I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH FRANKFORT HOSPITAL (15-1316) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[X] 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 gned)	TODD WILLIAMS
(Signod)	TODD WILLIAMS

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

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

Date/Time Prepared:

6:17 pm

Δ

5/28/2019 6:17 pm

Time:

Worksheet S

Parts I-III

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-1, 309, 064	-149, 226	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	-389, 802	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-1, 698, 866	-149, 226	0	0	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX		I FRANKFOR TA			N: 15-1316	Period From O			of For Workshe Part I		
										Date/Ti 5/28/20		
	1.00		00		3.00			4	1.00	5720720	JT J U. 1	
00	Hospital and Hospital Health Care Co Street: 1300 SOUTH JACKSON STREET	PO Box:										1.0
	City: FRANKFORT	State: I	N Z	ip Code	e: 4604	41 Cou	unty: CLIN	ITON				2.0
		Component Na		CCN umber	CBS Numb					nt Syst 0, or XVIII	N)	-
		1.00		2.00	3.0	0 4.00	5.0	0	6.00	7.00		
00	Hospital and Hospital-Based Componen Hospital	t Identification:		51316	999	15 1	01/21/	2003	N	0	0	3.
50		HOSPI TAL		51510	,,,,		01/21/	2005				0.
00 00 00 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	IU HEALTH FRANKF(HOSPITAL	ORT 1	5Z316	999 ⁻	15	01/21/	2003	Ν	0	N	4. 5. 6. 7.
00 00 00 00 00 00 00 00 00 00 00 00	Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FOHC Hospital-Based (CMHC) I Renal Dialysis Other											8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.
								From:		To		-
00	Cost Reporting Period (mm/dd/yyyy)						01/	1.00 01/20		2.0		20.
	Type of Control (see instructions)							2				21.
					-	1.00		2.00		3. (00	-
00	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §	stment, in accord r yes or "N" for 412.106(c)(2)(Pic	lance with no. Is thi kle amendm	42 CFR s		N		N				22.
01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft	compensated care mn 1, "Y" for yes riod occurring pr " for no for the	payments f s or "N" fo ior to Oct portion of	or no f tober 1 f the c	or	Ν		N				22.
02	Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1.	requires final u port settlement? " for no, for the er 1. Enter in co	Incompensat (see instr portion c lumn 2, "\	ted car ruction of the (" for	s) yes	Ν		Ν				22.
03	Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportin in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	ds for delineatin olumn 1, "Y" for g period prior to no for the portio er October 1. (se 100 but not more	ng statisti yes or "N" o October 1 on of the c ee instruct than 499 b	cal ar 'forn 1.Ente cost tions) peds (a	eas o r	Ν		Ν		Ν		22.
00	Which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, ente	of admission, 2 i of identifying th method used in th	f census o ne days in ne prior co <u>"N" for no</u>	days, o this c ost o <u>.</u>	r 3 ost		3	N				23.
			In-State Medicaid paid days	unpa day	caid ble aid /s	Out-of State Medicaid paid days	Out-of State Medicai eligibl unpaid	d H e	edicai MO day	/s Mec	ther li cai d lays	
00	If this provider is an IPPS hospital	, enter the	1.00	2.0	00	3.00	4.00	0	5.00	0	<u>. 00</u>) 24.
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in			5	Ū						

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA I	Provider CC	CN: 15-1316	Period: From 01/	01/2018	Works Part	neet S-2	2
				To 12/	31/2018	Date/	Fime Pre 2019 6:1	
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ays Me	Other edi cai d days	
00 If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0		0		Rural S		f Geogr	
					. 00		00	1
00 Enter your standard geographic classification (not wa		at the beg	ginning of t	he	2			26.
 cost reporting period. Enter "1" for urban or "2" for OD Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi OD If this is a sole community hospital (SCH), enter the 	ge) status "2" for r cation in d	ural. If ap column 2.	ppl i cabl e,		2			27.
effect in the cost reporting period.								
					nni ng: . 00		li ng: . 00	-
00 Enter applicable beginning and ending dates of SCH st		cript line	36 for numb					36.
of periods in excess of one and enter subsequent date 00 If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	s	0			37.
is in effect in the cost reporting period.					0			
01 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37.
00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					′/N		//N	_
00 Does this facility qualify for the inpatient hospital	pavment a	diustment f	or low volu		. 00 N		. 00 N	39.
hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or he mileage	(iii)? Ent requiremen	er in colum nts in	in				
00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for y			N		N	40.
					V	XVII 2.00		-
Prospective Payment System (PPS)-Capital								
00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	it for disp	roporti onat	e share in	accordance	e N	N	N	45.
00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.
00 Is this a new hospital under 42 CFR §412.300(b) PPS c 00 Is the facility electing full federal capital payment Teaching Hospitals			5		N N	N N	N N	47. 48.
	approved G	ME programs	S? Enter "Y	" for yes	N			56.
00 Is this a hospital involved in training residents in	app. orou o			approved	1			57.
	eriod duri yes or "N h of this ", complet	" for no in cost report e Worksheet	n column 1. ing period?	Enter "	("			
 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 00 If line 56 is yes, did this facility elect cost reimb 	eriod duri yes or "N h of this ", complet , if appli pursement fo	" for no in cost report e Worksheet cable. or physicia	n column 1. ing period? E-4. If co	Enter ") lumn 2 is	("			58.
 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 	eriod duri yes or "N h of this completo if appli complete W	" for no in cost report e Worksheet cable. or physicia kst. D-5.	n column 1. ting period? E-4. If co ans' service	Enter ") lumn 2 is	/"			
 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	eriod duri yes or "N h of this completo if appli complete W	" for no in cost report e Worksheet cable. or physicia kst. D-5.	n column 1. ting period? E-4. If co ans' service	' Enter '' lumn 2 is s as 35 Works	/" N	Qualif	Through Tication	
 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 00 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 	eriod duri yes or "N h of this completo if appli complete W	" for no in cost report e Worksheet cable. or physicia kst. D-5.	n column 1. ing period? E-4. If co ans' service Pt. I. NAHE 413.8	e Enter ") Iumn 2 is Es as 35 Works Lii	/" N N sheet A	Qualif Criter	ication	59.

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2018 o 12/31/2018		pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N			0.00	. 0. 00	61. C
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 ACA). (see instructions)						61. C
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61. C
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)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program 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. Of the FTEs in line 61.05, specify each expanded program special ty, 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		61.1
						1.00	
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	ler Settings	1.00 This base year	2.00	<u> </u>	
4. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	re June ty train n-primar all nor d non-pr	30, 2010. The residents by care provider timary care	0.00	-		64.(

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DA	TA Provider		eriod: rom 01/01/2018		
			То	b 12/31/2018	Date/Time Pre 5/28/2019 6:1	pared: 7 pm
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
_	1.00	2.00	3.00	4.00	5.00	1
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			0.00	0. OC	0. 000000	65. C
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	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 Settin	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	
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	67.0
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility PP 0.00 Is this facility an Inpatient Psy		PF), or does it con	tain an IPF subn			70. C
Enter "Y" for yes or "N" for no. .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) Inpatient Rehabilitation Facility	the facility have ar fore November 15, 2C umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	n approved GME teach DO4? Enter "Y" for lity train resident (D)? Enter "Y" for	ing program in t yes or "N" for n s in a new teach yes or "N" for n	he most no. (see ning no.	0	71. C
5.00 Is this facility an Inpatient Reh	abilitation Facility	(IRF), or does it	contain an IRF	N		75. C
subprovider? Enter "Y" for yes a 5.00 If line 75 is yes: Column 1: Did recent cost reporting period endi	the facility have ar				0	76.0

Health Financial Systems IU HEALTH FRAN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	KFORT HOSPITAL	1	Period: From 01/01/2018	u of Form CMS Worksheet S- Part I	-2		
			Го 12/31/2018	Date/Time Pr 5/28/2019 6:			
				1.00	_		
Long Term Care Hospital PPS				1.00			
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for ye 81.00 Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.			period? Enter	N N	80.00 81.00		
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)86.00Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00		
87.00 Is this hospital an extended neoplastic disease care hospital 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	tal classified	under section		Ν	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 hospi	tal 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	Ν	91.00		
full or in part? Enter "Y" for yes or "N" for no in the ap 92.00 Are title XIX NF patients occupying title XVIII SNF beds (N	92.00		
instructions) Enter "Y" for yes or "N" for no in the applie 93.00 Does this facility operate an ICF/IID facility for purpose		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,			N	N	94.00		
applicable column.			0.00	0.00	95.00		
	DO Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the						
97.00 If line 96 is "Y", enter the reduction percentage in the ap 98.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"	0.00 Y	97.00 98.00					
98.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for						
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the obed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes 			Ν	Y	98. 02		
 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y 			Ν	Ν	98. 03		
 for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAI outpatient services cost? Enter "Y" for yes or "N" for no in the services cost? 			Ν	Ν	98. 04		
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add I Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in	back the RCE di	sallowance on	Ν	Y	98. 05		
 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cos Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX. 			Ν	Y	98.06		
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 cost training programs? Enter "Y" for yes or "N" for no in colu yes, the GME elimination is not made on Wkst. B, Pt. I, col	nn 1. (see inst	ructions) lf	Ν		107.00		
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the		0	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	100.00		
109.00 f this hospital qualifies as a CAH or a cost provider, and therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	e Y	Y	N	N	109.00		
				1.00			
110.00 Did this hospital participate in the Rural Community Hospi Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and We applicable.	"Y" for yes or	"N" for no. I	f yes,	N	110.00		

Health Financial Systems IU HEALTH FRANKFO			Lieu of F		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1316	Period: From 01/01/2 To 12/31/2	2018 Part 2018 Date	'Time Pr	epared:
			5/28/	<u>2019 6:</u>	
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.	t reporting period? Enter umn 1 is Y, enter the icipating in column 2.	1.00 N		2.00	111.00
		-	1.00 2.0	0 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.	If column 2 is "E", enter for long term care (inc) based on the definition	r in column udes	N	0	115. 00
 16.00 Is this facility classified as a referral center? Enter "Y" for 17.00 Is this facility legally-required to carry malpractice insuration. 		r "N" for	N N		116.00 117.00
118.00 Is the malpractice insurance a claims-made or occurrence policical claim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the policy	yis	2		118.00
	Premiums	Losses	i Ins	urance	
	1.00	2.00		3.00	-
18.01 List amounts of malpractice premiums and paid losses:	29, 2	298	0		0118.0
		1.00		2.00	-
 18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedul and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold I §3121 and applicable amendments? (see instructions) Enter in of "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments: Enter in column 2, "Y" for yes or "N" for no. 	le listing cost centers Harmless provision in AC, column 1, "Y" for yes or lifies for the Outpatien			N	118. 02 119. 00 120. 00
21.00 Did this facility incur and report costs for high cost implan	table devices charged to	Y			121.00
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.				5.00	122. 00
Transplant Center Information 25.00Does this facility operate a transplant center? Enter "Y" for	ves and "N" for no. If	N			125. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, entri in column 1 and termination date, if applicable, in column 2.		e			126. 0
27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2.	r the certification date				127.0
28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter					128. 0 129. 0
column 1 and termination date, if applicable, in column 2. 30.00 If this is a Medicare certified pancreas transplant center, en date in column 1 and termination date, if applicable, in colum					130. 0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colum	enter the certification				131. 0
32.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.					132.0
33.00 If this is a Medicare certified other transplant center, enter in column 1 and termination date, if applicable, in column 2. 34.00 If this is an organ procurement organization (OPO), enter the					133. 0 134. 0
and termination date, if applicable, in column 2. All Providers					
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 are claimed, enter in column 2 the home office chain number.	es, and home office cost	5 Y	1	5H059	140. 00

