSTS-BLDG & FIXT - HOSPITAL				1. 01
1. 02	1	CAP REL COSTS-BLDG & FIXT - MOB				1. 02
4.00	1	EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	1	ADMINISTRATIVE & GENERAL				5. 00
7.00	00700	OPERATION OF PLANT				7. 00
7. 01	00701	OPERATION OF PLANT - HOSPITAL				7. 01
7.02	1	OPERATION OF PLANT - MOB				7. 02
8. 00		LAUNDRY & LINEN SERVICE				8. 00
9.00		HOUSEKEEPI NG				9.00
10.00	1	DI ETARY				10.00
		CAFETERIA NURSING ADMINISTRATION				11. 00 13. 00
		CENTRAL SERVICES & SUPPLY				14. 00
		PHARMACY	161, 039			15. 00
		MEDICAL RECORDS & LIBRARY	0	0		16. 00
		ENT ROUTINE SERVICE COST CENTERS	-1			
30.00	03000	ADULTS & PEDIATRICS	2, 777	0		30.00
		INTENSIVE CARE UNIT	0	0		31. 00
43.00		NURSERY	0	0		43. 00
		_ARY SERVICE COST CENTERS	405			50.00
50.00		OPERATING ROOM	185	0		50.00
52. 00 54. 00	1	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	0 1, 438	0		52. 00 54. 00
55. 00	1	RADI OLOGY-DI AGNOSTI C	1, 436	0		55. 00
56. 00	1	ULTRA SOUND	0	0		56.00
57. 00		CT SCAN	0	0		57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	Ö	0		58. 00
60.00	1	LABORATORY	0	0		60.00
66.00	06600	PHYSI CAL THERAPY	0	0		66. 00
67.00	06700	OCCUPATI ONAL THERAPY	0	0		67. 00
68. 00	06800	SPEECH PATHOLOGY	0	0		68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0		69. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0 116, 326	0		72. 00 73. 00
		ONCOLOGY DRUGS	24, 980	0		73.00
		CARDI OPULMONARY	110	0		76. 00
		TIENT SERVICE COST CENTERS	- 1			
90.00	09000	CLI NI C	0	0		90. 00
	l .	EMERGENCY	15, 223	0		91. 00
	4	OBSERVATION BEDS (NON-DISTINCT PART)				92.00
92. 01		OBSERVATION BEDS (DISTINCT PART)	0	0		92. 01
101 00		REIMBURSABLE COST CENTERS HOME HEALTH AGENCY	O	0		101. 00
101.00		AL PURPOSE COST CENTERS	٥			101.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	161, 039	0		118. 00
	NONRE	MBURSABLE COST CENTERS				
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
		RESEARCH	0	0		191. 00
	1	PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
192. 02	1	NONPALD WORKERS	0	0		192. 02 193. 00
		LEASED SPACE	0	0		194. 00
200.00		Cross Foot Adjustments	J	O		200.00
201.00		Negative Cost Centers				201. 00
202.00		Cost to be allocated (per Wkst. B,	1, 126, 968	0		202. 00
		Part I)				
203.00	1	Unit cost multiplier (Wkst. B, Part I)	6. 998106	0. 000000		203. 00
204. 00		Cost to be allocated (per Wkst. B,	45, 076	0		204. 00
205.00		Part II) Unit cost multiplier (Wkst. B, Part	0. 279907	0. 000000		205. 00
_00.00		11)	5. 217701	3. 300000		200.00
206.00		NAHE adjustment amount to be allocated				206. 00
00		(per Wkst. B-2)				
207. 00		NAHE unit cost multiplier (Wkst. D,				207. 00
	I	Parts III and IV)	ı		I	I

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 06/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 12:	pared:
		Title	: XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2. 00	3.00	4. 00	5. 00	

		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 153, 358		4, 153, 358	0	0	
31.00 03100 INTENSIVE CARE UNIT	0		0	0	0	31. 00
43. 00 04300 NURSERY	0		0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 318, 626		1, 318, 626	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 315, 982		1, 315, 982	0	0	0 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		0	0	0	
56.00 03630 ULTRA SOUND	0		0	0	0	00.00
57.00 05700 CT SCAN	0		0	0	0	07.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	
60. 00 06000 LABORATORY	1, 058, 183		1, 058, 183	0	0	
66. 00 06600 PHYSI CAL THERAPY	680, 674	0	680, 674	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	304, 011	0	304, 011	0	0	
68.00 06800 SPEECH PATHOLOGY	160, 072	0	160, 072	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	75, 993		75, 993	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	994, 534		994, 534	0	0	73. 00
73. 01 07301 0NCOLOGY DRUGS	213, 568		213, 568	o	0	73. 01
76. 00 03020 CARDI OPULMONARY	835, 041		835, 041	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		0	0	0	90.00
91. 00 09100 EMERGENCY	4, 225, 540		4, 225, 540	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 069, 982		1, 069, 982		0	92.00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0		0	o	0	92. 01
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0		0		0	101. 00
200.00 Subtotal (see instructions)	16, 405, 564	0	16, 405, 564	o	0	200. 00
201.00 Less Observation Beds	1, 069, 982		1, 069, 982		0	201. 00
202.00 Total (see instructions)	15, 335, 582	0	15, 335, 582	o	0	202. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316	Period: Worksheet C From 06/01/2017 Part I

Date/Time Prepared: To 12/31/2017 5/29/2018 12:13 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 108, 918 1, 108, 918 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 1 957955 0.000000 50.00 50.00 05000 OPERATING ROOM 2.433 671, 038 673, 471 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 148, 355 4, 144, 773 4, 293, 128 0.306532 0.000000 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0.000000 55.00 55.00 0 03630 ULTRA SOUND 0 0.000000 56.00 0 r 0.000000 56.00 57.00 05700 CT SCAN 0 0 0 0.000000 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0.000000 0.000000 58.00 06000 LABORATORY 1, 998, 896 0.494054 0.000000 60.00 142, 942 2, 141, 838 60.00 66.00 06600 PHYSI CAL THERAPY 182, 237 825, 194 1,007,431 0.675653 0.000000 66.00 06700 OCCUPATIONAL THERAPY 145, 520 334, 300 479, 820 0.633594 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 64,650 70, 772 135, 422 1.182024 0.000000 68.00 06900 FLECTROCARDI OLOGY 0.000000 69 00 0.000000 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 4, 399 4, 399 17. 275063 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 449, 176 1, 046, 015 1, 495, 191 0.000000 73.00 0.665155 73.00 07301 ONCOLOGY DRUGS 73.01 120, 668 120, 668 1.769881 0.000000 73.01 76.00 03020 CARDI OPULMONARY 97, 012 889, 844 986, 856 0.846163 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0.000000 90 00 09000 CLINIC 10, 959, 987 130, 384 11, 090, 371 91.00 09100 EMERGENCY 0.381010 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 11, 480 801, 893 813, 373 1. 315487 0.000000 92.00 09201 OBSERVATION BEDS (DISTINCT PART) 92.01 0.000000 0.000000 92.01 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101.00 200.00 Subtotal (see instructions) 2, 483, 107 21, 867, 779 24, 350, 886 200. 00 201 00 Less Observation Beds 201 00 202.00 Total (see instructions) 2, 483, 107 21, 867, 779 24, 350, 886 202.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316	From 06/01/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm
	T: 11 \0.0111	11	0 1

				5/29/2018 12:13 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description PF	PS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
31.00 03100 I NTENSI VE CARE UNI T				31. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 03630 ULTRA SOUND	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01 07301 0NCOLOGY DRUGS	0. 000000			73. 01
76. 00 03020 CARDI OPULMONARY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
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
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
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 FRANK	FORT HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	F	Period: From 06/01/2017 To 12/31/2017		
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 153, 358		4, 153, 358	0	4, 153, 358	30. 00
31.00 03100 INTENSIVE CARE UNIT	0		(0	0	31.00
43. 00 04300 NURSERY	0		(0	0	43.00
ANCILLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATI NG ROOM	1, 318, 626		1, 318, 626	0	1, 318, 626	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0		(0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 315, 982		1, 315, 982	2 0	1, 315, 982	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		(0	0	55. 00
56.00 03630 ULTRA SOUND	0		(0	0	56. 00
57. 00 05700 CT SCAN	0		(0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		(0	0	58. 00
60. 00 06000 LABORATORY	1, 058, 183		1, 058, 183	0	1, 058, 183	60.00
66. 00 06600 PHYSI CAL THERAPY	680, 674	0	680, 674	. 0	680, 674	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	304, 011	0	304, 011	0	304, 011	67. 00
68.00 06800 SPEECH PATHOLOGY	160, 072	0	160, 072	0	160, 072	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	75, 993		75, 993	0	75, 993	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		(0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	994, 534		994, 534	0	994, 534	73. 00
73. 01 07301 ONCOLOGY DRUGS	213, 568		213, 568	0	213, 568	73. 01
7/ 00 03030 CARRI ORUI MONARY	025 041	I	025 041		025 041	74 00

