## IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1311 Worksheet S Peri od. From 01/01/2017 Parts I-III AND SETTLEMENT SUMMARY 12/31/2017 Date/Time Prepared: То 5/29/2018 3:58 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/29/2018 Time: 3:58 pm use only Manually submitted cost report 2 [ ]If this is an amended report enter the number of times the provider resubmitted this cost report ]Medicare Utilization. Enter "F" for full or "L" for low. 3 Ο Ē 4 

 [1] Cost Report Status
 6. Date Received:

 (1) As Submitted
 7. Contractor No.

 (2) Settled without Audit
 8. [N] Initial Report for this Provider CCN

 (3) Settled with Audit
 9. [N] Final Report for this Provider CCN

 Contractor 5. use only Δ (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL. CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) for the cost reporting period beginning 01/01/2017 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. (Si aned) Officer or Administrator of Provider(s) CHIEF FINANCIAL OFFICER Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	228, 084	291, 643	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	415, 919	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	644, 003	291, 643	0	0	200.00

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

	Financial Systems		TH TIPTON					In Lie	u of Fo	rm CMS-:	2552-10
HOSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	ATA	Provi d	er CCN:	15-1311	Period: From 01/0		Part I	ieet S-2	
	1						To 12/3	1/2017		ime Pre 2018 8:4	
	1.00 Hospital and Hospital Health Care Co		. 00		3.00			4.00			
1.00	Street: 1000 SOUTH MAIN STREET	PO Box:									1.00
2.00	City: TIPTON	State: I Component Na		p Code	e: 46072 CBSA	Provi de	r Date	Paym	ent Sys	tem (P,	2.00
			Nu	umber	Number	Туре	Certifie	d T	, 0, or XVIII		
		1.00		2.00	3.00	4.00	5.00	6.00		-	
3.00	Hospital and Hospital-Based Componen Hospital	t Identification:		51311	99915	1	11/12/200	)5 N	0	0	3.00
		HOSPITAL									
4.00 5.00	Subprovi der – I PF Subprovi der – I RF										4.00 5.00
6.00 7.00	Subprovider - (Other) Swing Beds - SNF	IU HEALTH TIPTON	11	5Z311	29020		11/12/200	05 N	0	N	6.00 7.00
		HOSPITAL		52311	29020		11/12/200				
8.00 9.00	Swing Beds - NF Hospital-Based SNF										8.00 9.00
10.00	Hospital-Based NF										10.00
11.00 12.00	Hospi tal -Based OLTC Hospi tal -Based HHA										11.00
	Separately Certified ASC										13.00
14.00 15.00											14.00 15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00 18.00											17.00 18.00
19.00	Other						Fro			0:	19.00
							1. (			00	
20. 00 21. 00							01/01/		12/31	/2017	20.00 21.00
22.00	Does this facility qualify and is it									N	22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
00.01	amendment hospital?) In column 2, en	ter "Y" for yes o	or "N" for	no.							00.01
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						N			N	22.01
	reporting period occurring prior to for no for the portion of the cost r										
	(see instructions)	1 31	5								
22. 02	Is this a newly merged hospital that determined at cost report settlement						es N			N	22.02
	or "N" for no, for the portion of th	e cost reporting	period pri	or to	October	1. Enter					
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of the	cost r	eportino	g period (	on				
22.03	Did this hospital receive a geograph									N	22.03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column cost reporting period occurring on o						ne				
	hospital contain at least 100 but no	t more than 499 k	beds (as co				th				
23 00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25	bel ow?	In colum	n	3		N	23.00
20100	1, enter 1 if date of admission, 2 i	f census days, or	<sup>-</sup> 3 if date	of di	scharge.	. Is the		0			20100
	method of identifying the days in th used in the prior cost reporting per										
			In-State Medicaid	In-St Medio		Out-of State	Out-of State	Medica HMO da		Other di cai d	
			pai d days	eligi	ble M	edi cai d	Medi cai d		J	days	
				unpa day	·	aid days	el i gi bl e unpai d				
24.22			1.00	2.0	00	3.00	4.00	5.00		6.00	04.00
24.00	If this provider is an IPPS hospital in-state Medicaid paid days in colum		C		0	0	0		0	0	24.00
	Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in										
25.00	If this provider is an IRF, enter th	e in-state	c		о	о	0		о		25.00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column	3, out-of-state									
	Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day										
					1	I	1		'		

alth Financial Systems IU HEALTH <sup>-</sup> DSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TIPTON HOS Pro		N: 15-1311	Peri od:		Workshe		2552-10
				From 01/0 To 12/3	1/2017 1/2017		me Pre	pared:
						5/29/20 Date of	Geogr	
6.00 Enter your standard geographic classification (not wage)		the begi	inning of t	1. C	0 2	2.0	00	26.00
cost reporting period. Enter "1" for urban or "2" for ru 7.00 Enter your standard geographic classification (not wage) reporting period. Enter in column 1, "1" for urban or "2 enter the effective date of the geographic reclassificat	status at for rura?"	l. If app	of the cos plicable,	t	2			27.00
5.00 If this is a sole community hospital (SCH), enter the nu effect in the cost reporting period.			H status in		0			35.00
privet in the cost reporting porrod.				Begi nn		Endi		
5.00 Enter applicable beginning and ending dates of SCH statu	ıs. Subscri	pt line 3	36 for numb	1.0 er	0	2.0	0	36.00
of periods in excess of one and enter subsequent dates. 7.00 If this is a Medicare dependent hospital (MDH), enter th is in effect in the cost reporting period.	ne number d	of periods	s MDH statu	s	0			37.00
7.01 Is this hospital a former MDH that is eligible for the M accordance with FY 2016 OPPS final rule? Enter "Y" for y instructions)				N				37.01
3.00 If line 37 is 1, enter the beginning and ending dates of greater than 1, subscript this line for the number of pe enter subsequent dates.								38.00
				Y/I 1. C		Y/ 2.0		-
9.00 Does this facility qualify for the inpatient hospital pa hospitals in accordance with 42 CFR §412.101(b)(2)(i) or for yes or "N" for no. Does the facility meet the mileag with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 instructions)	(ii)? Ent je requiren	er in col Nents in a	lumn 1 "Y" accordance	me N	-	N		39.00
D. 00 Is this hospital subject to the HAC program reduction ad "N" for no in column 1, for discharges prior to October no in column 2, for discharges on or after October 1. (s)	1. Enter '	Y" for ye				N		40.00
					V	XVIII 2.00	XI X 3.00	-
Prospective Payment System (PPS)-Capital 5.00 Does this facility qualify and receive Capital payment f	or disprop	ortionate	e share in	accordance	N	N	N	45.00
with 42 CFR Section §412.320? (see instructions) 5.00 Is this facility eligible for additional payment excepti pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L					N	N	N	46.00
Pt. III. 7.00 Is this a new hospital under 42 CFR §412.300(b) PPS capi 3.00 Is the facility electing full federal capital payment? Teaching Hospitals					N	N	N N	47.00 48.00
5.00 Is this a hospital involved in training residents in app	proved GME	programs	? Enter "Y	" for yes	N			56.00
or "N" for no. 7.00 If line 56 is yes, is this the first cost reporting peri GME programs trained at this facility? Enter "Y" for ye is "Y" did residents start training in the first month o for yes or "N" for no in column 2. If column 2 is "Y", "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, i	es or "N" f of this cos complete W	`or no in st reporti /orksheet	column 1. ing period?	If column 1 Enter "Y"				57.0
3.00 If line 56 is yes, did this facility elect cost reimburs defined in CMS Pub. 15-1, chapter 21, §2148? If yes, com			ns' service	s as				58.00
9.00 Are costs claimed on line 100 of Worksheet A? If yes, c			Pt. I. NAHE 413.8	35 Worksho		Pass-Th		59.00
			Y/N	Line		Qualifi Criteric	cation	
0.00 Are you claiming nursing and allied health education (NA any programs that meet the criteria under §413.85? (see			1.00 N	2.0	0	3.0	00	60.00
Y.	7N I	ME	Direct GM	E IMI	Ξ	Di rect	GME	
	00 2 N	. 00	3.00	4.0	0.00	5.0		61.00
<ul> <li>Section 5503? Enter 4 for yes of N for horn</li> <li>column 1. (see instructions)</li> <li>1.01 Enter the average number of unweighted primary care</li> <li>FTEs from the hospital's 3 most recent cost reports</li> <li>ending and submitted before March 23, 2010. (see</li> </ul>								61. 0
<ul> <li>instructions)</li> <li>1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of</li> </ul>								61. 02
ACA). (see instructions) 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see								61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/29/2018 8:4	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>51.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>51.05 Enter the difference between the baseline primary</li> </ul>						61.04
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.00
	Pro	ogram Name			Direct GME FTE Count	
51.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	(1 10
51.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
51.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Ser 52.00 Enter the number of FTE residents that your hospital				riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instruc 52.01 Enter the number of FTE residents that rotated from a	ti ons) Teachi	ng Health Cen	ter (THC) int			62.00
during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ns)			-
53.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ttings	during this c			N	63.00
			Unwei ghted FTEs		Ratio (col. 1/	
			Nonprovider Site		(col. 1 + col. 2))	
Contion EEOA of the ACA Deve View ETE Devid a state		lon Cottine	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	•	Ũ				
4.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.00 in the base year period, the number of unweighted non-primary care resident 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						64.00
of (column 1 divided by (column 1 + column 2)). (see Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			JILE			

IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	TA Provider C	Fi	eriod: rom 01/01/2017	Worksheet S-2 Part I	
			To	b 12/31/2017	Date/Time Pre 5/29/2018 8:4	pared: 1 am
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	
5.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0.00	0. 000000	65.0
divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col. 1/	/
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Setting	gsEffective fo	or cost reporti	ng periods	
FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	nweighted non-primar L. Enter in column 3	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	, ,
-	1.00	2.00	3.00	4.00	5.00	1
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	0 67.00
				1.0	2 2 00 2 00	
Inpatient Psychiatric Facility PP 0.00 Is this facility an Inpatient Psy		PE) or does it cont	tain an IDE subr	1.00	0 2.00 3.00	70.00
Enter "Y" for yes or "N" for no. 1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions)	the facility have an fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	approved GME teachi 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y	, ng program in t yes or "N" for n s in a new teach yes or "N" for n	he most o. (see ing o.	0	71.0
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it o	contain an IRF	N		75.0
Subprovider? Enter "Y" for yes a If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t CFR 412.424 (d)(1)(iii)(D)? Enter	the facility have ar ng on or before Nove rain residents in a	ember 15, 2004? Enter new teaching program	"Y" for yes or n in accordance	"N" for	0	76.00

Health Financial Systems         IU HEALTH TIP           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	FON HOSPITAL Provider C		Period: From 01/01/2017	u of Form CMS Worksheet S- Part I	-2
			To 12/31/2017	Date/Time Pr 5/29/2018 8:	
				1.00	_
Long Term Care Hospital PPS					_
<ul> <li>80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye</li> <li>81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.</li> </ul>			period? Enter	N	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i86.00Did this facility establish a new Other subprovider (exclud §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 hospit 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	al classified	under section		N	87.00
			V	XI X	_
Title V and XIX Services			1.00	2.00	_
90.00 Does this facility have title V and/or XIX inpatient hospit	al services? E	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			N	N	91.00
full or in part? Enter "Y" for yes or "N" for no in the app92.00Are title XIX NF patients occupying title XVIII SNF beds (d	ual certificat			N	92.00
instructions) Enter "Y" for yes or "N" for no in the applic 93.00 Does this facility operate an ICF/IID facility for purposes		d XIX? Enter	N	N	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the ap			0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			N	N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the ap			0.00	0.00	97.00
98.00 Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"			N	Y	98.00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the r	eporting of ch	arges on Wkst.	N	Y	98.01
C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t title XIX.	itle V, and in	column 2 for			
98.02 Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 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 cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.			N	N	98. 03
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i			N	N	98.04
<pre>in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in</pre>			N	Y	98.05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in column or control of the title XVIII of title XVIII of the title XVIII of title XVIII of the title XVIII of title XVIII of the title XVIII of title XVIIII</pre>			Ν	Y	98.06
column 2 for title XIX. Rural Providers					_
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of payment	Y N		105.00 106.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cos	t reimbursemen	t for I&R	N		107.00
training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col					
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sche	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	<u></u>
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	N	Y	109.00
				1.00	-
110.00 Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00

lealth Financial Systems IU HEALTH TIPTO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	N HOSPITAL Provider CCN: 15		Period: From 01/01/ To 12/31/	2017	<u>of For</u> Workshe Part I Date/Ti	et S-2	2
			10 12/31/	2017	5/29/20		
			1.00		2.0	0	-
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting perio umn 1 is Y, enter icipating in colu	od? Enter the umn 2.	N		2.0		111.00
				1.00	2.00	3.00	_
Miscellaneous Cost Reporting Information 115.00 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. 116.00 Is this facility classified as a referral center? Enter "Y" f	If column 2 is "E for long term ca based on the de	E", enter are (inclu efinition	in column µdes	N		0	115.00
117.00 Is this facility legally-required to carry malpractice insura no.			"N" for	N			117.00
118.00 Is the malpractice insurance a claims-made or occurrence poli claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if th	ne policy	is	1			118.00
crammeniade. Enter 2 m the porrey 13 occurrence.	P	Premiums	Losse	5	Insura	ance	
		1.00	2.00		3.0	00	-
18.01 List amounts of malpractice premiums and paid losses:		56, 56	8	0		(	0 118. 0'
			1.00		2.0	00	-
<ol> <li>02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedu and amounts contained therein.</li> <li>19.00DO NOT USE THIS LINE</li> </ol>			N				118.02
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 qua Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for alifies for the Ou	r yes or utpatient	N		Ν		120. 00
21.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable devices cha	arged to	Y				121.00
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.			Y		5.0	00	122.00
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for	yes and "N" for	no. If	N				125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 f this is a Medicare certified kidney transplant center, ent		tion date					126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter	er the certificati	on date					127.0
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter	er the certificati	on date					128. 0
in column 1 and termination date, if applicable, in column 2. 29.00 of this is a Medicare certified lung transplant center, enter		on date ir	n				129. 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, e		cation					130. 0
date in column 1 and termination date, if applicable, in colu 31.00 of this is a Medicare certified intestinal transplant center,	enter the certif	i cati on					131. 00
date in column 1 and termination date, if applicable, in colu 32.00 If this is a Medicare certified islet transplant center, ente	er the certificati	on date					132. 00
in column 1 and termination date, if applicable, in column 2. 33.001f this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2.	er the certificati	on date					133. 00
<ul> <li>in column 1 and termination date, if applicable, in column 2.</li> <li>34.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.</li> </ul>		olumn 1					134. 00
Al I Provi ders							1
140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y		ce costs	Y		15H0	159	140. 00

IST THE AND HOST THE HEALTH OAKE COMPLE	X IDENTIFICATION DATA	TPTON HOSPITAL Provider CCI	N: 15-1311		i od: m 01/01/2017 12/31/2017		2 epared:
1.00		2.00		I	3.00		
If this facility is part of a chai				ne name	e and address	of the	
41.00 Name: INDIANA UNIVERSITY HEALTH	Contractor name and Contractor's Name:			actor!	s Number: 0810	)1	141.00
42.00 Street: 340 WEST 10TH STREET	PO Box:	WF3	Contr	actor	S NUMBER. OOT	)	141.00
143.00 City: INDIANAPOLIS	State:	IN	Zip C	ode:	4620	)2	143.00
							_
	<u> </u>					1.00	
144.00 Are provider based physicians' cos	sts included in Workshee	et A?				Y	144.00
				F	1.00	2.00	-
45.00 If costs for renal services are cl	aimed on Wkst. A, line	74, are the costs	for				145.00
inpatient services only? Enter "Y							
no, does the dialysis facility ind	lude Medicare utilizati	on for this cost	reporting	1			
period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolog		viously filed cost	roport?		Y	11/27/2017	146.00
Enter "Y" for yes or "N" for no ir				lf	T	11/2//2017	140.00
yes, enter the approval date (mm/c			_, _, _, (220)				
47.00						1.00	447 67
47.00 Was there a change in the statisti						Y N	147.00
48.00 Was there a change in the order of 49.00 Was there a change to the simplifi				for no		N	148.00
The second		Part A	Part		Title V	Title XIX	117.00
		1.00	2.00		3.00	4.00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	<u>'N" for no for each com</u>			B. (Se			155 00
55.00Hospital 56.00Subprovider - IPF		N . N	N N		N N	N N	155.00
57. 00 Subprovider - IRF		N	N		N	N	157.00
58. 00 SUBPROVI DER							158.00
59. 00 SNF		N	Ν		Ν	N	159.00
60.00 HOME HEALTH AGENCY		N	N		Ν	N	160. 00
61.00 CMHC			N		N	N	161.00
						1.00	-
Multicampus						1.00	
165.00 Is this hospital part of a Multica	ampus hospital that has	one or more campu	ses in di	fferen	t CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.	N	2		7. 0	0.000		
	Name 0	<u>County</u> 1.00	State 2.00	Zip C 3.0		FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	0	1.00	2.00	3.0	4.00		0 166. 00
campus enter the name in column						0.0	
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)							
	L I						-
						1.00	
Health Information Technology (HI					Act		
Health Information Technology (HI 67.00 Is this provider a meaningful user	r under §1886(n)? Enter	r "Y" for yes or "	N" for no	).		Y	
Health Information Technology (HI 67.001s this provider a meaningful user 68.001f this provider is a CAH (line 10	r under §1886(n)? Enter D5 is "Y") and is a mear	r "Y" for yes or " ningful user (line	N" for no	).		Y	
Health Information Technology (HI 67.001s this provider a meaningful user 68.001f this provider is a CAH (line 10 reasonable cost incurred for the H	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct	r "Y" for yes or " hingful user (line tions)	N" for no 167 is "	). Y"), e	nter the	Y	1 168. 00
Health Information Technology (HI 67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the H	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c	r "Y" for yes or "  hingful user (line tions) does this provider	N" for no 167 is " qualify	). Y"), e for a	nter the	Y	1 168. 00
Heal th Information Technology (HI 67.001s this provider a meaningful user 68.001f this provider is a CAH (line 10 reasonable cost incurred for the H 68.011f this provider is a CAH and is r exception under §413.70(a)(6)(i)) 69.001f this provider is a meaningful u	r under §1886(n)? Enter 25 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i	N" for nc 167 is " qualify nstructic	o. Y"), e for a ons)	nter the hardship	Y	1168. 00 168. 01
Health Information Technology (HI 67.001s this provider a meaningful user 68.001f this provider is a CAH (line 10 reasonable cost incurred for the H 68.011f this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	r under §1886(n)? Enter 25 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i	N" for nc 167 is " qualify nstructic	o. Y"), e for a ons)	nter the hardship ), enter the	Y 0. C	1168. 00 168. 01
Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(i) 69.00 If this provider is a meaningful to	r under §1886(n)? Enter 25 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i	N" for nc 167 is " qualify nstructic	o. Y"), e for a ons)	nter the hardship ), enter the Beginning	Y O. C Endi ng	1168. 00 168. 01
Heal th Information Technology (HI 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 if this provider is a CAH and is r exception under §413.70(a) (6) (ii) 69.00 if this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i and is not a CAH (	N" for nc 167 is " qualify nstructic line 105	o. Y"), e for a ons)	nter the hardshi p ), enter the Begi nni ng 1. 00	Y 0. C Endi ng 2. 00	1168.00 168.01 0169.00
Heal th Information Technology (HI 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 if this provider is a CAH and is r exception under §413.70(a) (6) (ii) 69.00 if this provider is a meaningful u transition factor. (see instruction	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i and is not a CAH (	N" for nc 167 is " qualify nstructic line 105	o. Y"), e for a ons)	nter the hardship ), enter the Beginning	Y O. C Endi ng	1168.00 168.01 0169.00
Heal th Information Technology (HI 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 if this provider is a CAH and is r exception under §413.70(a)(6)(ii) 69.00 if this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR to	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a ons)	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i and is not a CAH (	N" for nc 167 is " qualify nstructic line 105	o. Y"), e for a ons)	nter the hardship ), enter the Beginning 1.00 04/01/2017	Y 0. C Endi ng 2. 00 06/30/2017	167.00 1168.00 168.01 0169.00 170.00
Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, of ? Enter "Y" for yes or " user (line 167 is "Y") a pons) peginning date and endir	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i and is not a CAH ( ng date for the re	N" for nc 167 is " qualify nstructic line 105 porting	o. Y"), e for a ons)	nter the hardship ), enter the Beginning 1.00 04/01/2017 1.00	Y 0. 0 Endi ng 2. 00 06/30/2017 2. 00	1 168. 00 168. 01 0 169. 00 
Heal th Information Technology (HI 167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under \$413.70(a) (6) (ii) (1) 169.00 If this provider is a meaningful of transition factor. (see instruction 170.00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy) 171.00 If line 167 is "Y", does this provider is a meaning the second s	r under §1886(n)? Enter D5 is "Y") and is a mear HIT assets (see instruct not a meaningful user, or ? Enter "Y" for yes or " user (line 167 is "Y") a posp beginning date and endir	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see i and is not a CAH ( ng date for the re individuals enrol	N" for nc 167 is " qualify nstructic line 105 porting led in	o. Y"), e for a nns) is "N"	nter the hardship ), enter the Beginning 1.00 04/01/2017	Y 0. 0 Endi ng 2. 00 06/30/2017 2. 00	1168.00 168.01 0169.00
Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 69.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR th period respectively (mm/dd/yyyy)	r under §1886(n)? Enter D5 is "Y") and is a mear HT assets (see instruct not a meaningful user, c ? Enter "Y" for yes or " user (line 167 is "Y") a poginning date and endir vider have any days for reported on Wkst. S-3, F	r "Y" for yes or "I hingful user (line tions) does this provider 'N" for no. (see in and is not a CAH ( ng date for the rep individuals enrol Pt. I, line 2, col	N" for nc 167 is " qualify nstructic line 105 porting led in . 6? Ente	o. Y"), e for a nns) is "N"	nter the hardship ), enter the Beginning 1.00 04/01/2017 1.00	Y 0. 0 Endi ng 2. 00 06/30/2017 2. 00	1 168. 00 168. 0 0 169. 00 

SPI T.	Financial         Systems         IU         HEALTH         TIPTON           AL         AND         HOSPITAL         HEALTH         CARE         REIMBURSEMENT         QUESTIONNAI RE	Provider CO	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017		2
					5/29/2018 8:4	
				Y/N 1.00	Date 2.00	
	General Instruction: Enter Y for all YES responses. Enter N for	all NO re	sponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the be reporting period? If yes, enter the date of the change in colu	ginning of mn 2 (see	the cost	N		1.0
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare Prog	ram2 lf	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in column ${\bf 3},$ voluntary or "I" for involuntary.	"V" for				
00	Is the provider involved in business transactions, including ma contracts, with individuals or entities (e.g., chain home offic or medical supply companies) that are related to the provider of officers, medical staff, management personnel, or members of the of directors through ownership, control, or family and other si	ces, drug or its ne board	Y			3.0
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports Column 1: Were the financial statements prepared by a Certific Accountant? Column 2: If yes, enter "A" for Audited, "C" for ( or "R" for Reviewed. Submit complete copy or enter date availab column 3. (see instructions) If no, see instructions.	Compiled,	Y	A	02/22/2018	4.00
00	Are the cost report total expenses and total revenues different		Ν			5.0
	those on the filed financial statements? If yes, submit reconci	liation.		Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If	yes, is th	e provider is	s N		6.0
~~	the legal operator of the program?	5				
00 00	Are costs claimed for Allied Health Programs? If "Y" see instru Were nursing school and/or allied health programs approved and, cost reporting period? If yes, see instructions.		during the	N N		7.0 8.0
00	Are costs claimed for Interns and Residents in an approved grad program in the current cost report? If yes, see instructions.			N		9.00
. 00 . 00	Was an approved Intern and Resident GME program initiated or re- cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & F			N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes, se	e instruct	ions		Y	12.0
	If line 12 is yes, did the provider's bad debt collection polic period? If yes, submit copy.			ost reporting	N	13.0
. 00	If line 12 is yes, were patient deductibles and/or co-payments Bed Complement	waived? If	yes, see ins	structions.	N	14.0
. 00	Did total beds available change from the prior cost reporting p				N	15.0
		Par Y/N	t A Date	Par Y/N	t B Date	
		1.00	2.00	3.00	4.00	
	PS&R Data Was the cost report prepared using the PS&R Report only?	N		N		16.0
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	IN .		IN		
. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/04/2018	Y	04/04/2018	17.0
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		N		18. 0
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. 0

Health Financial Systems

## IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	CN: 15-1311	Peri od:	Worksheet S-	2	
				From 01/01/2017			
				To 12/31/2017	Date/Time Pr 5/29/2018 8:		
		Descri	ption	Y/N	Y/N		
		C		1.00	3.00		
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00	
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)		1.00	_	
	Capital Related Cost						
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00	
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	als made duri	ng the cost	N	23.00	
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost rep	orting period?	N	24.00	
25.00	Have there been new capitalized leases entered into during	ered into during the cost reporting period? If yes, see					
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	yes, see	N	26.00		
27.00	instructions. Has the provider's capitalization policy changed during th	e cost reportin	a period2 lf	ves submit	N	27.00	
27.00	copy.	e cost reporting	g period: II	yes, subilit	IN IN	27.00	
	Interest Expense						
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	ntered into dur	ing the cost	reporting	N	28.00	
29.00	Did the provider have a funded depreciation account and/or		bt Service Re	serve Fund)	N	29.00	
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat		debt? If yes,	see	N	30.00	
	instructions.				N	21 00	
31.00	Has debt been recalled before scheduled maturity without i instructions.	ssuance of new	debt? IT yes,	See	N	31.00	
	Purchased Services						
32.00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		d through con	tractual	N	32.00	
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		g to competit	ive bidding? If		33.00	
	no, see instructions.					_	
24 00	Provider-Based Physicians	prongoment with	nnovi don boo	ad physicians?	Y	24.00	
34.00	Are services furnished at the provider facility under an a If yes, see instructions.	rrangement with	provider-bas	eu physi ci ans?	ř	34.00	
35.00	If line 34 is yes, were there new agreements or amended ex		ts with the p	rovi der-based	N	35.00	
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Date		
				1.00	2.00		
	Home Office Costs						
36.00	Were home office costs claimed on the cost report?			Y		36.00	
37.00	If line 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		37.00	
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of	fice different	from that of	N		38.00	
39.00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			Y		39.00	
	see instructions. If line 36 is yes, did the provider render services to the		5	N		40.00	
40.00	instructions.		11 yes, see	IN IN		40.00	
		1.0	00	2	00	-	
	Cost Report Preparer Contact Information	1. 1	00	۷.	00		
41.00	Enter the first name, last name and the title/position	RHONDA		UTTER		41.00	
	held by the cost report preparer in columns 1, 2, and 3,						
42.00	respectively. Enter the employer/company name of the cost report	INDIANA UNIVER	SI TY ΗΓΑΙ ΤΗ			42.00	
12.00	preparer.		S. II HEALIN			12.00	
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 962. 1093		RUTTER@I UHEALT	H. ORG	43.00	

Health Financial Systems IU HEAL	TH TIPTON HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAL	RE Provider CCN: 15-1311	Period: From 01/01/2017	Worksheet S-2 Part II	
		To 12/31/2017		pared: <u>1 am</u>
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/positi	on DI RECTOR OF GOVERNMENT			41.00
held by the cost report preparer in columns 1, 2, an	nd 3, PROGRAMS			
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the	cost			43.00
report preparer in columns 1 and 2, respectively.				