	IU HEALTH F X IDENTIFICATION DATA		Provider CC	N: 15-131			/01/2018 2/31/2018	u of Form CMS- Worksheet S- Part I Date/Time Pro 5/28/2019 6:	2 epared:
1.00		2.00					3.00		
If this facility is part of a cha					he nar	me and	address	of the	
home office and enter the home of			actor numbe				0.040		-
41.00 Name: INDIANA UNIVERSITY HEALTH	Contractor's Nam	ne: WPS		Contr	actor	's Nur	mber: 0810	1	141.0
42.00 Street: 340 WEST 10TH STREET 43.00 City: INDIANAPOLIS	PO Box: State:	IN		Zip (`odo:		4620	10	142.0
43. 00 CT LY. TNDTANAPOLTS	state.	T IN			Joue.		4020	2	143.0
								1.00	-
44.00 Are provider based physicians' cos	sts included in Worksh	neet A?						Y	144. C
							1.00	2.00	
15.00 If costs for renal services are cl	aimed on Wkst. A, lir	ne 74, ar	e the costs	s for					145. 0
inpatient services only? Enter "Y									
no, does the dialysis facility ind	lude Medicare utiliza	ation for	this cost	reportino	9				
period? Enter "Y" for yes or "N"							N		140
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in							Ν		146. (
yes, enter the approval date (mm/		20D. 15-2	, chapter 4	10, 94020,)				
yes, enter the approval date (mm/						1			
								1.00	1
47.00Was there a change in the statist	cal basis? Enter "Y"	for yes	or "N" for	no.				N	147. (
18.00Was there a change in the order o	ີ allocation? Enter "ነ	/" for ye	es or "N" fo	or no.				N	148. (
49.00Was there a change to the simplifi	ed cost finding metho	od? Enter				-		N	149. (
			Part A	Part			tle V	Title XIX	
			1.00	2.00			3.00	4.00	
Does this facility contain a prov									
or charges? Enter "Y" for yes or	<u>'N" for no for each co</u>	omponent			B. (\$	<u>See 42</u>			
55.00 Hospi tal			N	N			N	N	155.0
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N			N N	N N	156.0
58. 00 SUBPROVIDER			IN	IN IN			IN	IN IN	157.0
59. 00 S0BPROVI DER 59. 00 SNF			Ν	N			N	N	158.0
60.00HOME HEALTH AGENCY			N	N			N	N	160.0
61. OOCMHC				N			N	N	161.0
								1.00	
Multicampus									
65.00 Is this hospital part of a Multica	ampus hospital that ha	as one or	more campu	ises in di	ffere	ent CB	SAs?	N	165. 0
Enter "Y" for yes or "N" for no.	News	0	· - · · - 4· · ·	Ctata	7:	Carla	CDCA		-
	Name		county 1.00	State		Code	CBSA 4.00	FTE/Campus 5.00	-
66.00 fline 165 is yes, for each	0		1.00	2.00	3.	00	4.00		0166.0
campus enter the name in column								0.0	0100.0
0 county in column 1 state in									
0, county in column 1, state in column 2, zip code in column 3.									
0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									
column 2, zip code in column 3,									
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									_
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								1.00	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI						Act			
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user	under §1886(n)? Ent	ter "Y" f	for yes or "	N" for no	Э.			Y	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10	r under §1886(n)? Ent D5 is "Y") and is a me	ter "Y" f eaningful	for yes or "	N" for no	Э.		the	Y	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I	under §1886(n)? Ent 05 is "Y") and is a me HT assets (see instru	ter "Y" f eaningful uctions)	or yes or " user (line	N" for no e 167 is '	o. 'Y"),	enter		Y	0168. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful used 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the 10 58.01 If this provider is a CAH and is n	under §1886(n)? Ent)5 is "Y") and is a me HT assets (see instru not a meaningful user,	ter "Y" f eaningful uctions) does th	or yes or " user (line is provider	N" for no e 167 is ' qualify	o. 'Y"), for a	enter		Y	0168. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I If this provider is a CAH and is n exception under §413.70(a)(6)(ii)	under §1886(n)? Ent 5 is "Y") and is a me 11T assets (see instru not a meaningful user, 2 Enter "Y" for yes or	ter "Y" f eaningful uctions) does th "N" for	for yes or " user (line nis provider no. (see i	N" for no 2 167 is ' qualify nstructio	o. 'Y"), for a ons)	enter a hard:	shi p	Y	0168. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I If this provider is a CAH and is n exception under §413.70(a)(6)(ii)	under §1886(n)? Ent 55 is "Y") and is a me HT assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y")	ter "Y" f eaningful uctions) does th "N" for	for yes or " user (line nis provider no. (see i	N" for no 2 167 is ' qualify nstructio	o. 'Y"), for a ons)	enter a hard:	shi p	Y	0168. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under \$413.70(a)(6)(ii) 59.00 If this provider is a meaningful user 59.00 If this provider is a meaningful user 50.00	under §1886(n)? Ent 55 is "Y") and is a me HT assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y")	ter "Y" f eaningful uctions) does th "N" for	for yes or " user (line nis provider no. (see i	N" for no 2 167 is ' qualify nstructio	o. 'Y"), for a ons)	enter a hard: N"), en Beg	ship nter the ginning	Y 0. 0 Endi ng	167. (0168. (168. (00169. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 59.00 If this provider is a meaningful user transition factor. (see instruction)	under §1886(n)? Ent 5 is "Y") and is a me 11 assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") nns)	ter "Y" f eaningful uctions) does th "N" for and is	or yes or " user (line is provider no. (see i not a CAH (N" for no e 167 is ' qualify nstructio [line 105	o. 'Y"), for a ons)	enter a hard: N"), en Beç	ship nter the ginning 1.00	Y 0. 0 Endi ng 2. 00	0168. (168. (0169. (
col umn 2, zip code in col umn 3, CBSA in col umn 4, FTE/Campus in col umn 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is a exception under §413.70(a) (6) (ii) (59.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in col umns 1 and 2 the EHR I	under §1886(n)? Ent 5 is "Y") and is a me 11 assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") nns)	ter "Y" f eaningful uctions) does th "N" for and is	or yes or " user (line is provider no. (see i not a CAH (N" for no e 167 is ' qualify nstructio [line 105	o. 'Y"), for a ons)	enter a hard: N"), en Beç	ship nter the ginning	Y 0. 0 Endi ng	0168. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 58.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)' 59.00 If this provider is a meaningful user transition factor. (see instruction)	under §1886(n)? Ent 5 is "Y") and is a me 11 assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") nns)	ter "Y" f eaningful uctions) does th "N" for and is	or yes or " user (line is provider no. (see i not a CAH (N" for no e 167 is ' qualify nstructio [line 105	o. 'Y"), for a ons)	enter a hard: N"), en Beç	ship nter the ginning 1.00	Y 0. 0 Endi ng 2. 00	0168. (168. (0169. (
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) (transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	under §1886(n)? Ent 5 is "Y") and is a me 11 assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") nns)	ter "Y" f eaningful uctions) does th "N" for and is	or yes or " user (line is provider no. (see i not a CAH (N" for no e 167 is ' qualify nstructio [line 105	o. 'Y"), for a ons)	enter a hard: N"), en Bec 01/	ship nter the ginning 1.00 01/2018	Y 0. 0 Endi ng 2. 00 03/31/2018	0168. (168. (0169. (
col umn 2, zip code in col umn 3, CBSA in col umn 4, FTE/Campus in col umn 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in col umns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	r under §1886(n)? Ent 55 is "Y") and is a me HIT assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") ons) peginning date and end	ter "Y" f eaningful uctions) does th - "N" for o and is ding date	or yes or " user (line is provider no. (see i not a CAH (e for the re	N" for no 167 is ' qualify nstruction line 105 eporting	o. 'Y"), for a ons)	enter a hard: N"), en Bec 01/	ship nter the ginning 1.00 01/2018 1.00	Y 0. 0 Endi ng 2. 00 03/31/2018 2. 00	0168. (168. (168. (0169. (170. (1
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 59.00 If this provider is a meaningful u transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 71.00 If line 167 is "Y", does this provi	r under §1886(n)? Ent 15 is "Y") and is a me 11 assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") pons) peginning date and enc vider have any days for	ter "Y" f eaningful uctions) does th "N" for and is ding date	or yes or " user (line no. (see i not a CAH (for the re duals enrol	N" for no e 167 is ' gualify nstructio line 105 eporting led in	o. 'Y"), for a ons) is "N	enter a hard: N"), en Bec 01/	ship nter the ginning 1.00 01/2018	Y 0. 0 Endi ng 2. 00 03/31/2018 2. 00	0168. 168. 0169.
 column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 57.00 Is this provider a meaningful user 88.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 99.00 If this provider is a meaningful u transition factor. (see instruction (see instruction) 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 	r under §1886(n)? Ent 15 is "Y") and is a me 11 assets (see instru- not a meaningful user, 2 Enter "Y" for yes or user (line 167 is "Y") peginning date and enc vider have any days for reported on Wkst. S-3,	ter "Y" f eaningful uctions) does th "N" for and is ding date pr indivi Pt. I,	or yes or " user (line no. (see i not a CAH (for the re duals enrol line 2, col	N" for no e 167 is ' gualify nstructio line 105 eporting led in . 6? Ente	o. 'Y"), for a ons) is "N	enter a hard: "), en Bec 01/	ship nter the ginning 1.00 01/2018 1.00	Y 0. 0 Endi ng 2. 00 03/31/2018 2. 00	0 168. 168. 0 169. - 170.

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	FORT HOSPITAL Provider C	CN: 15-1316	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2018 To 12/31/2018		
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	choncoc Ent		2.00	
	m/dd/yyyy format. COMPLETED BY ALL HOSPITALS		sponses. Litte			-
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.
	reporting period? IT yes, enter the date of the change in c		Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports			•		- ·
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities				I	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		Ν		7.
00	Were nursing school and/or allied health programs approved		l during the	Ν		8.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Ν		9.
. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o		he current	Ν		10.
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11
					Y/N 1.00	
00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	see instruct	ions		Y	12.
8. 00				ost reporting	N	13.
. 00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	yes, see ins	structions.	N	14.
. 00	Bed Complement Did total beds available change from the prior cost reporti	ng period? [f	ves, see ins	tructions.	N	15.
		Par	t A	Par	t B	
		Y/N	Date 2,00	Y/N 2,00	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		N		16.
. 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	04/03/2019	Y	04/03/2019	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		N		19.

Health Financial Systems

In Lieu of Form CMS-2552-10

Health Financial Systems IU HEALTH FRAN	KFORT HOSPI TAL	u of Form CMS-2552-								
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018							
			10 12/31/2010	5/28/2019 6						
	Descr	iption	Y/N	Y/N						
		0	1.00	3.00						
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	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					
				1.00						
CONDUCTED BY COST DELNDUDGED AND TEEDA HOCDUTALS ONLY (EVG				1.00						
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCL	EPT CHILDRENS F	HUSPITALS)			_					
Capital Related Cost	- !			N						
22.00 Have assets been relifed for Medicare purposes? If yes, se				N	22.00					
23.00 Have changes occurred in the Medicare depreciation expense	due to apprais	sais made duri	ng the cost	N	23.00					
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases enter	ed into during	this cost ror	orting period?	N	24.00					
	If yes, see instructions									
instructions.										
26.00 Were assets subject to Sec.2314 of DEFRA acquired during t	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see									
instructions.	instructions.									
27.00 Has the provider's capitalization policy changed during th	e cost reportin	ng period? If	yes, submit	N	27.00					
сору.										
Interest Expense				1						
28.00 Were new loans, mortgage agreements or letters of credit e	ntered into dur	ring the cost	reporting	N	28.00					
period? If yes, see instructions.	band funda (D	abt Carulaa Da	Corrup Fund)	N	1 20.00					
29.00 Did the provider have a funded depreciation account and/or		ebt Service Re	eserve Fund)	N	29.00					
treated as a funded depreciation account? If yes, see inst 30.00 Has existing debt been replaced prior to its scheduled mat		dobt2 If yos	500	N	30.00					
instructions.	unity with new	debt: 11 yes,	366	IN IN	30.00					
31.00 Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ves	See	N	31.00					
instructions.		dober if joo,	000		000					
Purchased Servi ces										
32.00 Have changes or new agreements occurred in patient care se	rvices furnishe	ed through cor	ntractual	N	32.00					
arrangements with suppliers of services? If yes, see instr										
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap	plied pertainir	ng to competit	ive bidding? If		33.00					
no, see instructions.										
Provi der-Based Physi ci ans				1						
34.00 Are services furnished at the provider facility under an a	rrangement with	n provider-bas	sed physi ci ans?	Y	34.00					
If yes, see instructions.	loting ognoomo	ata with the r	wouldon boood	N	25.00					
35.00 If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		its with the p	n ovi der -based	N	35.00					
physicians during the cost reporting period: in yes, see i			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 fline 36 is yes, has a home office cost statement been p	repared by the	home office?	Y		37.00					
If yes, see instructions.	-									
38.00 fline 36 is yes , was the fiscal year end of the home of			N		38.00					
the provider? If yes, enter in column 2 the fiscal year en										
39.00 If line 36 is yes, did the provider render services to oth	er chain compor	nents? If yes,	N		39.00					
see instructions.	home office		N I		40.00					
40.00 f line 36 is yes, did the provider render services to the instructions.	nome office?	TT yes, see	N		40.00					
		1.00 2								
	1.	00	2.							
Cost Report Preparer Contact Information		00			_					
41.00 Enter the first name, last name and the title/position	RHONDA	00	UTTER		41.00					
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,		. 00			41.00					
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RHONDA									
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report 										
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 	RHONDA		UTTER		41.00					
 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report 	RHONDA			H. ORG						

Heal th	Financial Systems IU HEALTH	FORT HOSPI TAL		In Lieu of Form CMS-2552-10				
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIF	Provider CCN: 15-13		eriod: rom 01/01/2018	Worksheet S-2 Part II			
				T				
			3.00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/positic	on	GOVERNMENT PROGRAMS DI	RECTOR			41.00	
	held by the cost report preparer in columns 1, 2, and	13,						
	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 c	cost					43.00	
	report preparer in columns 1 and 2, respectively.							

	Financial Systems I AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	U HEALTH FRANK	Provider CC	`N· 15_1316	Peri od:	u of Form CMS-2 Worksheet S-3	
	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC			N. 13-1310	From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/28/2019 6:1	pared: 7 pm
						I/P Days / O/P	1
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	<u>Visits / Trips</u> Title V	
	component	Line Number	NO. OI DEUS	Avai I abl e	CAIT HOURS	intro v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	25	9, 1	25 28, 992.00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO IRF Subprovider					0	4.00
5.00 6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	•
7.00	Total Adults and Peds. (exclude observation		25	9, 1	25 28, 992. 00		7.00
7.00	beds) (see instructions)		20	2, 1	20, 772.00	0	1.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.0
12.00	OTHER SPECIAL CARE (SPECIFY)						12.0
13.00	NURSERY						13.0
14.00	Total (see instructions)		25	9, 1	25 28, 992. 00	0	
15.00	CAH visits					0	15.0
16.00	SUBPROVIDER - IPF						16.0
17.00	SUBPROVIDER - IRF						17.0
18.00 19.00							18.0 19.0
20.00	SKILLED NURSING FACILITY NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						20.0
22.00	HOME HEALTH AGENCY	101.00				0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	101.00				Ŭ	23.0
24.00	HOSPI CE						24.0
24.10	HOSPICE (non-distinct part)	30.00					24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
27.00	Total (sum of lines 14-26)		25				27.0
8.00	Observation Bed Days					0	
29.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00 32.00	Employee discount days - IRF		0		0		31.0 32.0
32.00 32.01	Labor & delivery days (see instructions) Total ancillary labor & delivery room		0		U		32.0
32.01	outpatient days (see instructions)						32.0
33.00	LTCH non-covered days						33.00
	LTCH site neutral days and discharges						33.0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2018 To 12/31/2018 _		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	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	
. 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)	803	12	1, 20	8		1.00
. 00	HMO and other (see instructions)	207	69				2.00
. 00	HMO IPF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	237	0				5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		1		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 040	12	1, 52	6		7.00
. 00	I NTENSI VE CARE UNI T						8.00
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		10				13.0
4.00	Total (see instructions)	1,040	12		6 0.00	98.05	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
B. 00	SUBPROVIDER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE	0	0		0 0.00	0.00	21.0
2.00 3.00	HOME HEALTH AGENCY	U	0		0.00	0.00	22.0
4.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23.0
4.10	HOSPICE (non-distinct part)				0		24.0
5.00	CMHC - CMHC				0		24. 1
5.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
7.00	Total (sum of lines 14-26)	0	0		0.00		
3.00	Observation Bed Days		1	46		7 0.05	27.0
9.00 9.00	Ambul ance Trips	0	4	40	3		29.0
7.00 D.00	Employee discount days (see instruction)	0			0		30.0
1.00	Employee discount days (see first detroit)				0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
2.00	Total ancillary labor & delivery room	0	0		0		32.0
2. UI	outpatient days (see instructions)						32.0
3. 00	LTCH non-covered days	0					33.0
	LTCH site neutral days and discharges	0					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/28/2019 6:1	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ \\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ \\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 24.\ 00\\ 25.\ 00\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 32.\ 01\\ \end{array}$	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 HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC 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. 00	0		49 4 54 22 0 0 49 4	371	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 23.00 24.00 24.00 24.00 24.00 24.00 25.00 24.00 24.00 25.00 24.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00 32.00 32.01
33.00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0 0		33. 00 33. 01

Heal th	Financial Systems IU HEALTH FRANKFORT	HOSPI TAL		In Lie	u of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-13		eriod:	Worksheet S-1	0		
				rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/28/2019 6:1			
					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	rided by line 202 c	olumn	8)	0. 446500	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				1, 823, 942	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?	al normanta from M	odi ool	40	Y Y	3.00 4.00		
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr		edical	u <i>?</i>	Y O	4.00		
6.00	Medicaid charges				10, 719, 545	6.00		
7.00	Medicaid cost (line 1 times line 6)				4, 786, 277	7.00		
8.00	Difference between net revenue and costs for Medicaid program (< zero then enter zero)	line 7 minus sum o	fline	s 2 and 5; if	2, 962, 335	8.00		
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)						
9.00	Net revenue from stand-alone CHIP				0	9.00		
10.00	Stand-alone CHIP charges				0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0			
12.00	Difference between net revenue and costs for stand-alone CHIP (enter zero)	line 11 minus line	9; if	< zero then	0	12.00		
	Other state or local government indigent care program (see inst	ructions for each	line)					
13.00	Net revenue from state or local indigent care program (Not incl				0			
14.00	Charges for patients covered under state or local indigent care 10)	0	14.00					
15.00	State or local indigent care program cost (line 1 times line 14				0	15.00		
16.00	Difference between net revenue and costs for state or local ind	ligent care program	(line	15 minus line	0	16.00		
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/local	i ndi qo	at caro program				
	instructions for each line)	r anu stateriocai	r nur gei	nt care program	15 (566			
17.00	Private grants, donations, or endowment income restricted to fu	nding charity care			0	17.00		
	Government grants, appropriations or transfers for support of h				0	18.00		
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent care pro	grams	(sum of lines	2, 962, 335	19.00		
		Uni nsu pati e		Insured patients	Total (col. 1 + col. 2)			
		1.0		2.00	3.00			
	Uncompensated Care (see instructions for each line)		-					
20.00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility 2,5	38, 340	15, 959	2, 554, 299	20. 00		
21.00	Cost of patients approved for charity care and uninsured discou instructions)	ints (see 1,1	33, 369	15, 959	1, 149, 328	21.00		
22.00	Payments received from patients for amounts previously written charity care	off as	0	0	0	22. 00		
23.00	Cost of charity care (line 21 minus line 22)	1, 1	33, 369	15, 959	1, 149, 328	23.00		
					1.00			
24.00	Does the amount on line 20 column 2, include charges for patien	it days beyond a le	ngth o	f stay limit	N	24.00		
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		ogram':	s length of	0	25.00		
	stay limit							
26.00	Total bad debt expense for the entire hospital complex (see ins		`		2, 348, 380 220, 760			
27.00 27.01								
27.01		ee mstructruns)			339, 631 2, 008, 749			
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instruct	ions)		1, 015, 777			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				2, 165, 105			
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			5, 127, 440			
	· · · · · · · · · · · · · · · · · · ·					-		