835, 041

4, 225, 540

1, 069, 982

16, 405, 564

1, 069, 982

15, 335, 582

835, 041

4, 225, 540

1, 069, 982

16, 405, 564 1, 069, 982

15, 335, 582

0

0

835, 041

1, 069, 982

4, 225, 540 91.00

16, 405, 564 200. 00 1, 069, 982 201. 00 15, 335, 582 202. 00

0

0

76.00

90.00

92.00

92. 01 0

0 101. 00

76.00

92.00

92. 01

200.00

201.00

202.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

03020 CARDI OPULMONARY

101.00 10100 HOME HEALTH AGENCY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

09200 OBSERVATION BEDS (NON-DISTINCT PART) 09201 OBSERVATION BEDS (DISTINCT PART)

Subtotal (see instructions)

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316	Period: Worksheet C From 06/01/2017 Part I

					From 06/01/2017 Fo 12/31/2017	Part I Date/Time Pre 5/29/2018 12:	epared: 13 pm
			Titl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
I NPAT	TENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	1, 108, 918		1, 108, 91	3		30. 00
31.00 03100	INTENSIVE CARE UNIT	0		(31.00
43.00 04300	NURSERY	0		(43.00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	2, 433	671, 038	673, 47°			
	DELIVERY ROOM & LABOR ROOM	0	0	(0. 000000		
	RADI OLOGY-DI AGNOSTI C	148, 355	4, 144, 773	4, 293, 12			
	RADI OLOGY-THERAPEUTI C	0	0	(0. 000000		
	ULTRA SOUND	0	0	(0. 000000	0. 000000	
	CT SCAN	0	0	(0. 000000	0. 000000	
	MAGNETIC RESONANCE IMAGING (MRI)	0	0	(0. 000000	0. 000000	
	LABORATORY	142, 942	1, 998, 896			0. 000000	
	PHYSI CAL THERAPY	182, 237	825, 194				
	OCCUPATI ONAL THERAPY	145, 520	334, 300	· ·		0. 000000	
	SPEECH PATHOLOGY	64, 650	70, 772	135, 42:		0. 000000	
	ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	1
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 399	4, 39			1
	IMPL. DEV. CHARGED TO PATIENTS	0	0	(0. 000000		
	DRUGS CHARGED TO PATIENTS	449, 176	1, 046, 015				
	ONCOLOGY DRUGS	0	120, 668	· ·		0. 000000	
	CARDI OPULMONARY	97, 012	889, 844	986, 85	0. 846163	0. 000000	76. 00
	TIENT SERVICE COST CENTERS						
90. 00 09000		0	0		0. 000000		
	EMERGENCY	130, 384	10, 959, 987				1
	OBSERVATION BEDS (NON-DISTINCT PART)	11, 480	801, 893			0. 000000	
	OBSERVATION BEDS (DISTINCT PART)	0	0		0. 000000	0. 000000	92. 01
	REIMBURSABLE COST CENTERS				-1		ļ
	HOME HEALTH AGENCY	0	0)		101.00
200. 00	Subtotal (see instructions)	2, 483, 107	21, 867, 779	24, 350, 88			200. 00
201.00	Less Observation Beds		04 0/3				201. 00
202. 00	Total (see instructions)	2, 483, 107	21, 867, 779	24, 350, 88	b		202. 00

Health Financial Systems	IU HEALTH FRANKFO	RT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1316	Peri od: From 06/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepared: 5/29/2018 12:13 pm
		Title XIX	Hospi tal	Cost
Cook Cook of Donor in the co	DDC 1+!+	•		

				5/29/2018 12:13 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56.00 03630 ULTRA SOUND	0. 000000			56.00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
60. 00 06000 LABORATORY	0. 000000			60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	S 0.000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01 07301 ONCOLOGY DRUGS	0. 000000			73. 01
76. 00 03020 CARDI OPULMONARY	0. 000000			76. 00
OUTPATIENT SERVICE COST CENTERS				
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
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000			92. 01
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 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 FRANKFO	RT HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ANCILLARY SERVICE CAPIT	AL COSTS	Provider CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Prepared: 5/29/2018 12:13 pm

					From 06/01/2017 To 12/31/2017	Part II Date/Time Pre 5/29/2018 12:	pared: 13 pm
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
		Related Cost			Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS	T		1			
	OOO OPERATING ROOM	55, 343	673, 47	1		l	
•	200 DELIVERY ROOM & LABOR ROOM	0		0.00000		0	52. 00
	400 RADI OLOGY-DI AGNOSTI C	94, 911	4, 293, 12	1			
	500 RADI OLOGY-THERAPEUTI C	0		0.00000		0	55. 00
	630 ULTRA SOUND	0		0.00000		0	56. 00
	700 CT SCAN	0		0.00000		0	57. 00
	800 MAGNETIC RESONANCE IMAGING (MRI)	0		0.00000		0	58. 00
	000 LABORATORY	77, 733	2, 141, 83				60.00
	600 PHYSI CAL THERAPY	46, 451	1, 007, 43				66. 00
	700 OCCUPATI ONAL THERAPY	21, 739	479, 82	0. 04530	7 48, 352		67. 00
68. 00 068	800 SPEECH PATHOLOGY	12, 420	135, 42	2 0. 09171	3 54, 900	5, 035	68. 00
69. 00 069	900 ELECTROCARDI OLOGY	0		0.00000	0 0	0	69. 00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 438	4, 39	9 0. 55421	7 0	0	71. 00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0		0.00000	0	0	72.00
73. 00 073	300 DRUGS CHARGED TO PATIENTS	34, 105	1, 495, 19	1 0. 02281	0 290, 236	6, 620	73.00
73. 01 07:	301 ONCOLOGY DRUGS	7, 324	120, 66	8 0.06069	5 0	0	73. 01
76. 00 030	020 CARDI OPULMONARY	50, 068	986, 85	6 0. 05073	5 58, 899	2, 988	76.00
OU	TPATIENT SERVICE COST CENTERS						
90.00 090	000 CLI NI C	0		0.00000	0 0	0	90.00
91.00 09	100 EMERGENCY	137, 362	11, 090, 37	1 0. 01238	6 5, 325	66	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)	105, 017	813, 37	3 0. 12911	3 0	0	92.00
92. 01 092	201 OBSERVATION BEDS (DISTINCT PART)	0		0. 00000	0	0	92. 01
200.00	Total (lines 50 through 199)	644, 911	23, 241, 96	8	697, 912	25, 190	200. 00

Health Financial Systems	IU HEALTH FRANKFOR	RT HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1316	Peri od:	Worksheet D
THROUGH COSTS			From 06/01/2017	Part IV

THROUGH COSTS 12/31/2017 Date/Time Prepared: To 5/29/2018 12:13 pm Title XVIII Hospi tal Cost Center Description Non Physician Nursing School Nursing School Allied Health Allied Health Anesthetist Post-Stepdown Post-Stepdown Cost Adjustments Adjustments 1.00 2.00 3. 00 2A 3A ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 55.00 03630 ULTRA SOUND 0 0 56.00 0 56.00 05700 CT SCAN 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 60.00 06000 LABORATORY 0 60.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07301 ONCOLOGY DRUGS 0 0 0 73. 01 73. 01 03020 CARDI OPULMONARY 0 0 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 0 0 0 91. 00 09100 EMERGENCY 0 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 92.00 0 0 0 0 92.01

0 200.00

Total (lines 50 through 199)

200.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL			eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1316	Peri od:	Worksheet D

From 06/01/2017 Part IV
To 12/31/2017 Date/Time Prepared: THROUGH COSTS 5/29/2018 12:13 pm Title XVIII Hospi tal Cost All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total (from Wkst. C, to Charges Medi cal (sum of col 1 Outpati ent Education Cost through col. Cost (sum of Part I, col. (col. 5 ÷ col col. 2, 3 and 8) 4) 4.00 5.00 6.00 7.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 673, 471 0.000000 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 4, 293, 128 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 55.00 OI 03630 ULTRA SOUND 0 56.00 0.000000 56.00 0 57.00 05700 CT SCAN 0 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0.000000 58.00 0 0 60.00 06000 LABORATORY 2, 141, 838 0.000000 60 00 06600 PHYSI CAL THERAPY 0 0 1,007,431 66.00 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 479, 820 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 135, 422 68.00 06900 ELECTROCARDI OLOGY 0.000000 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 4, 399 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 495, 191 0.000000 73.00 73 00 0 0 73. 01 07301 ONCOLOGY DRUGS 0 120, 668 0.000000 73.01 76.00 03020 CARDI OPULMONARY 0 0 986, 856 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 0 0 0 0 0.000000 90 00 09000 CLI NI C 0 11, 090, 371 91. 00 | 09100 | EMERGENCY 0 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 813, 373 0.000000 92.00 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0 0.000000 92.01