	Financial Systems	IU HEALTH TIPT		N. 1E 1011		u of Form CMS-2	
	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CO	JN: 15-1311	Period: From 01/01/2017 To 12/31/2017	5/29/2018 8:4	pared: 1 am
						I/P Days / O/P Visits / Trips	1
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	oomportone	Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	25	9, 1	25 52, 968. 00	0	1.00
2.00 3.00 4.00 5.00 6.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	•
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 1	25 52, 968. 00		7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
$\begin{array}{c} 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00 \end{array}$	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)		25	9, 1.	25 52, 968. 00	0 0	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
24.00 24.10 25.00 26.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC PURAL HEALTH CLINIC	30. 00					24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.01	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	89.00	25 0		0	0	26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01
33. 00 33. 01	LTCH non-covered days LTCH site neutral days and discharges						33. 00 33. 01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	CN: 15-1311		eriod: rom 01/01/2017 o 12/31/2017	Worksheet S-3 Part I Date/Time Pre	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time I	<u>5/29/2018 8:4</u> Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients		Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8,00		9,00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1, 430	7		07			1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider	280 0	80 0					2.00 3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF	0 586	0		86			4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	2, 016	0 7	1 2, 9	15 08			6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY							8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	2,016 0	7 0		08	0.00	165. 50	14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00
24.00 24.10 25.00 26.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0	0		0			24.00 24.10 25.00 26.00
26. 25 27. 00 28. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	0	0		0 45	0.00 0.00		26.25
29.00 30.00 31.00 32.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF	0	0		43 0 0			29.00 29.00 30.00 31.00 32.00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0	U		0			32.00 32.01 33.00
	LTCH non-covered days LTCH site neutral days and discharges	0						33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Prep 5/29/2018 8:4	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ \\ 4.\ 00\\ \\ 5.\ 00\\ \\ 6.\ 00\\ \\ 7.\ 00\\ \\ 8.\ 00\\ \\ 9.\ 00\\ \\ 10.\ 00\\ \\ 11.\ 00\\ \\ 12.\ 00\\ \\ 13.\ 00\\ \\ 14.\ 00\\ \\ 15.\ 00\\ \\ 14.\ 00\\ \\ 15.\ 00\\ \\ 16.\ 00\\ \\ 17.\ 00\\ \\ 20.\ 00\\ \\ 21.\ 00\\ \\ 22.\ 00\\ \\ 24.\ 00\\ \\ 26.\ 00\\ \\ 27.\ 00\\ \\ 30.\ 00\\ \\ 31.\ 00\\ \\ 32.\ 01\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instructions) Total ancillary labor & delivery room	0. 00 0. 00 0. 00	0		11 4 31 0 0 0	786	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ 00\\ 24. \ 10\\ 25. \ 00\\ 24. \ 00$
33.00	LTCH site neutral days and discharges				0 0		33. 0 33. 0

Heal th	Financial Systems IU HEALTH TIPTON	HOSPI TAL		In Lie	eu of Form CMS-	2552-10
		Provider CC	CN: 15-1311	Peri od:	Worksheet S-1	0
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:4	pared: 1 am
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by lin	ne 202 columr	18)	0. 295775	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				416, 694	
3.00	Did you receive DSH or supplemental payments from Medicaid?		с н. н.	. 10	N	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplemental fline 4 is no, then enter DSH and/or supplemental payments fr			11 d ?	0	4.00
5.00 6.00	Medicaid charges	om mearcard	u		10, 955, 322	
7.00	Medicaid cost (line 1 times line 6)				3, 240, 310	
8.00	Difference between net revenue and costs for Medicaid program (	line 7 minu	us sum of lir	es 2 and 5: if	2, 823, 616	
	< zero then enter zero)	(			_,,	
	Children's Health Insurance Program (CHIP) (see instructions fo	or each line	e)		1	
9.00	Net revenue from stand-alone CHIP				0	
	Stand-al one CHIP charges				0	
11.00 12.00		(line 11 mi)	nua lina O. i	f . Tara than	0	
12.00	Difference between net revenue and costs for stand-alone CHIP ( enter zero)	line ii mii	nus line 9; i	r < zero then	0	12.00
	Other state or local government indigent care program (see inst	ructions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not incl				0	13.00
14.00	Charges for patients covered under state or local indigent care	e program (I	Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 14	1)			0	15.00
16.00	Difference between net revenue and costs for state or local inc		program (lir	o 15 minus lino	-	
10.00	13; if < zero then enter zero)	argent care				10.00
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e∕local indig	ent care progra	ns (see	
	instructions for each line)	<u> </u>			-	
	Private grants, donations, or endowment income restricted to fu				0	
18.00	Government grants, appropriations or transfers for support of H Total unreimbursed cost for Medicaid, CHIP and state and local			(cum of lines	0 2, 823, 616	
17.00	8, 12 and 16)	Thur gent		(Suil Of Thes	2,023,010	17.00
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	pati ents	+ col . 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00		cility	1, 754, 83	90, 813	1, 845, 647	20.00
	(see instructions)	5				
21.00	Cost of patients approved for charity care and uninsured discou	unts (see	519, 03	90, 813	609, 849	21.00
22.00	instructions) Payments received from patients for amounts previously written	off as	39, 64	0 0	39, 640	22.00
22.00	charity care	UTT as	37, 04	0 0	37,040	22.00
23.00	Cost of charity care (line 21 minus line 22)		479, 39	90, 813	570, 209	23.00
					1.00	
24 00	Does the amount on line 20 column 2, include charges for patier	nt days bev	ond a length	of stay limit	1.00 N	24.00
21.00	imposed on patients covered by Medicaid or other indigent care		ond a rength	or stay rimit		21.00
25.00	If line 24 is yes, enter the charges for patient days beyond the		care program	's length of	0	25.00
24.00	stay limit	+====>				24.00
26.00			ructions)		3, 027, 626	
27.00	Medicare reimbursable bad debts for the entire hospital complex Medicare allowable bad debts for the entire hospital complex (s				501, 269 771, 183	
	Non-Medicare bad debt expense (see instructions)		1 01157		2, 256, 443	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	oense (see i	instructions		937, 313	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	(000)			1, 507, 522	
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			4, 331, 138	
	-					

Heal th	Financial Systems	IU HEALTH TIPTON	N HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO		Peri od:	Worksheet A	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
					10 12/31/2017	5/29/2018 8:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
				+ col. 2)	ons (See A-6)		
						(col. 3 +-	
		1.00				col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 475, 730	1, 475, 73	-880, 546	595, 184	1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - INTERES		782, 994				1.00
2.00	00200 CAP REL COSTS MVBLE EQUIP		,02, ,,4		928, 632		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	49, 271	2, 554, 919	2, 604, 19			1
5.00	00500 ADMI NI STRATI VE & GENERAL	895, 783	6, 557, 652				5.00
7.00	00700 OPERATION OF PLANT	728, 102	4, 210, 659				
7.01	00701 OPERATION OF PLANT - OFFSITE	0	0		0 0		1
8.00	00800 LAUNDRY & LINEN SERVICE	48, 713	57, 263		-		1
9.00	00900 HOUSEKEEPI NG	295, 292	105, 707				9.00
10.00	01000 DI ETARY	423, 950	297, 857				1
11.00	01100 CAFETERI A	0	0		484, 631	484, 631	11.00
13.00	01300 NURSING ADMINISTRATION	429, 982	17, 925	447, 90			1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	10, 077				1
15.00	01500 PHARMACY	572, 770	2, 174, 595				
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
30.00	03000 ADULTS & PEDIATRICS	2, 053, 985	566, 939	2, 620, 92	4 -261,069	2, 359, 855	30.00
	ANCILLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	1, 064, 435	2, 338, 298				50.00
53.00	05300 ANESTHESI OLOGY	180, 202	311, 298			482, 339	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 074, 889	309, 630				1
60.00	06000 LABORATORY	1, 390	1, 174, 503				1
65.00	06500 RESPI RATORY THERAPY	356, 018	169, 908				
66.00	06600 PHYSI CAL THERAPY	627, 645	73, 083				66.00
67.00	06700 OCCUPATI ONAL THERAPY	150, 248	2, 809				1
69.00	06900 ELECTROCARDI OLOGY	415, 931	53, 106				69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		248, 495		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 273, 960		
73.00	07300 DRUGS CHARGED TO PATIENTS	177 5 14	0		0 1, 843, 685		1
73.01	03480 ONCOLOGY	177, 541	17, 494	195, 03	5 -12, 745		1
76.00	03160 CARDI OPULMONARY	0	0	00.50	J U	0	76.00
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	80, 889	9, 636	90, 52	5 -818	89, 707	76.97
91,00	09100 EMERGENCY	1, 148, 010	1, 521, 993	2, 670, 00	3 -83, 400	2, 586, 603	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 140, 010	1, 321, 773	2, 070, 00.	-03,400	2, 560, 005	92.00
72.00	SPECIAL PURPOSE COST CENTERS	<u> </u>					92.00
118.00		10, 775, 046	24, 794, 075	35, 569, 12	1 81, 447	35, 650, 568	118 00
	NONREI MBURSABLE COST CENTERS	10/ / / 0/ 0/ 0	21,771,070	00/00//12		00,000,000	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19001 MARKETI NG/PUBLIC RELATIONS	0	53, 295				
	19200 PHYSI CLANS' PRI VATE OFFI CES	129, 673	72, 290				
	19201 OCCUPATIONAL MEDICINE	34, 406	49, 647				
192.02	19202 VACANT SPACE	0	0		0 C	0	192. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	10, 939, 125	24, 969, 307	35, 908, 43	2 0	35, 908, 432	200. 00

	inancial Systems	IU HEALTH TIPT		01 45 4044		eu of Form CMS-25
ECLASSI	FICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C	CN: 15-1311	Period: From 01/01/2017	Worksheet A
					To 12/31/2017	Date/Time Prepa 5/29/2018 8:41
	Cost Center Description	Adjustments	Net Expenses			
			For Allocation			
		6.00	7.00			
	ENERAL SERVICE COST CENTERS			1		
	0100 CAP REL COSTS-BLDG & FIXT	769, 125	1, 364, 309			
	0101 CAP REL COSTS-BLDG & FIXT - INTERES	-180, 074	602, 920			
	0200 CAP REL COSTS-MVBLE EQUIP	146, 250	1, 074, 882	2		
	0400 EMPLOYEE BENEFITS DEPARTMENT	-268, 424	2, 335, 736	1		
00 00	0500 ADMINISTRATIVE & GENERAL	-1, 609, 214	5, 693, 390			
00 00	0700 OPERATION OF PLANT	-4, 941	4, 937, 959			
	0701 OPERATION OF PLANT - OFFSITE	0	C			
00 00	0800 LAUNDRY & LINEN SERVICE	0	105, 976			
00 00	0900 HOUSEKEEPI NG	-5, 295	370, 078			
0.00	1000 DI ETARY	0	237, 223			1
1.00 0	1100 CAFETERI A	-115, 691	368, 940			1
3.00 0	1300 NURSING ADMINISTRATION	-1,060	594,049			1
	1400 CENTRAL SERVICES & SUPPLY	0	880, 525	1		1
	1500 PHARMACY	-421,817	611, 662	1		1
	NPATIENT ROUTINE SERVICE COST CENTERS	,		1		
	3000 ADULTS & PEDI ATRI CS	-270, 688	2, 089, 167	1		3
	NCILLARY SERVICE COST CENTERS	2707000	2/00//10/	1		
	5000 OPERATING ROOM	-378,635	1, 094, 849			5
	5300 ANESTHESI OLOGY	-430, 829	51, 510	1		5
	5400 RADI OLOGY-DI AGNOSTI C	-121, 753	1, 178, 737			5
	6000 LABORATORY	0	1, 165, 468			6
	6500 RESPIRATORY THERAPY	-3, 616	498, 507	1		6
	6600 PHYSI CAL THERAPY	-6, 328	643, 673	1		6
	6700 OCCUPATI ONAL THERAPY	0,020	180, 997			6
	6900 ELECTROCARDI OLOGY	-21, 248	421, 033	1		6
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	-21, 240	248, 495	1		7
	7200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 273, 960			7
	7300 DRUGS CHARGED TO PATIENTS	0	1, 843, 685	1		7
	3480 ONCOLOGY	0	182, 290	1		
	3160 CARDI OPULMONARY	0	182, 290	1		7
	7697 CARDI AC REHABI LI TATI ON	0	89, 707	•		7
	UTPATIENT SERVICE COST CENTERS	0	09, 101			/
	9100 EMERGENCY	-929, 378	1, 657, 225			9
	9200 OBSERVATION BEDS (NON-DISTINCT PART	-727, 370	1,037,223	2		9
	PECIAL PURPOSE COST CENTERS			1		
		2 052 /1/	21 704 053			111
18.00 N	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	-3, 853, 616	31, 796, 952			11
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C			19
	9001 MARKETI NG/PUBLI C RELATI ONS	0	52, 471	•		19
	9200 PHYSI CLANS' PRI VATE OFFICES	0	136, 896	•		19
	9201 OCCUPATIONAL MEDICINE	0	68, 497	1		19
	9202 VACANT SPACE	0	08, 497	1		19
· = · U = [ T	TOTAL (SUM OF LINES 118 through 199)	-3, 853, 616		1		20

ASSI FI	ancial Systems CATIONS			ON HOSPITAL Provider CCN: 15-13	11 Period:	Worksheet A-6
-					From 01/01/2017 To 12/31/2017	Date/Time Prepar
		Increases				5/29/2018 8:41 a
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4.00	5.00		
	CAFETERIA		I			
	ETERI A	<u>11.</u> 00	284, 501	199, 915		1
			284, 501	199, 915		
	MEDI CAL SUPPLI ES	14.00	0	870, 502		1
	DI CAL SUPPLI ES CHARGED TO	71.00	0	248, 495		2
	TIENT	71.00	Ű	210, 170		-
IMP	PL. DEV. CHARGED TO	72.00	0	1, 273, 960		3
PAT	TENTS					
		0.00	0	0		4
		0.00	0	0		Ę
		0.00 0.00	0	0 0		
		0.00	0	0		8
		0.00	0	0		
		0.00	0	0		10
		0.00	0	Ō		1
		0.00	0	0		1
)		0.00	0	0		1
)		0.00	0	0		1
)		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	0		2
				0		2
	ALS DRUGS		U	2, 392, 957		
	ETERIA	11.00	0	215		
	RMACY	15.00	0	69, 824		
	IGS CHARGED TO PATIENTS	73.00	0	1, 843, 685		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		
		0.00	0	0		1
		0.00	0	0		1
		0.00 0.00	0	0 0		1
		0.00	0	0		1
		0.00	0	0		1
		0.00	0	Ö		1
	ALS		<sub>0</sub>	1, 913, 724		'
	EQUIPMENT DEPRECIATION					
	P REL COSTS-MVBLE EQUIP	2.00	0	928, 632		
		0.00	0	0		
		0.00	0	0		
		0.00	• •	Q		
	ALS		0	928, 632		
	ORTHOPEDIC CLERICAL STAFF	(7.00	27.040			
	CUPATI ONAL THERAPY	<u>67.</u> 00	2 <u>7, 940</u> 27, 940	<u>0</u>		
	VP OF NURSING		27, 940	U		
	SING ADMINISTRATION	13.00	147, 203	0		
	ALS		147, 203	<u>0</u>		
	SURGERY ON-CALL		117,200	<u> </u>		
	RATING ROOM	50.00	0	129, 985		
	ALS		<u>0</u>	129, 985		
	OVERHEAD IN NRCC					
	P REL COSTS-BLDG & FIXT	1.00	0	44, 266		
ADM	II NI STRATI VE & GENERAL	5.00	0	1, 108		
	RATION OF PLANT	7.00	0	1 <u>3, 8</u> 85		
	ALS		0	59, 259		
	ind Total: Increases		459, 644	5, 624, 472		500

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

## IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1311

 Period:
 Worksheet A-6

 From 01/01/2017
 Date/Time Prepared:

 To
 12/31/2017
 Date/Time Prepared:

						0 12/31/2017	5/29/2018 8:41 am
		Decreases					
	Cost Center	Line #	Salary		Wkst. A-7 Ref.		
0	6.00	7.00	8.00	9.00	10.00		
	A – CAFETERIA DI ETARY	10.00	284, 501	199, 915	0		1.
	OTALS		284, 501	<u>199,915</u> 199,915	<u> </u>		1.
	B - MEDI CAL SUPPLI ES		204, 301	177, 713			
	MPLOYEE BENEFITS DEPARTMENT	4.00	0	30	0		1.
	ADMI NI STRATI VE & GENERAL	5.00	Ő	186	0		2.
	PERATION OF PLANT	7.00	0	9, 746	0		3.
. 00 H	IOUSEKEEPI NG	9.00	0	25, 626	0		4.
.00 D	DI ETARY	10.00	0	168	0		5.
.00 N	IURSING ADMINISTRATION	13.00	0	1	0		6.
.00 P	PHARMACY	15.00	0	19, 875	0		7.
	DULTS & PEDIATRICS	30.00	0	114, 653	0		8.
	PERATING ROOM	50.00	0	2,042,469	0		9.
	NESTHESI OLOGY	53.00	0	770	0		10.
	RADI OLOGY-DI AGNOSTI C	54.00	0	21, 924	0		11.
	ABORATORY	60.00	0	10, 425	0		12.
	RESPIRATORY THERAPY	65.00	0	23, 596	0		13.
	PHYSI CAL THERAPY	66.00	0	22, 585	0		14.
	NCOLOGY	69.00 73.01	0	17, 768 10, 622	0		15.
	CARDI AC REHABI LI TATI ON	76.97	0	776	0		17.
	MERGENCY	91.00	0	61, 863	0		18.
	ARKETING/PUBLIC RELATIONS	190.01	0	824	0		19.
	PHYSICIANS' PRIVATE OFFICES	192.00	0	5, 770	0		20.
	OCCUPATIONAL MEDICINE	192.01	Ő	3, 280	0		21.
	TOTALS		0	2, 392, 957			
С	C - DRUGS						
00 A	ADMINISTRATIVE & GENERAL	5.00	0	4, 500	0		1.
00 C	CENTRAL SERVICES & SUPPLY	14.00	0	54	0		2.
	PHARMACY	15.00	0	1, 760, 065	0		3.
	ADULTS & PEDIATRICS	30.00	0	12, 906	0		4.
	ADULTS & PEDIATRICS	30.00	0	3, 525	0		5.
	PERATING ROOM	50.00	0	16, 765	0		6.
		53.00	0	8, 391	0		7.
	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54.00 65.00	0	62, 105 207	0		8.
	PHYSICAL THERAPY	66.00	0	207	0		10.
	LECTROCARDI OLOGY	69.00	0	8, 988	0		11.
	NCOLOGY	73.01	0	2, 123	0		12.
	CARDI AC REHABI LI TATI ON	76.97	0	42	0		13.
	MERGENCY	91.00	0	21, 537	0		14.
5.00 P	PHYSICIANS' PRIVATE OFFICES	192.00	0	38	0		15.
5.00 0	CCUPATI ONAL MEDI CI NE	192.01	0	1 <u>2, 2</u> 76	0		16.
	OTALS		0	1, 913, 724			
	- EQUIPMENT DEPRECIATION						
	CAP REL COSTS-BLDG & FIXT	1.00	0	922, 959	9		1.
	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 853	12		2.
	ADMINISTRATIVE & GENERAL	5.00	0	50			3.
		<u> </u>	0	<u>3,770</u>	<u>0</u>		4.
			0	928, 632			
	E – ORTHOPEDIC CLERICAL STAFF PHYSICAL THERAPY	66.00	27, 940	0	0		1.
	OTALS	00.00	27, 940	0	<u> </u>		1.
	- VP OF NURSING		27, 740	0	I I		
	ADMI NI STRATI VE & GENERAL	5.00	147, 203	0	0		1.
	OTALS		147, 203	0	⊢ — –		''
	G - SURGERY ON-CALL		,200		II		
	ADULTS & PEDIATRICS	30.00	0	129, 985	0		1.
	OTALS	†		129, 985	]		
Н	I - OVERHEAD IN NRCC						
00 P	PHYSICIANS' PRIVATE OFFICES	192.00	0	59, 259	10		1.
00		0.00	0	0	0		2.
. 00			0	<u>0</u>	0		3.
	OTALS		0	59, 259			
00 00 IG	Grand Total: Decreases		459, 644	5, 624, 472			500.