Health Financial Systems	U HEALTH FRANKFO	ORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Peri od:	Worksheet A	
				rom 01/01/2018 0 12/31/2018	Date/Time Pre	nared
					5/28/2019 6:1	
Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT		0	() 16, 226	16, 226	1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	(1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT - MOB	00.050	0	(,	31, 026	1.02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	23, 850	32, 890			1, 029, 311	4.00 5.00
7.00 00700 OPERATION OF PLANT	511, 072 382, 819	5, 479, 659 2, 511, 687	2, 894, 506		5, 301, 542 505, 954	5.00
7. 01 00700 OPERATION OF PLANT - HOSPITAL	302, 019	2, 511, 007	2, 094, 500		1, 409, 575	7.00
7.02 00702 OPERATION OF PLANT - MOB	0	0	(0	7.02
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	(50, 848	50, 848	
9.00 00900 HOUSEKEEPI NG	239, 687	239, 384	479, 071		384, 438	9.00
10. 00 01000 DI ETARY	144, 235	251, 979	396, 214	-254, 345	141, 869	10.00
11. 00 01100 CAFETERI A	0	0	(196, 257	11.00
13.00 01300 NURSING ADMINISTRATION	765, 967	160, 838			832, 409	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	178, 227	178, 227		537, 260	
15.00 01500 PHARMACY	393, 674	949, 930			1, 047, 210	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	(0 0	0	16.00
30. 00 03000 ADULTS & PEDIATRICS	961, 746	692, 076	1, 653, 822	-269, 101	1, 384, 721	30.00
ANCI LLARY SERVICE COST CENTERS	701,710	072,070	1,000,022	207,101	1,001,721	00.00
50. 00 05000 OPERATI NG ROOM	252, 710	926, 847	1, 179, 55	-446, 033	733, 524	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	599, 522	224, 183	823, 705	- 166, 780	656, 925	54.00
60. 00 06000 LABORATORY	0	688, 115			679, 862	60.00
66.00 06600 PHYSI CAL THERAPY	0	570, 988			550, 125	
67. 00 06700 OCCUPATI ONAL THERAPY	0	232, 632			232, 632	67.00
68.00 06800 SPEECH PATHOLOGY	67, 692	19, 640			72, 800	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	(-	0 58, 249	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		00/2//	16, 482	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	(221, 515	
73.01 07301 ONCOLOGY DRUGS	0	0	(58, 908	
76.00 03160 CARDI OPULMONARY	548, 194	209, 876	758, 070	-131, 336	626, 734	76.00
OUTPATIENT SERVICE COST CENTERS				1		
90. 00 09000 CLINIC	0	4, 812			0	90.00
91.00 09100 EMERGENCY	1, 059, 675	2, 365, 887	3, 425, 562	-379, 032	3, 046, 530	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
101.00 10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	0	0		, <u> </u>	0	101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 950, 843	15, 739, 650	21, 690, 493	3 20, 402	21, 710, 895	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190. 00
191. 00 19100 RESEARCH	0	0	(0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
192. 02 19202 MOB	0	50, 235			29, 833	
193.00 19300 NONPALD WORKERS	0	0	(193.00 194.00
194.00 07950 LEASED_SPACE 200.00 TOTAL (SUM OF LINES 118 through 199)	0 5, 950, 843	0 15, 789, 885	21, 740, 728	-		
200.00 TITL (SOM OF LINES TO THOUGH 199)	5, 750, 045	15, 707, 000	21, 740, 720	ין U	21,740,720	I [∠] 00.00

ECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	N: 15-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet A Date/Time P 5/28/2019 6	repared
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation			572872019 0	
		6.00	7.00				_
	GENERAL SERVICE COST CENTERS	1	1				
. 00	00100 CAP REL COSTS-BLDG & FIXT	0					1.0
. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	99, 718	1, 987, 681				1.0
. 02	00102 CAP REL COSTS-BLDG & FIXT - MOB	0	31, 026				1.
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	146, 180	1, 175, 491				4.
. 00	00500 ADMI NI STRATI VE & GENERAL	9, 254	5, 310, 796				5.
. 00	00700 OPERATION OF PLANT	-33, 301	472, 653				7.
. 01	00701 OPERATION OF PLANT - HOSPITAL	-98, 476					7.
. 02	00702 OPERATION OF PLANT - MOB	0					7.
. 00	00800 LAUNDRY & LINEN SERVICE	0					8.
. 00	00900 HOUSEKEEPI NG	0					9.
		-					
0.00		0					10.
1.00		-59, 292					11.
3.00		14, 208					13.
4.00		71, 613	608, 873				14.
5.00	01500 PHARMACY	-183, 601	863, 609				15.
6.00	01600 MEDICAL RECORDS & LIBRARY	0	0				16.
	INPATIENT ROUTINE SERVICE COST CENTERS						
0. 00		-251, 579	1, 133, 142				30.
0.00	ANCI LLARY SERVICE COST CENTERS	2011/01/	1,100,112				
0.00		-239, 588	493, 936				50.
4.00		237, 300					54.0
0.00		0					60.
6.00		s s	0007.20				66.
7.00		0	/				67.
8.00		0	,				68.
9.00		0	-				69.
1.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58, 249				71.
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	16, 482				72.
3.00	07300 DRUGS CHARGED TO PATIENTS	0	221, 515				73.
3. 01	07301 ONCOLOGY DRUGS	0	58, 908				73.
6.00		50, 055					76.
	OUTPATIENT SERVICE COST CENTERS						
0. 00		0	0				90.
1.00		-229, 846					91.0
		-229, 040	2, 816, 684				
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.
	OTHER REIMBURSABLE COST CENTERS	1	1				
01.0	0 10100 HOME HEALTH AGENCY	0	0				101.
	SPECIAL PURPOSE COST CENTERS						
18.0	0 SUBTOTALS (SUM OF LINES 1 through 117)	-704, 655	21, 006, 240				118.
	NONREI MBURSABLE COST CENTERS						
90.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.
	0 19100 RESEARCH	0					191.
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.
	2 19202 MOB						192.
		-					
	0 19300 NONPALD WORKERS	0					193.
	0 07950 LEASED SPACE	0	0				194.
DO. OC	0 TOTAL (SUM OF LINES 118 through 199)	-704, 655	21,036,073				200.

Financial Systems SIFICATIONS	11	J HEALTH FRANKF	ORT HOSPITAL Provider CCN:	From 01/C	In Lieu of Form CMS-2552- Worksheet A-6
					1/2018 Date/Time Prepared 5/28/2019 6:17 pm
Cost Contor	Increases	Colors	Othor		
Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
A – CAFETERIA					
	<u>11.00</u>	83, 718	112, 539		1.0
U B – DRUGS		83, 718	112, 539		
DRUGS CHARGED TO PATIENTS	73.00	0	221, 515		1.0
ONCOLOGY DRUGS	73.01	0	58, 908		2.0
	0.00 0.00	0	0		3. 0
	0.00	0	0		4.
	0.00	0	0		6.
	0.00	0	0		7.0
TOTALS		0			8.0
C - MEDICAL SUPPLIES		0	200, 423		
CENTRAL SERVICES & SUPPLY	14.00	0	382, 431		1.0
MEDICAL SUPPLIES CHARGED TO	71.00	0	58, 249		2.0
PATIENTS IMPL. DEV. CHARGED TO	72.00	o	16, 482		3.
PATIENTS	72.00	U U	10, 402		5.
ADMI NI STRATI VE & GENERAL	5.00	0	38		4. (
NURSING ADMINISTRATION	13.00	0	39		5.
	0.00 0.00	0	0		6. 7.
	0.00	Ő	0		8.
	0.00	О	0		9.
	0.00	0	0		10.
	0.00 0.00	0	0		11.
TOTALS		0	457, 239		12.
D – LAUNDRY	1				
LAUNDRY & LINEN SERVICE	8.00	0	50, 848		1.
	0.00 0.00	0	0		2. 3.
	0.00	o	0		4.
	0.00	0	0		5.
	0.00	0	0		6.
	0.00 0.00	0	0		7.
TOTALS		0	50, 848		0.
E - DEPRECIATION					
CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	1, 077, 160		1.
CAP REL COSTS-BLDG & FIXT -	1.02	0	5, 312		2.
МОВ		_			
МОВ	192.02	0	5, 312		3.
	0.00 0.00	0	0		4. 5.
	0.00	Ö	0		6.
	0.00	0	0		7.
	0.00	0	0		8.
	0.00 0.00	0	0		9. 10.
TOTALS		<u>0</u>	1,087,784		10.
F - OTHER CAPITAL					
CAP REL COSTS-BLDG & FIXT - HOSPITAL	1.01	0	810, 000		1.
CAP REL COSTS-BLDG & FIXT	1.00	o	16, 226		2.0
CAP REL COSTS-BLDG & FIXT -	1.01	0	803		3.
HOSPITAL		_	or		
CAP REL COSTS-BLDG & FIXT - MOB	1.02	0	25, 714		4.
TOTALS	+		852, 743		
G - OPERATION OF PLANT					
OPERATION OF PLANT -	7.01	0	1, 409, 575		1.
HOSPITAL	+		1, 409, 575		
H - EMPLOYEE BENEFITS		0	1, 107, 373		
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	972, 571		1.
	0.00	0	0		2.
	0.00 0.00	0	0		3.
	0.00	0	0		4. 5.
	0.00	0	Ö		6.
	0.00				7.0

Heal th	Financial Systems	I	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider C	CN: 15-1316	Period: From 01/01/2018	Worksheet A-	6
						To 12/31/2018	Date/Time Pr 5/28/2019 6:	epared: 17 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11.00		0.00	0	0				11.00
12.00	L	0.00	0	0				12.00
	TOTALS		0	972, 571				
	I – HOUSEKEEPING							
1.00	HOUSEKEEPI NG	9.00	0	1, 247				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
7.00	L	0.00	0	0				7.00
	TOTALS		0	1, 247				
	L - ONCOLOGY							
1.00	OPERATING ROOM	50.00	0					1.00
	TOTALS		0	4, 812				
500.00	Grand Total: Increases		83, 718	5, 229, 781				500.00

CLASSI	FICATIONS			Provi der	CCN: 15-1316	Period: From 01/01/2018	u of Form CMS-2552-1 Worksheet A-6
						To 12/31/2018	Date/Time Prepared: 5/28/2019 6:17 pm
	Cont Conton	Decreases	Calarra	Others		· · · ·	
	<u> </u>	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref 10.00	<u>.</u>	
A	A - CAFETERIA	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00	7100			
00 [DI ETARY		8 <u>3, 7</u> 18	11 <u>2, 5</u> 39		Q	1.00
C)		83, 718	112, 539			
	3 - DRUGS CENTRAL SERVICES & SUPPLY	14.00	0	953		o	1.00
	PHARMACY	14.00	0	240, 585		0	2.00
	ADULTS & PEDIATRICS	30.00	0	3, 270		0	3.00
00 0	OPERATING ROOM	50.00	0	2, 899		o	4.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 017		0	5.00
	PHYSI CAL THERAPY CARDI OPULMONARY	66. 00 76. 00	0	237 107		0	6. 00 7. 00
	EMERGENCY	91.00	0	13, 355		0	8.00
-	TOTALS		— — — o	280, 423			0.0
C	C - MEDICAL SUPPLIES					-	
	DPERATION OF PLANT	7.00	0	49, 554		0	1.00
	HOUSEKEEPING	9.00	0	5, 474		0	2.00
	DI ETARY PHARMACY	10. 00 15. 00	0	16 3, 731			3.00
	ADULTS & PEDIATRICS	30.00	0	85, 571		0	5.0
	DPERATING ROOM	50.00	Ō	106, 214		o	6. 0
	RADI OLOGY-DI AGNOSTI C	54.00	0	16, 468		0	7.0
		60.00	0	8, 253		0	8.00
	PHYSICAL THERAPY	66.00	0	17,470		0	9.0
	SPEECH PATHOLOGY CARDI OPULMONARY	68. 00 76. 00	0	19 13, 272		0	10.0
	EMERGENCY	91.00	0	151, 197		o	12.00
-	TOTALS			457, 239			
-	D - LAUNDRY				1	I	
		9.00	0	59		0	1.00
	CENTRAL SERVICES & SUPPLY ADULTS & PEDIATRICS	14.00 30.00	0	22, 445 7, 894			2.0
	DPERATING ROOM	50.00	0	3, 871		o	4.00
	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 469		o	5.00
	PHYSICAL THERAPY	66.00	0	2, 375		0	6.00
		76.00	0	100		0	7.00
	EMERGENCY	91.00	<u>0</u>	1 <u>1, 6</u> 35 50, 848			8.00
	E - DEPRECIATION	1 1	Ŋ	50, 840			
-	ADMI NI STRATI VE & GENERAL	5.00	0	645, 991		9	1.00
	OPERATION OF PLANT	7.00	0	16, 716		9	2.00
	HOUSEKEEPING	9.00	0	3, 577		0	3.0
	DI ETARY ADULTS & PEDI ATRI CS	10. 00 30. 00	0	6, 708 13, 580		0	4. 0 5. 0
	DPERATING ROOM	50.00	0	285, 509		0	6.0
	RADI OLOGY-DI AGNOSTI C	54.00	0	55, 127		0	7.0
	PHYSICAL THERAPY	66.00	0	781		0	8.0
		76.00	0	37, 956		0	9.0
	EMERGENCY FOTALS	91.00	<u>0</u>	2 <u>1, 8</u> 39 1, 087, 784			10. 0
	F - OTHER CAPITAL	<u> </u>	0	1,007,70-			
00 0	OPERATION OF PLANT	7.00	0	810, 000) 1	0	1.00
	ADMINISTRATIVE & GENERAL	5.00	0	16, 226			2.00
	DPERATION OF PLANT	7.00	0	803			3.0
	<u>ИОВ</u> ГОТALS	<u> </u>	<u>0</u>	2 <u>5, 7</u> 14 852, 743		2	4.0
-	G - OPERATION OF PLANT	<u> </u>	9	002,710			
00 0	DPERATION_OF_PLANT	7.00	0	1, 409, 575		0	1.00
-			0	1, 409, 575	- -		
-	H - EMPLOYEE BENEFITS	5.00	0	26, 996	J	0	1.0
	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5.00	0	26, 996 101, 904		0	2.0
	HOUSEKEEPING	9.00	o	86, 770		ŏ	3.0
	DI ETARY	10.00	Ō	51, 364		o	4.0
	NURSING ADMINISTRATION	13.00	0	94, 435	5	0	5.0
		15.00	0	51, 793		0	6.0
	ADULTS & PEDIATRICS	30.00	0	158, 603			7.0
	DPERATING ROOM RADIOLOGY-DIAGNOSTIC	50.00 54.00	0	52, 158 73, 685		0	8. 0 9. 0
	SPEECH PATHOLOGY	68.00	0	14, 513		ŏ	9.0
	CARDI OPULMONARY	76.00	ő	79, 860		o	11. 0
	EMERGENCY	91.00	0)	o	12.00
15	TOTALS	I T		972, 571			