23, 241, 968

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH FRANKF	ORT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS				From 06/01/2017		
				To 12/31/2017		pared:
					5/29/2018 12:	13 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	_	Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	2, 433		0 0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0)	0 0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	86, 114		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0)	0 0	0	55. 00
56. 00 03630 ULTRA SOUND	0. 000000	0)	0 0	0	56.00
57. 00 05700 CT SCAN	0. 000000	0	1	0	0	57. 00
EO OO OEOOO MACNETI C DECONANCE I MACINIC (MDI)	0.000000		.l		1	1 -0 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1316 Peri od: Worksheet D From 06/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/29/2018 12:13 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1. 957955 243, 207 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 0 0 0 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.306532 0 1, 032, 769 54 00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 0 0 55.00 56.00 03630 ULTRA SOUND 0.000000 0 0 56.00 57.00 05700 CT SCAN 0.000000 0 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 \cap 0 58.00 60.00 06000 LABORATORY 0.494054 541, 753 0 60.00 06600 PHYSI CAL THERAPY 66.00 0.675653 318, 306 0 66.00 06700 OCCUPATIONAL THERAPY 0.633594 111 043 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 1. 182024 19,034 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 17. 275063 641 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 0.000000 C Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.665155 0 316, 287 277 0 73.00 07301 ONCOLOGY DRUGS 1. 769881 25, 411 0 73.01 73.01 03020 CARDI OPULMONARY 0.846163 0 353, 056 0 0 76.00 76, 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 91.00 09100 EMERGENCY 0.381010 0 2, 688, 786 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 315487 92.00 0 295, 883 0 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0 0 Ω 5, 946, 176 200.00 Subtotal (see instructions) 0 0 200.00 277 Less PBP Clinic Lab. Services-Program 201.00 0 201. 00 Only Charges

0

5, 946, 176

0 202.00

277

202.00

Net Charges (line 200 - line 201)

| Peri od: | Worksheet D | From 06/01/2017 | Part V | To 12/31/2017 | Date/Time Prepared:

				10 12/31/2017	Date/IIme Pre 5/29/2018 12:	
		Title	XVIII	Hospi tal	Cost	
	Cost	S				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
		Services Not				
	Subj ect To	Subject To				
		ed. & Coins.				
	(see inst.)	(see inst.)				
ANOLILARY REDWINE ROOT REVIERS	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	477 400	0				
50. 00 05000 OPERATING ROOM	476, 188	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	316, 577	0				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 03630 ULTRA SOUND	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	0				58. 00
60. 00 06000 LABORATORY	267, 655	0				60.00
66. 00 06600 PHYSI CAL THERAPY	215, 064	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	70, 356	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	22, 499	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	11 070	0				69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 073	0				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	010 000	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	210, 380	184				73. 00
73. 01 07301 ONCOLOGY DRUGS	44, 974	0				73. 01
76. 00 03020 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	298, 743	0				76. 00
90. 00 09000 CLINIC		0				90.00
91. 00 09100 EMERGENCY	1, 024, 454	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	389, 230	0				92.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	307, 230	0				92.00
200.00 Subtotal (see instructions)	3, 347, 193	184				200. 00
201.00 Less PBP Clinic Lab. Services-Program	3, 347, 193	104				200. 00
Only Charges	١					201.00
202.00 Net Charges (line 200 - line 201)	3, 347, 193	184				202. 00
202.00 Net charges (True 200 - True 201)	3, 347, 173	104	I			1202.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL			In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1316	Peri od:	Worksheet D

From 06/01/2017 | Part V | Date/Time Prepared: Component CCN: 15-Z316 5/29/2018 12:13 pm Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1. 957955 0 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0. 306532 0 54.00 54 00 0 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0.000000 0 55.00 56.00 03630 ULTRA SOUND 0.000000 0 56.00 0 57.00 05700 CT SCAN 0.000000 0 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 0.000000 0 58.00 60.00 06000 LABORATORY 0.494054 0 60.00 06600 PHYSI CAL THERAPY 0 66.00 0.675653 0 66.00 06700 OCCUPATIONAL THERAPY 0.633594 0 67.00 67 00 0 68.00 06800 SPEECH PATHOLOGY 1. 182024 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 17. 275063 0 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72 00 0.000000 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.665155 0 0 73.00 07301 ONCOLOGY DRUGS 1. 769881 0 0 73.01 73.01 03020 CARDI OPULMONARY 0.846163 0 0 0 76.00 76, 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 90.00 91.00 09100 EMERGENCY 0.381010 0 0 0 0 0 0 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 315487 92.00 92.00 0 0 92. 01 09201 OBSERVATION BEDS (DISTINCT PART) 0.000000 92.01 0 n 0 200.00 Subtotal (see instructions) 0 0 200.00 Less PBP Clinic Lab. Services-Program 0 201.00 201. 00 Only Charges

0

0

0 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST		CN: 15-1316 CCN: 15-Z316	Peri od: From 06/01/2017 To 12/31/2017		
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				

		·			5/29/2018 12:13 pm
	_	Title	XVIII	Swing Beds - SNF	Cost
	Co:	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
	Ded. & Coins.	Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS	_				
50.00 05000 OPERATING ROOM	0	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56.00 03630 ULTRA SOUND	0	0			56. 00
57. 00 05700 CT SCAN	0	0			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			58. 00
60. 00 06000 LABORATORY	0	0)		60.00
66. 00 06600 PHYSI CAL THERAPY	0	0)		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0)		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)		73. 00
73. 01 07301 ONCOLOGY DRUGS	0	0)		73. 01
76. 00 03020 CARDI OPULMONARY	0	0			76. 00
OUTPATIENT SERVICE COST CENTERS	•		'		
90. 00 09000 CLI NI C	0	0)		90.00
91. 00 09100 EMERGENCY	0	0)		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)		92. 00
92.01 09201 OBSERVATION BEDS (DISTINCT PART)	0	0)		92. 01
200.00 Subtotal (see instructions)	0	0)		200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00 Net Charges (line 200 - line 201)	0	0)		202. 00
	1	•	•		

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co	CN: 15-1316	Peri od: From 06/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 12:	pared: 13 pm
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2. 00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	1. 957955			0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 306532	0			0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0			0	1
56. 00 03630 ULTRA SOUND	0. 000000	0		0	0	1
57. 00 05700 CT SCAN	0. 000000			0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	
60. 00 06000 LABORATORY	0. 494054	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 675653	0		0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0. 633594	Ö		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	1. 182024	0		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17. 275063	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 665155	0		0	0	73. 00
73. 01 07301 0NCOLOGY DRUGS	1. 769881	0		0	0	73. 01
76. 00 03020 CARDI OPULMONARY	0. 846163	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0	0	1 /0.00
91. 00 09100 EMERGENCY	0. 381010	0		0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 315487	0		0	0	
92. 01 09201 OBSERVATION BEDS (DISTINCT PART)	0. 000000	0		0	0	
200.00 Subtotal (see instructions)		0		0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges		_			_	000 00
202.00 Net Charges (line 200 - line 201)	[0		0 0	0	202. 00

APPURT	TUNMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		From 06/01/2017 To 12/31/2017	Part V Date/Time Pro	epared: 13 pm
		Cox	IITI sts	e XIX	Hospi tal	Cost	
	Cost Center Description	Cost	Cost	+			
	cost center bescriptron	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00	1			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0)			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
	03630 ULTRA SOUND	0	0)			56. 00
57.00	05700 CT SCAN	0	0				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1			58. 00
	06000 LABORATORY	0	0)			60.00
	06600 PHYSI CAL THERAPY	0	0				66. 00
	06700 OCCUPATI ONAL THERAPY	0	0				67. 00
	06800 SPEECH PATHOLOGY	0	0	1			68. 00
	06900 ELECTROCARDI OLOGY	0	0	1			69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1			72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	07301 ONCOLOGY DRUGS	0	0				73. 01
76.00	03020 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	1			76. 00
90. 00	09000 CLINIC	0	0	J			90. 00
	09100 EMERGENCY	0	1 0	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	09201 OBSERVATION BEDS (NON-DISTINCT PART)	0					92. 01
200.00							200. 00
201.00		0	Ĭ				201. 00
231.00	Only Charges						
202.00		0	О				202. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1316	Peri od: From 06/01/2017	Worksheet D-1
		10 12/31/2017	Date/Time Prepared: 5/29/2018 12:13 pm
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/29/2018 12: Cost	13 pm
	Cost Center Description	I tie XVIII	1103pi tai	COST	
	DIST. ALL DROWNER COMPONENTS			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		884	1. 00
2.00	Inpatient days (including private room days, excluding swing-			739	
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	od days)		517	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	122	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	m days) through Docombor	21 of the cost	23	7. 00
7.00	reporting period	ii days) tiii ougii beceiibei	31 Of the Cost	23	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3 ⁻	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	387	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom days)	122	10. 00
	through December 31 of the cost reporting period (see instruc-				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		n room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (frict during private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
	after December 31 of the cost reporting period (if calendar ye			_	
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
40.00	reporting period	61 6 1 31 6			40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	tne cost		18. 00
19. 00					19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	s)		4, 153, 358	21 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	3 565	24. 00
	7 x line 19)		.g p (-,	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			591, 573	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 561, 785	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			., ,	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	
29. 00	Pri vate room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	Line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	0 3, 561, 785	36. 00 37. 00
07.00	27 minus line 36)	and private room cost ar	Tronomeral (Trino	0,001,700	07.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 040 7:	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	*		4, 819. 74 1, 865, 239	
40. 00	Medically necessary private room cost applicable to the Progra	-		1, 803, 239	40. 00
	Total Program general inpatient routine service cost (line 39	,		1, 865, 239	