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL			In Lie	u of Form CMS-	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-1311	Pe	ri od:	Worksheet A-7	
						om 01/01/2017	Part I	
					То	12/31/2017		pared:
							5/29/2018 8:4	1 am
				Acqui si ti on:	s			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances	0.00			1.00	Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES	-			_	-	
1.00	Land	0	0		0	0	0	
2.00	Land Improvements	0	0		0	0	0	
3.00	Buildings and Fixtures	0	0		0	0	0	
4.00	Building Improvements	2, 098, 521	0		0	0	0	
5.00	Fixed Equipment	0	0		0	0	0	
6.00	Movable Equipment	10, 536, 337	221, 890		0	221, 890		
7.00	HIT designated Assets	969, 306	0		0	0	4, 943	7.00
8.00	Subtotal (sum of lines 1-7)	13, 604, 164	221, 890		0	221, 890	582, 768	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	13, 604, 164	221, 890		0	221, 890	582, 768	10.00
		Ending Balance	Fully					
		J	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES						
1.00	Land	0	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	0	0					3.00
4.00	Building Improvements	2, 098, 521	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	10, 180, 402	0					6.00
7.00	HIT designated Assets	964, 363	0					7.00
8.00	Subtotal (sum of lines 1-7)	13, 243, 286	0					8.00
9.00	Reconciling Items	13, 243, 200	0					9.00
10.00	Total (line 8 minus line 9)	13, 243, 286	0					10.00
10.00		10, 240, 200	0	I				1 10.00

Heal th	Financial Systems	IU HEALTH TIPT	TON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	i	Period: From 01/01/2017 Fo 12/31/2017		
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see i nstructi ons)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			ind 2	1		
1.00	CAP REL COSTS-BLDG & FIXT	1, 029, 648	C		51, 417	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	C	782, 99	4 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	C		0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 029, 648		782, 99	4 51, 417	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum	1			
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1.00	CAP REL COSTS-BLDG & FIXT	394, 665					1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	782, 994	•			1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	394, 665	2, 258, 724	•			3.00

Heal th F	inancial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCI L	I ATI ON OF CAPI TAL COSTS CENTERS		Provider C	-	Period: From 01/01/2017 Fo 12/31/2017	Date/Time Prep 5/29/2018 8:4	oared: 1 am
		COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	ART III - RECONCILIATION OF CAPITAL COSTS CE						
	AP REL COSTS-BLDG & FIXT	13, 243, 285	0	13, 243, 28			1.00
1.01 C	AP REL COSTS-BLDG & FIXT - INTERES	0	0	)	0. 000000	0	1.01
2.00 C	AP REL COSTS-MVBLE EQUIP	0	0		0. 000000	0	2.00
3.00 T	otal (sum of lines 1-2)	13, 243, 285	0	13, 243, 28	5 1. 000000	0	3.00
			TION OF OTHER (	-		OF 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	
PA	ART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
	AP REL COSTS-BLDG & FIXT	0	0	)	920, 834	-754	1.00
1.01 C	AP REL COSTS-BLDG & FIXT - INTERES	0	0	)	0 0	0	1.01
2.00 C	AP REL COSTS-MVBLE EQUIP	0	0		1, 074, 882	0	2.00
3.00 T	otal (sum of lines 1-2)	0	0		0 1, 995, 716	-754	3.00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11,00	12.00	13.00	14.00	15.00	
P	ART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	10.00	11.00	10.00	
	AP REL COSTS-BLDG & FIXT	0	49, 564		394, 665	1, 364, 309	1.00
	AP REL COSTS-BLDG & FIXT - INTERES	602, 920			0 0		1.01
	AP REL COSTS-MVBLE EQUIP	002, 720	0		0 0	1, 074, 882	2.00
	otal (sum of lines 1-2)	602, 920	49, 564		394, 665		3.00
5.00 JT		002,720	1,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	5,1,005	0,012,111	0.00

00001	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 8:4	pared 1 am
				Expense Classification o			
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	4.00		1. C
. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - INTERES	В	-180, 074	CAP REL COSTS-BLDG & FIXT - INTERES	1.01	11	1. 0
2. 00	(chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. (
. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other (chapter 2)		C		0.00	0	3. (
. 00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4. (
i. 00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		C		0.00	о	6.0
. 00	Telephone services (pay stations excluded) (chapter 21)		C		0.00	О	7.(
. 00	Television and radio service (chapter 21)		C		0.00	0	8.
	Parking lot (chapter 21) Provider-based physician	A-8-2	C -1, 953, 263		0.00	0 0	9. 10.
1. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
2. 00	Related organization transactions (chapter 10)	A-8-1	1, 006, 026			0	12.
	Laundry and linen service		C		0.00		
	Cafeteria-employees and guests Rental of quarters to employee		C		0.00 0.00		
6. 00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16.
7.00	patients Sale of drugs to other than patients	В	-412, 928	PHARMACY	15.00	0	17.
8. 00	Sale of medical records and		C		0.00	0	18.
9. 00	abstracts Nursing and allied health education (tuition, fees,		C		0.00	0	19.
0.00	books, etc.) Vending machines		C		0.00	о	20.
1. 00	Income from imposition of interest, finance or penalty		C		0.00	0	21.
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0. 00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSICAL THERAPY	66.00		24.
5.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25.
5.00	(chapter 21) Depreciation - CAP REL	А	855, 396	CAP REL COSTS-BLDG & FIXT	1.00	9	26.
5. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT -	1.01	0	26.
7.00	COSTS-BLDG & FIXT - INTERES Depreciation - CAP REL	A	135, 398	INTERES CAP REL COSTS-MVBLE EQUIP	2.00	9	27.
	COSTS-MVBLE EQUIP Non-physician Anesthetist		C	*** Cost Center Deleted ***			28.
	Physicians' assistant Adjustment for occupational	A-8-3	C	OCCUPATI ONAL THERAPY	0.00 67.00		29. 30.
0. 99	therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30.

ADJUSTMENTS TO EXPENSES           ADJUSTMENTS TO EXPENSES         Provider CCN: 15-1311         Period: From 01/01/2 To 12/31/2           Cost Center Description         Basis/Code (2)         Amount         Expense Classification on Worksheet / To/From Which the Amount is to be Adjust           Cost Center Description         Basis/Code (2)         Amount         Cost Center         Line #           31.00         Adjustment for speech pathology costs in excess of         A-8-3         0         *** Cost Center Deleted ***         68	017 ted	5/29/2018 8:4	pared:
Cost Center Description       Basi s/Code (2)       Amount       Cost Center       Line #         1.00       2.00       3.00       4.00         31.00       Adjustment for speech       A-8-3       0*** Cost Center Deleted ***       668	017 ted	5/29/2018 8:4	pared: 1 am
Cost Center Description     Basis/Code (2)     Amount     Cost Center     Line #       31.00     Adjustment for speech     A-8-3     0     *** Cost Center Deleted ***     668	ted	5/29/2018 8:4	
Cost Center Description     Basis/Code (2)     Amount     Cost Center     Line #       31.00     Adjustment for speech     A-8-3     0*** Cost Center Deleted ***     668	ted		
Cost Center Description       Basis/Code (2)       Amount       Cost Center       Line #         1.00       2.00       3.00       4.00         31.00       Adjustment for speech       A-8-3       0*** Cost Center Deleted ***       668			
1.00         2.00         3.00         4.00           31.00         Adjustment for speech         A-8-3         0 *** Cost Center Deleted ***         66			
1.00         2.00         3.00         4.00           31.00         Adjustment for speech         A-8-3         0 *** Cost Center Deleted ***         68	1		
1.00         2.00         3.00         4.00           31.00         Adjustment for speech         A-8-3         0         *** Cost Center Deleted ***         66			
1.00         2.00         3.00         4.00           31.00         Adjustment for speech         A-8-3         0         *** Cost Center Deleted ***         66			
1.00         2.00         3.00         4.00           31.00         Adjustment for speech         A-8-3         0         *** Cost Center Deleted ***         68		Wkst. A-7 Ref.	
		5.00	
pathology costs in excess of	. 00		31.00
limitation (chapter 14)			
	. 00	9	32.00
Depreciation and Interest	~		
	. 00	0	
	. 00 . 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	33.11
33. 12 MEDI CAI D HOSPI TAL ASSESSMENT B -800, 337 ADMI NI STRATI VE & GENERAL 5	. 00	0	33. 12
FEE			
	. 00	9	33.13
BLDG			
	. 00	9	33.14
	~		00.45
	. 00	0	
	. 00 . 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	0	
	. 00	9	
FORWARD A			
33. 24 EQUI PMENT DEPRECIATION - CARRY A 15, 476 CAP REL COSTS-MVBLE EQUI P 2	. 00	9	33.24
FORWA			
	. 00	10	
	. 00	0	
	. 00	0	
	. 00	0	
50. 00 TOTAL (sum of lines 1 thru 49) -3, 853, 616			50.00
(Transfer to Worksheet A, column 6, line 200.)			

 column 6, line 200.)

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

 (2) Basis for adjustment (see instructions).

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

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

Health Financial Syste	ms	IU HEALTH TI	PTON HOSPITAL	In Lie	eu of Form CMS-:	2552-10
	SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1311	Peri od:	Worksheet A-8	-1
OFFICE COSTS				From 01/01/2017 To 12/31/2017		narod
				10 12/31/2017	5/29/2018 8:4	
Li ne	No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
1. (		2.00	3.00	4.00	5.00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (	RGANIZATIONS OR	CLAIMED	
1.00		CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	97, 135	0	1.00
2.00		CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	782, 994		2.00
3.00	-	CAP REL COSTS-BEDG & FIXT -	HOME OFFICE ALLOCATION	58, 263		2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 648, 549		4.00
4.01		ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 572, 370		4.00
4.02		OPERATION OF PLANT	FACILITIES (SLA)	650, 237		4.01
4.03		NURSING ADMINISTRATION	NURSING ADMIN (SLA)	38, 785		4.03
4.04		OPERATING ROOM	OPERATING ROOM (SLA)	112, 560		4.04
4.05		RADI OLOGY-DI AGNOSTI C	RADI OLOGY (SLA)	121, 663		4.05
4.06		LABORATORY	LABORATORY (SLA)	1, 118, 260		4.06
4.07	65.00	RESPI RATORY THERAPY	RESPIRATORY THERAPY (SLA)	3, 168		4.07
4.08	69.00	ELECTROCARDI OLOGY	SLEEP LAB (SLA)	164, 719	164, 719	4.08
4.09	91.00	EMERGENCY	EMERGENCY (SLA)	1, 434, 663	1, 434, 663	4.09
4.10	190. 01	MARKETING/PUBLIC RELATIONS	MARKETING (SLA)	24, 606	24, 606	4.10
4.11	192.00	PHYSICIANS' PRIVATE OFFICES	PHYSICIAN SERVICES (SLA)	255, 843	255, 843	4.11
4.12	192. 01	OCCUPATIONAL MEDICINE	OCCUPATIONAL HEALTH (SLA)	26, 187		4.12
5.00 TOTALS (sum of				11, 110, 002	10, 103, 976	5.00
Transfer column						
Worksheet A-8,	column 2,					
line 12.		scripts as appropriate) are -	1			

\* 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

 boon pootod to normonoot n	· · · · · · · · · · · · · · · · · · ·				
			Related Organization(s) and/	or Home Office	1
			····		1
					1
					1
					1
					I
Symbol (1)	Name	Percentage of	Name	Percentage of	1
					1
		Ownershi p		Ownershi p	
1.00	2.00	3.00	4.00	5.00	1
	ED ORGANIZATION(S) AND/OR HO			· · · · · · · · · · · · · · · · · · ·	
D. INTERRELATIONSHIP TO RELAT	ED UKGANIZATIUN(S) AND/UK HU	WE UFFICE.			1

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	0.00 I U HEALTH 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

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

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet A-8-1 Date/Time Prepared:

					10 12/31/2017	5/29/2018 8:4	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6.00	7.00					
			MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED OF	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO						
1.00	97, 135	9					1.00
2.00	0	9					2.00
3.00	58, 263	9					3.00
4.00	1, 637, 396	0					4.00
4.01	-786, 768	0					4.01
4.02	0	0 0					4. 02
4.03	0	0					4.03
4.04	0	0					4.04
4.05	0	0					4.05
4.06	0	0					4.06
4.07	0	0					4.07
4.08	0	0 0					4.08
4.09	0	0					4.09
4.10	0	0					4.10
4.11	0	0 0					4.11
4.12	0	0 0					4.12
5.00	1,006,026						5.00
* The		•				(	

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

reriibu			
6.00	HEALTHCARE		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00		1	00.00
(1) 110	the following symbols to inc	licate interrelationship to related organizations:	

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

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

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

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

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

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

Heal th	Financial Syste	ems	IU HEALTH TH	PTON HOSPITAL		In Li	eu of Form CMS-	2552-10
	R BASED PHYSIC		-		CCN: 15-1311	Peri od:	Worksheet A-8	
						From 01/01/2017		
						To 12/31/2017		
							5/29/2018 8:4	1 am
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	270, 419	270, 419		0 0	0	1.00
2.00	50.00	OPERATING ROOM	378, 635	378, 635		o l	0	2.00
3.00	53.00	ANESTHESI OLOGY	250,000	250,000		o lc	0	3, 00
4.00		RADI OLOGY-DI AGNOSTI C	121, 663				0	4.00
5.00		RESPI RATORY THERAPY	3, 168				0	5.00
6.00		EMERGENCY	1, 404, 106		474, 72	-	0	6.00
		EWERGENCT	1, 404, 100					
7.00	0.00		0	0		0 0	0	7.00
8.00	0.00		0			0 0	0	8.00
9.00	0.00		0	-		0 0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			2, 427, 991	1, 953, 263	474, 72	B	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships 8	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0		0 0	0	1.00
2.00		OPERATING ROOM	0	0		0 0	0	2.00
3.00		ANESTHESI OLOGY	0			ol o	-	3.00
4.00		RADI OLOGY-DI AGNOSTI C	0				0	4.00
4.00 5.00		RESPI RATORY THERAPY		-			0	4.00 5.00
			-	-		-	-	
6.00		EMERGENCY	0	, s		0 0	0	6.00
7.00	0.00		0	0		0 0	0	7.00
8.00	0.00		0	-		0 0	0	8.00
9.00	0.00		0	0		0 0	0	9.00
10.00	0.00		0	0		0 0	0	10.00
200.00			0	0		0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0		270, 419		1.00
2.00		OPERATI NG ROOM	0			378, 635		2.00
3.00		ANESTHESI OLOGY	0			250,000		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0			121,663		4.00
			-	-				
5.00		RESPI RATORY THERAPY	0	-		3, 168		5.00
6.00		EMERGENCY	0	, s		929, 378		6.00
7.00	0.00		0			0 0		7.00
8.00	0.00		0	, v		0 0		8.00
9.00	0.00		0	0		0 0		9.00
10.00	0.00		0	0		o l		10.00
200.00			0	0		1, 953, 263		200.00

	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provider CC	N: 15-1311	Period: From 01/01/2017 To 12/31/2017		pared:
					Physical Therapy		
						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aides	s) (see instruc	tions)			21	1.00
2.00	Line 1 multiplied by 15 hours per week					315	2.00
3.00 4.00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy					69	3.00 4.00
4.00	nor therapist was on provider site (see instr		on provider si		iei supei vi soi	0	4.00
5.00	Number of unduplicated offsite visits - super	visors or ther				0	5.00
6.00	Number of unduplicated offsite visits - thera					0	6.00
	assistant and on which supervisor and/or ther instructions)	rapist was not	present during	the visit(s	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		Trai nees	
9.00	Total hours worked	1.00	2.00	3.00	4.00 25 0.00	5.00	9.00
10.00	AHSEA (see instructions)	0.00	81.04		78 0.00		
11.00	Standard travel allowance (columns 1 and 2,	40. 52	40. 52	30.	39		11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12.00
12.00	Number of travel hours (offsite)	0	0		0		12.00
13.00	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					1.00	
14.00	Supervisors (column 1, line 9 times column 1,						14.00
15.00	Therapists (column 2, line 9 times column 2,					49, 921	
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 an		ratory thorany	or lines 1	16 for all	1, 231 51, 152	
17.00	others)	iu io ioi respi	latory therapy	UTTIES 14	-10 101 all	51, 152	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li					0	19.00
20. 00	Total allowance amount (sum of lines 17-19 for						20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
21.00	Weighted average rate excluding aides and tra			n of columns	s 1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					0	22.00
23.00	Total salary equivalency (see instructions)					51, 152	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPU	JTATION - PF	ROVIDER SITE		
	Standard Travel Allowance						
		2.70/					
	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3 line 11)						
25. 00	Assistants (line 4 times column 3, line 11)	sum of lines 2	4 and 25 for al	l others)		0	25.00
					3 and 4 for all		
25. 00 26. 00 27. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or su	um of lines		0 2, 796 369	25.00 26.00 27.00
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	for respirator	y therapy or su	um of lines		0 2, 796 369	25.00 26.00 27.00
25.00 26.00 27.00 28.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel	for respirator travel expense Expense	y therapy or su at the provide	um of lines		0 2, 796 369 3, 165	25.00 26.00 27.00 28.00
25.00 26.00 27.00 28.00 29.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of	for respirator travel expense Expense of columns 1 and	y therapy or su at the provide	um of lines		0 2, 796 369 3, 165	25.00 26.00 27.00 28.00 29.00
25.00 26.00 27.00 28.00 28.00 29.00 30.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	for respiratory travel expense Expense of columns 1 and line 12)	y therapy or su at the provide d 2, line 12)	um of lines er site (sur		0 2, 796 369 3, 165 0 0	25.00 26.00 27.00 28.00 29.00 30.00
<ol> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al	um of lines er site (sur l others)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00
25.00 26.00 27.00 28.00 28.00 29.00 30.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al	um of lines er site (sur l others)	n of lines 26 and	0 2, 796 369 3, 165 0 0	25.00 26.00 27.00 28.00 29.00 30.00 31.00
<ol> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line	y therapy or su at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28)	um of lines er site (sur l others) atory therap	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 3, 165	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00
<ol> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respirator travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and	um of lines er site (sur l others) atory therap d 31)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 0 3, 165 369	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
<ol> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 0 3, 165 369 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
<ol> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 0 3, 165 369 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
<ol> <li>25. 00</li> <li>26. 00</li> <li>27. 00</li> <li>28. 00</li> <li>29. 00</li> <li>30. 00</li> <li>31. 00</li> <li>32. 00</li> <li>33. 00</li> <li>34. 00</li> <li>35. 00</li> <li>36. 00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 3, 165 369 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	for respiratory travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 3, 165 369 0 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respirator travel expense <u>Expense</u> of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum NCE AND TRAVEL	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 3, 165 369 0 0 VI DER_SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times 36 and 37) Standard travel expense (line 7 times the sum	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum NCE AND TRAVEL	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 3, 165 369 0 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	for respirator travel expense <u>Expense</u> of columns 1 and line 12) sum of lines 2 a 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 3, 165 369 0 0 VI DER_SITE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWF Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2 5 1 and 2, line expense (line expense (sum NCE AND TRAVEL	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 3, 165 369 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 2.01 times column Subtotal (sum of lines 40 and 41)	for respirator travel expense Expense of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an- Expense 1 times column a, line 10)	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10)	um of lines er site (sur l others) atory therap d 31) d 32)	n of lines 26 and	0 2, 796 369 3, 165 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	for respirator travel expense Expense of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an- Expense 1 times column a 3, line 10) n of columns 1-	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	um of lines er site (sur atory therap d 31) d 32) FATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	0 2, 796 369 3, 165 0 0 0 0 3, 165 369 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (column 3, line 12.01 times column Subtotal (sum of columns 1 and 2, line 12.07 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur Total Travel Allowance and Travel Expense - 0	for respirator travel expense Expense of columns 1 an- line 12) sum of lines 2 s 1 and 2, line expense (line expense (sum expense (sum NCE AND TRAVEL n of lines 5 an- Expense 1 times column a 3, line 10) n of columns 1-	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	um of lines er site (sur atory therap d 31) d 32) FATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	0 2, 796 369 3, 165 0 0 0 0 3, 165 369 0 0 VI DER SI TE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00
<ol> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>18.00</li> <li>19.00</li> <li>10.00</li> <li>11.00</li> <li>12.00</li> <li>13.00</li> <li>14.00</li> <li>15.00</li> <li>16.00</li> <li>17.00</li> <li>18.00</li> <li>19.00</li> <li>10.00</li> <li>10.00</li> <li>11.00</li> <li>2.00</li> <li>3.00</li> <li>44.00</li> <li>44.00</li> <li>44.00</li> <li>44.00</li> <li>44.00</li> </ol>	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and standard travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	for respiratory travel expense Expense of columns 1 and line 12) sum of lines 2 5 1 and 2, line expense (line expense (sum NCE AND TRAVEL n of lines 5 and Expense 1 times column a 3, line 10) n of columns 1- offsite Services expense (sum	y therapy or si at the provide d 2, line 12 ) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT d 6) 2, line 10) 3, line 13.01) 5; Complete ond of lines 38 and	um of lines er site (sur l others) atory therap d 31) d 32) TATION - SEF e of the fol d 39 - see i	n of lines 26 and by or sum of RVICES OUTSIDE PR lowing three line nstructions)	0 2, 796 369 3, 165 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	25. 0 26. 0 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0 33. 0 34. 0 35. 0 36. 0 37. 0 38. 0 37. 0 38. 0 39. 0 40. 0 41. 0 42. 0

01510	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	IU HEALTH TIPTO FURNISHED BY	Provider CC		Period: From 01/01/2017 To 12/31/2017		-3 pared:
				F	Physical Therapy	Cost	
						1.00	
6.00	Optional travel allowance and optional travel						46.00
		Therapists	Assistants	Aides	Trai nees	Total	
		1.00	2.00	3.00	4.00	5.00	
7.00	PART V - OVERTIME COMPUTATION Overtime hours worked during reporting	0.00	0.00	0.0	0.00	0.00	47.00
7.00	period (if column 5, line 47, is zero or	0.00	0.00	0.0	0.00	0.00	47.0
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each						
	column of line 56)						
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.0
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.0
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT				-		
0.00	Percentage of overtime hours by category	0.00	0.00	0.0	0 0.00	0.00	50.0
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5,						
1.00	line 47) Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.0
1.00	for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	51.0
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
2.00	Adjusted hourly salary equivalency amount	81.04	60. 78	0.0	0.00		52.0
	(see instructions)						
3.00	Overtime cost limitation (line 51 times line	0	0		0 0		53.0
	52)						
4.00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.C
	line 49 or line 53)		-		_		
5.00	Portion of overtime already included in	0	0		0 0		55.0
	hourly computation at the AHSEA (multiply line 47 times line 52)						
6.00	Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56. C
0.00	if negative enter zero) (Enter in column 5	0	0		0	Ū	00.0
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
7 00	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST /	ADJUSTMENT			F1 1F2	
	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from Linco 22	24 are 25))			51, 152	
8.00 9.00	Travel allowance and expense - provider site			<u>۱</u>		3, 165 0	
9.00 0.00	Overtime allowance (from column 5, line 56)		44, 45, 01 40	)		0	
1.00	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					54, 317	
	Total cost of outside supplier services (from	your records)				43, 779	
	Excess over limitation (line 64 minus line 63	J .	enter zero)				65.0
5.00	LINE 33 CALCULATION	<u>v</u>					1
5.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		2, 796	100. (
		/ therapy or sum	of lines 3 a	nd 4 for all	others	369	100. 0
00.00	Line 27 = line 7 times line 3 for respiratory					3, 165	100. C
00. 00 00. 01	Line 33 = line 28 = sum of lines 26 and 27						
00. 00 00. 01 00. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION						
00. 00 00. 01 00. 02 01. 00	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory				others	369	
00. 00 00. 01 00. 02 01. 00 01. 01	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				others	0	101.0
00. 00 00. 01 00. 02 01. 00 01. 01	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	
00.00 00.01 00.02 01.00 01.01 01.02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29	and 30 for a	II others	others	0 369	101. ( 101. (
00. 00 00. 01 00. 02 01. 00 01. 01 01. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	II others		0 369 0	101. ( 101. ( 102. (
00.00 00.01 00.02 01.00 01.01 01.02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29 sum of lines 29	and 30 for a and 30 for a	II others		0 369 0	101. 101.