Heal th	Financial Systems		IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider C	CCN: 15-1316	Period:	Worksheet A-	6
						From 01/01/2018 To 12/31/2018	Date/Time Pr 5/28/2019 6:	epared: 17 pm
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref			
	6. 00	7.00	8.00	9.00	10.00			
	I – HOUSEKEEPING							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	14		0		1.00
2.00	PHARMACY	15.00	0	285		0		2.00
3.00	ADULTS & PEDIATRICS	30.00	0	183		0		3.00
4.00	OPERATING ROOM	50.00	0	194		0		4.00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	14		0		5.00
6.00	CARDI OPULMONARY	76.00	0	41		0		6.00
7.00	EMERGENCY	91.00	0	516		0		7.00
	TOTALS		0	1, 247				
	L - ONCOLOGY							
1.00		90.00	0	4,812		0		1.00
	TOTALS		0	4, 812				
500.00	Grand Total: Decreases		83, 718	5, 229, 781				500.00

		U HEALTH FRANK			-		u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-1316		ri od:	Worksheet A-7 Part I	
					To	om 01/01/2018	Date/Time Pre	nared
					10	12/ 51/ 2010	Date/Time Pre 5/28/2019 6:1	7 pm
				Acqui si ti ons				
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	0	807, 164		0	807, 164	0	1.00
2.00	Land Improvements	0	0		0	0	0	2.00
3.00	Buildings and Fixtures	35, 315	11, 938		0	11, 938	0	3.00
4.00	Building Improvements	1, 417, 019	8, 458		0	8, 458	0	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	3, 899, 925	1, 568, 387		0	1, 568, 387	129, 270	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	5, 352, 259	2, 395, 947		0	2, 395, 947	129, 270	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	5, 352, 259	2, 395, 947		0	2, 395, 947	129, 270	10.00
		Ending Balance	Fully					
		U U	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	807, 164	0					1.00
2.00	Land Improvements	0	0					2.00
3.00	Buildings and Fixtures	47, 253	0					3.00
4.00	Building Improvements	1, 425, 477	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	5, 339, 042	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	7, 618, 936	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	7, 618, 936	0					10.00

Heal th	Financial Systems	U HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018		pared:
			SL	JMMARY OF CAP	ITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0		0 0	0	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0		0 0	0	1.02
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O					
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)		-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0				1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0				1.02
3.00	Total (sum of lines 1-2)	0	0	1			3.00

Heal th	n Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	eu of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F		Date/Time Prep 5/28/2019 6:17	
		COME	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)		Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	6, 922, 588		6, 922, 588			1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	696, 349	0	696, 349			1. 02
3.00	Total (sum of lines 1-2)	7, 618, 937	0	7, 618, 93			3.00
		ALLOCA	FION OF OTHER (-)F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relate d Costs		Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
-	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0) (0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	(1, 088, 973	810, 000	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	(5, 312	0	1.02
3.00	Total (sum of lines 1-2)	0	0	(1, 094, 285	810, 000	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS			-		
1.00	CAP REL COSTS-BLDG & FIXT	0	16, 226		-	16, 226	1.00
1.01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	87, 905	0			.,	1.01
1.02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	25, 714		01,020	1.02
3.00	Total (sum of lines 1-2)	87, 905	16, 226	26, 51	0	2, 034, 933	3.00

	Financial Systems MENTS TO EXPENSES	I	U HEALTH FRANKF	ORT HOSPITAL Provider CCN: 15-1316	In Lie Period:	eu of Form CMS-2 Worksheet A-8	
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1316	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			Т	Expense Classification c To/From Which the Amount is		5/28/2019 6: 1	7 pm
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1.00	2.00 0C	3.00 AP REL COSTS-BLDG & FIXT	4.00	5.00	1.00
1.01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL	В		AP REL COSTS-BLDG & FIXT - IOSPITAL	- 1.01	11	1. 01
1.02	(chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - MOB (chapter 2)			AP REL COSTS-BLDG & FLXT - 10B	- 1.02	0	1. 02
2.00	Investment income - CAP REL		0 *	** Cost Center Deleted **	2.00	0	2.00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		О		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00		5.00
6.00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7.00
8.00	21) Television and radio service (chapter 21)		О		0.00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -868, 117		0.00	0	
	adjustment Sale of scrap, waste, etc.		0		0.00	0	
	(chapter 23) Related organization	A-8-1	1, 588, 061			0	12.00
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
	Cafeteria-employees and guests Rental of quarters to employee		-59, 292 C 0	AFETERI A	11.00 0.00		
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17.00	patients Sale of drugs to other than		0		0.00	0	17.00
18.00	patients Sale of medical records and		0		0.00	0	18.00
19. 00	ADSTRACTS Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20.00	books, etc.) Vending machines		О		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	
	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0*	** Cost Center Deleted ***	65.00		23. 00
	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OP	HYSICAL THERAPY	66.00		24.00
	limitation (chapter 14) Utilization review - physicians' compensation		0 *	** Cost Center Deleted ***	* 114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL		oc	AP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL COSTS-BLDG & FIXT - HOSPITAL	А		: AP REL COSTS-BLDG & FIXT - IOSPITAL	- 1.01	9	26. 01
26. 02	Depreciation - CAP REL COSTS-BLDG & FIXT - MOB		oc	IOSETTAL IAP REL COSTS-BLDG & FIXT - IOB	- 1.02	0	26. 02
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			** Cost Center Deleted ***	* 2.00	0	27.00
	Non-physician Anesthetist Physicians' assistant		0 *	** Cost Center Deleted ***	* 19.00 0.00		28. 00 29. 00

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems		U HEALIH FRANK	FORT HOSPITAL	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1316	Peri od:	Worksheet A-8	
					From 01/01/2018 To 12/31/2018		narod
					10 12/31/2018	5/28/2019 6:1	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is			
					-		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1	1.00	2.00	3.00	4.00	5.00	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30.99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
21 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	(0,00		21 00
31.00	pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	limitation (chapter 14)						
32.00			0		0.00	0	32.00
52.00	Depreciation and Interest		0		0.00	0	52.00
33 00	EMPLOYEE BENEFITS	A	-973 507	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.00
33.01	MEDICALD HAF FEES	A		ADMI NI STRATI VE & GENERAL	5.00		
33.02	MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00		
33.03		В		OPERATION OF PLANT -	7.01		•
				HOSPI TAL			
33.04	MI SCELLANEOUS I NCOME	В	-52, 930	OPERATING ROOM	50.00	0	33.04
33.05	ACCRUED PTO	A	-7,606	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	33.05
33.06	ACCRUED PTO	A	-121, 657	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	CONTRI BUTI ON EXPENSE	A	-4,040	ADMINISTRATIVE & GENERAL	5.00	0	33.07
33.08	TELEPHONE EXP	A	-544	CENTRAL SERVICES & SUPPLY	14.00	0	33.08
33.09	TELEPHONE EXP	A	-77	OPERATING ROOM	50.00	0	33.09
33. 10	TELEPHONE EXP	A	-362	EMERGENCY	91.00	0	33.10
33. 11	AMORTIZED START UP COSTS	A	647, 994	ADMI NI STRATI VE & GENERAL	5.00	0	00
33. 12	MARKETING	A	-60	ADMI NI STRATI VE & GENERAL	5.00		00.12
33.13	MARKETING	A	-	NURSING ADMINISTRATION	13.00	-	
33.14		A		CAP REL COSTS-BLDG & FIXT -	1.01	9	33.14
	ASSETS			HOSPI TAL			
33. 15	START UP COST NEW HOSPITAL	A		ADMI NI STRATI VE & GENERAL	5.00	0	001.10
50.00			-704,655				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

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

Heal th	Financial Systems	IU HEALTH FRAN	IKFORT HOSPI TAL	In Lie	eu of Form CMS-:	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1316	Period: From 01/01/2018 To 12/31/2018		pared:
	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN HOME OFFICE COSTS:					
1.00	1. 01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE	692, 636	810, 000	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 127, 293	0	2.00
3.00		ADMINISTRATIVE & GENERAL	HOME OFFICE	3, 561, 131	3, 140, 305	3.00
3.01		ADMINISTRATIVE & GENERAL	RELATED PARTY	585, 921	502, 768	3.01
3.02		OPERATION OF PLANT	RELATED PARTY	53, 216		3. 02
3.03	-			55, 240		3.03
4.00		NURSING ADMINISTRATION	RELATED PARTY	14, 218		4.00
4.01	14.00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	210, 109	137, 952	4.01
4.02	15.00	PHARMACY	RELATED PARTY	396, 305	579, 906	4.02
4.03		ADULTS & PEDIATRICS	RELATED PARTY	93, 330	48, 372	4.03
4.04	50.00	OPERATING ROOM	RELATED PARTY	202, 216	92, 266	4.04
4.05	76.00	CARDI OPULMONARY	RELATED PARTY	50, 055	0	4.05
4.06	91.00	EMERGENCY	RELATED PARTY	114, 504	68, 939	4.06
4.07	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	296, 537	296, 537	4.07
4.08	50.00	OPERATING ROOM	SHARED EMPLOYEES	316, 531	316, 531	4.08
4.09	60.00	LABORATORY	SHARED EMPLOYEES	664, 248	664, 248	4.09
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,			8, 433, 490	6, 845, 429	5.00
	line 12.					
* The	amounto on lineo 1 4 (and out		harmen General in detail to War	· · · · · · · · · · · · · · · · · · ·	(]]	

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

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

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

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

1 CT IIID GT					
6.00	В	IU HEALTH	100.00	0.00	6.00
7.00	В	I UH ARNETT	1.00	0.00	7.00
8.00			0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

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

Health Financial Systems	IU HEALTH FRANKFORT I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM F OFFICE COSTS	RELATED ORGANIZATIONS AND HOME Pr	rovider CCN: 15-1316	From 01/01/2018	Worksheet A-8-1 Date/Time Prepared:

			5/28/2019	6:17 pm
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
			MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO		1	
1.00	-117, 364			1.00
2.00	1, 127, 293			2.00
3.00	420, 826			3.00
3.01	83, 153			3. 01
3.02	-33, 301			3. 02
3.03	-45,848			3. 03
4.00	14, 218			4.00
4.01	72, 157			4.01
4.02	-183, 601			4. 02
4.03	44, 958			4.03
4.04	109, 950			4.04
4.05	50, 055			4.05
4.06	45, 565	0		4.06
4.07	0	0		4.07
4.08	0	0		4. 08
4.09	0	0		4.09
5.00	1, 588, 061			5.00
* The	amounts on lin	es 1-4 (and sub	bscripts as appropriate) are transferred in detail to Worksheet A. column 6. lines a	5

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

Rel ated Organization(s)		
and/or Home Office		
Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
100.00	100.00
(1) Use the fallowing symbols to indicate intervalationship to related ergeni	zati enc.

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

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

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

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

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

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

Heal th	Financial Syste	ems	IU HEALTH FRAN	KFORT HOSPITAL		In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC			Provider (CCN: 15-1316	Period: From 01/01/2018		
						To 12/31/2018	Date/Time Pre 5/28/2019 6:1	epared: 17 nm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	7 pm
		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	296, 537	296, 537	(0 0	0	1.00
2.00	50.00	OPERATING ROOM	296, 531	296, 531	(0 0	0	2.00
3.00	91.00	EMERGENCY	1, 749, 129	275, 049	1, 474, 080	0 0	0	3.00
4.00	0.00		0	0	(0	4.00
5.00	0.00		0	0	(o o	0	5.00
6.00	0.00		0	0	(0 0	0	6.00
7.00	0, 00		0	0	(0 0	0	
8.00	0.00		0	0	(0	0	
9.00	0.00		0	0	(0	
10.00	0.00		0	0	(0	
200.00	0.00		2, 342, 197	868, 117	1, 474, 080		0	
-	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	200.00
		I denti fi er		Unadjusted RCE			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	50.00	OPERATING ROOM	0	0	(o o	0	2.00
3.00	91.00	EMERGENCY	0	0	(o o	0	3.00
4.00	0, 00		0	0	(o l	0	4.00
5.00	0, 00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0	
7.00	0.00		0	0	(0	
8.00	0.00		0	0	(0	
9.00	0.00		0	0	(-	0	
10.00	0.00		0	0	(°	0	
200.00	0.00		0	0	(0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		200100
		I denti fi er	Component	Limit	Di sal l owance			
			Share of col.	21.111.1	bi our ronanoo			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	(296, 537		1.00
2.00	50.00	OPERATING ROOM	0	0	(296, 531		2.00
3.00		EMERGENCY	0	0	(3.00
4.00	0.00		0	0	(4.00
5.00	0.00		0	0	(ol o		5.00
6.00	0.00		0	0	(-		6.00
7.00	0.00		0	0	(7.00
8.00	0.00		0	0	(8.00
9.00	0.00		0	0	(-		9.00
10.00	0.00		0	0	(10.00
200.00	0.00		0	0		868, 117		200.00
200.00		I	. 0	0		000,117	I	200.00