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH FRANKE		CN: 15-1316	In Lie	eu of Form CMS- Worksheet D-1	
001111	ATTOM OF THE MITTERS OF ELECTRIC GOOT		l'iovidei e	. 10 1010	From 06/01/2017		
					To 12/31/2017	Date/Time Pre 5/29/2018 12:	eparea: 13 pm
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total	Average Per		Program Cost (col. 3 x col.	
		Impatrent costi	inpatrent bays	col. 2)	7	4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	0	(0.	00 0	C	42. 00
43. 00	INTENSIVE CARE UNIT	0	(0.0	00 0		43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	oost conten bescriptron					1. 00	
	Program inpatient ancillary service cost (W					459, 156	
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ons)		2, 324, 395	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	patient routine s	services (from	n Wkst D sur	m of Parts I and		50.00
	III)	,		,			
51. 00	Pass through costs applicable to Program in	patient ancillary	y services (fr	om Wkst. D,	sum of Parts II	C	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52. 00
53. 00	Total Program inpatient operating cost excl		ated, non-phy	ysician anestl	netist, and		
	medical education costs (line 49 minus line			, 	·		
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						F 4 00
	Program discharges Target amount per discharge						54.00
	Target amount (line 54 x line 55)						56.00
	Difference between adjusted inpatient opera	ting cost and tar	get amount (I	ine 56 minus	line 53)	C	
58. 00	Bonus payment (see instructions)	anarting paried a	andina 1007 .	undated and a	ampaundad by tha	0.00	58. 00 59. 00
59. 00	Lesser of lines 53/54 or 55 from the cost r market basket	eporting period e	enarng 1996, t	updated and co	onipounded by the	0.00	59.00
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00	If line 53/54 is less than the lower of lin					C	61. 00
	which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		s (IInes 54 X	60), or 1% of	r the target		
62. 00	Relief payment (see instructions)	riisti detrons)				C	62.00
63. 00	Allowable Inpatient cost plus incentive pay	ment (see instruc	ctions)			C	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Decem	mber 31 of the	cost reporti	ng period (See	588 008	64. 00
04.00	instructions) (title XVIII only)	313 thi ough becch	inder 31 of the	cost reporti	riig perrou (see	300, 000	04.00
65. 00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the d	cost reporting	g period (See	C	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout</pre>	ino costs (lino 6	64 plus lipo 4	55) (+i +l o VVII	II only) For	500 NNG	66. 00
00.00	CAH (see instructions)	The costs (The C	54 prus rine (os)(title xvi)	ii oniy). Toi	300,000	00.00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 d	of the cost re	eporting period	C	67. 00
49 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	no costs ofter Do	combon 21 of	the cost ron	arting pariod		40 00
00.00	(line 13 x line 20)	ne costs arter be	ecember 31 or	the cost repo	ortring period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ine 67 + line	e 68)		c	69. 00
70.00	PART III - SKILLED NURSING FACILITY, OTHER					T	70.00
70. 00 71. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service)		70.00
	Program routine service cost (line 9 x line		75 . 11116	-/			72. 00
73. 00	Medically necessary private room cost appli	cable to Program					73. 00
	Total Program general inpatient routine ser	•			Dort II oction		74.00
75. 00	Capital-related cost allocated to inpatient 26. line 45)	routine service	costs (from V	worksneet B, I	rant II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77. 00	Program capital-related costs (line 9 x lin	,					77. 00
	Inpatient routine service cost (line 74 min	,	sovi don nocon	46)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				nus line 79)		79.00
81. 00	Inpatient routine service cost per diem lim	•			,		81. 00
82. 00	Inpatient routine service cost limitation (82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i		S)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85.00
	Total Program inpatient operating costs (su						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					
07.0-		`					
87. 00 88. 00	Total observation bed days (see instruction Adjusted general inpatient routine cost per	•	line 2)			222 4, 819. 74	

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 12:	
		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	407, 645	4, 153, 358	0. 09814	1, 069, 982	105, 017	90.00
91.00 Nursing School cost	0	4, 153, 358	0.00000	1, 069, 982	0	91.00
92.00 Allied health cost	0	4, 153, 358	0.00000	1, 069, 982	0	92.00
93.00 All other Medical Education	0	4, 153, 358	0.00000	1, 069, 982	0	93. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1316	Peri od: From 06/01/2017	Worksheet D-1		
		To 12/31/2017	Date/Time Pre 5/29/2018 12:		
	Title XIX	Hospi tal	Cost		
0 1 0 1 5 1 11					

		Title XIX	Hospi tal	5/29/2018 12: Cost	13 pm_
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			884 739	1. 00 2. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-t Private room days (excluding swing-bed and observation bed day		vate room days	739	3.00
0.00	do not complete this line.	is). It you have omly pri	vate room days,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be			517	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	122	5. 00
6. 00	Teporting period Total_swing-bed_SNF_type_inpatient_days_(including_private_roc	om davs) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	23	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	, .,			
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	5	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Join days)	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XIX		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (Therduring private	e room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar yellow Medically necessary private room days applicable to the Program			0	14. 00
14. 00 15. 00	Total nursery days (title V or XIX only)	ill (excluding swing-bed to	lays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	155. 02	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng poriod (Line	4, 153, 358 0	21. 00 22. 00
22.00	5 x line 17)	si 31 of the cost reporti	ng perrou (Trile	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	21 of the cost reporting	na ported (Line	2 565	24. 00
24.00	7 x line 19)	31 of the cost reporter	ig period (Title	3, 303	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			591, 573	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ([line 21 minus line 26)		3, 561, 785	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	I and observation bed cha	arges)	0	28. 00 29. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	22) (h:>	0.00	33.00
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x lir	, ,	LI OHS)	0. 00 0. 00	34. 00 35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	01)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	3, 561, 785	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			4, 819. 74	38. 00
39.00	Program general inpatient routine service cost (line 9 x line			24, 099	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 24, 099	40. 00 41. 00
11.00	1.02a ogram gonorar impatront routine service cost (fille 37		ı	27,077	1 11.00

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH FRANKF		CN: 15-1316	In Lie	u of Form CMS- Worksheet D-1	
COMI OT	ATTON OF THE ATTENT OF ENATTING COST		Trovider e	ON. 13 1310	From 06/01/2017		
					To 12/31/2017	Date/Time Pre 5/29/2018 12:	epared: 13 pm
			_	le XIX	Hospi tal	Cost	
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	npatrent bays	col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	(0.	00 0	C	42. 00
43. 00	Intensive Care Type Inpatient Hospital Unit INTENSIVE CARE UNIT	S 0		0.	00 0	C	43.00
44. 00	CORONARY CARE UNIT	٩		0.	00		44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (W	/kst. D-3, col. 3,	line 200)			12, 360	48.00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	ee instructi	ons)		36, 459	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS	unationt mouting o	and and (from	w Wkat D au	m of Donto L and		J 50 00
50.00	Pass through costs applicable to Program in	ipatrent routine s	services (IIO	II WKSt. D, Su	II OI PAILS I AND	C	50.00
51.00	Pass through costs applicable to Program in	patient ancillary	services (fi	rom Wkst. D,	sum of Parts II	C	51.00
	and IV)					_	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost excl		atad non nh	rci ci an anact	hotist and	[
33.00	medical education costs (line 49 minus line		ateu, non-pn	ysician anest	netist, and		33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges						54.00
	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
	Difference between adjusted inpatient opera	iting cost and tar	get amount (ine 56 minus	line 53)		•
58. 00	Bonus payment (see instructions)	g	9 (-			C	
59. 00	Lesser of lines 53/54 or 55 from the cost r	reporting period e	endi ng 1996, เ	updated and c	ompounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost renort und	lated by the r	market hasket		0.00	60.00
	If line 53/54 is less than the lower of lin					0.00	1
	which operating costs (line 53) are less th		(lines 54 x	60), or 1% o	f the target ´		
42.00	amount (line 56), otherwise enter zero (see	e instructions)				C	62.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive pay	ment (see instruc	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST	(000 1110 110 110	, , , , , , , , , , , , , , , , , , , ,			-	
64. 00	Medicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	e cost report	ing period (See	C	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decembe	or 31 of the o	rost reportin	n neriod (See	C	65. 00
00.00	instructions) (title XVIII only)	oto di tei beccimbe	. 01 01 1110 1	sost roportin	g perrou (occ		00.00
66. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line o	65)(title XVI	II only). For	C	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi	no costs through	Docombor 21	of the cost r	operting period	C	67. 00
07.00	(line 12 x line 19)	ne costs through	December 31 (of the cost i	eporting perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after De	ecember 31 of	the cost rep	orting period	С	68. 00
(0.00	(line 13 x line 20)		!	- (0)			
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER	•					69. 00
70. 00	Skilled nursing facility/other nursing faci)		70.00
71. 00	Adjusted general inpatient routine service	cost per diem (li					71.00
	Program routine service cost (line 9 x line		(line 14 v li	no 2E)			72.00
73. 00 74. 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73.00
75. 00	Capital -related cost allocated to inpatient	•			Part II, column		75. 00
	26, line 45)						
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin						76. 00 77. 00
	Inpatient routine service cost (line 74 min	,					78.00
79. 00	Aggregate charges to beneficiaries for exce	,	ovi der record	ds)			79. 00
	Total Program routine service costs for com	•	st limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem lim Inpatient routine service cost limitation (81. 00 82. 00
83. 00	Reasonable inpatient routine service cost	•					83.00
84. 00	Program inpatient ancillary services (see i	•	•				84. 00
85. 00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (su		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					222	87. 00
	Adjusted general inpatient routine cost per	•	line 2)			4, 819. 74	
88. 00	Maj de ted general impatrent reatine cost per	arem (Tribe 27	11110 2)			1,017.71	1 00.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 06/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 12:	
		Ti tl	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	407, 645	4, 153, 358	0. 09814	1, 069, 982	105, 017	90.00
91.00 Nursing School cost	0	4, 153, 358	0.00000	0 1, 069, 982	0	91.00
92.00 Allied health cost	0	4, 153, 358	0.00000	0 1, 069, 982	0	92.00
93.00 All other Medical Education	0	4, 153, 358	0. 00000	1, 069, 982	0	93. 00