REASON	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	IU HEALTH TIPT FURNI SHED BY	ON HOSPITAL Provider CC		In Lie Period: From 01/01/2017 To 12/31/2017 Respiratory Therapy	u of Form CMS-2 Worksheet A-8- Parts I-VI Date/Time Prep 5/29/2018 8:4 Cost	-3 pared:
						1.00	
1 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	) (coo instruc	tions)			41	1.00
1.00 2.00	Line 1 multiplied by 15 hours per week		61 915	2.00			
3.00	Number of unduplicated days in which supervis					177	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider sit	te but neithe	r supervisor	0	4.00
5.00	Number of unduplicated offsite visits - super	visors or ther				0	5.00
6.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					0	6.00
	instructions)						
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile	5.35 0.00					
8.00	optional travel expense rate per mire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	8.00
0.00	Total hours worked	1.00	2.00	3.00	4.00	5.00	0.00
9.00 10.00	AHSEA (see instructions)	0. 00 0. 00	2, 047. 33 63. 70	0. C 0. C		0.00 0.00	9.00 10.00
11.00	Standard travel allowance (columns 1 and 2,	31.85	31.85	0. C	00		11.00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01 13.00
13.00	Number of miles driven (offsite)	6	0		0		13.00
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 130, 415	
16.00	Assistants (column 3, line 9 times column 3,					0	16.00
17.00	Subtotal allowance amount (sum of lines 14 ar others)	nd 15 for respi	ratory therapy	or lines 14-	16 for all	130, 415	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, li			47 440		0	19.00
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					130,415 nology or	20.00
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete		no entries on I	ines 21 and	22 and enter on	line 23	
21.00	Weighted average rate excluding aides and tra		divided by sur	m of columns	1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,					0	22.00
22.00 23.00	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)		es fille 21)			130, 415	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPU	JTATION - PRO	VIDER SITE		
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					5, 637	24.00
25.00	Assistants (line 4 times column 3, line 11)					0	25.00
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				and 4 for all	5, 637 947	26.00 27.00
	others)						
28.00	Total standard travel allowance and standard 27)	travel expense	at the provide	er site (sum	of lines 26 and	6, 584	28.00
	Optional Travel Allowance and Optional Travel						
29.00 30.00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		a 2, line 12)			0	29.00 30.00
31.00	Subtotal (line 29 for respiratory therapy or	sum of lines 2				0	31.00
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	5 1 and 2, line	13 for respira	atory therapy	or sum of	0	32.00
33.00	Standard travel allowance and standard travel					6, 584	33.00
34.00 35.00	Optional travel allowance and standard travel Optional travel allowance and optional travel					0	34.00 35.00
55.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO		33.00
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)	of Lince F and	d 6)			0	
39.00	Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel		u o)			0	39.00
40.00	Therapists (sum of columns 1 and 2, line 12.0	1 times column	2, line 10)			0	
	00 Assistants (column 3, line 12.01 times column 3, line 10)						41.00
41.00	0 Subtotal (sum of lines 40 and 41) 0						
	Optional travel expense (line 8 times the sur					0	43.00
41. 00 42. 00				e of the foll	owing three line	0	43.00

4:.00       Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)       1.00         46:.00       Optional travel allowance and standard travel expense (sum of lines 42 and 43 - see instructions)       1.00         46:.00       Optional travel allowance and standard travel expense (sum of lines 42 and 43 - see instructions)       Trata         47:.00       Operation fravel allowance and standard travel expense (sum of lines 42 and 43 - see instructions)       Trata         47:.00       Operator Nerkod during reporting periting periting and (frame starting transmitter)       0.00       0.00       0.00       0.00       0.00         47:.00       Operator Than 2,080, do not column of line 56)       0.00	rksh rts te/T 29/2	Pa Da	od: n 01/01/2017 12/31/2017 espi ratory	Fro To	N: 15-1311	Provider CCN	FURNI SHED BY	BLE COST DETERMINATION FOR THERAPY SERVICES SUPPLIERS	
45.00         Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) <ul> <li>46.00</li> <li>Optional travel allowance and optional travel expense (sum of lines 42 and 3 - see instructions)</li> <li>Therapists</li> <li>Assistants</li> <li>Aldes</li> <li>Trainees</li> <li>Total</li> <li>0.00</li> <li>2.00</li> <li>3.00</li> <li>4.00</li> <li>5.00</li> <li>0.00</li>                &lt;</ul>			Therapy						
46.00         Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)           PART V - OVERTIME COMPUTATION         Therapists         Aides         Trainees           1.00         2.00         3.00         4.00         5.00           47.00         Övertime hours worked during reporting         0.00         <	1.		uctions)	instr	1 42 - see i	lines 39 and	expense (sum o	Optional travel allowance and standard trave	5.00 0
PART V - OVERTIME COMPUTATION         1.00         2.00         3.00         4.00         5.00           74.00         Overtime hours worked during reporting period (if column 5, line 47, is zero or complete lines 48-55 and enter zero in each complete line worked - column 5, line 47)         0.00				instr				Optional travel allowance and optional trave	0 00
PART V OVERTINE COMPUTATION           0.00         Overtime hours worked during reporting equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 550 and itowarce) (multiply line 47 times line 48)         0.00         0.00         0.00         0.00           80.00         Overtime rate (see instructions)         0.00         0.00         0.00         0.00         0.00           81.00         Overtime rate (see instructions)         0.00         0.00         0.00         0.00         0.00           80.00         Overtime (not using base and overtime of interval)         0.00         0.00         0.00         0.00         0.00           80.00         Derivation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)         0.00         0.00         0.00         0.00         0.00           80.00         Derivation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)         0         0         0         0         0         0           80.00         Derivation of provider's standard work year for on of overtime cost (enter the lesser of bline 40 or line 53)         0         0         0         0         0         0         0         0         0         0         0         0         0         0		<u> </u>							
period (if column 5, line 47, is zero`or         on           equal to or greater than 2,080, do not         couplete lines 48-55 and enter zero in each         0.00         0.00         0.00         0.00           80.00 Overtime rate (see instructions)         0.00         0.00         0.00         0.00         0.00           80.00 Overtime rate (see instructions)         0.00         0.00         0.00         0.00         0.00           80.00 Overtime (including base and overtime         0.00         0.00         0.00         0.00         0.00           64.00 Overtime (including base and overtime         0.00         0.00         0.00         0.00         0.00           64.01 Overtime (including base and overtime         0.00         0.00         0.00         0.00         0.00           64.01 Overtime (including base and overtime         0.00         0.00         0.00         0.00         0.00           7.00 Aljustefin of provider's standard work year         0.00         0.00         0.00         0.00         0.00           8.00 Aljustef hourly salary equivalency amount         63.70         0.00         0.00         0.00           50.00 Aljustef hourly salary equivalency amount         63.70         0.00         0.00         0           50.00 Aljustef hourly salary equiva	0.	<u> </u>	4.00		3.00	2.00	1.00	PART V - OVERTIME COMPUTATION	P
99.00       Total overtime (including base and overtime       0.00       0.00       0.00       0.00         All owance) (multiply line 47 times line 48)       0.00       0.00       0.00       0.00         00       Opercentage of overtime hours by category (divide the hours in each column on line 47)       0.00       <			0.00	. 00	0.	0.00	0. 00	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	p e c
al lowance) (multiply line 47 times line 48)								Overtime rate (see instructions)	3. 00 0
00.00       Percentage of overtime hours by category       0.00 <t< td=""><td></td><td></td><td>0.00</td><td>. 00</td><td>0.</td><td>0.00</td><td>0.00</td><td>allowance) (multiply line 47 times line 48)</td><td>а</td></t<>			0.00	. 00	0.	0.00	0.00	allowance) (multiply line 47 times line 48)	а
1.00       Allocation of provider's standard work year       0.00			0.00	. 00	0.	0.00	0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked – column 5,	). 00 P ( b
22 00 Adjusted hourly salary equivalency amount (see instructions)       63.70       0.00       0.00       0.00         33 00 Overtime cost limitation (line 51 times line 52)       0       0       0       0       0         44 00 Maximum overtime cost (enter the lesser of line 49 or line 53)       0       0       0       0       0       0         50 OP ortion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)       0       0       0       0       0         66.00 Overtime already and columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)       0       0       0       0       0       0         Incomputation of the columns 1, and 4 for respiratory therapy and columns 1 through 3 for all others.)       130.4         Incomputation of the columns 1 through 3 for all others.)       130.4       5         Incomputation of the columns 1 through 3 for all others.)       130.4         Incomputation of the column 5, line 56         Incomputation of t			0.00	. 00	0.	0. 00	0.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	.00 A f
(see instructions)       (see instructions)         3.00       Overtime cost (imitation (line 51 times line 52)       0       0       0       0         4.00       Maximum overtime cost (enter the lesser of line 49 or line 53)       0       0       0       0         5.00       Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)       0       0       0       0         6.00       Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3       0       0       0       0         7.00       Salary equivalency amount (from line 23)       130, 4'       1.00         8.00       Travel allowance and expense - provider site (from lines 33, 34, or 35))       130, 4'         9.00       Travel allowance and expense - opfsite services (from lines 44, 45, or 46)       130, 4'         0.00       Overtime allowance (sum of lines 57-62)       133, 6'         1.00       Excess over limitation (line 64 minus line 63 - if negative, enter zero)       133, 6'         1.00       Excess over limitation (line 64 minus line 63 - if negative, enter zero)       133, 6'         1.00       UNE 33 CALCULATION       6 or respiratory therapy or sum of lines 3 and 4 for all others       9         0.01       Cotal allow			0.00	00	0	0.00	63 70		
4.00       Maximum overtime cost (enter the lesser of line 44 or line 53)       0					0.			(see instructions) Overtime cost limitation (line 51 times line	s. 00 0
5.00       Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 51 ine 52)       0       100 </td <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>О</td> <td>0</td> <td>Maximum overtime cost (enter the lesser of</td> <td>. OO M</td>			0	0		О	0	Maximum overtime cost (enter the lesser of	. OO M
if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)       1.00         Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT       1.00         None Target all owance and expense - provider site (from lines 33, 34, or 35))       130, 4         9.00       Travel allowance and expense - provider site (from lines 44, 45, or 46)       6, 50         0.00       Overtime allowance (from column 5, line 56)       1.00         1.00       Equipment cost (see instructions)       133, 6         2.00       Supplies (see instructions)       133, 6         3.00       Total allowance (sum of lines 57-62)       136, 90         1.00       Excess over limitation (line 64 minus line 63 - if negative, enter zero)       133, 6         1.01       Excess over limitation (line 64 minus line 63 - if negative, enter zero)       5, 60         0.01       Line 26 = line 24 for respiratory therapy or sum of lines 2 and 25 for all others       9, 60         0.02       Line 33 = line 28 = sum of lines 26 and 27       6, 51         0.100       Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others       9, 10         0.101       Line 31 = line 27 and 31       9, 10         0.102       Line 34 = sum of lines 27 and 31       9, 10         0.103       Line 34			0	0		0	Ο	Portion of overtime already included in hourly computation at the AHSEA (multiply	i. 00   P   h
for all others.)       1.00         Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT       1.00         7.00 Salary equivalency amount (from line 23)       130,4         8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))       130,4         9.00 Travel allowance and expense - offsite services (from lines 44, 45, or 46)       6,50         0.00 Overtime allowance (from column 5, line 56)       6,50         1.00 Equipment cost (see instructions)       3         2.00 Supplies (see instructions)       136,90         3.00 Total allowance (sum of lines 57-62)       136,90         4.00 Total cost of outside supplier services (from your records)       133,66         5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)       133,66         LINE 33 CALCULATION       6,51         00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others       9,651         00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       9,651         01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       9,651         01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       9,6151         01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       9,6151			0	0		0	0	if negative enter zero) ( Enter in column 5 the sum of columns 1, 3, and 4 for	i t
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT         57.00       Salary equivalency amount (from line 23)         58.00       Travel allowance and expense - provider site (from lines 33, 34, or 35))         59.00       Travel allowance and expense - Offsite services (from lines 44, 45, or 46)         0.00       Overtime allowance (from column 5, line 56)         50.00       Equipment cost (see instructions)         52.00       Supplies (see instructions)         53.00       Total allowance (sum of lines 57-62)         100       Total cost of outside supplier services (from your records)         55.00       Excess over limitation (line 64 minus line 63 - if negative, enter zero)         11NE 33 CALCULATION       11NE 33 CALCULATION         00.00       Line 24 for respiratory therapy or sum of lines 24 and 25 for all others         00.01       Line 25 = sum of lines 26 and 27         11NE 34 CALCULATION       6,51         01.00       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others         01.01       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 29 and 30 for all others         01.02       Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others         01.02       Line 34 = sum of lines 27 and 31         11NE 35 CALCULATION       94 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
7.00Salary equivalency amount (from line 23)130, 48.00Travel allowance and expense - provider site (from lines 33, 34, or 35))6, 549.00Travel allowance and expense - Offsite services (from lines 44, 45, or 46)6, 540.00Overtime allowance (from column 5, line 56)11.00Equipment cost (see instructions)136, 943.00Total allowance (sum of lines 57-62)136, 941.00Excess over limitation (line 64 minus line 63 - if negative, enter zero)133, 651.11LINE 33 CALCULATION5, 6000.00Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others9, 6501.01Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others9, 6501.01Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others9, 6101.02Line 34 = sum of lines 27 and 319, 74ULINE 35 CALCULATION9, 749, 7401.02Line 34 = sum of lines 20 mm of lines 29 and 30 for all others9, 7401.02Line 34 = sum of lines 27 and 319, 7401.02Line 34 = sum of lines 27 and 319, 7401.03Line 34 = sum of lines 27 and 319, 7401.04Line 35 CALCULATION9, 7401.05Line 35 CALCULATION9, 7401.06Line 34 = sum of lines 27 and 319, 7401.07Line 35 CALCULATION9, 7401.08Line 35 CALCULATION9, 7401.09Line 34 = sum of lines 27 and 31 <td>1.</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	1.								
8.00       Travel allowance and expense - provider site (from lines 33, 34, or 35))       6,54         9.00       Travel allowance and expense - Offsite services (from lines 44, 45, or 46)       6,54         0.00       Overtime allowance (from column 5, line 56)       100         1.00       Equipment cost (see instructions)       116,94         2.00       Supplies (see instructions)       136,94         3.00       Total allowance (sum of lines 57-62)       136,94         4.00       Total cost of outside supplier services (from your records)       133,65         5.00       Excess over limitation (line 64 minus line 63 - if negative, enter zero)       133,65         LINE 33 CALCULATION       00.00       Line 26 = line 24 for respiratory therapy or sum of lines 3 and 4 for all others       9,65         00.01       Line 23 = line 28 = sum of lines 26 and 27       6,55         01.00       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       9,65         01.02       Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others       9,65         01.01       Line 34 = sum of lines 27 and 31       9,75         01.02       Line 34 = sum of lines 27 and 31       9,75         01.02       Line 34 = sum of lines 27 and 31       9,75         01.02       Line 34 =						DJUSTMENT	ND EXCESS COST		
00.01       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       94         00.02       Line 33 = line 28 = sum of lines 26 and 27       6, 54         LINE 34 CALCULATION       6, 54         01.00       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       94         01.01       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       94         01.01       Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others       94         01.02       Line 34 = sum of lines 27 and 31       94         LINE 35 CALCULATION       94						4, 45, or 46)	n your records)	Travel allowance and expense - provider site Travel allowance and expense - Offsite servin Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65	B. 00       T         D. 00       T         D. 00       0         . 00       E         2. 00       S         3. 00       T         4. 00       T         5. 00       E
01.00       Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others       94         01.01       Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others       94         01.02       Line 34 = sum of lines 27 and 31       94         LINE 35 CALCULATION       94			ers	l oth				Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27	0.00 L 0.01 L 0.02 L
02.00 Line 31 = Line 29 for respiratory therapy or sum of Lines 29 and 30 for all others	_		ers	l oth				Line 27 = line 7 times line 3 for respirator Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	01.00 L 01.01 L 01.02 L
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others			1-3, line	lumns				Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line	)2. 00 L )2. 01 L

	Financial Systems     IU HEALTH TIPTON HOSPITAL     In Lie       IABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY     Provider CCN: 15-1311     Period: From 01/01/2017 To 12/31/2017       VE     SUPPLIERS     Occupational Therapy		-3 pared:					
		1.00						
1 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions)	E	1 00					
1.00 2.00	Line 1 multiplied by 15 hours per week	5	1.00 2.00					
3.00	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)	15	3.00					
4.00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)	0	4.00					
5.00	Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.00					
6.00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see	0	6.00					
	instructions)							
7.00 8.00	Standard travel expense rate Optional travel expense rate per mile	5.35 0.00	7.00 8.00					
8.00	Supervi sors Therapi sts Assi stants Ai des	Trai nees	8.00					
0.00	1.00         2.00         3.00         4.00           Total hours worked         0.00         119.50         0.00         0.00	5.00	0.00					
9.00 10.00	Total hours worked         0.00         119.50         0.00         0.00           AHSEA (see instructions)         0.00         76.82         0.00         0.00		9.00 10.00					
11.00	Standard travel allowance (columns 1 and 2, 38.41 38.41 0.00		11.00					
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)							
12.00	Number of travel hours (provider site) 0 0 0		12.00					
12.01 13.00	Number of travel hours (offsite)000Number of miles driven (provider site)000		12. 01 13. 00					
13.01	Number of miles driven (offsite)     0     0		13.01					
		1.00						
	Part II - SALARY EQUIVALENCY COMPUTATION	1						
14.00 15.00	Supervisors (column 1, line 9 times column 1, line 10) Therapists (column 2, line 9 times column 2, line 10)	0 9, 180						
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16.00					
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	9, 180	17.00					
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18.00					
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19.00					
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pat		20.00					
	occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on the amount from line 20. Otherwise complete lines 21-23.							
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	0.00	21.00					
22.00	for respiratory therapy or columns 1 thru 3, line 9 for all others)	0	22.00					
22.00 23.00	Weighted allowance excluding aides and trainees (line 2 times line 21) Total salary equivalency (see instructions)	-	22.00 23.00					
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE							
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)	576	24.00					
25.00	Assistants (line 4 times column 3, line 11)	0	25.00					
26.00 27.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	576 80	26.00 27.00					
	others)							
28.00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)	656	28.00					
	Optional Travel Allowance and Optional Travel Expense		~~ ~~					
29.00 30.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) Assistants (column 3, line 10 times column 3, line 12)	0	29.00 30.00					
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00					
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)	0	32.00					
33.00	Standard travel allowance and standard travel expense (line 28)	656	33.00					
34.00 35.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32)	80 0	34.00 35.00					
35.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PR		35.00					
24 00	Standard Travel Expense	0	24 00					
36.00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	0	36.00 37.00					
37.00	Subtotal (sum of lines 36 and 37)	0	38. 00 39. 00					
37.00 38.00	00 Standard travel expense (line 7 times the sum of lines 5 and 6) 0							
37.00								
37.00 38.00 39.00 40.00	Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40. 00					
<ul> <li>37.00</li> <li>38.00</li> <li>39.00</li> <li>40.00</li> <li>41.00</li> </ul>	Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00					
37.00 38.00 39.00 40.00	Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0 0 0						
37.00 38.00 39.00 40.00 41.00 42.00	Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Subtotal (sum of lines 40 and 41)	0 0 0	41.00 42.00					

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider C		Period: From 01/01/2017 To 12/31/2017 Occupational	Worksheet A-8- Parts I-VI Date/Time Prep 5/29/2018 8:4 Cost	pared:
					Therapy		
45.00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see in:	structions)	1.00	45.00
	Optional travel allowance and optional travel	expense (sum	of lines 42 an	d 43 - see in:	structions)	0	
		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	3.00	
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0. 00	0.0	0 0.00	0.00	47.00
48.00	Overtime rate (see instructions)	0. 00	0.00				48.00
49.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0 0.00		49.00
	CALCULATION OF LIMIT	1					
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0 0.00	0.00	50. 00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0 0.00	0.00	51.00
F.O. 00	DETERMINATION OF OVERTIME ALLOWANCE	74.00		0.0			50.00
52.00 53.00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	76. 82 0	0.00		0 0.00 0 0		52.00 53.00
54.00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
55.00	Portion of overtime already included in	0	0		0 0		55.00
	hourly computation at the AHSEA (multiply line 47 times line 52)						
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		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				
58.00 59.00 60.00 61.00 62.00 63.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	es (from lines		)			58.00 59.00 60.00 61.00
65.00	5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION						65.00
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION						80	100. 00 100. 01 100. 02
101. 01 101. 02	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 2	9 and 30 for a	II others	others	0	101. 00 101. 01 101. 02
102 00	Line 31 = line 29 for respiratory therapy or				mps 1 2 lino		102. 00 102. 01
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 Tor respira	tory therapy o	I Sull OI COIU	ins 1-3, The	0	102.01

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Pre 5/29/2018 8:4	pared:
		CAP	TAL RELATED	0/2//2010 0.4		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT · INTERES	• MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	1.01	2.00	4.00	
GENERAL SERVICE COST CENTERS			1			
1.00 00100 CAP REL COSTS-BLDG & FIXT	1, 364, 309	1, 364, 309	(			1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - INTERES 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	602, 920	0	602, 92	0 1, 074, 882		1.01 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 074, 882 2, 335, 736	5, 740	3, 01	1	2, 349, 089	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	5, 693, 390	80, 334			2, 349, 089	5.00
7.00 00700 OPERATION OF PLANT	4, 937, 959	298, 927	129, 95		159, 704	7.00
7.01 00701 OPERATION OF PLANT - OFFSITE	0	0		0 0	0	7.01
8.00 00800 LAUNDRY & LINEN SERVICE	105, 976	21, 248	11, 17	4 17,005	10, 685	8.00
9. 00 00900 HOUSEKEEPI NG	370, 078	12, 661	6, 65	8 10, 132	64, 770	9.00
10. 00 01000 DI ETARY	237, 223	17, 333			30, 587	10.00
11. 00 01100 CAFETERI A	368, 940	38, 107	20, 04		62, 403	•
13.00 01300 NURSING ADMINISTRATION	594, 049	35, 570			126, 601	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	880, 525	31, 082	16, 34		0	14.00
15. 00 01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	611, 662	10, 591	5, 57	0 8, 476	125, 633	15.00
30.00 03000 ADULTS & PEDIATRICS	2, 089, 167	144, 224	75, 84	6 115, 423	450, 531	30, 00
ANCI LLARY SERVICE COST CENTERS	2,009,107	144, 224	/3,04	0 115,425	430, 331	30.00
50. 00 05000 OPERATING ROOM	1,094,849	161, 498	84, 93	1 129, 247	233, 476	50.00
53.00 05300 ANESTHESI OLOGY	51, 510	2, 966			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 178, 737	83, 570			235, 769	54.00
60. 00 06000 LABORATORY	1, 165, 468	32, 637	17, 16	4 26, 120	305	60.00
65. 00 06500 RESPI RATORY THERAPY	498, 507	1, 977	1, 04		78, 090	•
66. 00 06600 PHYSI CAL THERAPY	643, 673	40, 829			131, 541	66.00
67.00 06700 OCCUPATI ONAL THERAPY	180, 997	9, 266			39, 084	67.00
69. 00 06900 ELECTROCARDI OLOGY	421,033	17, 848			91, 232	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS	248, 495 1, 273, 960	0		0 0 0 0	0	71.00
72.00 07200 TMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	1, 273, 960	0		0 0	0	72.00
73. 01   03480   0NCOLOGY	182, 290	13, 096			38, 942	
76. 00 03160 CARDI OPULMONARY	02,270	10,070	0,00	0 0	00, 712	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	89, 707	13, 597	7, 15	0 10, 881	17, 742	
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	1, 657, 225	76, 280	40, 11	5 61, 047	251, 808	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	31, 796, 952	1, 149, 381	573, 83	0 919, 853	2, 313, 099	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN		0				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 MARKETING/PUBLIC RELATIONS	0 52, 471	0 4, 897	2, 57	0 0 5 3, 919		190. 00 190. 01
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	136, 896	4, 897 177, 882				190.01
192. 01 19201 OCCUPATI ONAL MEDI CI NE	68, 497	10, 934				192.00
192. 02 19202 VACANT SPACE	0	21, 215				192.02
200.00 Cross Foot Adjustments		_ , _ 10			0	200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	32, 054, 816	1, 364, 309	602, 92	0 1, 074, 882	2, 349, 089	202.00

Heal th I	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	LOCATION - GENERAL SERVICE COSTS		Provider C		Period:	Worksheet B	
					From 01/01/2017	Part I	
					To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
	Cost Center Description	Subtotal A	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	
	cost center bescription	Subtotal	& GENERAL	PLANT	PLANT -	LINEN SERVICE	
			& GENERAL		OFFSI TE		
		4A	5.00	7.00	7.01	8.00	
C	GENERAL SERVICE COST CENTERS						
1.00	DO100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 0	DO101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00 0	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 0	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 0	DO500 ADMINISTRATIVE & GENERAL	6, 044, 458	6, 044, 458				5.00
7.00 0	DO700 OPERATION OF PLANT	5, 765, 773	1, 339, 877	7, 105, 65	0		7.00
7.01 0	00701 OPERATION OF PLANT - OFFSITE	0	0	366, 94	5 366, 945		7.01
8.00 0	DO800 LAUNDRY & LINEN SERVICE	166, 088	38, 597	150, 45	5 0	355, 140	8.00
9.00 0	DO900 HOUSEKEEPI NG	464, 299	107, 897	89, 64	8 0	0	9.00
10.00	D1000 DI ETARY	308, 131	71, 606	122, 73	5 0	0	10.00
11.00 0	D1100 CAFETERI A	519, 987	120, 838	269, 83	0 0	0	11.00
13.00 0	01300 NURSING ADMINISTRATION	800, 024	185, 915	206, 50	3 15, 844	0	13.00
14.00 0	01400 CENTRAL SERVICES & SUPPLY	952, 828	221, 425	220, 08	3 0	0	14.00
15.00	D1500 PHARMACY	761, 932	177, 063	74, 99	4 0	0	15.00
1	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	2, 875, 191	668, 157	1, 021, 22	0 0	355, 140	30.00
	ANCILLARY SERVICE COST CENTERS			r	- T		
	D5000 OPERATI NG ROOM	1, 704, 001	395, 988				
	05300 ANESTHESI OLOGY	58, 410	13, 574	21, 00			53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 608, 906	373, 889				54.00
	D6000 LABORATORY	1, 241, 694	288, 554	231, 09			60.00
	06500 RESPI RATORY THERAPY	581, 196	135, 062	14, 00			65.00
	D6600 PHYSI CAL THERAPY	870, 191	202, 221	289, 10			66.00
	D6700 OCCUPATI ONAL THERAPY	241, 636	56, 153	65, 61			67.00
	06900 ELECTROCARDI OLOGY	553, 782	128, 692	126, 37			69.00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	248, 495	57, 747		0 0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 273, 960	296, 052		0 0		72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 843, 685	428, 448		0 0	0	73.00
	03480 ONCOLOGY	251, 696	58, 491	92, 72		0	73.01
	D3160 CARDI OPULMONARY	0	0	0/ 07	0 0		
	07697 CARDI AC REHABI LI TATI ON	139, 077	32, 320	96, 27	5 0	0	76.97
	DUTPATIENT SERVICE COST CENTERS	2 00/ 475	40.4 070	F 40, 10	7		01 00
	09100 EMERGENCY	2,086,475	484, 870	540, 12	7 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
118.00	SPECIAL PURPOSE COST CENTERS	31, 361, 915	E 002 424	5, 734, 00	7 15, 844	255 140	110 00
	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	51, 301, 913	5, 883, 436	5, 734, 00	10,044	355, 140	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19000 MARKETING/PUBLIC RELATIONS	63, 862	14, 841	34, 67	-		190.00
	19200 PHYSICIANS' PRIVATE OFFICES	504, 471	14, 841				190.01
	19200 PHTSICIANS PREVATE OFFICES	101, 478	23, 582	77, 42			192.00
	19202 VACANT SPACE	23, 090	5, 366		0 0		192.01
200.00	Cross Foot Adjustments	23, 090	5, 500			0	200.00
200.00	Negative Cost Centers	0	Ω		0 0	n –	200.00
202.00	TOTAL (sum lines 118 through 201)	32, 054, 816	6, 044, 458	7, 105, 65	0 366, 945		
202.00		02,001,010	3, 511, 750	., 100,00	-1 000, 740	1 000, 140	