	NABLE COST DETERMINATION FOR THERAPY SERVICES I DE SUPPLIERS	FURNI SHED BY	Provider CO	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018		pared:
					Physical Therapy		
						1.00	
	PART I - GENERAL INFORMATION		· •				
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	1.00 2.00
2.00	Number of unduplicated days in which supervis	sor or therapis	t was on provi	der site (se	e instructions)	293	3.00
4.00	Number of unduplicated days in which therapy					205	4.00
	nor therapist was on provider site (see instr						
5.00 5.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				by therapy	0	5.00 6.00
5.00	assistant and on which supervisor and/or ther					Ű	
	instructions)						
7.00 3.00	Standard travel expense rate Optional travel expense rate per mile					5. 45 0. 00	7.00 8.00
5.00		Supervi sors	Therapi sts	Assi stants		Trai nees	0.00
9.00	Total hours worked	<u> </u>	2.00	3.00	4.00 .78 1,117.35	5.00	9.00
10.00		0.00	82. 91		. 18 23. 05		
11.00		41.46	41.46		. 09		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
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00		0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	Lino 10)					14.00
15.00						468, 170	
16.00						99, 972	
17.00		nd 15 for respi	ratory therapy	or lines 14	4-16 for all	568, 142	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				25, 755	18.00
19.00	•					23, 733	19.00
20. 00						593, 897	20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.				11110 23	
21.00	5 5 5			m 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						593, 897	
		ANCE AND TRAVE	L EXPENSE COMP	UTATION - PF	ROVI DER SITE		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW						
24 00	Standard Travel Allowance					12 148	24 00
24. 00 25. 00	<u>Standard Travel Allowance</u> Therapists (line 3 times column 2, line 11)					12, 148 6, 373	
25.00 26.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or					6, 373 18, 521	25.00 26.00
25.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				3 and 4 for all	6, 373	
25.00 26.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 s	um of lines		6, 373 18, 521	25.00 26.00 27.00
25.00 26.00 27.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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)	for respirator travel expense	y therapy or s	um of lines		6, 373 18, 521 2, 714	25.00 26.00 27.00
25.00 26.00 27.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 s at the provid	um of lines er site (sur		6, 373 18, 521 2, 714	25.00 26.00 27.00 28.00
25.00 26.00 27.00 28.00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 4, line 10 times	for respirator travel expense Expense of columns 1 an line 12)	y therapy or s at the provid d 2, line 12)	um of lines er site (sur		6, 373 18, 521 2, 714 21, 235	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 respirator travel expense Expense of columns 1 an line 12) sum of lines 2	y therapy or s at the provid d 2, line 12) 9 and 30 for a	um of lines er site (sur	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 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	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 0 Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	for respirator travel expense Expense of columns 1 an line 12) sum of lines 2	y therapy or s at the provid d 2, line 12) 9 and 30 for a	um of lines er site (sur	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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)	for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir	um of lines er site (sur	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an	um of lines er site (sur Il others) atory thera d 31)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 0 0 0 0 21, 235 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 optional 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 expense (sum	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 expense (sum	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 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 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)	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 expense (sum	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 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 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)	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 expense (sum	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 21, 235 0 0 0 VI DER_SI TE 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	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (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 expense (sum NCE AND TRAVEL	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 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 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columnscolumns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelOptional travel allowance and standard travelDational travel expenseTherapists (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 sunOptional Travel Allowance and Optional 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 expense (sum NCE AND TRAVEL	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 21, 235 0 0 0 VI DER SI TE	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	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 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 Dotional travel allowance and standard travel Deal travel allowance and standard travel Dotional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, 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 respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 a 1 and 2, line expense (line expense (sum NCE AND TRAVEL n of lines 5 an <u>Expense</u> 1 times column	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 21, 235 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
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.0Assistants (column 3, line 12.01 times column	for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 a 1 and 2, line expense (line expense (sum NCE AND TRAVEL n of lines 5 an <u>Expense</u> 1 times column	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6)	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 0 21, 235 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 39. 00 40. 00 41. 00
25.00 26.00 27.00 28.00 29.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard travelOptional travel allowance and optional travelOptional travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.01Assistants (column 3, line 12.01 times columnSubtotal (sum of lines 40 and 41)	for respirator travel expense <u>Expense</u> of columns 1 an line 12) sum of lines 2 s 1 and 2, line expense (sum expense (sum expense (sum NCE AND TRAVEL n of lines 5 an <u>Expense</u> 1 times column n 3, line 10)	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10)	um of lines er site (sur II others) atory therap d 31) d 32)	n of lines 26 and	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 21, 235 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 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 33.00 33.00 35.00 36.00 37.00 38.00 37.00 39.00 40.00 41.00	Standard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum ofAssistants (column 3, line 10 times column 3,Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times columnscolumns 1-3, line 13 for all others)Standard travel allowance and standard travelOptional travel allowance and optional travelPart IV - STANDARD AND OPTIONAL TRAVEL ALLOWAStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the sumOptional Travel Allowance and Optional TravelTherapists (column 3, line 12.01 times columnSubtotal (sum of columns 1 and 2, line 12.02Assistants (column 3, line 40 and 41)Optional travel expense (line 8 times the sumTotal 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 s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01)	um of lines er site (sur ll others) atory therap d 31) d 32) TATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 21, 235 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 39. 00 40. 00 41. 00 42. 00
 15.00 16.00 17.00 18.00 19.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 10.00 10.00 11.00 	Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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 optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.00 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum Total Travel Allowance and Travel Expense - Co or 46, as appropriate.	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 expense (sum NCE AND TRAVEL n of lines 5 an <u>Expense</u> 1 times column n 3, line 10) n of columns 1- offsite Service	y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 an of lines 31 an EXPENSE COMPU d 6) 2, line 10) 3, line 13.01) s; Complete on	um of lines er site (sur ll others) atory theran d 31) d 32) TATION - SEF	n of lines 26 and by or sum of RVICES OUTSIDE PRO	6, 373 18, 521 2, 714 21, 235 0 0 21, 235 0 0 0 21, 235 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

EASONABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provider CC	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018		pared:
				Physical Therapy		
					1.00	
5.00 Optional travel allowance and optional travel	expense (sum o	flines 42 an	d 43 - see in	structions)		46.00
	Therapists	Assi stants	Ai des	Trai nees	Total	
	1.00	2.00	3.00	4.00	5.00	
PART V - OVERTIME COMPUTATION	0.00	0.00			0.00	1 17 0
7.00 Overtime hours worked during reporting 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)						
3.00 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					50.0
0.00 Percentage of overtime hours by category (divide the hours in each column on line 47	0.00	0.00	0.0	0.00	0.00	50.0
by the total overtime worked - column 5,						
line 47)						
I.00 Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.0
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE	00.04					
2.00 Adjusted hourly salary equivalency amount	82. 91	62.18	23.0	0.00		52. C
(see instructions) 3.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.0
52)	0	0		0		35.0
1.00 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)		0		0 0	0	
5.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56.0
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
					1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST /	ADJUSTMENT			F02 007	
7.00 Salary equivalency amount (from line 23) 3.00 Travel allowance and expense - provider site	(from lines 22	24 or $25))$			593, 897 21, 235	
9.00 Travel allowance and expense - Offsite service)		21, 235	59.0
). 00 Overtime allowance (from column 5, line 56)		11, 10, 01 10)		0	60.0
I.00 Equipment cost (see instructions)					0	61.0
2.00 Supplies (see instructions)					0	62.0
3.00 Total allowance (sum of lines 57-62)					615, 132	63.0
1.00 Total cost of outside supplier services (from	, , , , , , , , , , , , , , , , , , ,				543, 329	
5.00 Excess over limitation (line 64 minus line 65	3 - if negative,	enter zero)			0	65.0
LINE 33 CALCULATION		and 05 fac a			10 501	100 0
00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respiratory				othorc	18, 521 2, 714	
00.02 Line 33 = line 28 = sum of lines 26 and 27	y therapy of Sum	UTTHES 3 a		Utilet S	2, 714	
LINE 34 CALCULATION					21,200	100.0
01.00 Line 27 = line 7 times line 3 for respiratory	v therapy or sum	of lines 3 a	nd 4 for all	others	2, 714	101.0
01.01 Line 31 = line 29 for respiratory therapy or						101. C
01.02 Line 34 = sum of lines 27 and 31					2, 714	101. C
LINE 35 CALCULATION						
02.00 Line 31 = line 29 for respiratory therapy or						102. C
02.01 Line 32 = line 8 times columns 1 and 2, line	13 for respirate	ory therapy o	r sum of colu	mns 1-3, line	0	102. 0
13 for all others)2.02 Line 35 = sum of lines 31 and 32					0	102.

	WABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS		ORT HOSPITAL Provider CC	N: 15-1316	In Lie Period: From 01/01/2018 To 12/31/2018 Occupational Therapy		-3 pared:
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	a) (and instruct	ti ana)			52	1.00
2.00	Line 1 multiplied by 15 hours per week	s) (see mistruct	li uns)				2.00
3.00	Number of unduplicated days in which supervi	sor or therapist	t was on provid	der site (see	e instructions)	197	3.00
4.00	Number of unduplicated days in which therapy		on provider si	te but neithe	er supervisor	221	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		anists (see in	structions)		0	5.00
6.00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the	apy assistants ((include only	visits made b		0	6.00
	instructions)	iapist was not p	bi esent dui ring	the visit(s)) (see		
7.00	Standard travel expense rate					5.45	
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5. 00	
9.00	Total hours worked	0.00	1, 580. 25	1, 695. 8		0.00	
10.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0.00 39.30	78.60 39.30	58.9 29.4		0.00	10.00
11.00	one-half of column 2, line 10; column 3,	39.30	39.30	29.2	+0		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01 13.00
13.01	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	, line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					124, 208	
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		satory thorapy	or lines 14	16 for all	99, 970 224, 178	16.00 17.00
17.00	others)	nu is ioi respir	atory therapy	OI TITLES 14-		224, 170	17.00
18.00	Aides (column 4, line 9 times column 4, line					11, 631	18.00
19.00	Trainees (column 5, line 9 times column 5, l			- 17 10	for all atheres	0	19.00
20.00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					235, 809	20.00
	occupational therapy, line 9, is greater than	n line 2, make r					
21.00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tr		divided by cu	n of columns	1 and 2 line 0	0.00	21.00
21.00	for respiratory therapy or columns 1 thru 3,				Tanu Z, TTHE 9	0.00	21.00
22.00	Weighted allowance excluding aides and train	ees (line 2 time	es line 21)				
23.00	Total salary equivalency (see instructions)					0	22.00
		VANCE AND TRAVEL	EVDENSE COMDI		WIDED SITE	0 235, 809	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	VANCE AND TRAVEL	EXPENSE COMPL	JTATION - PRO	WIDER SITE		
24.00		VANCE AND TRAVEL	EXPENSE COMPL	JTATION - PRO	DVIDER SITE		23. 00
25.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOU Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)				IVIDER SITE	235, 809 7, 742 6, 515	23. 00 24. 00 25. 00
25. 00 26. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOU Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	4 and 25 for al	I others)		235, 809 7, 742 6, 515 14, 257	23.00 24.00 25.00 26.00
25.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOU Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	sum of lines 24	4 and 25 for al	I others)		235, 809 7, 742 6, 515	23.00 24.00 25.00 26.00
25. 00 26. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOU Standard Travel Allowance Therapists (line 3 times column 2, line 11) 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	sum of lines 24 for respiratory	4 and 25 for al y therapy or su	l others) um of lines 3	and 4 for all	235, 809 7, 742 6, 515 14, 257	23. 00 24. 00 25. 00 26. 00 27. 00
25.00 26.00 27.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	sum of lines 24 for respiratory travel expense	4 and 25 for al y therapy or su	l others) um of lines 3	and 4 for all	235, 809 7, 742 6, 515 14, 257 2, 278	23. 00 24. 00 25. 00 26. 00 27. 00
25.00 26.00 27.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sum	sum of lines 24 for respiratory travel expense Expense of columns 1 and	4 and 25 for a y therapy or su at the provide	l others) um of lines 3	and 4 for all	235, 809 7, 742 6, 515 14, 257 2, 278	23. 00 24. 00 25. 00 26. 00 27. 00
25.00 26.00 27.00 28.00 29.00 30.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12)	4 and 25 for al y therapy or su at the provide d 2, line 12)	l others) um of lines 3 er site (sum	and 4 for all	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
25.00 26.00 27.00 28.00 29.00 30.00 31.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy or	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al	l others) um of lines 3 er site (sum l others)	3 and 4 for all of lines 26 and	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00
25.00 26.00 27.00 28.00 29.00 30.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al	l others) um of lines 3 er site (sum l others)	3 and 4 for all of lines 26 and	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0	23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional Travel allowance and optional TravelTherapists (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column columns 1-3, line 13 for all others)Standard travel allowance and standard travel	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line	4 and 25 for al y therapy or si at the provide d 2, line 12) 9 and 30 for al 13 for respira 28)	l others) um of lines 3 er site (sum l others) atory therapy	3 and 4 for all of lines 26 and	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and standard trave	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and	l others) um of lines 3 er site (sum l others) atory therapy d 31)	3 and 4 for all of lines 26 and	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 0 0 0 0 0 16, 535 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional Travel allowance and optional TravelTherapists (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column columns 1-3, line 13 for all others)Standard travel allowance and standard travel	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line expense (sum of	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 16, 535 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelThrapists (column 2, line 10 times the sumAssistants (column 2, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel Expense	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line expense (sum of	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 0 0 0 0 VI DER_SI TE	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00
25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and standard travePart 1V - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line expense (sum of	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 0 0 0 16, 535 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 31.00 31.00 33.00 34.00 35.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelTherapists (column 2, line 10 times the sum 4Assistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional Travel Allowance and Optional TravelTherapists (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)	sum of lines 24 for respiratory travel expense Expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line expense (sum of	4 and 25 for al y therapy or su at the provide d 2, line 12) 9 and 30 for al 13 for respira 28) of lines 27 and of lines 31 and	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 0 0 0 0 VI DER_SI TE	23.00 24.00 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	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and standard travePart 1V - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of NCE AND TRAVEL	4 and 25 for al 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	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 0 0 0 0 16, 535 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 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 39. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (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 suOptional Travel Allowance and Optional Travel	sum of lines 24 for respiratory travel expense <u>Expense</u> of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of ANCE AND TRAVEL	4 and 25 for al 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)	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 16, 535 0 0 0 16, 535 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 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	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveColumns 1-3, line 13 for all others)Standard travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.1	sum of lines 24 for respiratory travel expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of l expense (sum of aNCE AND TRAVEL	4 and 25 for al 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)	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 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
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	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (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 suOptional Travel Allowance and Optional Travel	sum of lines 24 for respiratory travel expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of l expense (sum of aNCE AND TRAVEL	4 and 25 for al 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)	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32)	3 and 4 for all of lines 26 and 7 or sum of	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 16, 535 0 0 0 16, 535 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 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	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveoptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12.Assistants (column 3, line 12.01 times columSubtotal (sum of lines 40 and 41)Optional travel expense (line 8 times the su	sum of lines 24 for respiratory travel expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of NACE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-3	4 and 25 for al 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)	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32) FATION - SERV	3 and 4 for all of lines 26 and 7 or sum of 7 ICES OUTSIDE PRC	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 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	23.00 24.00 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	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel Allowance and Optional TravelTherapists (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times columnSubtotal (sum of columns 1 and 2, line 12, Assistants (column 3, line 12.01 times column	sum of lines 24 for respiratory travel expense of columns 1 and , line 12) sum of lines 29 s 1 and 2, line l expense (line l expense (sum of expense (sum of NACE AND TRAVEL n of lines 5 and Expense D1 times column n 3, line 10) m of columns 1-3	4 and 25 for al 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)	l others) um of lines 3 er site (sum l others) atory therapy d 31) d 32) FATION - SERV	3 and 4 for all of lines 26 and 7 or sum of 7 ICES OUTSIDE PRC	235, 809 7, 742 6, 515 14, 257 2, 278 16, 535 0 0 0 16, 535 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	23.00 24.00 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