ealth Financial Systems IU HEALTH FRANKFO NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Peri od: From 06/01/2017 To 12/31/2017		pared:
	Ti +l c	xVIII	Hospi tal	5/29/2018 12: Cost	13 pm
Cost Center Description	TI CI C	Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
80. 00 03000 ADULTS & PEDI ATRI CS			678, 305		30.00
81.00 03100 I NTENSI VE CARE UNI T 13.00 04300 NURSERY			0		31. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS] 43.00
50, 00 05000 OPERATING ROOM		1. 95795	55 2, 433	4. 764	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.00000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 30653	86, 114	26, 397	54.00
55. OO 05500 RADI OLOGY-THERAPEUTI C		0.00000	00	0	55.00
66.00 03630 ULTRA SOUND		0.00000		0	
57. 00 05700 CT SCAN		0.00000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	
00. 00 06000 LABORATORY		0. 49405			
66. 00 06600 PHYSI CAL THERAPY		0. 67565			
57. 00 06700 OCCUPATI ONAL THERAPY		0. 63359			
98. 00 06800 SPEECH PATHOLOGY		1. 18202			
99. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		17. 27506 0. 00000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 66515		_	
73. 01 07300 BROGS CHARGED TO FATTENTS		1. 76988			
76. 00 03020 CARDI OPULMONARY		0. 84616			
OUTPATIENT SERVICE COST CENTERS		0.04010	30,077	1 47,030	70.00
00. 00 09000 CLI NI C		0.00000	00 0	0	90.00
21. 00 09100 EMERGENCY		0. 38101	0 5, 325	2, 029	91.00
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 31548	37 O	0	92.00
22.01 09201 OBSERVATION BEDS (DISTINCT PART)		0.00000		0	
Total (sum of lines 50 through 94 and 96 through 98)			697, 912		
201.00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0	l .	201. 00
Net charges (line 200 minus line 201)		[697, 912		202.00

	nancial Systems	IU HEALTH FRANKFORT HOSPITAL			eu of Form CMS-2	
I NPATI ENT	F ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
		Component C		From 06/01/2017 To 12/31/2017		nared:
		Component	JON. 13 2310	10 12/31/2017	5/29/2018 12:	
		Title	XVIII	Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS				1	
	000 ADULTS & PEDIATRICS			0		30.00
	100 INTENSIVE CARE UNIT			0		31.00
	300 NURSERY					43. 00
	CILLARY SERVICE COST CENTERS				ı	
	OOO OPERATING ROOM		1. 95795		0	00.00
	200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
	400 RADI OLOGY-DI AGNOSTI C		0. 30653			
	500 RADI OLOGY-THERAPEUTI C		0.00000		0	
	630 ULTRA SOUND		0.00000		0	00.00
	700 CT SCAN		0.00000		0	07.00
	800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000		0	00.00
	000 LABORATORY		0. 49405			
	600 PHYSI CAL THERAPY		0. 67565			
	700 OCCUPATIONAL THERAPY		0. 63359			
	800 SPEECH PATHOLOGY		1. 18202		2, 663	
	900 ELECTROCARDI OLOGY		0.00000		0	07.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		17. 27506		0	71. 00
	200 IMPL. DEV. CHARGED TO PATIENTS		0.00000		0	72. 00
	300 DRUGS CHARGED TO PATIENTS		0. 66515		15, 352	
	301 ONCOLOGY DRUGS		1. 76988	31 0	0	1
76. 00 030	020 CARDI OPULMONARY		0. 84616	2, 654	2, 246	76. 00
	TPATIENT SERVICE COST CENTERS					
	000 CLI NI C		0.00000		0	, , , , , ,
	100 EMERGENCY		0. 38101		0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 31548		_	
02 01 00	201 OBSEDVATION PEDS (DISTINCT DART)		0 00000	0		02 01

91.00 | 09100 | EMERGENCY 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 92.01 | 09201 | OBSERVATION BEDS (DISTINCT PART) 200.00 | Total (sum of lines 50 through 94 and 96 through 98) 201.00 | Less PBP Clinic Laboratory Services-Program only charges (line 61) 202.00 | Net charges (line 200 minus line 201)

0 92. 01

127, 286 200. 00

0.000000

196, 085

196, 085

201. 00

202. 00

		HEALTH FRANKFORT HOSPITAL	CN. 1E 121/		u of Form CMS-1	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 06/01/2017	Worksheet D-3	i
				To 12/31/2017	Date/Time Pre	pared:
					5/29/2018 12:	
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			4.00	0.00	2)	
	INDATI ENT DOUTINE CEDVICE COCT CENTEDS		1.00	2. 00	3. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS		1	0.100		30.00
	03100 INTENSIVE CARE UNIT			9, 100		
	04300 NURSERY			0		31. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		1. 95795	55 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
	05400 RADI OLOGY-DI AGNOSTI C		0. 30653			
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 00000		1, 636	
	03630 ULTRA SOUND		0.00000		0	
57. 00	05700 CT SCAN		0. 00000		0	
	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 00000		Ö	
	06000 LABORATORY		0. 49405			
66. 00	06600 PHYSI CAL THERAPY		0. 67565			
	06700 OCCUPATI ONAL THERAPY		0. 63359		387	
	06800 SPEECH PATHOLOGY		1. 18202		0	68. 00
69.00	06900 ELECTROCARDI OLOGY		0.00000	00	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		17. 27506	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	00	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 66515	6, 713	4, 465	73.00
73. 01	07301 ONCOLOGY DRUGS		1. 76988	31 0	0	73. 01
76.00	03020 CARDI OPULMONARY		0. 84616	3 219	185	76. 00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0.00000	00	0	90.00
91.00	09100 EMERGENCY		0. 38101	9, 510	3, 623	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 31548	37 0	0	92.00
	09201 OBSERVATION BEDS (DISTINCT PART)		0.00000	00	0	92. 01
200.00				26, 449	12, 360	200. 00
201.00		ram only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			26, 449		202. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1316	Period: From 06/01/2017 To 12/31/2017	Worksheet E Part B Date/Time Prepared: 5/29/2018 12:13 pm