Heal th	Financial Systems	IU HEALTH TIPTO	N HOSPITAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider CC		Peri od:	Worksheet B	
					From 01/01/2017	Part I	
					To 12/31/2017	Date/Time Pre	pared:
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	5/29/2018 8:4 CENTRAL	
	cost center bescription	HOUSEKEEPING	DIETARY	CAFETERIA	ADMI NI STRATI ON		
					ADMINISTRATION	SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	13.00	14.00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - OFFSITE						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPING	661, 844					9.00
	01000 DI ETARY	13, 636	516, 108				10.00
	01100 CAFETERI A	29, 979	010, 100	940, 63	4		11.00
	01300 NURSI NG ADMI NI STRATI ON	22, 943	0	42, 74			13.00
	01400 CENTRAL SERVICES & SUPPLY	24, 452	0		0 0	1, 418, 788	
	01500 PHARMACY	8, 332	0	46, 19	-	12, 263	1
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	0, 332	9	40,17	0 0	12,205	13.00
30.00	03000 ADULTS & PEDI ATRI CS	113, 462	516, 108	250, 89	8 789, 413	51, 543	30.00
	ANCI LLARY SERVICE COST CENTERS	110, 102	010, 100	200,07	0 707, 110	01,010	00.00
	05000 OPERATI NG ROOM	127, 054	0	100, 39	9 192, 614	354, 869	50.00
	05300 ANESTHESI OLOGY	2, 333	o	6, 69		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	65, 745	0	106, 76		11, 308	
	06000 LABORATORY	25, 676	0	62, 36		6, 193	
	06500 RESPI RATORY THERAPY	1, 555	0	36, 38		14, 018	1
	06600 PHYSI CAL THERAPY	32, 121	0	56, 26		9, 514	
	06700 OCCUPATIONAL THERAPY	7, 290	ō	24, 38		0	1
	06900 ELECTROCARDI OLOGY	14, 041	0	32, 53		10, 487	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	147, 628	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	756, 849	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
	03480 ONCOLOGY	10, 303	0	16, 50	25, 191	6, 312	1
	03160 CARDI OPULMONARY	0	0		0 0	0	1
	07697 CARDI AC REHABI LI TATI ON	10, 697	0	7,09	1 24, 420	461	76.97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	60, 011	0	127, 10	6 218, 653	32, 770	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	•					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	569, 630	516, 108	916, 31	3 1, 273, 973	1, 414, 215	118.00
	NONREI MBURSABLE COST CENTERS	•					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
190.01	19001 MARKETI NG/PUBLI C RELATI ONS	3, 852	О		0 0	490	190.01
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	79, 760	О	17, 95	9 0	2, 221	192.00
192.01	19201 OCCUPATI ONAL MEDI CI NE	8, 602	0	6, 36	2 0	1, 862	192.01
192.02	19202 VACANT SPACE	0	О		0 0	0	192. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	О		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	661, 844	516, 108	940, 63	4 1, 273, 973	1, 418, 788	202.00

Health Fi	nancial Systems	IU HEALTH TIPTO	ON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLO	OCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017		manadi
					To 12/31/2017	5/29/2018 8:4	ipareu: 1 am
	Cost Center Description	PHARMACY	Subtotal	Intern &	Total	0,2,7,2010 011	
	'			Residents Co	st		
				& Post			
				Stepdown			
				Adjustments			
0.51		15.00	24.00	25.00	26.00		
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT			1			1 1 00
							1.00
	101 CAP REL COSTS-BLDG & FIXT - INTERES 200 CAP REL COSTS-MVBLE EQUIP						2.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	500 ADMI NI STRATI VE & GENERAL						5.00
	700 OPERATION OF PLANT						7.00
	701 OPERATION OF PLANT - OFFSITE						7.00
	800 LAUNDRY & LINEN SERVICE						8.00
	900 HOUSEKEEPING						9.00
	000 DI ETARY						10.00
	100 CAFETERI A						11.00
	300 NURSI NG ADMI NI STRATI ON						13.00
	400 CENTRAL SERVICES & SUPPLY						14.00
	500 PHARMACY	1,080,774					15.00
I NE	PATIENT ROUTINE SERVICE COST CENTERS						1
30.00 030	000 ADULTS & PEDI ATRI CS	8, 784	6, 649, 916		0 6, 649, 916		30.00
	CILLARY SERVICE COST CENTERS						
50.00 050	000 OPERATI NG ROOM	8, 878	4,027,337		0 4, 027, 337		50.00
	300 ANESTHESI OLOGY	0	102, 098		0 102, 098		53.00
	400 RADI OLOGY-DI AGNOSTI C	2, 244	2, 760, 594		0 2, 760, 594		54.00
	000 LABORATORY	0	1, 855, 573		0 1, 855, 573		60.00
	500 RESPI RATORY THERAPY	117	782, 330		0 782, 330		65.00
	600 PHYSI CAL THERAPY	101	1, 459, 515		0 1, 459, 515		66.00
	700 OCCUPATI ONAL THERAPY	0	395, 080		0 395, 080		67.00
	900 ELECTROCARDI OLOGY	193	889, 702	1	0 889, 702		69.00
	100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	453, 870	1	0 453, 870		71.00
	200 IMPL. DEV. CHARGED TO PATIENTS 300 DRUGS CHARGED TO PATIENTS	0	2, 326, 861		0 2, 326, 861 0 3, 313, 383		72.00
	480 ONCOLOGY	1,041,250	3, 313, 383				73.00 73.01
	160 CARDI OPULMONARY	1, 190 0	462, 412 0		0 462, 412 0 0		76.00
	697 CARDI AC REHABI LI TATI ON	24	310, 365		0 310, 365		76.97
	TPATIENT SERVICE COST CENTERS	24	310, 303	1	0 310, 303	1	/0. 7/
	100 EMERGENCY	12, 163	3, 562, 175		0 3, 562, 175		91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	12, 100	0,002,170		0 0,002,170		92.00
	ECIAL PURPOSE COST CENTERS					1	12100
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,074,944	29, 351, 211		0 29, 351, 211		118.00
	NREI MBURSABLE COST CENTERS				, , , , , =		1
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
190.01 190	001 MARKETING/PUBLIC RELATIONS	О	117, 719		0 117, 719		190. 01
192.00 192	200 PHYSI CLANS' PRI VATE OFFI CES	21	2, 332, 314		0 2, 332, 314		192.00
192.01 192	201 OCCUPATIONAL MEDICINE	5, 809	225, 116	,	0 225, 116		192.01
192.02 192	202 VACANT SPACE	0	28, 456	,	0 28, 456		192. 02
200.00	Cross Foot Adjustments		0		0 0		200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	1, 080, 774	32, 054, 816	,	0 32, 054, 816		202.00

Health Fin	ancial Systems	IU HEALTH TIPT	FON HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATI ON	N OF CAPITAL RELATED COSTS		Provider C	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/29/2018 8:4	
			CAP	I TAL RELATED	COSTS	1 37 2 97 2018 8.4	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	BLDG & FIXT INTERES	- MVBLE EQUIP	Subtotal	
		Related Costs 0	1.00	1.01	2.00	2A	
GEN	ERAL SERVICE COST CENTERS	0	1.00	1.01	2.00	20	
1.00 0010 1.01 0010 2.00 0020	00 CAP REL COSTS-BLDG & FIXT 01 CAP REL COSTS-BLDG & FIXT - INTERES 00 CAP REL COSTS-MVBLE EQUIP						1.00 1.01 2.00
	00 EMPLOYEE BENEFI TS DEPARTMENT 00 ADMI NI STRATI VE & GENERAL	0	5, 740 80, 334			13, 353 186, 872	
7.00 0070 7.01 0070	OO OPERATION OF PLANT OI OPERATION OF PLANT - OFFSITE	0	298, 927 0	129, 95	50 239, 233 0 0	668, 110 0	7.00 7.01
	00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING	0	21, 248 12, 661	11, 17 6, 65		49, 427 29, 451	1
	00 DI ETARY	0	17, 333			40, 321	
	00 CAFETERI A	0	38, 107			88, 644	
	00 NURSI NG ADMI NI STRATI ON 00 CENTRAL SERVI CES & SUPPLY	0	35, 570 31, 082			79, 374 72, 303	1
	00 PHARMACY	0	10, 591			24, 637	
	ATIENT ROUTINE SERVICE COST CENTERS			1			
	00 ADULTS & PEDIATRICS	0	144, 224	75, 84	115, 423	335, 493	30.00
	ILLARY SERVICE COST CENTERS	0	161, 498	84, 93	129, 247	375, 676	50.00
	00 ANESTHESI OLOGY	0	2, 966			6, 900	1
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	0	83, 570	43, 94	66, 881	194, 400	54.00
	00 LABORATORY	0	32, 637			75, 921	
		0	1, 977			4, 599	
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	40, 829			94, 977	1
	00 ELECTROCARDI OLOGY	0	9, 266 17, 848			21, 555 41, 517	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	1
72.00 0720	00 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
	00 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
	80 ONCOLOGY	0	13, 096	6, 88	10, 481	30, 464	
	60 CARDI OPULMONARY 97 CARDI AC REHABI LI TATI ON	0	0 13, 597	7, 15	0 0 50 10, 881	0 31, 628	
	PATIENT SERVICE COST CENTERS	0	15, 577	1,10	10, 001	51, 020	/0. //
91.00 0910	00 EMERGENCY	0	76, 280	40, 11	5 61, 047	177, 442	
	00 OBSERVATI ON BEDS (NON-DI STI NCT PART					0	92.00
118.00	CIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	0	1, 149, 381	573, 83	919, 853	2, 643, 064	118.00
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	01 MARKETI NG/PUBLI C RELATI ONS	0	4, 897				190.01
	00 PHYSI CI ANS' PRI VATE OFFI CES 01 OCCUPATI ONAL MEDI CI NE	0	177, 882 10, 934			339, 132	192.00
	02 VACANT SPACE	0	21, 215				192.01
200.00	Cross Foot Adjustments	0	21,213	, 0,			200.00
201.00	Negative Cost Centers		0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 364, 309	602, 92	1, 074, 882	3, 042, 111	202.00

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CO		Period: From 01/01/2017	Worksheet B Part II	
					To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
	Cost Center Description		ADMI NI STRATI VE			LAUNDRY &	
		BENEFITS DEPARTMENT	& GENERAL	PLANT	PLANT - OFFSI TE	LINEN SERVICE	
		4.00	5.00	7.00	7.01	8.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	13, 353					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	933	187, 805				5.00
7.00	00700 OPERATION OF PLANT	908	41, 641	710, 65	9		7.00
7.01	00701 OPERATION OF PLANT - OFFSITE	0	0	36, 69	9 36, 699		7.01
8.00	00800 LAUNDRY & LINEN SERVICE	61	1, 199	15, 04	8 0	65, 735	8.00
9.00	00900 HOUSEKEEPI NG	368	3, 352	8, 96	6 0	0	9.00
10.00	01000 DI ETARY	174	2, 225	12, 27	5 0	0	10.00
11.00	01100 CAFETERI A	355	3, 754	26, 98	7 0	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	720	5, 776	20, 65	3 1, 585	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	6, 879	22, 01	1 0	0	14.00
15.00	01500 PHARMACY	714	5, 501	7, 50	0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 559	20, 759	102, 13	5 0	65, 735	30.00
	ANCILLARY SERVICE COST CENTERS	r		r	T		
50.00	05000 OPERATING ROOM	1, 327	12, 303	114, 36		0	50.00
53.00	05300 ANESTHESI OLOGY	0	422	2, 10		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 340	11, 616	59, 18		0	54.00
60.00	06000 LABORATORY	2	8, 965	23, 11		0	60.00
65.00	06500 RESPI RATORY THERAPY	444	4, 196	1, 40		0	65.00
66.00	06600 PHYSI CAL THERAPY	748	6, 283	28, 91		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	222	1, 745	6, 56		0	67.00
69.00	06900 ELECTROCARDI OLOGY	519	3, 998	12, 63		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 794		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	9, 198		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13, 311		0 0	0	73.00
73.01	03480 ONCOLOGY	221	1, 817	9, 27		0	73.01
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	101	1, 004	9, 62	9 0	0	76.97
	OUTPATIENT SERVICE COST CENTERS	4 400	15 0/1	54.00			
91.00	09100 EMERGENCY	1, 432	15, 064	54, 02	0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
440.00	SPECIAL PURPOSE COST CENTERS	40.440	100.000	570.47	4 505	(5.305	110 00
118.00		13, 148	182, 802	573, 47	6 1, 585	65, 735	118.00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			0	190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 MARKETING/PUBLIC RELATIONS	0	0 461	3, 46	0 0 8 0		190.00
	1900 MARKETING/POBLIC RELATIONS	162	3, 642	125, 97			190.01
	19201 OCCUPATI ONAL MEDI CI NE	43	5, 642				192.00
	219201 OCCUPATIONAL MEDICINE	43	167	7, 74	0 0		192.01
200.00		0	107			0	200.00
200.00			0		0 0	0	200.00
201.00	5	13, 353	187, 805	710, 65	0		201.00
202.00		1 10,000	107,000	, 10, 00	1 30,077	00,700	1-02.00

Heal th	Financial Systems	IU HEALTH TIPTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	<u>5/29/2018 8: 4</u> CENTRAL SERVI CES & SUPPLY	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	13.00	14.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - OFFSITE						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING	42, 137					9.00
10.00	01000 DI ETARY	868	55, 863				10.00
11.00	01100 CAFETERIA	1, 909	00,000	121, 64	.9		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 461	0	5, 52			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 557	0		0 0	102, 750	
15.00	01500 PHARMACY	530	0	5, 97	-	888	•
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			-,	-		1
30, 00	03000 ADULTS & PEDI ATRI CS	7, 224	55, 863	32, 44	7 71, 319	3, 733	30.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 087	0	12, 98	4 17, 402	25, 700	50.00
53.00	05300 ANESTHESI OLOGY	149	0	86		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 186	0	13, 80	07 0	819	54.00
60.00	06000 LABORATORY	1, 635	0	8, 06	5 0	449	60.00
65.00	06500 RESPI RATORY THERAPY	99	0	4,70	05 0	1, 015	65.00
66.00	06600 PHYSI CAL THERAPY	2, 045	0	7,27	6 0	689	66.00
67.00	06700 OCCUPATI ONAL THERAPY	464	0	3, 15	4 0	0	67.00
69.00	06900 ELECTROCARDI OLOGY	894	0	4, 20	8 2, 132	759	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	10, 691	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	54, 813	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
73.01	03480 ONCOLOGY	656	0	2, 13	4 2, 276	457	73.01
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	681	0	91	7 2, 206	33	76.97
	OUTPATIENT SERVICE COST CENTERS	L					
91.00	09100 EMERGENCY	3, 821	0	16, 43	8 19, 754	2, 373	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	<u> </u>		440.50		100 110	
118.00		36, 266	55, 863	118, 50	115, 097	102, 419	118.00
100.00	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19001 MARKETI NG/PUBLI C RELATI ONS 19200 PHYSI CLANS' PRI VATE OFFI CES	245	0		-		190. 01 192. 00
		5,078	0	2, 32			
	19201 OCCUPATI ONAL MEDI CI NE 19202 VACANT SPACE	548	0	82			192.01
200.00		0	0		0 0	0	192.02 200.00
200.00			~			0	200.00
201.00	5	42, 137	55, 863	121, 64	9 115,097	102, 750	•
202.00		42,137	55, 605	121,04	113,077	102,750	202.00

Heal th	Financial Systems	IU HEALTH TIPTO	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Prep 5/29/2018 8:4	
	Cost Center Description	PHARMACY	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments			
		15.00	24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - OFFSITE						7.01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9.00
	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY	45 744					14.00
15.00	01500 PHARMACY	45, 744					15.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	372	697, 639		0 697, 639		30.00
30.00	ANCI LLARY SERVICE COST CENTERS	572	097,039		0 097,039		30.00
50.00	05000 OPERATING ROOM	376	568, 224		0 568, 224		50.00
53.00	05300 ANESTHESI OLOGY	0	10, 445		0 10, 445		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	95	285, 445		0 285, 445		54.00
60.00	06000 LABORATORY	0	118, 150		0 118, 150		60.00
65.00	06500 RESPI RATORY THERAPY	5	16, 463		0 16, 463		65.00
66.00	06600 PHYSI CAL THERAPY	4	140, 936		0 140, 936		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	33, 702		0 33, 702		67.00
69.00	06900 ELECTROCARDI OLOGY	8	66, 674		0 66, 674		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	12, 485		0 12, 485		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	64, 011		0 64, 011		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	44, 071	57, 382		0 57, 382		73.00
73.01	03480 ONCOLOGY	50	47, 349		0 47, 349		73.01
	03160 CARDI OPULMONARY	0	0		0 0		76.00
76.97	07697 CARDI AC REHABI LI TATI ON	1	46, 200		0 46, 200		76.97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	515	290, 859		0 290, 859		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
	SPECIAL PURPOSE COST CENTERS			1			
118.00		45, 497	2, 455, 964		0 2, 455, 964		118.00
100.00	NONREI MBURSABLE COST CENTERS			1			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19001 MARKETI NG/PUBLI C RELATI ONS	-	15,600		0 15,600		190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	1	511, 585		0 511, 585		192.00
	19201 OCCUPATI ONAL MEDI CI NE 19202 VACANT SPACE	246	35, 705		0 35, 705 0 23, 257		192. 01 192. 02
200.00		0	23, 257				192.02 200.00
200.00	· · · · · · · · · · · · · · · · · · ·	~	0		0 0 0 0		200.00
201.00	5	45, 744	3, 042, 111		0 3, 042, 111		201.00
202.00		40,744	5,042,111	I	J, U42, ITI	l l	202.00

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		0.00				5/29/2018 8:4	1 am
		CAP	ITAL RELATED CO	DSTS			
	Cost Center Description	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	EMPLOYEE	Reconciliation	
	'	(SQUARE FEET)	I NTERES	(SQUARE FEET)	BENEFITS		
			(SQUARE FEET)		DEPARTMENT		
					(GROSS		
		1.00	1.01	2.00	SALARI ES) 4. 00	5A	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	4.00	54	
1.00	00100 CAP REL COSTS-BLDG & FIXT	207,006					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	0	173, 953				1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP			203, 78			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	871	871	1		( 044 450	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	12, 189 45, 356	12, 189 37, 493			-6, 044, 458	5.00 7.00
7.00	00701 OPERATION OF PLANT - OFFSITE	45, 350	0 37,493		0 728, 102	0	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	3, 224	3, 224		0	0	8.00
9.00	00900 HOUSEKEEPI NG	1, 921	1, 921			0	9.00
10.00	01000 DI ETARY	2, 630	2, 630	2, 63	0 139, 449	0	10.00
11.00	01100 CAFETERI A	5, 782	5, 782			0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	5, 397	4, 425			0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	4, 716				0	14.00
15.00	01500 PHARMACY	1, 607	1, 607	1, 60	7 572, 770	0	15.00
30, 00	03000 ADULTS & PEDIATRICS	21, 883	21, 883	21, 88	3 2, 053, 985	0	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	21,000	21,000	21,00	2,000,700		00.00
50.00	05000 OPERATING ROOM	24, 504	24, 504	24, 50	4 1, 064, 435	0	50.00
53.00	05300 ANESTHESI OLOGY	450	450	45	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	12, 680	12, 680			0	54.00
60.00	06000 LABORATORY	4, 952	4, 952			0	60.00
65.00		300	300			0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 195	6, 195			0	66.00 67.00
69.00	06900 ELECTROCARDI OLOGY	1, 406 2, 708	1, 406 2, 708			0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,700	2,700		0 413, 731	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	)	o o	0	73.00
73.01	03480 ONCOLOGY	1, 987	1, 987	1, 98	7 177, 541	0	73.01
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	2,063	2, 063	2,06	3 80, 889	0	76.97
91.00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	11, 574	11, 574	11, 57	4 1, 148, 010	0	91.00
		11, 574	11, 574	11, 57	4 1, 140, 010	0	92.00
72.00	SPECIAL PURPOSE COST CENTERS			1			72.00
118.00		174, 395	165, 560	174, 39	5 10, 545, 573	-6, 044, 458	118.00
	NONREI MBURSABLE COST CENTERS		1			1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		0 0		190.00
	19001 MARKETI NG/PUBLI C RELATI ONS	743					190.01
	19200 PHYSI CLANS' PRI VATE OFFI CES	26, 990					192.00
	I 19201 OCCUPATIONAL MEDICINE 2 19202 VACANT SPACE	1, 659 3, 219			9 34, 406		192. 01 192. 02
200.00		5,219	541		0	0	200.00
200.00	5						201.00
202.00		1, 364, 309	602, 920	1, 074, 88	2 2, 349, 089		202.00
	Part I)						
203.00		6. 590674	3. 465994	5. 27453			203.00
204.00					13, 353		204.00
205 00	Part II)				0 001047		205 00
205.00	D Unit cost multiplier (Wkst. B, Part				0.001247		205.00
206.00							206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)			1		I	