OUTSI D	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider CC		Period: From 01/01/2018 To 12/31/2018	Date/Time Prep 5/28/2019 6:1	pared:
					Occupati onal Therapy	Cost	
						1.00	
	Optional travel allowance and standard travel					0	
16.00	Optional travel allowance and optional travel	expense (sum o Therapists	of lines 42 an Assistants	d 43 - see ins Aides	structions) Trainees	0 Total	46.00
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION						
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.00	0.00	0.00	47.00
8.00	Overtime rate (see instructions)	0. 00	0.00				48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		49.00
	CALCULATION OF LIMIT						
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.00	0.00	0.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	70. (0)	50.05	00.0			50.00
2.00	Adjusted hourly salary equivalency amount (see instructions)	78.60	58.95	23. 0	5 0.00		52.00
3.00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.00
4.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.OC
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0	(0 0		55. OC
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3	0	0	(0 0	0	56.00
	for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FXCESS COST	ADJUSTMENT			1.00	
7.00	Salary equivalency amount (from line 23)					235, 809	57. OC
8.00	Travel allowance and expense - provider site	•		`		16, 535	
9.00 0.00	Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56)	es (from frines	44, 45, 01 46)		0	
	Equipment cost (see instructions)					0	
1.00						0	10000
2.00	Supplies (see instructions)					0	
2.00 3.00	Total allowance (sum of lines 57-62)					252, 344	63.00
2.00 3.00 4.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from		enter zero)			252, 344 232, 632	63.00 64.00
2.00 3.00 4.00	Total allowance (sum of lines 57-62)		enter zero)			252, 344 232, 632	63.00 64.00
2.00 3.00 4.00 5.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	<u>sum of lines 24</u>	and 25 for a			252, 344 232, 632 0 14, 257	63. 00 64. 00 65. 00
2.00 3.00 4.00 5.00 00.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION 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	<u>sum of lines 24</u>	1 and 25 for a		others	252, 344 232, 632 0 14, 257	63.00 64.00 65.00 100.00
2.00 3.00 4.00 5.00 00.00 00.01 00.02	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory	3 - if negative, sum of lines 24 / therapy or sum	4 and 25 for a n of lines 3 a	nd 4 for all o		252, 344 232, 632 0 14, 257 2, 278 16, 535	63.00 64.00 65.00 100.00 100.01
2.00 3.00 4.00 5.00 00.00 00.01 00.02 01.00 01.01	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 34 CALCULATION Line 34 CALCULATION Line 37 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 24 therapy or sum therapy or sum	4 and 25 for a n of lines 3 a n of lines 3 a	nd 4 for all (nd 4 for all (252, 344 232, 632 0 14, 257 2, 278 16, 535 2, 278 0	63.00 64.00 65.00 100.00 100.01 100.02
2.00 3.00 4.00 5.00 00.01 00.01 00.02 01.00 01.01 01.02 02.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	sum of lines 24 therapy or sum therapy or sum sum of lines 29 sum of lines 29	4 and 25 for a n of lines 3 a n of lines 3 a 9 and 30 for a 9 and 30 for a	nd 4 for all o nd 4 for all o II others II others	others	252, 344 232, 632 0 14, 257 2, 278 16, 535 2, 278 0 2, 278 0 2, 278	63. 00 64. 00 65. 00 100. 01 100. 02 101. 00 101. 01

Heal th	Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
	LOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre	pared:
						5/28/2019 6:1	7 pm
			CAP	TAL RELATED (.0515		
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - HOSPITAL	- BLDG & FIXT - MOB	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	1.01	1. 02	4.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT	16, 226	16, 226				1.00
	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	1, 987, 681	0	1, 987, 68			1.01
-	00102 CAP REL COSTS-BLDG & FIXT - MOB	31, 026	0		0 31, 026		1.02
	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 175, 491	57	7, 78		1, 183, 331	4.00
	00500 ADMI NI STRATI VE & GENERAL	5, 310, 796	2, 258			102, 036	•
	00700 OPERATION OF PLANT	472, 653	283	38, 35		76, 430	•
	00701 OPERATION OF PLANT - HOSPITAL	1, 311, 099	3, 162	428, 37	8 0	0	
	00702 OPERATION OF PLANT - MOB	0	0		0 0	0	
	00800 LAUNDRY & LINEN SERVICE	50, 848	0		0 0	0	
	00900 HOUSEKEEPI NG	384, 438	518	70, 09		47, 854	•
	01000 DI ETARY	141, 869	422	57, 20		12, 082	•
	01100 CAFETERI A	136, 965	584	79, 13		16, 714	•
	01300 NURSING ADMINISTRATION	846, 617	85	11, 56		152, 926	•
	01400 CENTRAL SERVICES & SUPPLY	608, 873	285	38, 53		0	
	01500 PHARMACY	863, 609	270	36, 61		78, 597	•
	01600 MEDICAL RECORDS & LIBRARY	0	0		0 0	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			L			
	03000 ADULTS & PEDIATRICS	1, 133, 142	1, 674	226, 70	5 0	192, 014	30.00
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	493, 936	1, 416	191, 83		50, 454	
	05400 RADI OLOGY-DI AGNOSTI C	656, 925	708	95, 84		119, 695	•
	06000 LABORATORY	679, 862	597	80, 85		0	
	06600 PHYSI CAL THERAPY	550, 125	394	53, 31		0	
	06700 OCCUPATI ONAL THERAPY	232, 632	183	24, 73		0	
	06800 SPEECH PATHOLOGY	72, 800	96	13, 02		13, 515	•
		50.040	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58, 249	0		0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	16, 482	0		0 0	0	
	07301 ONCOLOGY DRUGS	221, 515 58, 908	0		0 0	0	
	03160 CARDI OPULMONARY	676, 789	375	50, 77		109, 447	
	OUTPATIENT SERVICE COST CENTERS	070,707	575	50,77	4 0	107, 447	/0.00
	09000 CLINIC	0	0		0 0	0	90.00
	09100 EMERGENCY	2, 816, 684	688	93, 26		211, 567	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,010,001	000	,0,20	Ŭ Ŭ	211,007	92.00
	OTHER REIMBURSABLE COST CENTERS						/2.00
	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
H	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>		
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	21, 006, 240	14, 055	1, 903, 85	0 0	1, 183, 331	1118.00
	NONREI MBURSABLE COST CENTERS		,	.,		.,	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		o o		192.00
	19202 MOB	29, 833	1, 552		0 31, 026		192.02
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 LEASED SPACE	0	619	83, 83	1 0		194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	21, 036, 073	16, 226	1, 987, 68	1 31, 026		

	Financial Systems I ALLOCATION - GENERAL SERVICE COSTS	U HEALTH FRANKE	Provider CC	CN: 15-1316	Peri od:	u of Form CMS- Worksheet B	
					From 01/01/2018 To 12/31/2018		pared:
	Cost Center Description	Subtotal A	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - HOSPITAL	OPERATION OF PLANT - MOB	
		4A	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS	· ·					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	5, 720, 930	5, 720, 930				5.00
7.00	00700 OPERATION OF PLANT	587, 718	219, 540	807, 25			7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	1, 742, 639	650, 958	187, 33			7.01
7.02	00702 OPERATION OF PLANT - MOB	0	0		0 0	0	
8.00	00800 LAUNDRY & LINEN SERVICE	50, 848	18, 994		0 0	0	
9.00	00900 HOUSEKEEPI NG	502, 909	187, 860	30, 65		0	
10.00	01000 DI ETARY	211, 582	79, 036	25, 01		0	
11.00	01100 CAFETERI A	233, 398	87, 185	34, 60		0	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 011, 190	377, 727	5, 05		0	
14.00	01400 CENTRAL SERVICES & SUPPLY	647, 697	241, 945	16, 85		0	
15.00	01500 PHARMACY	979, 088	365, 735	16, 01		0	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 552 525	F00 010	00.1/	0 404 (22	0	200.00
30.00	03000 ADULTS & PEDIATRICS	1, 553, 535	580, 318	99, 14	484, 633	0	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	737, 639	275, 543	83, 89	410, 086	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	873, 170	326, 170	41, 91		0	
60.00	06000 LABORATORY	761, 315	284, 387	35, 36		0	
66.00	06600 PHYSI CAL THERAPY	603, 837	225, 561	23, 31		0	
67.00	06700 OCCUPATI ONAL THERAPY	257, 547	96, 206	10, 81		0	
68.00	06800 SPEECH PATHOLOGY	99, 432	37, 143	5, 69		0	
69.00	06900 ELECTROCARDI OLOGY	0	07,110	0,07	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58, 249	21, 759		0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	16, 482	6, 157		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	221, 515	82, 746		0 0	0	1
73.01	07301 ONCOLOGY DRUGS	58, 908	22,005		0 0	0	
76.00	03160 CARDI OPULMONARY	837, 385	312, 803	22, 20	108, 540	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	3, 122, 199	1, 166, 293	40, 78	199, 364	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		20, 889, 212	5, 666, 071	678, 66	2, 401, 727	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
		0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	Ŭ	0	01.02	0		192.00
		62, 411	23, 313	91, 93			192.02
	19300 NONPAI D WORKERS 07950 LEASED SPACE		01 E44	24.44	0 0		193.00
200.00		84, 450	31, 546	36, 66	179, 208	0	194.00 200.00
200.00		0	_		0 0	_	200.00
201.00		21, 036, 073	5, 720, 930	807, 25	0		201.00
202.00		21,030,073	5, 120, 930	007,20	2, 300, 935	0	1202.00

Cost Center Description LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA	Worksheet B Part I Date/Time Prepared: 5/28/2019 6:17 pm NURSING ADMINISTRATION 13.00 1.00 1.00 1.00 5.00 7.00 7.00 7.00 8.00 9.00 10.00
To 12/31/2018 To 12/31/2018 LAUNDRY & HOUSEKEEPING DI ETARY CAFETERIA AI LINEN SERVICE DI ETARY CAFETERIA AI 8.00 9.00 10.00 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 0100 11.00 11.00 0100 11.00	Date/Time Prepared: 5/28/2019 6: 17 pm NURSI NG NURSI NO 13.00 1.00 1.00 1.00 1.00 7.00 7.00 7.00 7.00 8.00 9.00
Cost Center Description LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA Ait GENERAL SERVICE COST CENTERS 8.00 9.00 10.00 11.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT Ait 1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 000400 Ait Ait 1.02 00102 CAP REL COSTS-BLDG & FIXT - MOB 00400 EMPLOYEE BENEFITS DEPARTMENT 000000 Ait 5.00 00500 ADMINI STRATI VE & GENERAL 00000 ADMINI STRATI VE & GENERAL 000000 ADMINI STRATI VE & GENERAL 000000 000000 ABI, 765 0000000 ABI, 765 0000000 ABI, 765 000000 ABI, 765 000000 ABI, 765 000000 584, 989 000000 ABI, 765 0000000 584, 989 0000000 70, 372 000000000000000000000000000000000000	5/28/2019 6: 17 pm NURSI NG NDMI NI STRATI ON 13. 00 1. 00 1. 00 1. 00 1. 00 1. 00 7. 00 7. 00 7. 00 7. 00 8. 00 9. 00
Cost Center Description LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA AI 8.00 9.00 10.00 11.00 8.00 9.00 10.00 11.00 00100 CAP REL COSTS CENTERS 5.00 9.00 10.00 11.00 1.01 00101 CAP REL COSTS BLDG & FIXT 1.00 10.00 11.00 10.00 11.00 1.02 00102 CAP REL COSTS BLDG & FIXT - MOB 1.00 10.00 10.00 11.00 10.00 10.00 11.00 10.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 11.00 10.00 10.00 11.00 10.00 </td <td>NURSI NG <u>ADMI NI STRATI ON</u> 13. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 7. 00 7. 00 7. 00 8. 00 9. 00</td>	NURSI NG <u>ADMI NI STRATI ON</u> 13. 00 1. 00 1. 00 1. 00 1. 00 1. 00 1. 00 7. 00 7. 00 7. 00 8. 00 9. 00
LINEN SERVICE AI 8.00 9.00 10.00 11.00 00100 CAP REL COSTS -BLDG & FIXT 1.00 00100 CAP REL COSTS -BLDG & FIXT 1.01 00101 CAP REL COSTS -BLDG & FIXT 1.02 00102 CAP REL COSTS -BLDG & FIXT 1.02 00102 CAP REL COSTS -BLDG & FIXT 1.02 00102 CAP REL COSTS -BLDG & FIXT - MOSPI TAL 1.02 00102 CAP REL COSTS -BLDG & FIXT - MOSPI TAL 1.02 00102 CAP REL COSTS -BLDG & FIXT - MOSPI TAL 1.02 00102 CAP REL COSTS -BLDG & FIXT - MOSPI TAL 1.02 00100 CAP REL COSTS -BLDG & FIXT - MOB 1.02 00500 ADMI NI STRATI VE & GENERAL 1.02 00700 OPERATI ON OF PLANT 1.02 00700 OPERATI ON OF PLANT 1.03 1.02 00701 OPERATI ON OF PLANT 1.03 1.03 0.0300 LUNDRY & LI NEN SERVICE 69, 842 69, 842 69, 842 69, 842 69, 842 69, 842 69, 843 69, 843 69, 642 69, 843 69, 843 69, 843 69, 842 69, 843 69, 843 69, 843 69, 60, 629 69, 843 6	ADMI NI STRATI ON 13. 00 1. 00 1. 00 1. 00 1. 00 1. 00 5. 00 7. 00 7. 00 7. 00 7. 00 8. 00 9. 00
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT 1.02 00102 CAP REL COSTS-BLDG & FIXT MOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT HOSPI TAL 7.01 00701 OPERATI ON OF PLANT HOSPI TAL 7.02 00702 OPERATI ON OF PLANT MOB 8.00 00800 LAUNDRY & LI NEN SERVI CE 69, 842 69, 842 69, 0 871, 278 60 10.00 01000 DI ETARY 0 43, 830 481, 765 11.00 60, 629 584, 989 13.00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	1. 00 1. 0 1. 0 4. 00 5. 00 7. 00 7. 00 7. 0 8. 00 9. 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT HOSPITAL 1.02 00102 CAP REL COSTS-BLDG & FIXT MOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT HOSPITAL 7.01 00701 OPERATION OF PLANT HOSPITAL 7.02 00702 OPERATION OF PLANT MOB 8.00 00800 LAUNDRY & LINEN SERVICE 69, 842 9.00 00900 HOUSEKEEPING 0 10.00 DI ETARY 0 43, 830 481, 765 11.00 O1100 CAFETERIA 0 60, 629 584, 989 13.00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	1.0 1.0 4.0 5.0 7.0 7.0 7.0 8.0 9.0
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.02 00102 CAP REL COSTS-BLDG & FIXT - MOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - HOSPITAL 7.02 00702 OPERATION OF PLANT - MOB 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 0 01100 CAFETERIA 11.00 01100 CAFETERIA 0 60, 629 0 53.00 01300 NURSING ADMINISTRATION	1.0 1.0 4.0 5.0 7.0 7.0 7.0 8.0 9.0
1.02 00102 CAP REL COSTS-BLDG & FIXT - MOB 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 7.01 00701 OPERATI ON OF PLANT - HOSPI TAL 7.02 00702 OPERATI ON OF PLANT - MOB 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 0 60, 629 0 13.00 01300 NURSI NG ADMI NI STRATI ON	1. 0. 4. 00 5. 00 7. 00 7. 0 7. 0 8. 00 9. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT 7. 01 00701 OPERATION OF PLANT - HOSPITAL 7. 02 00702 OPERATION OF PLANT - MOB 8. 00 00800 LAUNDRY & LINEN SERVICE 69, 842 9. 00 00900 HOUSEKEEPING 0 10. 00 01000 DI ETARY 0 11. 00 01100 CAFETERIA 0 60, 629 0 13. 00 01300 NURSING ADMINISTRATION 0 8, 858 0 70, 372	4. 0 5. 0 7. 0 7. 0 7. 0 8. 0 9. 0
5.00 00500 ADMI NI STRATI VE & GENERAL 7.00 00700 OPERATI ON OF PLANT 7.01 00701 OPERATI ON OF PLANT 7.02 00702 OPERATI ON OF PLANT - HOSPI TAL 7.02 00702 OPERATI ON OF PLANT - MOB 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 D1000 DI ETARY 11.00 01100 CAFETERI A 0 60, 629 0 13.00 D1300 NURSI NG ADMI NI STRATI ON	5. 0 7. 0 7. 0 7. 0 8. 0 9. 0
7.00 00700 OPERATI ON OF PLANT 7.01 00701 OPERATI ON OF PLANT - HOSPI TAL 7.02 00702 OPERATI ON OF PLANT - MOB 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 0 13.00 NURSI NG ADMI NI STRATI ON	7.00 7.0 7.0 8.00 9.00
7. 01 00701 OPERATI ON OF PLANT - HOSPI TAL 7. 02 00702 OPERATI ON OF PLANT - MOB 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPI NG 10. 00 01 ETARY 0 11. 00 CAFETERIA 0 13. 00 01300 NURSI NG ADMI NI STRATI ON	7. 0 7. 0 8. 0 9. 0
7. 02 00702 OPERATI ON OF PLANT - MOB 8. 00 00800 LAUNDRY & LI NEN SERVICE 69, 842 9. 00 00900 HOUSEKEEPI NG 0 10. 00 01000 DI ETARY 0 43, 830 481, 765 11. 00 01100 CAFETERI A 0 60, 629 0 584, 989 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	7. 0. 8. 00 9. 0
8.00 00800 LAUNDRY & LI NEN SERVICE 69, 842 9.00 00900 HOUSEKEEPI NG 0 871, 278 10.00 01000 DI ETARY 0 43, 830 481, 765 11.00 01100 CAFETERI A 0 60, 629 0 584, 989 13.00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	8. 0 9. 0
9. 00 00900 HOUSEKEEPI NG 0 871, 278 10. 00 01000 DI ETARY 0 43, 830 481, 765 11. 00 01100 CAFETERI A 0 60, 629 0 584, 989 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	9. 0
10. 00 01000 DI ETARY 0 43, 830 481, 765 11. 00 01100 CAFETERIA 0 60, 629 0 584, 989 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	
11. 00 01100 CAFETERIA 0 60, 629 0 584, 989 13. 00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	10.0
13. 00 01300 NURSI NG ADMI NI STRATI ON 0 8, 858 0 70, 372	
	11.0
14. 00 01400 CENTRAL SERVICES & SUPPLY 0 29, 526 0 0	1, 497, 919 13. 0
	0 14.0
15. 00 01500 PHARMACY 0 28, 050 0 32, 109	0 15.0
16.00 01600 MEDI CAL RECORDS & LI BRARY 0 0 0 0	0 16.0
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDIATRICS 69, 842 173, 690 481, 765 116, 051	662, 118 30. 0
ANCI LLARY SERVICE COST CENTERS	
50. 00 05000 OPERATING ROOM 0 146, 971 0 30, 926	92, 293 50. 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 73, 428 0 67, 295	0 54.0
60. 00 06000 LABORATORY 0 59, 564	0 60.0
66.00 06600 PHYSI CAL THERAPY 0 0 0 0	0 66.0
67. 00 06700 OCCUPATI ONAL THERAPY 0 18, 948 0 0	0 67.0
68. 00 06800 SPEECH PATHOLOGY 0 9, 976 0 5, 917	0 68.0
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	0 69.0
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0	0 71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0	0 72.0
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	0 73.0
73.01 07301 0NCOLOGY DRUGS 0 0 0	0 73.0
76. 00 03160 CARDI OPULMONARY 0 38, 900 0 63, 903	0 76.0
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 0 0	0 90.0
91. 00 09100 EMERGENCY 0 71, 450 0 138, 852	743, 508 91. 0
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	92.0
OTHER REIMBURSABLE COST CENTERS	
101.00 10100 HOME HEALTH AGENCY 0 0 0	0 101. 0
SPECIAL PURPOSE COST CENTERS	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 69,842 807,052 481,765 584,989	1, 497, 919 118. 0
NONREI MBURSABLE COST CENTERS	
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	0 190. 0
191.00 19100 RESEARCH 0 0 0 0	0 191. 0
192.00 PHYSI CLANS' PRI VATE OFFI CES 0 <t< td=""><td>0 192. 0</td></t<>	0 192. 0
192.02 19202 MOB 0 0 0	0 192. 0
	0 193. 0
193. 00 19300 NONPAI D WORKERS 0 0 0 0	0 194. 0
194.00 07950 LEASED SPACE 0 64, 226 0 0	1000 0
194.00 07950 LEASED SPACE 0 0 200.00 Cross Foot Adjustments 0 64, 226 0 0	200. 0
194. 00 07950 LEASED SPACE 0 64, 226 0 0	200. 0 0 201. 0 1, 497, 919 202. 0

COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1316	Peri od:	Worksheet B	
					From 01/01/2018	Part I	
					To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	Subtotal	Intern &	
		SERVICES &		RECORDS &		Residents Cost	
		SUPPLY		LI BRARY		& Post	
						Stepdown	
		14.00	15.00	1/ 00	24.00	Adjustments	
	GENERAL SERVICE COST CENTERS	14.00	15.00	16.00	24.00	25.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION	1 010 107					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 018, 407	1 500 7/1				14.00
		9, 502	1, 508, 761		0		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0		16.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	212, 894	16, 462		0 4, 450, 450	0	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	212,074	10, 402		0 4,430,430	0	30.00
50.00	05000 OPERATI NG ROOM	111, 374	8, 271		0 1, 896, 995	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	41, 274	4, 556		0 1, 632, 689	0	54.00
60.00	06000 LABORATORY	20, 237	0		0 1, 395, 659	0	60.00
66.00	06600 PHYSI CAL THERAPY	44, 863	0		0 1, 052, 406	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 436, 387	0	67.00
68.00	06800 SPEECH PATHOLOGY	47	0		0 186, 044	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	142, 606	0		0 222, 614	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	40, 351	0		0 62, 990	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 115, 151		0 1, 419, 412	0	73.00
73.01	07301 ONCOLOGY DRUGS	0	296, 555		0 377, 468		73.01
76.00		29, 290	534		0 1, 413, 559	0	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	90.00
	09100 EMERGENCY	365, 969	67, 232		0 5, 915, 651	0	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	303, 909	07,232		0 5, 915, 051	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS					0	72.00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 018, 407	1, 508, 761		0 20, 462, 324	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19202 MOB	0	0		0 177, 658		192. 02
	19300 NONPAI D WORKERS	0	0		0 0		193.00
	07950 LEASED SPACE	0	0		0 396, 091		194.00
200 00	Cross Foot Adjustments				0	0	200.00
200.00			اہ		<u> </u>	-	001 00
200.00	Negative Cost Centers	0 1, 018, 407	0 1, 508, 761		0 0 0 21, 036, 073		201.00

Heal th	Financial Systems	IU HEALTH FRANKFO	RT HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Prepared:
				To 12/31/2018	5/28/2019 6:17 pm
	Cost Center Description	Total			
	1	26.00			
	GENERAL SERVICE COST CENTERS	- 1			
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL				1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB				1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5.00
7.00 7.01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL				7.00
7.01					7.01
7.02 8.00	00702 OPERATION OF PLANT - MOB 00800 LAUNDRY & LINEN SERVICE				8.00
8.00 9.00	00900 HOUSEKEEPING				9.00
9.00 10.00	01000 DI ETARY				9.00
10.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
14.00	01500 PHARMACY				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				10.00
30.00	03000 ADULTS & PEDIATRICS	4, 450, 450			30.00
50.00	ANCI LLARY SERVICE COST CENTERS	4,430,430			
50.00	05000 OPERATI NG ROOM	1, 896, 995			50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 632, 689			54.00
60.00	06000 LABORATORY	1, 395, 659			60.00
66.00	06600 PHYSI CAL THERAPY	1, 052, 406			66.00
67.00	06700 OCCUPATI ONAL THERAPY	436, 387			67.00
68.00	06800 SPEECH PATHOLOGY	186, 044			68.00
69.00	06900 ELECTROCARDI OLOGY	0			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	222, 614			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	62, 990			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 419, 412			73.00
73.01	07301 ONCOLOGY DRUGS	377, 468			73.01
76.00	03160 CARDI OPULMONARY	1, 413, 559			76.00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0			90.00
91.00	09100 EMERGENCY	5, 915, 651			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	OTHER REIMBURSABLE COST CENTERS				
101.00	10100 HOME HEALTH AGENCY	0			101.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117 NONREIMBURSABLE COST CENTERS) 20, 462, 324			118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.00
	19100 RESEARCH	0			191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
	19202 MOB	177, 658			192.02
	19300 NONPALD WORKERS	0			193.00
	07950 LEASED SPACE	396, 091			194.00
200.00		0			200.00
	5	0			201.00
201.00					

	Financial Systems TION OF CAPITAL RELATED COSTS	U HEALTH FRANK	Provider C	CN. 1E 1214		Workshoot R	2552-10
ALLUCA	ITON OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2018	Worksheet B Part II	
					To 12/31/2018		epared:
			CAP	I TAL RELATED (COSTS	1 37 287 2019 0. 1	
	Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -		Subtotal	
		Assigned New Capital		HOSPI TAL	MOB		
		Related Costs					
		0	1.00	1.01	1. 02	2A	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FLXT - HOSPITAL						1.01
1.02 4.00	00102 CAP REL COSTS-BLDG & FIXT - MOB 00400 EMPLOYEE BENEFITS DEPARTMENT	0	57	7, 78	3 0	7, 840	1.02
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	0	2, 258			308, 098	
7.00	00700 OPERATI ON OF PLANT	0	283			38, 635	
7.01	00701 OPERATION OF PLANT - HOSPITAL	0	3, 162	428, 37		431, 540	
7.02	00702 OPERATION OF PLANT - MOB	0	C		0 0	0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	C		0 0	0	
9.00	00900 HOUSEKEEPI NG	0	518	70, 09	9 0	70, 617	9.00
10.00	01000 DI ETARY	0	422	57, 20	9 0	57, 631	10.00
11.00	01100 CAFETERI A	0	584	79, 13	5 0	79, 719	11.00
	01300 NURSING ADMINISTRATION	0	85			11, 647	
	01400 CENTRAL SERVICES & SUPPLY	0	285	38, 53		38, 824	
	01500 PHARMACY	0	270			36, 882	
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	C		0 0	0	16.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1 / 7 4	224 70	-	220.270	20.00
30.00	03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	0	1, 674	226, 70	5 0	228, 379	30.00
50.00	05000 OPERATING ROOM	0	1, 416	191, 83	3 0	193, 249	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	708			96, 550	
60.00	06000 LABORATORY	0	597	80, 85		81, 453	
66.00	06600 PHYSI CAL THERAPY	0	394	53, 31		53, 712	
67.00	06700 OCCUPATI ONAL THERAPY	0	183			24, 915	
68.00	06800 SPEECH PATHOLOGY	0	96			13, 117	
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
	07301 ONCOLOGY DRUGS	0	0	50.77	0 0	0	
76.00		0	375	50, 77	4 0	51, 149	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	C		0 0	0	90.00
90.00 91.00	09100 EMERGENCY	0	688			93, 948	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	000	73,20	0 0	93, 948	
72.00	OTHER REIMBURSABLE COST CENTERS					0	72.00
101.00	10100 HOME HEALTH AGENCY	0	C		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS			1			1
118.00		0	14, 055	1, 903, 85	0 0	1, 917, 905	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0		190. 00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0		192.00
	19202 MOB	0	1, 552		0 31, 026		192.02
	19300 NONPAID WORKERS	0	0		0		193.00
	07950 LEASED SPACE	0	619	83, 83	0		194.00
200.00							200.00
201.00 202.00		0	16, 226	1 007 40	1 21 024		
202.00	I TOTAL (Sum TIMES TIN UNROUGH ZUT)	I U	10, 226	1, 987, 68	1 31, 026	∠, ∪34, 933	1202.00

		U HEALTH FRANKF				u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet B Part II Date/Time Pre 5/28/2019 6:1	pared: 7 pm
	Cost Center Description	BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	PLANT - HOSPI TAL	OPERATION OF PLANT - MOB	
		4.00	5.00	7.00	7.01	7.02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7,840					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	676	308, 774	50.00			5.00
7.00	00700 OPERATION OF PLANT	506	11, 849	50, 99			7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL	0	35, 133	11, 83		0	7.01
7.02	00702 OPERATION OF PLANT - MOB	0	1 025		0 0	0	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 025		0 0	0	8.00
9.00	00900 HOUSEKEEPING	317	10, 139	1, 93		0	9.00
10.00	01000 DI ETARY	80	4, 266	1, 58		0	10.00
11.00	01100 CAFETERIA	111	4, 706	2, 18		0	11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON	1,013	20, 387	31		0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	9	13, 058	1,06		0	14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	521 0	19, 739 0	1, 01	1 14, 511 0 0	0	16.00
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	UU	U		0 0	0	10.00
30, 00	03000 ADULTS & PEDIATRICS	1, 272	31, 321	6, 26	2 89, 853	0	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	1,272	51, 521	0,20	2 07,000	0	30.00
50.00	05000 OPERATI NG ROOM	334	14, 872	5, 29	9 76,030	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	793	17,604	2,64		0	54.00
60.00	06000 LABORATORY	0	15, 349	2, 23		0	60.00
66.00	06600 PHYSI CAL THERAPY	Ő	12, 174	1,47		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	o	5, 192	68		0	67.00
68.00	06800 SPEECH PATHOLOGY	90	2,005	36		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 174		o o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	332		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 466		o o	0	73.00
73.01	07301 ONCOLOGY DRUGS	0	1, 188		0 0	0	73.01
76.00	03160 CARDI OPULMONARY	725	16, 883	1, 40	3 20, 123	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	1, 402	62, 951	2, 57	6 36, 962	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS	<u>г</u>					
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	7,840	305, 813	42, 86	7 445, 282	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19100 RESEARCH	0	0		0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192 03	2 19202 MOB	0	1, 258	5, 80	7 0	0	192.02
	19300 NONPALD WORKERS	o	0		o o	0	193.00
			1 702	2, 31	4 22.225	0	194.00
193.00	07950 LEASED SPACE	0	1, 703	2, 31	6 33, 225	0	194.00
193.00	Cross Foot Adjustments	0	1, 703	2, 31	0 33,225	0	200.00
193.00 194.00	Cross Foot Adjustments	0	1, 703	50, 99	o o		

		IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018		nared.
					10 12/31/2018	5/28/2019 6:1	7 pm
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		8.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS		•			•	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE	1, 025					8.00
9.00	00900 HOUSEKEEPI NG	0	110, 792				9.00
10.00	01000 DI ETARY	0	5, 574	91, 8	05		10.00
11.00	01100 CAFETERI A	0	7, 710		0 125, 796		11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	1, 126		0 15, 133	54, 207	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	3, 755		0 0	0	14.00
15.00	01500 PHARMACY	0	3, 567		0 6,905	0	
16.00	01600 MEDICAL RECORDS & LIBRARY	0			0 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		. · · ·				
30, 00	03000 ADULTS & PEDIATRICS	1,025	22, 085	91, 8	05 24, 956	23, 961	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	18, 689		0 6,650	3, 340	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 337		0 14, 471	0	54.00
60,00	06000 LABORATORY	0			0 12,809	0	60.00
66.00	06600 PHYSI CAL THERAPY	0			0 0	0	
67.00	06700 OCCUPATI ONAL THERAPY	0			0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0			0 1, 272	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
73.01	07301 ONCOLOGY DRUGS	0			0 0	0	
76.00	03160 CARDI OPULMONARY	0			0 13, 742		
10.00	OUTPATIENT SERVICE COST CENTERS		.,,,,,		0 10//12		/ 01 00
90.00	09000 CLINIC	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	0			0 29, 858	26, 906	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-					92.00
	OTHER REIMBURSABLE COST CENTERS						
101 00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
118.00		1,025	102, 625	91, 8	05 125, 796	54 207	118.00
110.00	NONREI MBURSABLE COST CENTERS	1,020	102, 020	, , , ,	120,770	01,207	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19100 RESEARCH	0			0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
	19202 MOB	0	0		0 0		192.00
	19202 MOD 19300 NONPALD WORKERS		0				192.02
	07950 LEASED SPACE	0	8, 167				193.00
200.00		0	0, 10/		0		200.00
200.00	· · · · · · · · · · · · · · · · · · ·	0	_		0	_	200.00
201.00	5	1, 025	110, 792	91, 8	0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	1,025	1 110, 792	91,8	120, 790	J 34, 207	1202.00