PARL B - REDICAL AND OTHER HEALTH SHAPES 1.00			10 12/31/201	/ Date/lime Pre	
NATE 8			Title XVIII Hospital		тэ рііі
New York					
Medical and other services (see Instructions)				1. 00	
Medical and other services reliabursed under DPPS (see Instructions)					
0 00 00 00 00 00 00 00		· · · · · · · · · · · · · · · · · · ·			1
Out Fire payment (see instructions)		· · · · · · · · · · · · · · · · · · ·	tions)		1
0.000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.00000					
Enter the hospital specific payment to cost ratio (see instructions)					
Line 2 times in 6		· · · · · · · · · · · · · · · · · · ·	ctions)		
1.00 Content			,	l .	1
9,00	7.00			0.00	7. 00
10.00 organ acquisitions 3,347,377 1.00				1	
11.00 Total cost (sum of lines 1 and 10) (see instructions) 3,347,377 10.00 COMPUTATION OF LESSER PG COST OR CHARGES Reasonable charges 12.00 Ancil Ilary service charges 12.00 12.00 13.00			IV, col. 13, line 200	_	
COMPUTATION OF LESSER OF COST OR CHARGES CREATED		9 1			
Reasonable charges	11.00			3, 347, 377	111.00
2.00 Ancil lary service charges 0 12.00 12.00 12.00 10.01 10.00 10.01 10.00 10.01 10.00 10.01 10.00 10.01 10.00 10.01 10.00 10.01 10.00 10.01 10.00 10.0					-
13.00 organ acquisition charges (From Wist, D.4, Pt. III., col. 4, Iiine 69) 0 13.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 15.00 Oggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Nameuris that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Nameuris that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Nameuris that would have been realized from patients liable for payment for services on a chargebasis 0 16.00	12. 00			0	12. 00
Customary charges 15.00 Agrogate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 16.00 Amounts that would have been rade in accordance with 42 CFB \$413.13(e) 0.000000 17.00 17.00 17.00 18.00 17.00 18.00			ine 69)		1
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	14.00	Total reasonable charges (sum of lines 12 and 13)		0	14. 00
16.00 Amounts that would have been realized from patients iable for payment for services on a chargebasis 0 16.00 Nad such payment been made in accordance with 42 CFR \$413.13(e) 17.00					
had such payment been made in accordance with 42 CFR \$413.13(e)					
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00	16.00			0	16.00
18.00 Total customary charges (see instructions) 0 18.00 18.00 19.	17 00			0 000000	17 00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19. 00				i e	1
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19.00		ly if line 18 exceeds line 11) (see	0	19. 00
instructions					
2.00 Lesser of cost or charges (see instructions) 3.380,851 21.00 22.00 22.00 Cost of physicians' services in a teaching hospital (see instructions) 0.22.00 22.00	20. 00		ly if line 11 exceeds line 18) (see	0	20. 00
22.00 Interns and residents See instructions 0 22.00 23.0	21 00			2 200 051	21 00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 23. 00 24. 0					
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF RETINBURSEMENT SETTLEMENT			ructions)		1
25.00 Deductible sand coinsurance (For CAH, see instructions) 2, 238 25.00			,		1
26.00 Deductible sand Coinsurance relating to amount on line 24 (for CAH, see instructions) 1,077,529 26.00 27.00 Instructions) 2,301,084 27.00 18.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 28.00 Dispension of the control o		COMPUTATION OF REIMBURSEMENT SETTLEMENT			
27. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 10 10 10 10 10 10 10 1					
Instructions					
28. 00	27.00		prus the sum of fines 22 and 23] (see	2, 301, 084	27.00
29.00 ESRD difrect medical education costs (from Wkst. E-4, line 36) 29.00 30.00 Subtotal (sum of lines 27 through 29) 2, 301,084 30.00 31.00 Primary payer payments 0 31.00 32.00 Aubtotal (line 30 minus line 31) 2, 301,084 32.00 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 34.00 Allowable bad betts (see instructions) 54,018 34.00 35.00 Allowable bad debts (see instructions) 35,112 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 54,018 36.00 37.00 Subtotal (see instructions) 2, 336,196 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.90 39.99 Pactial or full credits received from manufacturers for replaced devices (see instructions) 39.99 40.01 Sequestration payment adjustment amount after sequestration	28 00		ine 50)	0	28 00
30.00 Subtotal (sum of lines 27 through 29) 2, 301,084 30.00 31.00 Primary payer payments 2, 301,084 32.00 Subtotal (line 30 minus line 31) 2, 301,084 32.00 Subtotal (line 30 minus line 31) 2, 301,084 32.00 Subtotal (line 30 minus line 31) 2, 301,084 32.00 Subtotal (line 30 minus line 31) 33.00 Subtotal (ser rate ESRD (from Wkst. I -5, line 11) 0 33.00 33.00 34.00 All owable bad debts (see instructions) 54,018 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 35,112 35.00 36.00 All lowable bad debts for dual eligible beneficiaries (see instructions) 54,018 36.00 37.00 Subtotal (see instructions) 2,336,196 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.90 39.90 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.90 39.90 RECOVERY OF ACCELERATED DEPRECIATION 0 39.90 46,724 40.00				i e	1
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. l-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 54,018 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 54,018 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 54,018 36.00 37.00 Subtotal (see instructions) 2,336,196 37.00 38.00 MSP-LCC reconciliation amount from PS&R 2,336,196 37.00 39.50 From the properties of the pr	30.00	Subtotal (sum of lines 27 through 29)		2, 301, 084	30. 00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33. 00 34. 00 Allowable bad debts (see instructions) 54, 018 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 35, 112 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 54, 018 36. 00 37. 00 Subtotal (see instructions) 2, 336, 196 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 336, 196 40. 00 40. 01 Sequestration adjustment (see instructions) 2, 336, 196 40. 00 40. 02 Demonstration payment adjustment amount after sequestration 46, 724 40. 01 41. 00 Interim payments 441, 124 41. 00 42. 00 Tentative settlement (for contractors use only) 42. 00 43. 00 Bal ance due provider/program (see instructions) 1, 848, 348 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35, 542 5115. 2				0	1
33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 All owable bad debts (see instructions) 54,018 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 35,112 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 54,018 36.00 37.00 Subtotal (see instructions) 2,336,196 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 40.00 Subtotal (see instructions) 2,336,196 40.00 40.01 Sequestration adjustment (see instructions) 2,336,196 40.00 40.01 Sequestration adjustment (see instructions) 2,336,196 40.00 40.01 Interim payments 441,124 41.00 42.00 Interim payments 441,124 41.00 42.00 Interim payments 441,124 41.00 42.00 Tentative settlement (for contractors use only) 42.00 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 00 Ottlier reconciliation adjustment amount (see instructions) 0 90.00 91.00 Ottlier reconciliation adjustment amount (see instructions) 0 91.00 00 Ottlier reconciliation adjustment amount (see instructions) 0 90.00 91.00 00 Ottlier reconciliation adjustment amount (see instructions) 0 91.00 00 00 00 00 00 00 00	32. 00		>	2, 301, 084	32. 00
34. 00 All owable bad debts (see instructions) 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 35. 101 35. 00 35. 00 All lowable bad debts (for dual eligible beneficiaries (see instructions) 54. 018 36. 00 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 39. 50 39. 90 MERCAUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 90	22.00	·	CES)	1 0	22.00
35. 00 Adjusted reimbursable bad debts (see instructions) 35, 112 35. 00 36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 54, 018 36. 00 37. 00 Subtotal (see instructions) 2, 336, 196 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 97 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99 40. 00 Subtotal (see instructions) 2, 336, 196 40. 00 40. 01 Sequestration adjustment (see instructions) 46, 724 40. 01 40. 01 Interim payments 441, 124 41. 00 41. 00 Interim payments 441, 124 41. 00 42. 00 Tentative settlement (for contractors use only) 0 0 42. 00 43. 00 Bal ance due provider/program (see instructions) 1, 848, 348 43. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35, 542 44. 00 59. 00 Original outlier amount (see instructions) 0 90. 00 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 90. 00 Outlier reconciliation adjustment amount (see instructions) 0 91. 00 90. 00 Outlier research to Time Value of Money (see instructions) 0 93. 00					1
36.00					
37.00 Subtotal (see instructions) 2, 336, 196 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 39.97 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2, 336, 196 40.00 40.01 Sequestration adjustment (see instructions) 2, 336, 196 40.00 40.02 Demonstration payment adjustment amount after sequestration 2, 336, 196 40.00 40.02 Demonstration payment adjustment amount after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.02 Tentative settlement (for contractors use only) 441, 124 41.00 42.00 43.00 Balance due provider/program (see instructions) 42.00 Tentative settlement (for contractors use only) 43.00 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35, 542 44.00 115.2 10.00 115.00 10.00			ructions)		
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 Demonstration payment adjustment amount before sequestration 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2, 336, 196 40.00 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 1 Interim payments 40.02 Interim payments 441, 124 41.00 42.00 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35, 542 41.00 41.00 Original outlier amount (see instructions) 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Original outlier amount (see instructions) 93.00 Original outlier of Money (see instructions) 93.00 Original outlier of Money (see instructions) 93.00 Original value of Money (see instructions) 93.00 Original value of Money (see instructions) 93.00 Original value of Money (see instructions) 94.00 Original value of Money (see instructions) 95.00 Original value of Money (see instructions) 96.00 Original value of Money (see instructions)	37.00		•	2, 336, 196	37. 00
39. 50 39. 97 39. 98 39. 99 Recovery Of Accelerated Depreciations (see instructions) 39. 97 39. 98 39. 99 Recovery Of Accelerated Depreciations (see instructions) 39. 99 40. 00 40. 01 40. 02 41. 00 41. 00 42. 00 43. 00 43. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 48. 00 48. 00 49. 00 49. 00 40. 00		MSP-LCC reconciliation amount from PS&R		l .	
39. 97 39. 98 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 40. 00 Subtotal (see instructions) 39. 99 40. 01 Sequestration adjustment (see instructions) 39. 99 40. 01 Interim payment adjustment amount after sequestration 40. 02 Interim payments 40. 00 Interim payments 41. 00 Interim payments 441, 124 Interim payments Additional lowable cost report items in accordance with CMS Pub. 15-2, chapter 1, and a special payments Interim paym				0	
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98		1 7 7 7	S)		
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 99			and dayions (see instructions)	l .	1
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41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30,00 45.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30,00 45.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30,00 45.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30,00 46.00 Protested amounts (nonal lowable cost repor		,			
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43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35,542 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 93.00		1 3		1	1
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\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)			nco with CMS Dub 15 2 chanton 1	ı	1
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90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 92.00 93.00 Original outlier amount (see instructions) 90.00 91.00 91.00 92.00 92.00 93.00					1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90.00			0	90.00
93.00 Time Value of Money (see instructions) 0 93.00				1	1
				1	1
94.00 Iotal (sum of lines 91 and 93) 0 94.00					
	94.00	Tiotal (Sum of Tines 91 and 93)		1 0	J 94. UU