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH TIP	Provider C	CN: 15-1311	eriod:	u of Form CMS-: Worksheet B-1	
CUSTA	LLUCATION - STATISTICAL DASIS		FION der C	F	rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 8:4	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	OPERATION OF PLANT - OFFSITE (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (TOTAL PATI ENT DAYS)	HOUSEKEEPI NG (SQUARE FEET)	
		5.00	7.00	7.01	8.00	9.00	
	GENERAL SERVICE COST CENTERS						
1.00 1.01 2.00 4.00 5.00 7.00 7.01 8.00 9.00 10.00 11.00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - INTERES 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA	26, 010, 358 5, 765, 773 0 166, 088 464, 299 308, 131 519, 987	152, 262 7, 863 3, 224 1, 921 2, 630	22, 512 C C	2, 207 0 0	127, 647 2, 630 5, 782	10.00
	01300 NURSI NG ADMI NI STRATI ON	800, 024			-	4, 425	
14.00	01400 CENTRAL SERVICES & SUPPLY	952, 828				4, 425	
	01500 PHARMACY	761, 932			-	1,607	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS	701,702	1,007		0	1,007	10.00
30.00	03000 ADULTS & PEDIATRICS	2, 875, 191	21, 883	C	2, 207	21, 883	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 704, 001	24, 504	C	0	24, 504	50.00
53.00	05300 ANESTHESI OLOGY	58, 410	450			450	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 608, 906			-	12, 680	
60.00	06000 LABORATORY	1, 241, 694			-	4, 952	
65.00	06500 RESPI RATORY THERAPY	581, 196			0	300	
66.00	06600 PHYSI CAL THERAPY	870, 191			0	6, 195	
67.00	06700 OCCUPATIONAL THERAPY	241, 636			0	1,406	
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	553, 782 248, 495			0	2, 708 0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 273, 960			0	0	
	07300 DRUGS CHARGED TO PATIENTS	1, 843, 685			0	0	
	03480 ONCOLOGY	251, 696			0	1, 987	
76.00	03160 CARDI OPULMONARY	0	0	c c	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	139, 077	2, 063	C	0	2, 063	76.97
	OUTPATIENT SERVICE COST CENTERS		·	•			
	09100 EMERGENCY	2,086,475	11, 574	C	0	11, 574	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS	1		1			
118.00		25, 317, 457	122, 870	972	2, 207	109, 862	1118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		C	l c	0		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 MARKETING/PUBLIC RELATIONS	63, 862			0		190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	504, 471			0	15, 383	
	19201 OCCUPATI ONAL MEDI CI NE	101, 478					192.0
	19202 VACANT SPACE	23, 090			0		192.02
200.00		20,070			0	0	200.00
201.00							201.00
202.00		6, 044, 458	7, 105, 650	366, 945	355, 140	661, 844	
203.00		0. 232387	46. 667258	16. 299973	160. 915270	5. 184955	203.00
204.00		187, 805	710, 659	36, 699		42, 137	204.00
205.00	11)	0. 007220	4. 667343	1. 630197	29. 784776	0. 330106	
206.00	(per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Heal th F	inancial Systems	IU HEALTH TIPT	ON_HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALI	LOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2017	Worksheet B-1	
				T		Date/Time Pre	
	Cret Creter Decerinties				CENTRAL	5/29/2018 8:4	1 am
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (FTE' S)	NURSING ADMINISTRATION	CENTRAL SERVI CES &	PHARMACY (COSTED	
		(WLALS SLAVED)	(IIL 3)	ADMINI STRATION	SUPPLY	REQUIS.)	
				(DI RECT	(COSTED	REGOLD. )	
				NURSING HOURS)	REQUIS.)		
		10.00	11.00	13.00	14.00	15.00	
G	ENERAL SERVICE COST CENTERS						
	0100 CAP REL COSTS-BLDG & FIXT						1.00
	0101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
	0200 CAP REL COSTS-MVBLE EQUIP						2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT						5.00
	0700 OPERATION OF PLANT - OFFSITE						7.00 7.01
	0800 LAUNDRY & LINEN SERVICE						8.00
	0900 HOUSEKEEPING						9.00
	1000 DI ETARY	8, 724					10.00
	1100 CAFETERIA	0	14, 194				11.00
13.00 0	1300 NURSI NG ADMI NI STRATI ON	0	645				13.00
	1400 CENTRAL SERVICES & SUPPLY	0	0	0	2, 388, 169		14.00
15.00 0	1500 PHARMACY	0	697	0	20, 642	1, 913, 668	15.00
	NPATIENT ROUTINE SERVICE COST CENTERS	· ·					
	3000 ADULTS & PEDI ATRI CS	8, 724	3, 786	71, 669	86, 760	15, 554	30.00
	NCI LLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0	1, 515		597, 332	15, 720	•
	5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0	101		0	0	53.00
	6000 LABORATORY	0	1, 611 941		19, 034 10, 425	3, 973 0	54.00 60.00
	6500 RESPIRATORY THERAPY	0	549		23, 596	207	
1	6600 PHYSI CAL THERAPY	0	849		16, 015	179	66.00
	6700 OCCUPATI ONAL THERAPY	0	368		10, 015	0	67.00
	6900 ELECTROCARDI OLOGY	0 0	491		17, 652	342	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		248, 495	0	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1, 273, 960	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1, 843, 684	73.00
	3480 ONCOLOGY	0	249	2, 287	10, 625	2, 107	
	3160 CARDI OPULMONARY	0	0		0	0	
	7697 CARDI AC REHABI LI TATI ON	0	107	2, 217	776	42	76.97
_	UTPATIENT SERVICE COST CENTERS		1 010	10.051	FF 1(0	01 507	01 00
	9100 EMERGENCY	0	1, 918	19, 851	55, 160	21, 537	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART PECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 724	13, 827	115, 661	2, 380, 472	1, 903, 345	118 00
	ONREI MBURSABLE COST CENTERS	0,724	15, 027	113,001	2, 300, 472	1, 703, 343	1110.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	9001 MARKETI NG/PUBLIC RELATIONS	0	0		824		190.01
192.001	9200 PHYSI CLANS' PRI VATE OFFI CES	0	271	0	3, 739	38	192.00
192.011	9201 OCCUPATIONAL MEDICINE	0	96	0	3, 134	10, 285	192. 01
	9202 VACANT SPACE	0	0	0	0	0	192. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	516, 108	940, 634	1, 273, 973	1, 418, 788	1, 080, 774	202.00
203.00	Part I)		(( )(0))	11 014715	0 504000	0 544744	202.00
203.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	59. 159560	66. 269832			0.564766	•
204.00	Part II)	55, 863	121, 649	115, 097	102, 750	45, 744	204.00
205.00	Unit cost multiplier (Wkst. B, Part	6. 403370	8. 570452	0. 995124	0.043025	0.023904	205 00
200.00		0.400070	0.070402	0. 775124	0.040020	0. 020704	
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)	I		I			I

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2017 To 12/31/2017		
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 649, 916		6, 649, 91	6 0	0	30.00
ANCI LLARY SERVICE COST CENTERS			-			
50.00 05000 OPERATING ROOM	4, 027, 337		4, 027, 33	7 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	102, 098		102, 09	8 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 760, 594		2, 760, 59	4 0	0	54.00
60. 00 06000 LABORATORY	1, 855, 573		1, 855, 57	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	782, 330	0	782, 33	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 459, 515	0	1, 459, 51	5 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	395, 080	0	395, 08	0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	889, 702		889, 70	2 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	453, 870		453, 87	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 326, 861		2, 326, 86	1 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 313, 383		3, 313, 38	3 0	0	73.00
73. 01 03480 ONCOLOGY	462, 412		462, 41	2 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	310, 365		310, 36	5 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	3, 562, 175		3, 562, 17		e e	,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 396, 525		1, 396, 52		0	1 2.00
200.00 Subtotal (see instructions)	30, 747, 736	0				200. 00
201.00 Less Observation Beds	1, 396, 525		1, 396, 52			201.00
202.00  Total (see instructions)	29, 351, 211	0	29, 351, 21	1 0	0	202.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017	Worksheet C Part I	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 404 000		0 404 00			0.0.00
30. 00 03000 ADULTS & PEDI ATRI CS	2, 421, 080		2, 421, 08	0		30.00
ANCI LLARY SERVI CE COST CENTERS	7 720 112	15 000 450	22 541 57	0 0. 170928	0. 000000	50.00
50. 00 05000 0PERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	7, 738, 112 343, 082	15, 823, 458 484, 267			0.000000	50.00
54. 00 05400 RADI OLOGY -DI AGNOSTI C	343,082	484, 267 9, 002, 858			0.000000	53.00
60. 00 06000 LABORATORY	927, 012	5, 231, 545			0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	471, 693	667, 733			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	862, 746	1, 619, 241				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	378, 266	297, 700			0.000000	67.00
69. 00 06900 ELECTROCARDI OLOGY	287, 992	3, 923, 089			0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	938, 538	942, 021			0.000000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	8, 994, 809	2, 588, 273			0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 653, 065	7, 646, 307			0. 000000	73.00
73. 01 03480 ONCOLOGY	0	1, 338, 068			0.000000	73.01
76.00 03160 CARDI OPULMONARY	0	0		0. 000000	0.000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	580, 964	580, 96	4 0. 534224	0.000000	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	471, 743	19, 574, 735	20, 046, 47	8 0. 177696	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	9, 671	2, 620, 414	2, 630, 08	5 0. 530981	0.00000	92.00
200.00 Subtotal (see instructions)	26, 894, 142	72, 340, 673	99, 234, 81	5		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	26, 894, 142	72, 340, 673	99, 234, 81	5		202.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311	Period: From 01/01/2017	Worksheet C Part I	
			To 12/31/2017	Date/Time Pre	
		Title XVIII	Hospi tal	5/29/2018 8:4 Cost	I am
Cost Center Description	PPS Inpatient		iospi tai	COST	
COST CENTER DESCRIPTION	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVICE COST CENTERS					1
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73. 01 03480 ONCOLOGY	0. 000000				73.01
76. 00 03160 CARDI OPULMONARY	0. 000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76.97
OUTPATIENT SERVICE COST CENTERS	1				
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00  Total (see instructions)					202.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017		
		Ti tl	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	6, 649, 916		6, 649, 9	6 0	6, 649, 916	30.00
ANCI LLARY SERVI CE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				i	1
50.00 05000 OPERATI NG ROOM	4, 027, 337		4, 027, 33	37 0	4, 027, 337	50.00
53. 00 05300 ANESTHESI OLOGY	102, 098		102, 09	0 8	102, 098	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 760, 594		2, 760, 59	04 0	2, 760, 594	54.00
60. 00 06000 LABORATORY	1, 855, 573		1, 855, 57	/3 0	1, 855, 573	60.00
65. 00 06500 RESPI RATORY THERAPY	782, 330	0	782, 33	80 0	782, 330	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 459, 515	0	1, 459, 51	5 0	1, 459, 515	
67.00 06700 OCCUPATI ONAL THERAPY	395, 080	0	395, 08	30 0	395, 080	67.00
69. 00 06900 ELECTROCARDI OLOGY	889, 702		889, 70		889, 702	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	453, 870		453, 87		453, 870	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 326, 861		2, 326, 86		2, 326, 861	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 313, 383		3, 313, 38		3, 313, 383	
73. 01 03480 ONCOLOGY	462, 412		462, 41	2 0	462, 412	
76. 00 03160 CARDI OPULMONARY	0			0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	310, 365		310, 36	05 0	310, 365	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	3, 562, 175		3, 562, 17		0/002/1/0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 396, 525		1, 396, 52		1, 396, 525	
200.00 Subtotal (see instructions)	30, 747, 736	0	30, 747, 73		30, 747, 736	
201.00 Less Observation Beds	1, 396, 525		1, 396, 52		1, 396, 525	
202.00  Total (see instructions)	29, 351, 211	0	29, 351, 21	1 0	29, 351, 211	202.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017	Worksheet C Part I	
				To 12/31/2017	Date/Time Pre	
					5/29/2018 8:4 Cost	1 am
	Title XIX Hospital					
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpati ent	
	6.00	7.00	8.00	9.00	<u>Ratio</u> 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	8.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIATRICS	2, 421, 080		2, 421, 08			30,00
ANCI LLARY SERVICE COST CENTERS	2,421,000		2,421,00	0		30.00
50. 00 05000 OPERATING ROOM	7, 738, 112	15, 823, 458	23, 561, 57	0 0. 170928	0, 000000	50.00
53. 00 05300 ANESTHESI OLOGY	343, 082	484, 267			0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	396, 333	9,002,858			0. 000000	54.00
60. 00 06000 LABORATORY	927, 012	5, 231, 545			0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	471, 693	667, 733			0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	862, 746	1, 619, 241			0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	378, 266	297, 700	675, 96	6 0. 584467	0.000000	67.00
69. 00 06900 ELECTROCARDI OLOGY	287, 992	3, 923, 089	4, 211, 08	0. 211276	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	938, 538	942, 021	1, 880, 55	9 0. 241348	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	8, 994, 809	2, 588, 273	11, 583, 08	2 0. 200884	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 653, 065	7, 646, 307	10, 299, 37	2 0. 321707	0.00000	73.00
73. 01 03480 ONCOLOGY	0	1, 338, 068	1, 338, 06		0.00000	73.01
76.00 03160 CARDI OPULMONARY	0	0		0 0. 000000		76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	580, 964	580, 96	4 0. 534224	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	471, 743				0.000000	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	9, 671	2, 620, 414			0. 000000	92.00
200.00 Subtotal (see instructions)	26, 894, 142	72, 340, 673	99, 234, 81	5		200.00
201.00 Less Observation Beds	26 004 142	70 040 (70	00 004 01	-		201.00
202.00  Total (see instructions)	26, 894, 142	72, 340, 673	99, 234, 81	p		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 15-1311         Period: Tro 01/01/2017 To 12/31/2017         Porksheet C Part I StervTime Prepared: 52/9/2018 8: 41 am 52/9/2018 8: 41 am 50: 00           INPATIENT ROUTINE SERVICE COST CENTERS 30: 00         Interview Prepared: 70: 00         Title XIX         Hospital         Cost           INPATIENT ROUTINE SERVICE COST CENTERS 50: 00         03000/ADULTS & PEDIATRICS         30: 00         30: 00           50: 00         05000 OPERATING ROOM 0: 000000         0: 000000         50: 00         50: 00           50: 00         05000 OPERATING ROOM 0: 000000         0: 000000         50: 00         50: 00           50: 00         05000 OPERATING RORY THERAPY         0: 000000         54: 00         66: 00           60: 00         0: 000000         0: 000000         54: 00         66: 00         66: 00           60: 00         0: 000000         0: 000000         0: 000000         72: 00         71: 00           71: 00         0: 000000         0: 000000         0: 72: 00         72: 00         72: 00           71: 00         0: 000000         0: 000000         0: 72: 00         72: 00         73: 00         73: 00         73: 00           <	Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2	552-10
To         12/31/2017         Date/Time Prepared: 5/29/2018 8: 41 am           Cost Center Description         PPS Inpatient Ratio 11.00         Title XIX         Hospital         Cost           30.00         03000 ADULTS & PEDIATRICS         30.00         30.00         05300 ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         50.00         05300 ADULTS & PEDIATRICS         30.00         50.00           50.00         05300 ADULTS & DEDIATRICS         0.000000         50.00         53.00         50.00           51.00         05300 ANESTHESI OLOGY         0.000000         50.00         53.00         50.00         54.00           66.00         06500 RESPI RATORY THERAPY         0.000000         65.00         66.00         65.00         66.00         65.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         71.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         72.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00         73.00	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311			
Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         Cost           30.00         03000 ADULTS & PEDIATRICS					Date/Time Prep	
Cost Center Description         PPS Inpatient Ratio         1         0         1         0         30         00         50         00         55.00         05.00         53.00         50.00         53.00         50.00         53.00         50.00         53.00         60.00         66.00         60.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         6						am
Ratio         11.00         11.00           30.00         03000 ADULTS & PEDI ATRICS         30.00           ANCILLARY SERVICE COST CENTERS         30.00           50.00         05000 OPERATING ROOM         0.000000           53.00         05300 AMESTHESI OLOGY         0.000000           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.000000           60.00         06600 PLSPI RATORY THERAPY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           66.00         06700 OCCUPATI ONAL THERAPY         0.000000           67.00         06700 DCCUPATI ONAL THERAPY         0.000000           69.00         06700 DCCUPATI ONAL THERAPY         0.000000           71.00         07200 IMPL. DEV. CHARGED TO PATI ENT         0.000000           73.01         07300 DRUGS CHARGED TO PATI ENTS         0.000000           73.01         03400 ONCOLOGY         0.000000           73.01         03400 ONCOLOGY         0.000000           73.01         03400 ORCOLOGY         0.000000           73.01         03400 ONCOLOGY         0.000000           73.01         03400 ONCOLOGY         0.000000           73.01         03400 ONCOLOGY         0.000000           73.01			Title XIX	Hospi tal	Cost	
INPATIENT ROUTINE SERVICE COST CENTERS           30.00         Ogool ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         50.00         5000 (PERATING ROM         0.000000         50.00           53.00         05300 (ABUTS) & PEDIATRICS         0.000000         50.00         50.00           54.00         05400 (RABIOLOGY         0.000000         53.00         54.00           66.00         06400 (LABORATORY         0.000000         60.00         60.00           65.00         06500 (RESPI RATORY THERAPY         0.000000         65.00         66.00           67.00         06700 (OCUPATIONAL THERAPY         0.000000         67.00         67.00           67.00         06700 OCUPATIONAL THERAPY         0.000000         67.00         67.00           69.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENT         0.000000         71.00           72.00         07200 IMPL. DEV. CHARGED TO PATIENTS         0.000000         73.01           73.01         03480 (NCOLOGY         0.000000         73.01           74.00         07400 DENDES CHARGED TO PATIENTS         0.000000         73.01           76.00         07697 (CARDIAC REABELITATION         0.000000         73.01           76.00         03160 (CARDIOPUL	Cost Center Description					
INPATIENT ROUTINE SERVICE COST CENTERS         30.00           30.00         03000[ADULTS & PEDIATRICS         30.00           ANCILLARY SERVICE COST CENTERS         30.00           50.00         05000[PERATING ROOM         0.000000           53.00         05300[ANESTHESIOLOGY         0.000000           54.00         05400 RADIOLOGY-DIAGNOSTIC         0.000000           60.00         LABORATORY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           66.00         06600 LABORATORY         0.000000           66.00         06600 PHYSI CAL THERAPY         0.000000           67.00         0CCUPATI ONAL THERAPY         0.000000           67.00         0CCUPATI ONAL THERAPY         0.000000           69.00         0.06000 LECTROCARDI OLOGY         67.00           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENT         0.000000           72.00         07200 [NMEL. DEV. CHARGED TO PATIENTS         0.000000           73.00         73.00         73.00           73.00         07300 DRUGS CHARGED TO PATIENTS         0.000000           73.01         03480 ONCOLOGY         74.00           74.00         03480 ONCOLOGY         0.000000         73.01						
30. 00       O3000 ADULTS & PEDIATRICS       30. 00         ANCI LLARY SERVICE COST CENTERS		11.00				
ANCI LLARY SERVICE COST CENTERS           50.00         05000 OPERATI NG ROM         0.000000           53.00         05300 ANESTHESI OLOGY         0.000000           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.000000           60.00         06000 LABORATORY         0.000000           60.00         06500 RESPI RATORY THERAPY         0.000000           65.00         06500 RESPI RATORY THERAPY         0.000000           66.00         06700 OCCUPATI ONAL THERAPY         0.000000           67.00         06700 OCCUPATI ONAL THERAPY         0.000000           69.00         06900 ELECTROCARDI OLOGY         0.000000           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT         0.000000           72.00         07300 DRUGS CHARGED TO PATI ENTS         0.000000           73.01         03480 ONCOLOGY         0.000000         73.01           76.97         07697 CARDI AC REHABI LITATI ON         0.000000         76.97           71.00         09100 EMERGENCY         0.000000         76.97           71.00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART         0.000000         92.00           701.00         DILAC ENTRERS         0.000000         76.97           71.00         09200 OBSERVATI ON BEDS (NON-DI						20.00
50.00         05000         OPERATING ROOM         0.000000         53.00           53.00         ANESTHESI OLOGY         0.000000         53.00           54.00         O5400         RADI OLOGY-DI AGNOSTI C         0.000000         60.00           60.00         O6500         RESPI RATORY         0.000000         60.00           65.00         O6500         RESPI RATORY THERAPY         0.000000         65.00           66.00         O6600         PHYSI CAL THERAPY         0.000000         66.00           67.00         O6700 OCCUPATI ONAL THERAPY         0.000000         67.00           69.00         CLECTROCARDI OLOGY         0.000000         69.00           71.00         O7100         MEDI CAL SUPPLIES CHARGED TO PATI ENT         0.000000           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0.000000         73.00           73.01         03480         ONCOLOGY         0.000000         73.00         73.01           74.00         O1140 CARDI OPULMONARY         0.000000         76.00         76.00           74.00         O7697 CARDI AC REHABI LI TATI ON         0.000000         76.00         76.00           75.00         O79700         CARDI AC REHABI LI TATI ON         0.000000<						30.00
53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       54.00         60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       65.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       67.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.97       CARDI AC EHABI LI TATI ON       0.000000       76.00         91.00       O9200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       91.00         92.00       O9200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       201.00       201.00 <td></td> <td>0.000000</td> <td></td> <td></td> <td></td> <td></td>		0.000000				
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.00000       54.00         60.00       06000       LABORATORY       0.000000       60.00         65.00       0500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06000       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       67.00         69.00       06700       CCUPATI ONAL THERAPY       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         73.01       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.01         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.01         74.00       03480       ONCOLOGY       0.000000       73.01         75.00       07697       CARDI AC REHABI LI TATI ON       0.000000       73.01         76.97       07697       CARDI AC REHABI LI TATI ON       0.000000       91.00         70.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       92.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
60.00       06000       LABORATORY       0.000000       60.00         65.00       06500       RESPI RATORY THERAPY       0.000000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       0CCUPATI ONAL THERAPY       0.000000       67.00         69.00       0ECUPATI ONAL THERAPY       0.000000       67.00         69.00       0EQUE TROCARDI OLOGY       0.000000       69.00         71.00       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       OT497       CARDI AC REHABILITATI ON       0.000000       76.97         91.00       O9200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       91.00         92.00       O9200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       200.00         200.00       Subtotal (see i nstructi ons)		1				
65.00       06500       RESPI RATORY THERAPY       0.00000       65.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       OAGPT CARDI AC REHABILITATION       0.000000       76.97         010000       09100       EMERGENCY       0.000000       91.00         91.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00						
66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       69.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       73.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       07697       CARDI AC REHABI LI TATI ON       0.000000       76.97         09100       EMERGENCY       0.000000       91.00       91.00         92.00       095ERVATI ON BEDS (NON-DI STI NCT PART       0.000000       92.00       92.00       92.00       005ERVATI ON BEDS (NON-DI STI NCT PART       0.000000       92.00       92.00       92.00       92.00       200.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       201.00       <						
67.00       06700       0CCUPATIONAL THERAPY       0.000000       67.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.01         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       07697       CARDI AC REHABILITATION       0.000000       76.97         01000       UTPATIENT SERVICE COST CENTERS       0.000000       91.00         91.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       92.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       200.00         201.00       Less Observation Beds       200.00       201.00       201.00						
69.00       06900       ELECTROCARDIOLOGY       0.000000       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       OT697       CARDI AC REHABILITATION       0.000000       76.97         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       92.00         200.00       Subtotal (see instructions)       200.000       201.00       201.00						
71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       07697       CARDI AC REHABILITATION       0.000000       76.97         00TPATIENT SERVICE COST CENTERS       0.000000       76.97       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       92.00         200.00       Subtotal (see instructions)       0.000000       201.00       201.00						
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI AC REHABILITATION       0.000000       76.00         76.00       07697       CARDI AC REHABILITATION       0.000000       76.00         00TPATIENT SERVICE COST CENTERS       0.000000       76.00       76.00         91.00       09100       EMERGENCY       0.000000       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00       201.00						
73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         73.01       03480       ONCOLOGY       0.000000       73.01         76.00       03160       CARDI OPULMONARY       0.000000       76.00         76.97       OZADI AC REHABILITATION       0.000000       76.97         0UTPATIENT SERVICE COST CENTERS       0.000000       76.97         91.00       O9100       MERGENCY       0.000000         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART 0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00						
73. 01       03480       ONCOLOGY       0.000000       73. 01         76. 00       03160       CARDI OPULMONARY       0.000000       76. 00         76. 97       07697       CARDI AC       REHABI LI TATI ON       0.000000       76. 97         0UTPATI ENT SERVICE COST CENTERS       0.000000       91.00       91.00       99100       EMERGENCY       0.000000       91.00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART       0.000000       92.00       92.00       92.00       200. 00       201. 00 <t< td=""><td></td><td>1</td><td></td><td></td><td></td><td></td></t<>		1				
76.00         03160         CARDI OPULMONARY         0.000000         76.00           76.07         07697         CARDI AC REHABILITATION         0.000000         76.97           000000000000000000000000000000000000						
76. 97         07697         CARDI AC REHABILITATION         0.000000         76. 97           0UTPATIENT SERVICE COST CENTERS         0000000         91.00         91.00         91.00         91.00         92.00         9200         0BSERVATION BEDS (NON-DISTINCT PART 0.000000         92.00<						
OUTPATIENT SERVICE COST CENTERS           91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART 0.000000         92.00         92.00           200.00         Subtotal (see instructions)         200.00         200.00         201.00         201.00						
91.00         09100         EMERGENCY         0.000000         91.00           92.00         09200         OBSERVATION BEDS (NON-DISTINCT PART         0.000000         92.00           200.00         Subtotal (see instructions)         200.00         200.00         200.00           201.00         Less Observation Beds         201.00         201.00         201.00						
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00		0. 000000				91.00
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
					2	200.00
202.00   Total (see instructions)   202.00	201.00 Less Observation Beds				2	201.00
	202.00 Total (see instructions)				2	202.00

Health Financial Systems	IU HEALTH TIP			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part II Date/Time Pre 5/29/2018 8:4	pared: 1 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	r	1			
50. 00 05000 OPERATI NG ROOM	568, 224					
53. 00 05300 ANESTHESI OLOGY	10, 445				1, 936	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	285, 445	9, 399, 191	0. 03036	9 181, 925	5, 525	54.00
60. 00 06000 LABORATORY	118, 150		0. 01918	5 512, 873	9, 839	60.00
65. 00 06500 RESPI RATORY THERAPY	16, 463	1, 139, 426	0. 01444		3, 197	65.00
66. 00 06600 PHYSI CAL THERAPY	140, 936	2, 481, 987	0. 05678	4 369, 060	20, 957	66.00
67.00 06700 OCCUPATI ONAL THERAPY	33, 702	675, 966	0. 04985	8 180, 135	8, 981	67.00
69. 00 06900 ELECTROCARDI OLOGY	66, 674	4, 211, 081	0. 01583	3 199, 473	3, 158	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 485	1, 880, 559	0. 00663	9 417, 618	2, 773	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	64, 011	11, 583, 082	0. 00552	6 4, 044, 743	22, 351	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	57, 382	10, 299, 372	0. 00557	1, 276, 722	7, 113	73.00
73. 01 03480 ONCOLOGY	47, 349	1, 338, 068	0. 03538	6 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0	0	0.00000	0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	46, 200	580, 964	0. 07952	3 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	290, 859	20, 046, 478	0. 01450	10, 034	146	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	146, 508	2, 630, 085	0. 05570	5 546	30	92.00
200.00 Total (lines 50 through 199)	1, 904, 833	96, 813, 735		11, 169, 736	172, 876	200 00