Health Financial Systems I U HEALTH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 06/01/2017 Part I
To 12/31/2017 Date/Time Prepared: 5/29/2018 12:13 pm Provi der CCN: 15-1316

Impatient Part A						5/29/2018 12: 1	13 pm
mm/dd/yyyy					Hospi tal	Cost	
Total interim payments paid to provider			Inpatien	t Part A	Par	⁻t B	
Total interim payments paid to provider			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
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 neter a zero.				2.00		4.00	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero. 3.01	1.00	Total interim payments paid to provider		709, 64	1	441, 124	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00			·	0	0	2.00
write "NONE" or enter a zero		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		services rendered in the cost reporting period. If none,					
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)		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00	List separately each retroactive lump sum adjustment					3.00
Bayment, If none, write "NONE" or enter a zero. (1) Program to Provider		amount based on subsequent revision of the interim rate					
Program to Provider		for the cost reporting period. Also show date of each					
ADJUSTMENTS TO PROVIDER							
3.03 3.04 3.05 3.06 3.07 3.07 3.08 3.09		Program to Provider					
3.03 0 0 0 0 3.4 3.05 Provider to Program 3.50 3.50 3.50 3.51 3.52 3.53 0 0 0 3.5 3.52 3.53 0 0 0 3.5 3.50 3.50 3.50 3.50 3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 709,641 441,124 4.6 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.01 Extra to Program 1.50 1.50 1.50 5.02 Provider to Program 1.50 1.50 5.03 Provider to Program 1.50 1.50 5.04 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETLEMENT TO PROGRAM 1.463,331 1.848,348 6.6 6.02 SETILEMENT TO PROGRAM 0 0 0 0 7.00 Total Medicare program liability (see instructions) 0 1.00 2.200 Total Medicare program liability (see instructions) 0 1.00 2.00 Contractor Number (Mo/Day/Yr) 2.20 2.20 2.20 Contractor Number (Mo/Day/Yr) 2.20	3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.04 0 0 0 3.4 3.05 Provider to Program	3.02				0	0	3. 02
3.05 Provider to Program	3.03				0	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM O O O O O O O O O	3.04				0	0	3.04
3.50 ADJUSTMENTS TO PROGRAM	3.05				0	o	3.05
3.50 ADJUSTMENTS TO PROGRAM		Provider to Program			<u> </u>	•	
3.51 3.52 3.53 3.53 3.54 3.52 3.53 3.54 3.55	3.50				0	0	3. 50
3.53 3.54 0 0 0 3.1	3. 51				0	0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 709,641 441,124 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3.52				0	0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3.53				0	ol	3. 53
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3. 54				0	o	3. 54
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4.00	Total interim payments (sum of lines 1, 2, and 3.99)		709, 64	1	441, 124	4.00
appropriate TO BE COMPLETED BY CONTRACTOR		(transfer to Wkst. E or Wkst. E-3. line and column as		·			
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1) Program to Provider	5.00	List separately each tentative settlement payment after					5.00
Program to Provider		desk review. Also show date of each payment. If none,					
TENTATI VE TO PROVIDER		write "NONE" or enter a zero. (1)					
5.02		Program to Provider					
Description	5.01	TENTATI VE TO PROVI DER			0	0	5. 01
Provider to Program	5.02				0	0	5. 02
TENTATI VE TO PROGRAM	5.03				0	0	5. 03
5.51 5.52 0 0 0 0 5.5 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 0 0 5.5 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0.01 SETTLEMENT TO PROVIDER 1,463,331 1,848,348 0.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Provider to Program					
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Subtotal (sum of lines 6.00	5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 1,463,331 1,848,348 6.0 0 0 6.0 0 6.0 0 0 6.0 0 0 0 0 0 0 0	5. 51				0	0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5.52				0	0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) O 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) 1, 463, 331 1, 848, 348 6.0 0 6.1 2, 172, 972 Contractor Number (Mo/Day/Yr) 0 1.00 2.00		5. 50-5. 98)					
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00	Determined net settlement amount (balance due) based on					6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 2,172,972 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6. 01	SETTLEMENT TO PROVIDER		1, 463, 33	1	1, 848, 348	6. 01
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program liability (see instructions)		2, 172, 97	2	2, 289, 472	7. 00
Number (Mo/Day/Yr) 0 1.00 2.00						NPR Date	
0 1.00 2.00						(Mo/Day/Yr)	
8.00 Name of Contractor 8.0			()	1. 00	2. 00	
	8. 00	Name of Contractor					8. 00

	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der C	F	eriod: rom 06/01/2017	Worksheet E-1 Part I	
		Component	CCN: 15-Z316 T	o 12/31/2017	Date/Time Prep 5/29/2018 12:	pared: 13 pm
				wing Beds - SNF	Cost	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		242, 232		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provi der ADJUSTMENTS TO PROVI DER	I	1 0		0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER		0			
3. 02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Dravidar to Dragram				0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADJUSTINIENTS TO FROGRAM				0	3. 50
3. 51					0	3. 52
3. 52					0	3. 53
3. 54					0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				Ö	3. 99
0. 77	3. 50-3. 98)				Ü	0. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		242, 232		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	T	T	T		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	
5. 03			0		0	5. 03
E E0	Provider to Program TENTATIVE TO PROGRAM	I	1 0		0	F 50
5. 50 5. 51	TENTATIVE TO PROGRAM		0		0	5. 50 5. 51
5. 51					0	5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
J. 77	5. 50-5. 98)		١		ا	J. 79
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		465, 766		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		707, 998		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	T.,	()	1. 00	2. 00	
8. 00	Name of Contractor	I		1		8.00

8. 00

8.00 Name of Contractor

Heal th	Financial Systems IU HEALTH FRANKFO	ORT HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1316 From 06/01/2017 To 12/31/2017				
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	, , , ,				9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
22 00	Polones due providor (line 0 (or line 10) minus line 30 and	line 21) (coo inctruction	- 1		22.00

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

30. 00 31. 00 32. 00

Health Financial Systems	IU HEALTH FRANKFO	RT HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1316	Peri od: From 06/01/2017	Worksheet E-2
		Component CCN: 15-Z316		Date/Time Prepared:

		Component CCN: 15-Z316	10 12/31/201/	5/29/2018 12:	
-		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		593, 888	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)	A	120 550	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		128, 559	0	3. 00
4. 00	Per diem cost for interns and residents not in approved teachi			0.00	4.00
00	instructions)	(555		0.00	
5.00	Program days		122	0	5.00
6.00	Interns and residents not in approved teaching program (see in	structions)		0	6. 00
7.00	Utilization review - physician compensation - SNF optional met	hod only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		722, 447	0	
9. 00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		722, 447	0	
11. 00	Deductibles billed to program patients (exclude amounts applic professional services)	able to physician	0	0	11. 00
12. 00	Subtotal (line 10 minus line 11)		722, 447	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	722, 447	0	1
10.00	for physician professional services)	(exertade corrisarance	Ĭ	· ·	10.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	722, 447	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	•			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ation) payment	0		16. 55
1/ 00	adjustment (see instructions)			0	1, 00
16. 99 17. 00	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	1
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)	Ö	0	
	Total (see instructions)	401.01.0)	722, 447	0	
	Sequestration adjustment (see instructions)		14, 449	0	1
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
20.00	Interim payments		242, 232	0	20.00
	Tentative settlement (for contractor use only)		0	0	
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a		465, 766	0	
23. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub. 15-2,	7, 598	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr</pre>	ation) Adiustment			-
200 00	Is this the first year of the current 5-year demonstration per				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	Tod drider the 21st			200.00
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lir	ne		202. 00
000 00	200 (title XVIII swing-bed SNF))				000 00
	Total (sum of lines 201 and 202)				203. 00 204. 00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	ent 5 year demonst		204.00
	period)	irrat year or the curre	art 5-year demonst	1 4 (1 011	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr	•			207. 00
208. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	, col. 1, sum of lines	1		208. 00
000 00	and 3)				000 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc Reserved for future use	LTORS)			209. 00 210. 00
∠10.00	Comparision of PPS versus Cost Reimbursement				12 10. 00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
2.3.00	instructions)	2. 2. 00 2. 0) (300			[
			. '		•

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1316	From 06/01/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 12:13 pm
	Title XVIII	Hospi tal	Cost

			10 12/31/2017	5/29/2018 12:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			2, 324, 395	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3.00	Organ acqui si ti on			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			2, 324, 395	4.00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 347, 639	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routine service 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	payment for services on a	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for	r payment for services o	n a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e))			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13. 00
14.00	Total customary charges (see instructions)			0	14. 00
15.00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds line	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			_	
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 347, 639	
20.00	Deductibles (exclude professional component)			130, 284	
21. 00	Excess reasonable cost (from line 16)			0 017 055	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 217, 355	ı
23. 00	Coinsurance			987	ı
24. 00	Subtotal (line 22 minus line 23)			2, 216, 368	1
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		1, 461	
26. 00	Adjusted reimbursable bad debts (see instructions)			950	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 461	ı
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 217, 318	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	S)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0 017 010	29. 99
30.00	Subtotal (see instructions)			2, 217, 318	
30. 01				44, 346	
30. 02				700 (41	30. 02
31.00				709, 641	•
32.00	Tentative settlement (for contractor use only)	2.1 and 22)		1 4/2 221	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0)		chantar 1	1, 463, 331	
34. 00	Protested amounts (nonallowable cost report items) in accordance 115.2	TICE WITH CMS PUB. 15-2, (chapter I,	24, 689	34.00
	§115. 2				I

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

Provider CCN: 15-1316

Period: Worksheet G From 06/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 12: 13 pm

oni y)				10 12/01/201/	5/29/2018 12:	13 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1				
1.00	Cash on hand in banks	-781, 014		0	0	
2. 00 3. 00	Temporary investments Notes receivable	0			0	
4. 00	Accounts receivable	2, 174, 072	1	٥	0	
5. 00	Other receivable	-5, 299, 088		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	0		0	0	6. 00
7.00	Inventory	287, 688		0	0	
8.00	Prepai d expenses	69, 373	1	0	0	
9.00	Other current assets	0		1	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	-3, 548, 969		0	0	1
11.00	FIXED ASSETS	-3, 346, 707		<u> </u>	0	11.00
12. 00	Land	0) (0	0	12. 00
13.00	Land improvements	0) (0	0	13. 00
14.00	Accumulated depreciation	0)	0		1
15. 00	Bui I di ngs	0	1	0	0	
16.00	Accumulated depreciation	0	1	0	0	1
17. 00 18. 00	Leasehold improvements Accumulated depreciation	0			0	
19. 00	Fi xed equipment				Ö	
20. 00	Accumulated depreciation	0		o o	Ö	
21.00	Automobiles and trucks	0		0	0	21. 00
22. 00	Accumul ated depreciation	0	1	0	0	
23. 00	Major movable equipment	4, 423, 608		0	0	1
24. 00	Accumulated depreciation	-475, 739	1	0	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0			0	
27. 00	HIT designated Assets				0	
28. 00	Accumul ated depreciation				Ö	
29.00	Mi nor equi pment-nondepreci abl e	0		0	0	
30.00	Total fixed assets (sum of lines 12-29)	3, 947, 869) (0	0	30.00
	OTHER ASSETS	_			_	
31.00	Investments	0		0	· -	
32. 00 33. 00	Deposits on Leases Due from owners/officers	0		-		
34. 00	Other assets	833, 437	1	1	Ö	1
35. 00	Total other assets (sum of lines 31-34)	833, 437	•	o o	Ö	
36.00	Total assets (sum of lines 11, 30, and 35)	1, 232, 337	1	0	0	36. 00
	CURRENT LIABILITIES					_
37. 00	Accounts payable	8, 391, 331	1	0		1
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	490, 167	1	0	0	
40.00	Notes and Loans payable (short term)	25, 211				
41. 00	Deferred income				ĺ	
42. 00	Accel erated payments	0			_	42.00
43.00	Due to other funds	-817, 371		0	0	43. 00
44. 00	Other current liabilities	0	1	0	ľ	
45. 00	Total current liabilities (sum of lines 37 thru 44)	8, 089, 338	3 (0	0	45. 00
46. 00	LONG TERM LIABILITIES	1 0			0	46. 00
47. 00	Mortgage payable Notes payable		1			
48. 00	Unsecured Loans		1		l	1
49. 00	Other long term liabilities	0	1	o o	Ö	
50.00	Total long term liabilities (sum of lines 46 thru 49)	0) (0	0	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	8, 089, 338	3 (0	0	51.00
52.00	General fund balance	-6, 857, 001				52. 00
53.00	Specific purpose fund		(O C		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance Plant fund balance - invested in plant		1		0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1			
- 3. 50	replacement, and expansion					-5.00
59. 00	Total fund balances (sum of lines 52 thru 58)	-6, 857, 001		0	0	1
60.00	Total liabilities and fund balances (sum of lines 51 and	1, 232, 337	'	0	0	60.00
	[59]	I	I	1	I	I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1316

					To		Date/Time Pro 5/29/2018 12:	epa : 13	red:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	t	
		1.00	2.00	3.00		4. 00	5. 00		
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		0 -6, 857, 000			0			1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		-6, 857, 000 -6, 857, 000			0			3. 00
4.00	Additions (credit adjustments) (specify)	0	2, 22., 222		0	_	(4. 00
5.00		0			0		(5.00
6. 00 7. 00		0			0		(6. 00 7. 00
8. 00					0				8. 00
9.00		0			0		(9. 00
10.00	Total additions (sum of line 4-9)		0 (057 000			0			10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) ROUNDING	1	-6, 857, 000		0	0			11. 00 12. 00
13. 00	INCONDI NO				0			- 1	13. 00
14. 00		o			0				14. 00
15.00		0			0		(15. 00
16. 00 17. 00					0				16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)		1			0	-	- 1	18. 00
19. 00	Fund balance at end of period per balance		-6, 857, 001			0		-	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				+	
		Endownert Tund	Traire	Tunu					
		6. 00	7. 00	8. 00					
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0				1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)	0			0				3. 00
4.00	Additions (credit adjustments) (specify)		0						4. 00
5. 00			0						5. 00
6. 00 7. 00			0						6. 00 7. 00
8. 00			0						8. 00
9.00			0						9. 00
10.00	Total additions (sum of line 4-9)	0			0				10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) ROUNDING		0		0				11. 00 12. 00
13. 00	TOOMET NO		Ö						13. 00
14.00			0						14.00
15. 00 16. 00			0						15. 00 16. 00
16.00			0						16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	o	J		0				18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			'	19. 00

Health Financial Systems IU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1316

			10 12/31/201/	5/29/2018 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	
		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	1, 108, 91	8	1, 108, 918	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	1)	0	5. 00
6.00	Swing bed - NF	1	0	0	6. 00
7. 00	SKILLED NURSING FACILITY			_	7. 00
8.00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	1, 108, 91	R	1, 108, 918	10.00
10.00	Intensive Care Type Inpatient Hospital Services	1, 100, 71	J	1, 100, 710	10.00
11. 00	INTENSIVE CARE UNIT)	0	11. 00
12. 00	CORONARY CARE UNIT			o l	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)	1			15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	1	o	0	16. 00
16.00	11-15)			U	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	1, 108, 91	0	1, 108, 918	17. 00
18. 00	Ancillary services	1, 108, 41		11, 338, 224	18. 00
19. 00	Outpatient services	141, 86			19. 00
	RURAL HEALTH CLINIC		0 0	11, 903, 744	
20. 00 21. 00			0	0	20.00
	FEDERALLY QUALIFIED HEALTH CENTER	,	J	0	21. 00
22. 00	HOME HEALTH AGENCY		U	U	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wk	st. 2, 483, 10	7 21, 867, 779	24, 350, 886	28. 00
	G-3, line 1)				
20.00	PART II - OPERATING EXPENSES		12 040 742		20.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		13, 949, 743		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			O		31.00
32.00			0		32. 00
33. 00			O		33.00
34.00			O		34.00
35. 00		'	O		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			O		39. 00
40. 00			O		40. 00
41. 00			O		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	nsfer	13, 949, 743		43.00
	to Wkst. G-3, line 4)	I			

		U HEALTH FRANKFORT HOSPITAL			u of Form CMS-2	
STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 15			Worksheet G-3	
			To	06/01/2017 12/31/2017		nared:
					5/29/2018 12:	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				24, 350, 886	1
2.00	Less contractual allowances and discounts on	patients' accounts			17, 400, 801	
3.00	Net patient revenues (line 1 minus line 2)				6, 950, 085	1
4.00	Less total operating expenses (from Wkst. G-2				13, 949, 743	
5.00	Net income from service to patients (line 3 r	ninus line 4)			-6, 999, 658	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	
7.00	Income from investments				0	
8. 00						
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				0	
11. 00	Rebates and refunds of expenses				0	
12. 00	Parking Lot receipts				0	
13. 00	· · · · · · · · · · · · · · · · · · ·					
14. 00	Revenue from meals sold to employees and gues	sts			0	
15. 00	Revenue from rental of living quarters				0	
16. 00						16. 00
17. 00	Revenue from sale of drugs to other than pati				0	
18. 00	Revenue from sale of medical records and abst				0	
19. 00	Tuition (fees, sale of textbooks, uniforms, e				0	
20. 00	Revenue from gifts, flowers, coffee shops, ar	nd canteen			0	
21. 00	Rental of vending machines				0	
22. 00	Rental of hospital space				0	
23. 00	Governmental appropriations				0	23. 00
24. 00	MI SCELLANEOUS I NCOME				142, 658	
25. 00	Total other income (sum of lines 6-24)				142, 658	1
26. 00	Total (line 5 plus line 25)				-6, 857, 000	
27 00	OTHER EXPENSES (SPECIFY)				0	27 00

0 27. 00

-6, 857, 000 29. 00

28. 00

27. 00 OTHER EXPENSES (SPECIFY)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)