Health Financial Systems	IU HEALTH TIP	TON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2017	Part IV	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
		Title	× XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School				
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. 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 03480 ONCOLOGY	0	0		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		narad
				10 12/31/2017	5/29/2018 8:4	pareu. 1 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	through col.	Cost (sum of		(col. 5 ÷ col.	
		4)	col. 2, 3 and	(8 1	7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	0	0		0 23, 561, 570		
53.00 05300 ANESTHESI OLOGY	0	0		0 827, 349		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 399, 191	0.00000	
60. 00 06000 LABORATORY	0	0		0 6, 158, 557		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 139, 426		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 481, 987		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 675, 966		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 4, 211, 081	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 1, 880, 559		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 11, 583, 082		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 299, 372		
73. 01 03480 ONCOLOGY	0	0		0 1, 338, 068		
76. 00 03160 CARDI OPULMONARY	0	0		0 0	0.00000	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 580, 964	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS	1		1	1		
91.00 09100 EMERGENCY	0	0		0 20, 046, 478		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 2, 630, 085		
200.00  Total (lines 50 through 199)	0	0	l	0 96, 813, 735		200. 00

Health Financial Systems	IU HEALTH TIPT	ON_HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	EVICE OTHER PASS	Provider CO		Period: From 01/01/2017 To 12/31/2017		pared: 1 am
		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.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	3, 602, 029		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	153, 326		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	181, 925		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	512, 873		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	221, 252		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	369, 060		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	180, 135		0 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	199, 473		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	417, 618		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4,044,743		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 276, 722		0 0	0	73.00
73. 01 03480 ONCOLOGY	0. 000000	0		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	· · ·					
91.00 09100 EMERGENCY	0. 000000	10, 034		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	546		0 0	0	92.00
200.00   Total (lines 50 through 199)		11, 169, 736		0 0	0	200. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 8:4	
		Title	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 170928		4, 172, 30		0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 123404		91, 44		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 293705		3, 314, 74		0	54.00
60. 00 06000 LABORATORY	0. 301300		1, 679, 92		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 686600		275, 27		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 588043		676, 74	9 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 584467		104, 47	9 0	0	67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 211276	0	1, 572, 88	5 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 241348	0	186, 43	7 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 200884	0	558, 11	5 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 321707	0	3, 614, 94	8 611	0	73.00
73. 01 03480 ONCOLOGY	0. 345582	0	833, 42	5 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 534224	0	301, 78	5 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 177696	0	6, 465, 63	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 530981	0	1, 453, 09	5 0	0	92.00
200.00 Subtotal (see instructions)		0	25, 301, 25	0 611	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	25, 301, 25	0 611	0	202.00

Health Financial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CC		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 8:4	
		Title	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	710.1/1					
50. 00 05000 OPERATING ROOM	713, 164					50.00
53.00 05300 ANESTHESI OLOGY	11, 284	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	973, 556	0				54.00
60. 00 06000 LABORATORY	506, 161	0				60.00
65. 00 06500 RESPI RATORY THERAPY	189, 007	0				65.00
66.00 06600 PHYSI CAL THERAPY	397, 958					66.00
67.00 06700 OCCUPATI ONAL THERAPY	61,065					67.00
69. 00 06900 ELECTROCARDI OLOGY	332, 313					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44, 996					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	112, 116					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 162, 954					73.00
73. 01 03480 ONCOLOGY	288, 017	0				73.01
76.00 03160 CARDI OPULMONARY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	161, 221	0				76.97
OUTPATIENT SERVICE COST CENTERS	1					
91. 00 09100 EMERGENCY	1, 148, 918					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	771, 566	0				92.00
200.00 Subtotal (see instructions)	6, 874, 296	197				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	6, 874, 296	197				202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component (		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 8:4	
		Title	XVIII	Swing Beds - SNF	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-		-1 -	-	
50. 00 05000 OPERATI NG ROOM	0. 170928			0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 123404			0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 293705			0 0	0	54.00
60. 00 06000 LABORATORY	0. 301300			0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 686600			0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 588043			0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 584467			0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 211276			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 241348			0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 200884			0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 321707			0 0	0	
73. 01 03480 ONCOLOGY	0. 345582			0 0	0	
76.00 03160 CARDI OPULMONARY	0. 000000			0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 534224	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	1	1		1		
91. 00 09100 EMERGENCY	0. 177696			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 530981	0		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lieu of Form CMS-2552-1		
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1311 CCN: 15-Z311	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre	pared.
		oomponone .		10 12/01/2017	5/29/2018 8:4	
		Title	XVIII	Swing Beds - SNF	Cost	
	Co	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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 03480 ONCOLOGY	0	0				73.01
76.00 03160 CARDI OPULMONARY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS		1				
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00   Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/29/2018 8:4	
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS		-		-	-	
50. 00 05000 OPERATI NG ROOM	0. 170928		120, 07		0	
53.00 05300 ANESTHESI OLOGY	0. 123404		10, 01		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 293705		67, 20		0	
60. 00 06000 LABORATORY	0. 301300		31, 39		0	
65. 00 06500 RESPI RATORY THERAPY	0. 686600		45		0	
66. 00 06600 PHYSI CAL THERAPY	0. 588043		5, 37		0	00.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 584467		25		0	07100
69. 00 06900 ELECTROCARDI OLOGY	0. 211276	0	16, 19	3 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 241348	0	5, 82	9 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 200884	0	80		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 321707	0	34, 12	9 0	0	73.00
73. 01 03480 ONCOLOGY	0. 345582	0	43	8 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 534224	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 177696	0	243, 42	5 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 530981	0	11, 07	4 0	0	92.00
200.00 Subtotal (see instructions)		0	546, 65	4 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	546, 65	4 0	0	202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC		Period: From 01/01/2017 To 12/31/2017	5/29/2018 8:4	
			e XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50.00 OPERATING ROOM	20, 524					50.00
53. 00 05300 ANESTHESI OLOGY	1, 236					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	19, 740					54.00
60. 00 06000 LABORATORY	9, 458					60.00
65. 00 06500 RESPI RATORY THERAPY	310	-				65.00
66. 00 06600 PHYSI CAL THERAPY	3, 159					66.00
67.00 06700 OCCUPATI ONAL THERAPY	148	0				67.00
69. 00 06900 ELECTROCARDI OLOGY	3, 421	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 407	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	161	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	10, 980	0				73.00
73. 01 03480 ONCOLOGY	151	0				73.01
76. 00 03160 CARDI OPULMONARY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	43, 256	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5, 880	0				92.00
200.00 Subtotal (see instructions)	119, 831	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	119, 831	0				202.00

MPUL	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1311	Period: From 01/01/2017	Worksheet D-1	
			To 12/31/2017	Date/Time Prep 5/29/2018 8:4	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			0. (50	
00 00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing			3, 653 2, 952	1
	Private room days (excluding swing-bed and observation bed d		ivate room days,	2, 702	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	had dave)		2, 207	
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	586	
00	reporting period Total swing-bed SNF type inpatient days (including private n	nom davs) after December	21 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	com days) arter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private ro	om days) through December	31 of the cost	115	7
00	reporting period Total swing-bed NF type inpatient days (including private ro	om days) after December 3	1 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)			1 420	
00	Total inpatient days including private room days applicable newborn days)	to the program (excluding	swing-bed and	1, 430	ģ
00	Swing-bed SNF type inpatient days applicable to title XVIII		room days)	586	10
00	through December 31 of the cost reporting period (see instru- Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X			0	1.1
. 00	through December 31 of the cost reporting period	ix only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)		5.	0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 d	of the cost		17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	155.02	19
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instructio	ns)		6, 649, 916	21
	Swing-bed cost applicable to SNF type services through Decem		ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reportir	na period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost reporti	ng period (line	17, 827	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			1, 116, 302	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 533, 614	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation had at	arges)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed ci	lai ges)	0	29
	Semi-private room charges (excluding swing-bed charges)	lino 29)		0	30
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 $\div$ line 3)			0. 000000 0. 00	
00	Average semi-private room per diem charge (line 30 $\div$ line 4)		ati ana)	0.00	33
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l		ctions)	0.00 0.00	
. 00	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	tterential (line	5, 533, 614	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (se			1, 874. 53	38
	Program general inpatient routine service cost (line 9 x line)			1, 874. 53 2, 680, 578	39
. 00					40

IPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1311	Period: From 01/01/2017	Worksheet D-1	1
				To 12/31/2017		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	+
00 NURSERY (title V & XIX only)		2100	0.00		0100	42.
Intensive Care Type Inpatient Hospital Un	i ts					1
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT						43
00 CORONARY CARE UNIT 00 BURN INTENSIVE CARE UNIT						44
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	_
00 Program inpatient ancillary service cost	(Wkst D-3 col 3	Line 200)			1.00 2,685,050	) 48
00 Total Program inpatient costs (sum of lin			ns)		5, 365, 628	
PASS THROUGH COST ADJUSTMENTS	5 7 7					
00 Pass through costs applicable to Program	inpatient routine	services (from	Wkst. D, su	m of Parts I and	0	50
<pre>00 Pass through costs applicable to Program</pre>	innationt ancillar	v corvicos (fr	om Wkst D	cum of Parts II	0	51
and IV)	inpatrent anci i a	y services (II	UIII WKSL. D,	Sum OF Faits II	1	
00 Total Program excludable cost (sum of lir	,				0	
00 Total Program inpatient operating cost ex		lated, non-phy	sician anest	netist, and	0	53
medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)				i	
00 Program di scharges					0	54
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient ope	rating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the cost	roporting poriod	onding 1006 u	ndatod and o	ampounded by the	0.00	
market basket	reporting period	enuring 1990, u		Silpounded by the	0.00	/ 37
00 Lesser of lines 53/54 or 55 from prior ye					0.00	
00 If line 53/54 is less than the lower of l					0	61
which operating costs (line 53) are less amount (line 56), otherwise enter zero (s		s (Tines 54 x	60), or 1% o	r the target		
00 Relief payment (see instructions)					0	62
00 Allowable Inpatient cost plus incentive p	ayment (see instru	ctions)			0	63
PROGRAM INPATIENT ROUTINE SWING BED COST 00 Medicare swing-bed SNF inpatient routine	anata through Daga	mbor 21 of the	aget separt	ing partial (Cas	1 000 475	
00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	COSTS THEOUGH DECE		cost report	ng period (see	1, 098, 475	04
00 Medicare swing-bed SNF inpatient routine	costs after Decemb	er 31 of the c	ost reporting	g period (See	0	65
instructions)(title XVIII only)						
00 Total Medicare swing-bed SNF inpatient rc CAH (see instructions)	utine costs (line	64 plus line 6	5)(title XVI	ll only). For	1, 098, 475	66
00 Title V or XIX swing-bed NF inpatient rou	tine costs through	December 31 d	f the cost r	eporting period	0	67
(line 12 x line 19)	0					
00 Title V or XIX swing-bed NF inpatient rou	tine costs after D	ecember 31 of	the cost rep	orting period	0	68 (
(line 13 x line 20) 00 Total title V or XIX swing-bed NF inpatie	nt routino costs (	lino 67 i lino	60)		0	69
PART III - SKILLED NURSING FACILITY, OTHE						1 07
00 Skilled nursing facility/other nursing fa		•		)		70
00 Adjusted general inpatient routine service		ine 70 ÷ line	2)			71
00 Program routine service cost (line 9 x li		(line 14 v li	no 25)			72
00 Medically necessary private room cost app 00 Total Program general inpatient routine s	U	•	ne 35)			73
00 Capital -related cost allocated to inpatie	•		orksheet B, I	Part II, column		75
26, line 45)						
00 Per diem capital-related costs (line 75 ÷	,					76
00 Program capital-related costs (line 9 x l 00 Inpatient routine service cost (line 74 m						77
00 Aggregate charges to beneficiaries for ex	,	rovi der record	s)		1	79
00 Total Program routine service costs for c			· · · · · · · · · · · · · · · · · · ·	nus line 79)	1	80
00 Inpatient routine service cost per diem I						81
00 Inpatient routine service cost limitation	•	· .				82
00 Reasonable inpatient routine service cost 00 Program inpatient ancillary services (see	•	5)				83
00 Utilization review - physician compensati		ns)			1	85
00 Total Program inpatient operating costs (					l	86
PART IV - COMPUTATION OF OBSERVATION BED						
	000)				745	5  87
00 Total observation bed days (see instructi 00 Adjusted general inpatient routine cost p		line 2)			1, 874. 53	

Health Financial Systems	IU HEALTH TIP	FON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	697,639	6, 649, 916	0. 10490	9 1, 396, 525	146, 508	90.00
91.00 Nursing School cost	0	6, 649, 916	0.00000	0 1, 396, 525	0	91.00
92.00 Allied health cost	0	6, 649, 916	0.00000	0 1, 396, 525	0	92.00
93.00 All other Medical Education	0	6, 649, 916	0.00000	1, 396, 525	0	93.00

INI           00         In           00         In           00         Pr           00         To           00         Sw           .00         Sw           .00         Sw           .00         Me           .00         Me           .00         Me           .00         Me           .00         Sw           .00         <	Cost Center Description ART I - ALL PROVIDER COMPONENTS VPATIENT DAYS npatient days (including private room days and swing-bed da npatient days (including private room days, excluding swing rivate room days (excluding swing-bed and observation bed d o not complete this line. emi-private room days (excluding swing-bed and observation otal swing-bed SNF type inpatient days (including private r eporting period otal swing-bed SNF type inpatient days (including private r eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable ewborn days) wing-bed SNF type inpatient days applicable to title XVIII hrough December 31 of the cost reporting period (if calendar year, wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period wing-bed NF type inpatient days applicable to ti	Title XIX Ho Title XIX Ho ys, excluding newborn) -bed and newborn days) ays). If you have only private to bed days) oom days) through December 31 of om days) after December 31 of om days) through December 31 of to the Program (excluding swing- only (including private room day ctions) only (including private room day enter 0 on this line) IX only (including private room IX only (including private room year, enter 0 on this line)	room days, the cost the cost the cost bed and (s) (s) after days)	Date/Time Prep 5/29/2018 8: 41 Cost 1.00 3, 653 2, 952 0 2, 207 586 0 1115 0 7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
INI           00         In           00         In           00         Pr           00         To           00         Sw           .00         Sw           .00         Sw           .00         Me           .00         Me           .00         Me           .00         Me           .00         Sw           .00         <	ART I - ALL PROVIDER COMPONENTS IPATIENT DAYS npatient days (including private room days and swing-bed da npatient days (including private room days, excluding swing rivate room days (excluding swing-bed and observation bed do o not complete this line. emi-private room days (excluding swing-bed and observation otal swing-bed SNF type inpatient days (including private r eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private r eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private ro eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private ro eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable ewborn days) wing-bed SNF type inpatient days applicable to title XVIII hrough December 31 of the cost reporting period (if calendar year, wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X	ys, excluding newborn) -bed and newborn days) ays). If you have only private of bed days) oom days) through December 31 of oom days) after December 31 of om days) through December 31 of om days) after December 31 of th to the Program (excluding swing- only (including private room day enter 0 on this line) IX only (including private room IX only (including private room IX only (including private room year, enter 0 on this line)	room days, the cost the cost the cost the cost bed and (s) (s) after days)	1.00 3,653 2,952 0 2,207 586 0 115 0 7 0 0 0 0 0 0 0 0 0 0 0 0 0
INI           00         In           00         In           00         Pr           00         To           00         Sw           .00         Sw           .00         Sw           .00         Me           .00         Me           .00         Me           .00         Me           .00         Sw           .00         <	NPATIENT DAYS npatient days (including private room days and swing-bed da npatient days (including private room days, excluding swing rivate room days (excluding swing-bed and observation bed d o not complete this line. emi-private room days (excluding swing-bed and observation otal swing-bed SNF type inpatient days (including private r eporting period otal swing-bed SNF type inpatient days (including private r eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days applicable to title XVIII hrough December 31 of the cost reporting period (see instru wing-bed SNF type inpatient days applicable to title XVIII hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period otal nursery days (title V or XIX only) ursery days (title V or XIX only)	-bed and newborn days) ays). If you have only private n bed days) oom days) through December 31 of oom days) after December 31 of om days) through December 31 of om days) after December 31 of th to the Program (excluding swing- only (including private room day ctions) only (including private room day enter 0 on this line) IX only (including private room IX only (including private room year, enter 0 on this line)	the cost the cost the cost bed and (s) (s) after days)	3, 653 2, 952 0 2, 207 586 0 115 0 7 0 0 0 0
00         In           00         In           00         Pr           00         Pr           00         For           00         To           00         Sw           .00         Sw           .00         Me           .00         Me           .00         Me           .00         Me           .00         Sw           .00         Sw <td< th=""><th>npatient days (including private room days and swing-bed da npatient days (including private room days, excluding swing rivate room days (excluding swing-bed and observation bed d o not complete this line. emi-private room days (excluding swing-bed and observation otal swing-bed SNF type inpatient days (including private r eporting period otal swing-bed SNF type inpatient days (including private r eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable ewborn days) wing-bed SNF type inpatient days applicable to title XVIII hrough December 31 of the cost reporting period (see instru wing-bed SNF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period of f calendar edically necessary private room days applicable to the Prog otal nursery days (title V or XIX only)</th><th>-bed and newborn days) ays). If you have only private n bed days) oom days) through December 31 of oom days) after December 31 of om days) through December 31 of om days) after December 31 of th to the Program (excluding swing- only (including private room day ctions) only (including private room day enter 0 on this line) IX only (including private room IX only (including private room year, enter 0 on this line)</th><th>the cost the cost the cost bed and (s) (s) after days)</th><th>2, 952 0 2, 207 586 0 115 0 7 0 0 0 0</th></td<>	npatient days (including private room days and swing-bed da npatient days (including private room days, excluding swing rivate room days (excluding swing-bed and observation bed d o not complete this line. emi-private room days (excluding swing-bed and observation otal swing-bed SNF type inpatient days (including private r eporting period otal swing-bed SNF type inpatient days (including private r eporting period (if calendar year, enter 0 on this line) otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period otal swing-bed NF type inpatient days (including private ro eporting period (if calendar year, enter 0 on this line) otal inpatient days including private room days applicable ewborn days) wing-bed SNF type inpatient days applicable to title XVIII hrough December 31 of the cost reporting period (see instru wing-bed SNF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X hrough December 31 of the cost reporting period wing-bed NF type inpatient days applicable to titles V or X fter December 31 of the cost reporting period of f calendar edically necessary private room days applicable to the Prog otal nursery days (title V or XIX only)	-bed and newborn days) ays). If you have only private n bed days) oom days) through December 31 of oom days) after December 31 of om days) through December 31 of om days) after December 31 of th to the Program (excluding swing- only (including private room day ctions) only (including private room day enter 0 on this line) IX only (including private room IX only (including private room year, enter 0 on this line)	the cost the cost the cost bed and (s) (s) after days)	2, 952 0 2, 207 586 0 115 0 7 0 0 0 0
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af 00 Me 00 No 00 Nu <u>SW</u> 00 Me re 00 Me re 00 Me re 00 Me re 00 Sw 50 Sw 7 00 Sw 7 00 Sw 7 00 Sw	fter December 31 of the cost reporting period (if calendar edically necessary private room days applicable to the Prog otal nursery days (title V or XIX only) ursery days (title V or XIX only)	year, enter 0 on this line)	days)	0
00         Me           00         To           00         Nu           00         Me           00         Me           00         Me           00         Me           00         Solution	edically necessary private room days applicable to the Prog otal nursery days (title V or XIX only) ursery days (title V or XIX only)			
OU         Nu           00         Me           re         00           00         Me           re         00           00         Me           re         00           00         Sw	ursery days (title V or XIX only)			0
SWI           00         Me           00         Su           00         X				0
00 Re 00 Me re 00 Me re 00 To 00 Sw 5 00 Sw x 00 Sw 7 00 Sw x x				
00 Me re 00 Me re 00 To 00 Sw 5 00 Sw 7 00 Sw 7 00 Sw 7 00 Sw 7	edicare rate for swing-bed SNF services applicable to servi eporting period	ces through December 31 of the o	cost	
00 Me re 00 Me re 00 To 00 Sw 5 00 Sw 7 00 Sw 7 00 Sw x	edicare rate for swing-bed SNF services applicable to servi	ces after December 31 of the co	st	
00 Me re 00 To 00 Sw 5 00 Sw x 00 Sw 7 00 Sw 7 00 Sw x	eporting period edicaid rate for swing-bed NF services applicable to servic	es through December 31 of the co	ost	155.02
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5 00 00 00 7 00 5w 7 00 5w 7 00 5w 8w 8x	otal general inpatient routine service cost (see instructio wing-bed cost applicable to SNF type services through Decem	<i>,</i>	riod (line	6, 649, 916 0
x 00 Sw 7 00 Sw x	x line 17)			-
00   7   Sw   X	wing-bed cost applicable to SNF type services after Decembe line 18)	r 31 of the cost reporting perio	ba (line 6	0
00 Sw	wing-bed cost applicable to NF type services through Decemb x line 19)	er 31 of the cost reporting peri	od (line	17, 827
	wing-bed cost applicable to NF type services after December	31 of the cost reporting period	d (line 8	0
	line 20) otal swing-bed cost (see instructions)			1, 116, 302
.00 Ge	eneral inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 533, 614
	RIVATE ROOM DIFFERENTIAL ADJUSTMENT eneral inpatient routine service charges (excluding swing-b	ed and observation bed charges)		0
00 Pr	rivate room charges (excluding swing-bed charges)			0
	emi-private room charges (excluding swing-bed charges) eneral inpatient routine service cost/charge ratio (line 27	· Lipo 28)		0 0. 000000
	verage private room per diem charge (line 29 ÷ line 3)	÷ Trhe 20)		0.000000
	verage semi-private room per diem charge (line 30 ÷ line 4)			0.00
	verage per diem private room charge differential (line 32 m			0.00
				0.00
	verage per diem private room cost differential (line 34 x l		tial (line	0 5, 533, 614
27	verage per diem private room cost differential (line 34 x l rivate room cost differential adjustment (line 3 x line 35)			
	verage per diem private room cost differential (line 34 x l rivate room cost differential adjustment (line 3 x line 35) eneral inpatient routine service cost net of swing-bed cost 7 minus line 36)			
	verage per diem private room cost differential (line 34 x l rivate room cost differential adjustment (line 3 x line 35) eneral inpatient routine service cost net of swing-bed cost 7 minus line 36) ART II - HOSPITAL AND SUBPROVIDERS ONLY	IUSTMENTS		1, 874. 53
	verage per diem private room cost differential (line 34 x l rivate room cost differential adjustment (line 3 x line 35) eneral inpatient routine service cost net of swing-bed cost 7 minus line 36)			
.00 Me .00 To	verage per diem private room cost differential (line 34 x l rivate room cost differential adjustment (line 3 x line 35) eneral inpatient routine service cost net of swing-bed cost 7 minus line 36) ART II - HOSPITAL AND SUBPROVIDERS ONLY ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	e instructions)		13, 122

MPUIA	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1311	Period: From 01/01/2017	Worksheet D-1	
					To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)						42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	\$ 					1 42
	CORONARY CARE UNIT						43
	BURN INTENSIVE CARE UNIT						45
	SURGICAL INTENSIVE CARE UNIT						46
00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (W	<pre></pre>	line 200)	-		70, 339	48
	Total Program inpatient costs (sum of lines			ns)		83, 461	
	PASS THROUGH COST ADJUSTMENTS						
	Pass through costs applicable to Program in	patient routine s	services (from	ı Wkst. D, su	m of Parts I and	C	50
	III) Pass through costs applicable to Program in	patient ancillary	v services (fr	om Wkst D	sum of Parts II	C	51
	and IV)		,	0			
	Total Program excludable cost (sum of lines					C	
	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-phy	sician anest	netist, and	0	53
-	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					C	54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient opera Bonus payment (see instructions)	ting cost and tai	rget amount (I	ine 56 minus	line 53)		
	Lesser of lines 53/54 or 55 from the cost re	eporting period (	endina 1996. u	updated and c	ompounded by the	0.00	
	market basket						
	Lesser of lines 53/54 or 55 from prior year					0.00	
	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					C	61
	amount (line 56), otherwise enter zero (see		5 (TTHES 54 X	00), 01 1% 0	i the target		
	Relief payment (see instructions)	,				C	
	Allowable Inpatient cost plus incentive payr	ment (see instru	ctions)			0	63
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	sts through Decer	mber 31 of the	cost report	ing period (See	C	64
	instructions) (title XVIII only)	sts through becer		cost report	ng period (see		/  04
00	Medicare swing-bed SNF inpatient routine cos	sts after Decembe	er 31 of the c	ost reporting	g period (See	C	65
	instructions)(title XVIII only)		(4				
	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Trne o	54 prus rine c	s)(title xvi	TT ONLY). FOR	C	66
	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 c	of the cost r	eporting period	C	67
	(line 12 x line 19)						
	Title V or XIX swing-bed NF inpatient routin	ne costs after De	ecember 31 of	the cost rep	orting period	C	68
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ()	line 67 + line	68)		C	69
	PART III - SKILLED NURSING FACILITY, OTHER N						
	Skilled nursing facility/other nursing facil				)		70
	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v li	ne 35)			72
	Total Program general inpatient routine serv	U	•				74
	Capital -related cost allocated to inpatient	•			Part II, column		75
1	26, line 45)	2					
	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
	Inpatient routine service cost (line 74 min						78
	Aggregate charges to beneficiaries for exces	· ·	rovider record	ls)			79
1	Total Program routine service costs for com		ost limitatior	ı (line 78 mi)	nus line 79)		80
	Inpatient routine service cost per diem limitation (		)				81
	Inpatient routine service cost limitation ( Reasonable inpatient routine service costs						82
	Program inpatient ancillary services (see in	•	- /				84
00	Utilization review - physician compensation	(see instruction					85
	Total Program inpatient operating costs (sur		rough 85)				86
-	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					745	87
	Adjusted general inpatient routine cost per		line 2)			1, 874. 53	
. 00			11110 2)				

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	697, 639	6, 649, 916	0. 10490	9 1, 396, 525	146, 508	90.00
91.00 Nursing School cost	0	6, 649, 916	0.00000	0 1, 396, 525	0	91.00
92.00 Allied health cost	0	6, 649, 916	0.00000	1, 396, 525	0	92.00
93.00 All other Medical Education	0	6, 649, 916	0.00000			93.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1311	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
			10 12/31/2017	5/29/2018 8:4	1 am
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDIATRICS			1, 248, 996		30.00
ANCI LLARY SERVICE COST CENTERS		1	1, 240, 770		50.00
50. 00 05000 OPERATING ROOM		0. 17092	3, 602, 029	615, 688	50.00
53.00 05300 ANESTHESI OLOGY		0. 12340			•
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29370	181, 925	53, 432	54.00
60. 00 06000 LABORATORY		0. 30130	512, 873	154, 529	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 68660	221, 252	151, 912	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 58804	13 369, 060	217, 023	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 58446	57 180, 135	105, 283	
69. 00 06900 ELECTROCARDI OLOGY		0. 21127			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24134			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20088			•
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32170		410, 730	•
73. 01 03480 ONCOLOGY		0.34558		0	
76. 00 03160 CARDI OPULMONARY		0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 53422	24 0	0	76.97
91. 00 09100 EMERGENCY		0, 17769	76 10, 034	1 702	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 53098			92.00
200.00 Total (sum of lines 50 through 94 and 9	(A through 98)	0. 550%	11, 169, 736		
201.00 Less PBP Clinic Laboratory Services-Pro			11, 109, 730	2,000,000	200.00
202.00 Net charges (line 200 minus line 201)	Stan only charges (The OT)		11, 169, 736		201.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	
		Component		From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
		•			5/29/2018 8:4	
		Title		Swing Beds - SNF		
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1	0		30.00
ANCI LLARY SERVICE COST CENTERS			1	0	I	30.00
50. 00 05000 OPERATING ROOM			0. 17092	8 12, 547	2, 145	50.00
53.00 05300 ANESTHESI OLOGY			0. 12340		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 29370	5 26, 983	7, 925	54.00
60. 00 06000 LABORATORY			0. 30130	0 142, 863	43, 045	60.00
65. 00 06500 RESPI RATORY THERAPY			0. 68660	0 113, 746	78, 098	65.00
66. 00 06600 PHYSI CAL THERAPY			0. 58804	3 178, 483	104, 956	66.00
67.00 06700 OCCUPATI ONAL THERAPY			0. 58446	7 82, 486	48, 210	67.00
69. 00 06900 ELECTROCARDI OLOGY			0. 21127			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 24134			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 20088		, e	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 32170			73.00
73. 01 03480 ONCOLOGY			0. 34558	-	0	73.01
76. 00 03160 CARDI OPULMONARY			0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0. 53422	4 0	0	76. 97
91.00 09100 EMERGENCY			0. 17769		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 17789			91.00 92.00
200.00 Total (sum of lines 50 through 94 and 9	(16)		0. 55096	840, 308	-	
201.00 Less PBP Clinic Laboratory Services-Pro		(line 61)		040, 300		200.00
202.00 Net charges (line 200 minus line 201)	Syrain only charges	(The OI)		840, 308		201.00
			I	040, 300	I	202.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-1311	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
			10 12/31/2017	5/29/2018 8:4	1 am
	Tit	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			4, 872		30,00
ANCI LLARY SERVICE COST CENTERS			4,072		30.00
50. 00 05000 OPERATING ROOM		0. 17092	128, 845	22, 023	50.00
53. 00 05300 ANESTHESI OLOGY		0. 12340			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29370			
60. 00 06000 LABORATORY		0.30130		68	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 68660	5, 506	3, 780	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 58804	43 6, 280	3, 693	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 58440	57 1, 578	922	67.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2112	76 219	46	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 24134			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20088		27, 888	•
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32170		8, 124	•
73.01 03480 ONCOLOGY		0. 34558		0	73.01
76. 00 03160 CARDI OPULMONARY		0.0000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 53422	24 0	0	76.97
0UTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY		0, 1776	( 7( )	1 202	01 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 1776		1, 202 0	91.00 92.00
200.00 Total (sum of lines 50 through 94 and 9	(through 08)	0. 53098	326, 740	-	200.00
201.00 Less PBP Clinic Laboratory Services-Pro			320, 740		200.00
202.00 Net charges (line 200 minus line 201)	gram only charges (TTHE OT)		326, 740		201.00
202.00 [Net charges (The 200 minus The 201)		1	520, 740	l	202.00

	Financial Systems IU HEALTH TIPT( ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1311	Peri od:	wof Form CMS-2 Worksheet E	2002-1
			From 01/01/2017 To 12/31/2017		
		Title XVIII	Hospi tal	5/29/2018 8:4 Cost	1 am
			nooprear		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			6, 874, 493	
2.00 3.00	Medical and other services reimbursed under OPPS (see instru OPPS payments	uctions)		0	
4.00	Outlier payment (see instructions)			0	
4.01	Outlier reconciliation amount (see instructions)			0	
5.00 6.00	Enter the hospital specific payment to cost ratio (see instr Line 2 times line 5	ructions)		0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8.0
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			6, 874, 493	
	COMPUTATION OF LESSER OF COST OR CHARGES			-,,	
10.00	Reasonable charges			0	1 1 2 0
12.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	12.0 13.0
	Total reasonable charges (sum of lines 12 and 13)			0	
4 - 00	Customary charges		· · ·		1 4 5 0
15.00 16.00	Aggregate amount actually collected from patients liable for Amounts that would have been realized from patients liable f	1 3	U U	0	15.0 16.0
10.00	had such payment been made in accordance with 42 CFR §413.13	1 3	on a chargebasi s	Ū	10.0
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds li	ine 11) (see	0	
17.00	instructions)	ing in the to exceeds in		0	17.0
20. 00	Excess of reasonable cost over customary charges (complete c	only if line 11 exceeds l	ine 18) (see	0	20.0
21.00	instructions) Lesser of cost or charges (see instructions)			6, 943, 238	21 0
22.00	Interns and residents (see instructions)			0, 710, 200	
23.00	Cost of physicians' services in a teaching hospital (see ins			0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.0
25.00	Deductibles and coinsurance (for CAH, see instructions)			33, 889	25.0
26.00	Deductibles and Coinsurance relating to amount on line 24 (f			4, 712, 669	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	) plus the sum of lines 2	2 and 23] (see	2, 196, 680	27.0
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.0
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36	5)		0	
30.00	Subtotal (sum of lines 27 through 29) Primary payer payments			2, 196, 680 0	
32.00	Subtotal (line 30 minus line 31)			2, 196, 680	
~~ ~~	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	/I CES)			
33.00 34.00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			725, 447	33.0 34.0
35.00	Adjusted reimbursable bad debts (see instructions)			471, 541	
36.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		531, 097	
37.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 668, 221 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction				39.5
39.97	Demonstration payment adjustment amount before sequestration		-+:>	0	
39. 98 39. 99	Partial or full credits received from manufacturers for repl RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see fisting	ctrons)	0	
40.00	Subtotal (see instructions)			2, 668, 221	
40.01	Sequestration adjustment (see instructions)			53, 364	
40.02 41.00	Demonstration payment adjustment amount after sequestration Interim payments			0 2, 323, 214	
42.00	Tentative settlement (for contractors use only)			2, 323, 214	
43.00	Balance due provider/program (see instructions)			291, 643	
44.00	Protested amounts (nonallowable cost report items) in accord §115.2	ance with CMS Pub. 15-2,	cnapter 1,	237, 676	44.0
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90.0
91.00 92.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91.0 92.0
92.00 93.00	Time Value of Money (see instructions)				92.00
	Total (sum of lines 91 and 93)				94.0

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1311	Period: From 01/01/2017 To 12/31/2017		pare
		Title	XVIII	Hospi tal	Cost	i uni
		I npati en			rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		4, 579, 95	56	2, 323, 214	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	I				
01	ADJUSTMENTS TO PROVIDER	07/07/2017	102, 20	00	0	3
02				0	0	3
03				0	0	3
04				0	0	3
05				0	0	3
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	3
53				0	0	3
54			100.00	0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		102, 20	00	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 682, 15	56	2, 323, 214	4
00	(transfer to Wkst. E or Wkst. E-3, line and column as		4,002,10		2, 525, 214	- I
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
~ 1	Program to Provider					
01 02	TENTATI VE TO PROVIDER			0	0	5
)2 )3				0	0	5
55	Provider to Program			0	0	
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6
~ 4	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		228, 08	34	291, 643	6
02	SETTLEMENT TO PROGRAM		4 010 0	0	0	6
00	Total Medicare program liability (see instructions)		4, 910, 24		2, 614, 857	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C	)	1.00	2.00	
	Name of Contractor		,	1.00	2.00	8

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent (	CN: 15-1311 CCN: 15-Z311	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
				Curline Deale CN	5/29/2018 8:4	1 am
			XVIII t Part A	Swing Beds - SN Pa	F <u>Cost</u> rtB	
		•				
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 028, 0	0	0	
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.0
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 01				0	0	
. 03				0	0	
. 04				0	0	
. 05				0	0	3.0
50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. !
51				0	0	
52				0	0	
53				0	0	
. 54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 9
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 028, 0 <sup>-</sup>	15	0	4. (
	TO BE COMPLETED BY CONTRACTOR		1	-	T	
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	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0
02				0	0	
03				0	0	
	Provider to Program	;				
50 E 1	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)				_	6.0
01	SETTLEMENT TO PROVIDER		415, 9	19	0	
02 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 443, 93	34	0	
00			L 1, 110, 7	Contractor	NPR Date	7.0
			2	Number	(Mo/Day/Yr)	
00	Name of Contractor	(	2	1.00	2.00	8.

Heal th	Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT			CCN: 15-1311	Period: From 01/01/2017	Worksheet E-1 Part II		
	To 12/31/2017							
	Title XVIII Hospital							
						1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD						-	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION		<u> </u>				1	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						1.00	
2.00							2.00	
3.00								
4.00	0 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12							
5.00	Total hospital charges from Wkst C, Pt. I, co						5.00	
6.00	Total hospital charity care charges from Wkst	. S-10, col. 3 li	ne 20				6.00	
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168						7.00	
8.00	Calculation of the HIT incentive payment (see	instructions)					8,00	
9.00	Sequestration adjustment amount (see instruct						9,00	
	Calculation of the HIT incentive payment afte		see instru	uctions)			10.00	
101.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & (		000 1110 110					
30.00	Initial/interim HIT payment adjustment (see i	nstructions)					30.00	
	Other Adjustment (specify)	,					31.00	
	5 (1 5)							

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	Provider CCN: 15-1311	Peri od:	Worksheet E-2	
	c	Component CCN: 15-Z311	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
		Title XVIII	Swing Beds - SNF		i din
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		1, 109, 460	0	1.
00	Inpatient routine services - swing bed-NF (see instructions)				2.
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	A, and sum of Wkst. D,	378, 825	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr				
00	Per diem cost for interns and residents not in approved teaching	g program (see		0.00	4.
0	instructions)		FO	0	
	Program days	tructione)	586	0	5
00	Interns and residents not in approved teaching program (see inst Utilization review – physician compensation – SNF optional metho		0	0	6
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	Su only	1, 488, 285	0	8
	Primary payer payments (see instructions)		1, 400, 205	0	
	Subtotal (line 8 minus line 9)		1, 488, 285	0	10
	Deductibles billed to program patients (exclude amounts applicat	ole to physician	1, 100, 200	0	
	professional services)		Ū	0	
. 00	Subtotal (line 10 minus line 11)		1, 488, 285	0	12
00	Coinsurance billed to program patients (from provider records) (	(exclude coinsurance	16, 121	0	13
	for physician professional services)				
. 00	80% of Part B costs (line 12 x 80%)			0	14
00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	)	1, 472, 164	0	15
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstrat	tion) payment	0		16
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		1 005	0	
	Allowable bad debts (see instructions)		1,905	0	17
	Adjusted reimbursable bad debts (see instructions)	ati ana)	1, 238 0	0	17
	Allowable bad debts for dual eligible beneficiaries (see instruc Total (see instructions)	ctrons)	1, 473, 402	0	18 19
	Sequestration adjustment (see instructions)		29, 468	0	19
	Demonstration payment adjustment amount after sequestration)		27,400	0	19
	Interim payments		1, 028, 015	0	20
	Tentative settlement (for contractor use only)		0	0	21
	Balance due provider/program (line 19 minus lines 19.01, 20, and	d 21)	415, 919	0	22
	Protested amounts (nonallowable cost report items) in accordance		33, 031	0	23
	chapter 1, §115.2				
[	Rural Community Hospital Demonstration Project (§410A Demonstrat	tion) Adjustment			
D. 00	Is this the first year of the current 5-year demonstration perio	od under the 21st			200
ļ	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
1.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201
2 00	66 (title XVIII hospital)) Medicare swing hed SNE inpetient ancillary corvice costs (from N	Wet D 2 col 2 lin			202
	Medicare swing-bed SNF inpatient ancillary service costs (from V 200 (title XVIII swing-bed SNF))	WKSL. D-3, COL. 3, III	ie		202
	Total (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				203
	Computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curre	nt 5-vear demonst		201
	peri od)				
5. 00	Medicare swing-bed SNF target amount				205
o. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 time	es line 204)			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursen	nent			
	Program reimbursement under the §410A Demonstration (see instruc				207
3. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ions)			209
	Reserved for future use				210
	Comparision of PPS versus Cost Reimbursement				0
5 (1(1)	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 instructions)	y prus rine 210) (see			215

CALCUL					2552-10
UNLOUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Peri od:	Worksheet E-3	
			From 01/01/2017 To 12/31/2017	Part V Date/Time Pre	narod
			10 12/31/2017	5/29/2018 8:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	RE PART A SERVICES - CUST	REIMBURSEMENT	E 24E 420	1 1 00
1.00	Inpatient services	tione)		5, 365, 628 0	
2.00 3.00	Nursing and Allied Health Managed Care payment (see instruct Organ acquisition	tions)		0	
3.00 4.00	Subtotal (sum of lines 1 through 3)			5, 365, 628	
4.00 5.00	Primary payer payments			5, 305, 028	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 419, 284	
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			5, 417, 204	0.00
	Reasonable charges				1
7.00	Routi ne servi ce charges			0	7.00
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.00
	Customary charges				1
11.00	Aggregate amount actually collected from patients liable for	r payment for services on	a charge basis	0	11.00
12.00	Amounts that would have been realized from patients liable	for payment for services o	on 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)			0.00000	13.00
14.00	Total customary charges (see instructions)			0	
15.00	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds li	ne 6) (see	0	15.00
	instructions)			_	
16.00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds lir	ne 14) (see	0	16.00
17 00	instructions)	-+		0	17 00
17.00	Cost of physicians' services in a teaching hospital (see in: COMPUTATION OF REIMBURSEMENT SETTLEMENT	structions)		0	17.00
18.00	Direct graduate medical education payments (from Worksheet )	E_4 line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5, 419, 284	
20.00	Deductibles (exclude professional component)			437, 325	
21.00	Excess reasonable cost (from line 16)			437, 323	
22.00	Subtotal (line 19 minus line 20 and 21)			4, 981, 959	
23.00	Coinsurance			0	
24.00	Subtotal (line 22 minus line 23)			4, 981, 959	
25.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		43, 831	
26.00	Adjusted reimbursable bad debts (see instructions)	, , , , , , , , , , , , , , , , , , , ,		28, 490	
27.00	Allowable bad debts for dual eligible beneficiaries (see in	structions)		27, 264	
28.00	Subtotal (sum of lines 24 and 25, or line 26)	~		5, 010, 449	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	
29.99	Demonstration payment adjustment amount before sequestration			0	29.99
30.00	Subtotal (see instructions)			5, 010, 449	30.00
30. 01	Sequestration adjustment (see instructions)			100, 209	30.01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
31.00	Interim payments			4, 682, 156	31.00
32.00	Tentative settlement (for contractor use only)			0	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.	.02, 31, and 32)		228, 084	33.00
		dance with CMS Pub. 15-2,		177, 898	34.00

	SHEET (If you are nonproprietary and do not maintain	Provider C		Period:	Worksheet G	
nd-ty y)	pe accounting records, complete the General Fund column			From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 8:4	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS	22 242 455	1	0 0	0	
	Cash on hand in banks Temporary investments	23, 243, 655		0 0 0 0	0	
	Notes receivable			0 0	0	
	Accounts receivable	5, 063, 401		0 0	0	
	Other receivable	-1, 096, 050		0 0	0	
00 A	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
00  1	nventory	692, 457		0 0	0	
	Prepaid expenses	188, 845		0 0	0	
	Other current assets	0		0 0	0	
	Due from other funds	0		0 0	0	
	Total current assets (sum of lines 1-10)	28, 092, 308		0 0	0	1
	I XED_ASSETS _and	0		0 0	0	11:
	_and improvements			0 0	0	
	Accumul ated depreciation			0 0	0	
	Buildings	9, 767, 795		0 0	0	
	Accumulated depreciation	0		0 0	0	
. 00 L	_easehold improvements	2, 098, 521		0 0	0	1
	Accumulated depreciation	-969, 835		0 0	0	
	Fixed equipment	C		0 0	0	1
	Accumulated depreciation	0		0 0	0	
	Automobiles and trucks	0		0 0	0	
	Accumulated depreciation Major movable equipment	11, 138, 928		0 0	0	
	Accumulated depreciation	-9, 070, 336			0	
	Minor equipment depreciable	, 070, 330		0 0	0	
	Accumul ated depreciation			0 0	0	
	HT designated Assets	C		0 0	0	
. 00   A	Accumulated depreciation	0		0 0	0	28
. 00   N	Ai nor equi pment-nondepreci abl e	C		0 0	0	29
	Total fixed assets (sum of lines 12-29)	12, 965, 073		0 0	0	30
	THER ASSETS	(00 557				
	nvestments Deposits on Leases	680, 557		0 0 0 0	0	
	Due from owners/officers			0 0	0	
	Other assets	14, 403, 983		0 0	0	
	Total other assets (sum of lines 31-34)	15, 084, 540		0 0	0	
	Total assets (sum of lines 11, 30, and 35)	56, 141, 921		0 0	0	
	URRENT LI ABI LI TI ES					
	Accounts payable	2, 411, 245		0 0	0	3
	Salaries, wages, and fees payable	1, 128, 192		0 0	0	
	Payroll taxes payable	C		0 0	0	
	Notes and Loans payable (short term)	0		0 0	0	
	Deferred income			0 0	0	
	Accelerated payments Due to other funds			o o	0	42
	Other current liabilities	3, 755, 426		0 0	0	
	Total current liabilities (sum of lines 37 thru 44)	7, 294, 863		0 0	0	
	ONG TERM LIABILITIES	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			0	1 ``
	Mortgage payable	0		0 0	0	40
	Notes payable	15, 655, 000		0 0	0	4
	Insecured Loans	0		0 0	0	
	Other long term liabilities	421, 383		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49)	16, 076, 383		0 0	0	
-	Total liabilities (sum of lines 45 and 50)	23, 371, 246	1	0 0	0	5
	CAPITAL ACCOUNTS General fund balance	22 770 475				- -
	Specific purpose fund	32, 770, 675		0		52
	Donor created - endowment fund balance - restricted			Γ		54
	Donor created - endowment fund balance - unrestricted			0		5!
	Governing body created - endowment fund balance			0		50
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
r	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	32, 770, 675		0 0	0	
. 00   1	Fotal liabilities and fund balances (sum of lines 51 and	56, 141, 921			0	60

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL			In Lie	u of Form CMS	-25	552-10
STATEMENT OF CHANGES IN FUND BALANCES		Provider CCN: 15-131		CN: 15-1311	311 Period: From 01/01/2017 To 12/31/2017		Worksheet G- Date/Time Pr 5/29/2018 8:	-1 Tepa 41	ared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fun	d	
1.00	Fund balances at beginning of period	1.00	2.00 31,015,840	3.00		4.00	5.00	+	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TEMP RESTRICTED PERM RESTRICTED	11 0 0 0 0 0 0 21, 684 43, 721 0 0 0	1, 820, 229 32, 836, 069 11 32, 836, 080			0		0 0 0 0 0	$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	65, 405 32, 770, 675		0	0 0			17. 00 18. 00 19. 00
		Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	0	0 0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) TEMP RESTRICTED PERM RESTRICTED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems IU HEALTH TIPTO	HUSPITAL		In Lie	eu of Form CMS-2	2552-10
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1311	Period: From 01/01/2017 To 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/29/2018 8:4	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
1.00	General Inpatient Routine Services Hospital		2, 421, 0	20	2, 421, 080	1.00
2.00	SUBPROVIDER - IPF		2, 421, 00	50	2, 421, 000	2.00
3.00	SUBPROVI DER – I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			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)		2, 421, 08	30	2, 421, 080	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	- lines		0	0	16.00
17.00	11-15) Total inpatient routine care services (sum of lines 10 and 16		2, 421, 0	20	2, 421, 080	17.00
17.00	Ancillary services	)	23, 991, 6			18.00
19.00	Outpati ent services		481, 4			19.00
20.00	RURAL HEALTH CLINIC		401, 4	0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			0		22.00
23.00	AMBULANCE SERVICES					23.00
24.00	СМНС					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27.00	PHYSICIAN REVENUE			0 2, 212, 476		27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	26, 894, 14	41 74, 553, 149	101, 447, 290	28.00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES			25 000 422		20.00
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200)			35, 908, 432 0		29.00 30.00
30.00	ADD (SPECI FY)			0		30.00
32.00				0		32.00
32.00				0		32.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		35, 908, 432		43.00
	to Wkst. G-3, line 4)					

Heal th	th Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu			u of Form CMS-2	2552-10		
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Peri od:	Worksheet G-3			
				From 01/01/2017 To 12/31/2017	Date/Time Pre	harod	
				10 12/31/2017	5/29/2018 8:4		
					1.00		
1.00	Total patient revenues (from Wkst. G-2, Par				101, 447, 290	1.00	
2.00	Less contractual allowances and discounts of	on patients' accoun	ts		65, 076, 286	2.00	
3.00	Net patient revenues (line 1 minus line 2)				36, 371, 004	3.00	
4.00	Less total operating expenses (from Wkst. G		43)		35, 908, 432	4.00	
5.00	Net income from service to patients (line 3	3 minus line 4)			462, 572	5.00	
( 00	OTHER I NCOME				0	<i>(</i> 00	
6.00	Contributions, donations, bequests, etc				0	6.00	
7.00	Income from investments				0	7.00 8.00	
	.00 Revenues from telephone and other miscellaneous communication services						
9.00	Revenue from television and radio service				0	9.00	
10.00	Purchase di scounts				0	10.00	
11.00	Rebates and refunds of expenses				0	11. 00 12. 00	
12.00	Parking lot receipts				0		
13.00	Revenue from Laundry and Linen service				0	13.00 14.00	
14.00 15.00	Revenue from meals sold to employees and gu	lests			-	14.00	
	Revenue from rental of living quarters Revenue from sale of medical and surgical s	upplies to other th	ann nationta		0	15.00 16.00	
			nan patrents		0	17.00	
	Revenue from sale of drugs to other than pa Revenue from sale of medical records and ab				0	17.00	
	Tuition (fees, sale of textbooks, uniforms,				0	19.00	
20.00	Revenue from gifts, flowers, coffee shops,	,			0	20.00	
20.00	Rental of vending machines	and canteen			0	20.00	
21.00	Rental of hospital space				0	21.00	
23.00	Governmental appropriations				0	22.00	
23.00	MI SCELLANEOUS I NCOME				1, 357, 657		
24.00	Total other income (sum of lines 6-24)				1, 357, 657		
26.00	Total (line 5 plus line 25)				1, 820, 229		
27.00	OTHER EXPENSES (SPECIFY)				1, 020, 229	27.00	
	Total other expenses (sum of line 27 and su	(hscrints)			0	28.00	
	Net income (or loss) for the period (line 2				1, 820, 229		
27.00		20)		l l	., 020, 227	_// 00	