Heal th	Financial Systems I	U HEALTH FRANKF	ORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018		pared: 7 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY		Intern & Residents Cost & Post Stepdown Adjustments	
		14.00	15.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS			[
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 1.02	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - MOB						1.01 1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01	00701 OPERATION OF PLANT - HOSPITAL						7.01
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	71, 976					14.00
15.00	01500 PHARMACY	672	83, 808				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0		16.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			L			
30.00	03000 ADULTS & PEDI ATRI CS	15, 046	914		0 536, 879	0	30.00
	ANCI LLARY SERVICE COST CENTERS	7 071	450	[0 22(702	0	
50.00	05000 OPERATI NG ROOM 05400 RADI OLOGY-DI AGNOSTI C	7, 871 2, 917	459 253		0 326, 793 0 182, 557	0	50.00
54.00 60.00	06000 LABORATORY	2,917	253		0 182, 557 0 153, 197	0	54.00 60.00
66.00	06600 PHYSI CAL THERAPY	3, 171	0		0 96, 856	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	3, 171	0		0 43,001	0	67.00
68.00	06800 SPEECH PATHOLOGY	3	0		0 23, 277	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 079	0		0 11, 253	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2,852	0		0 3, 184	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	61, 944		0 66, 410	0	73.00
73.01	07301 ONCOLOGY DRUGS	0	16, 473		0 17, 661	0	73.01
76.00	03160 CARDI OPULMONARY	2,070	30		0 111, 072	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0		0 0	0	
91.00	09100 EMERGENCY	25, 865	3, 735		0 293, 289	0	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					0	92.00
404 00	OTHER REIMBURSABLE COST CENTERS					0	101 00
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	71, 976	83, 808		0 1, 865, 429	0	118.00
110.00	NONREI MBURSABLE COST CENTERS	71,970	03, 000		0 1, 865, 429	0	110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19100 RESEARCH	0	0		0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
	19202 MOB	0	0		0 39, 643		192.00
	19300 NONPALD WORKERS	Ő	0		0 0		193.00
	07950 LEASED SPACE	Ő	0		0 129, 861		194.00
200.00			_		0	0	200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	71, 976	83, 808		0 2, 034, 933	0	202.00

	nancial Systems I N OF CAPITAL RELATED COSTS	U HEALTH FRANKFO	Provider CCN: 15-1316	Period:	u of Form CMS-25 Worksheet B	JZ-1
ALLUCATIO	N OF CAPITAL RELATED COSTS			From 01/01/2018	Part II	
				To 12/31/2018	Date/Time Prepa 5/28/2019 6:17	
	Cost Center Description	Total		- I	0/20/2017 0.17	pin
		26.00				
	NERAL SERVICE COST CENTERS					
	100 CAP REL COSTS-BLDG & FIXT					1.0
	101 CAP REL COSTS-BLDG & FIXT - HOSPITAL					1.0
	102 CAP REL COSTS-BLDG & FIXT - MOB					1.0
	400 EMPLOYEE BENEFITS DEPARTMENT					4.0
	500 ADMINISTRATIVE & GENERAL					5.C
	700 OPERATION OF PLANT					7.0
1	701 OPERATION OF PLANT - HOSPITAL					7.0
	702 OPERATION OF PLANT - MOB					7.0
	BOO LAUNDRY & LINEN SERVICE					8.0
	900 HOUSEKEEPI NG					9. C
	DOO DI ETARY				1	10. C
1.00 011	100 CAFETERI A				1	11. C
3.00 013	300 NURSI NG ADMI NI STRATI ON				1	13.0
4.00 014	400 CENTRAL SERVICES & SUPPLY				1	14.0
5.00 015	500 PHARMACY				1	15.0
6.00 016	500 MEDICAL RECORDS & LIBRARY				1	16.0
I NF	PATIENT ROUTINE SERVICE COST CENTERS					
30.00 030	DOO ADULTS & PEDIATRICS	536, 879			3	30.0
ANC	CILLARY SERVICE COST CENTERS					
0.00 050	DOO OPERATING ROOM	326, 793			5	50.0
4.00 054	400 RADI OLOGY-DI AGNOSTI C	182, 557			5	54.0
0. 00 060	DOO LABORATORY	153, 197			6	60. C
1	500 PHYSI CAL THERAPY	96, 856				66. 0
	700 OCCUPATIONAL THERAPY	43,001				67.0
1	BOO SPEECH PATHOLOGY	23, 277				68. (
	POO ELECTROCARDI OLOGY	20, 27,				69. (
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 253				71.0
	200 I MPL. DEV. CHARGED TO PATIENTS	3, 184				72. (
	300 DRUGS CHARGED TO PATIENTS	66, 410				73. (
	301 ONCOLOGY DRUGS	17,661				73.0
	160 CARDI OPULMONARY	111,072				76.0
	IPATIENT SERVICE COST CENTERS	111,072				70.0
	DOO CLINIC	0				90. (
	100 EMERGENCY	293, 289				91.0
	200 OBSERVATION BEDS (NON-DISTINCT PART)				,	92. (
	HER REIMBURSABLE COST CENTERS					~ ~ ~
	100 HOME HEALTH AGENCY	0			10	01.0
	ECIAL PURPOSE COST CENTERS					
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 865, 429			11	18.0
	NREI MBURSABLE COST CENTERS	0			10	~~ ~
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0				90.0
	100 RESEARCH	0				91.0
	200 PHYSI CLANS' PRI VATE OFFI CES	0				92.0
92. 02 192		39, 643				92. (
	300 NONPAI D WORKERS	0				93. (
	950 LEASED SPACE	129, 861				94. (
00.00	Cross Foot Adjustments	0			20	00. (
01.00	Negative Cost Centers	0			20	01.0
202.00	TOTAL (sum lines 118 through 201)	2,034,933			20	02.0

	Financial Systems LOCATION - STATISTICAL BASIS	U HEALTH FRANK		CN: 15 1214 D		Worksheet B-1	
COST A	LUCATION - STATISTICAL BASIS		Provider C	F	eriod: ^om 01/01/2018		
				T	b 12/31/2018	Date/Time Pre 5/28/2019 6:1	pared: 7 pm
		CAP	TAL RELATED CO	DSTS		0,20,201,0.1	
	Cost Conton Deportintion			BLDG & FIXT -		Decenciliation	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	HOSPITAL	MOB	EMPLOYEE BENEFI TS	Reconciliation	
		(,	(SQUARE FEET)	(SQUARE FEET)	DEPARTMENT		
					(GROSS		
		1.00	1.01	1.02	SALARI ES) 4. 00	5A	
	GENERAL SERVICE COST CENTERS	1.00	1.01	1.02	4.00	54	
	00100 CAP REL COSTS-BLDG & FIXT	117, 484					1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	106, 247	1			1.01
1.02 4.00	00102 CAP REL COSTS-BLDG & FIXT - MOB 00400 EMPLOYEE BENEFITS DEPARTMENT	416	0 416		5, 926, 993		1.02
5.00	00500 ADMI NI STRATI VE & GENERAL	16, 348	16, 348		511, 072		
7.00	00700 OPERATION OF PLANT	2, 050	2, 050	0	382, 819		7.00
	00701 OPERATION OF PLANT - HOSPITAL	22, 898	22, 898		0	-	
	00702 OPERATION OF PLANT - MOB 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	7.02
	00900 HOUSEKEEPING	3,747	3, 747	0	239, 687		9.00
	01000 DI ETARY	3, 058	3, 058	1	60, 517		10.00
	01100 CAFETERI A	4, 230	4, 230		83, 718		11.00
	01300 NURSI NG ADMI NI STRATI ON	618	618		765, 967		13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	2, 060 1, 957	2, 060 1, 957	0	0 393, 674	-	14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY	0	0		0,074	0	•
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
	03000 ADULTS & PEDI ATRI CS	12, 118	12, 118	0	961, 746	0	30.00
	ANCILLARY SERVICE COST CENTERS	10.254	10.254	0	252 710	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	10, 254 5, 123	10, 254 5, 123		252, 710 599, 522		
	06000 LABORATORY	4, 322	4, 322		0,,,022		60.00
66.00	06600 PHYSI CAL THERAPY	2, 850	2, 850		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	1, 322	1, 322	0	0	0	67.00
	06800 SPEECH PATHOLOGY	696	696	0	67, 692		68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		0	0	0	69.00 71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07301 ONCOLOGY DRUGS	0	0	0	0	0	
76.00		2,714	2, 714	0	548, 194	0	76.00
90, 00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	09100 EMERGENCY	4, 985	-		1, 059, 675		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS						1.01.00
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101.00
118.00		101, 766	101, 766	0	5, 926, 993	-5, 720, 930	118.00
	NONREIMBURSABLE COST CENTERS	· · ·	· ·				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191.00 192.00
	19200 MOB	11, 237		11, 237	0		192.00
	19300 NONPALD WORKERS	0	0	0	0		193.00
	07950 LEASED SPACE	4, 481	4, 481	0	0		194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	44.004	1 007 /01	04.000	1 100 001		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	16, 226	1, 987, 681	31, 026	1, 183, 331		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 138112	18. 708114	2. 761057	0. 199651		203.00
204.00	Cost to be allocated (per Wkst. B,				7, 840		204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part				0. 001323		205.00
206.00	II) NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

SI ALL	inancial Systems _OCATION - STATISTICAL BASIS	IU HEALTH FRANK	Provider C	CN: 15-1316 P	eriod:	u of Form CMS-2 Worksheet B-1
				F	rom 01/01/2018	
				T	o 12/31/2018	Date/Time Pre 5/28/2019 6:1
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &
		& GENERAL	PLANT	PLANT -	PLANT - MOB	LINEN SERVICE
		(ACCUM. COST)	(SQUARE FEET)	HOSPI TAL	(SQUARE FEET)	(PATIENT DAYS)
				(SQUARE FEET)		
		5.00	7.00	7.01	7.02	8.00
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT	1	1	1		
	0101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 0102 CAP REL COSTS-BLDG & FIXT - MOB					
	0400 EMPLOYEE BENEFITS DEPARTMENT					
	0500 ADMINI STRATI VE & GENERAL	15, 315, 143				
	0700 OPERATION OF PLANT	587, 718				
	0700 OPERATION OF PLANT - HOSPITAL	1, 742, 639				
	0701 OPERATION OF PLANT - MOSPITAL	1, 742, 039	22, 090	04, 555	11, 237	
	0702 OPERATION OF PLANT - MOD 0800 LAUNDRY & LINEN SERVICE	50, 848		0	11, 237	1, 526
	0900 HOUSEKEEPING	502, 909	, o	3, 747	0	1, 520
	1000 DI ETARY	211, 582	3, 747		0	0
	1100 CAFETERIA	233, 398			0	0
	1300 NURSI NG ADMI NI STRATI ON	1, 011, 190			0	0
	1400 CENTRAL SERVICES & SUPPLY	647, 697	2,060		0	0
	1500 PHARMACY			1, 957	0	0
	1600 MEDICAL RECORDS & LIBRARY	979, 088			0	0
	NPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0
	3000 ADULTS & PEDIATRICS	1, 553, 535	12, 118	12, 118	0	1, 526
	NCI LLARY SERVICE COST CENTERS	1, 555, 555	12,110	12,110	0	1, 520
	5000 OPERATI NG ROOM	737, 639	10, 254	10, 254	0	0
	5400 RADI OLOGY-DI AGNOSTI C	873, 170			0	0
	6000 LABORATORY	761, 315		4, 322	0	0
	6600 PHYSI CAL THERAPY	603, 837	2, 850		0	0
	6700 OCCUPATI ONAL THERAPY	257, 547	1, 322		0	0
	6800 SPEECH PATHOLOGY	99, 432	696		0	0
	6900 ELECTROCARDI OLOGY	77, 432	0,0	0,00	0	0
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	58, 249		0	0	0
	7200 I MPL. DEV. CHARGED TO PATIENTS	16, 482		0	0	0
	7300 DRUGS CHARGED TO PATIENTS	221, 515		0	0	0
	7301 ONCOLOGY DRUGS	58, 908	0	0	0	0
	3160 CARDI OPULMONARY	837, 385	2, 714	2, 714	0	0
	UTPATIENT SERVICE COST CENTERS	001/000	2,7.1	2,7.1		
	9000 CLINIC	0	0	0	0	0
	9100 EMERGENCY	3, 122, 199	4, 985	4, 985	0	0
00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)					
0	THER REIMBURSABLE COST CENTERS		•			
1.001	0100 HOME HEALTH AGENCY	0	0	0	0	0
SI	PECIAL PURPOSE COST CENTERS			_		
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	15, 168, 282	82, 952	60, 054	0	1, 526
	ONREIMBURSABLE COST CENTERS		1			
). 00 1	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	-
		1 0	0	0	0	0
1.001	9100 RESEARCH	0			0	0
1.001 2.001	9200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	
2. 00 1 2. 00 1 2. 02 1	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB	0 62, 411	0 11, 237	0	0 11, 237	0
2. 00 1 2. 00 1 2. 02 1 3. 00 1	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS	0	0	0 0 0	0 11, 237 0	0 0
1.001 2.001 2.021 3.001 4.000	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE	62, 411 0 84, 450	0	0 0 0 4, 481	0 11, 237 0 0	0
. 00 1 2. 00 1 2. 02 1 3. 00 1 4. 00 0 0. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments	0	0	0 0 0 4, 481	0 11, 237 0 0	0 0 0
. 00 1 2. 00 1 2. 02 1 3. 00 1 4. 00 0 0. 00 . 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers	0 84, 450	0 4, 481		0	0 0 0
I. 00 1 2. 00 1 2. 02 1 3. 00 1 4. 00 0 0. 00 I. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B,	0	0 4, 481		0	0 0 0
I. 00 1 2. 00 1 2. 02 1 3. 00 1 4. 00 0 0. 00 I. 00 2. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	0 84, 450 5, 720, 930	0 4, 481 807, 258	2, 580, 935	0 0 0	0 0 0 69, 842
1. 00 1 2. 00 1 2. 02 1 3. 00 1 4. 00 0 0. 00 1. 00 2. 00 3. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I)	0 84, 450 5, 720, 930 0. 373547	0 4, 481 807, 258 8. 181393	2, 580, 935 39. 992795	0	0 0 69, 842 45. 768021
1.001 2.001 2.021 3.001	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	0 84, 450 5, 720, 930	0 4, 481 807, 258 8. 181393	2, 580, 935 39. 992795	0 0 0	0 0 0 69, 842
I. 00 1 ¹ 2. 02 1 ¹ 3. 00 1 ¹ 4. 00 0 5. 00 I. 00 2. 00 4. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	0 84, 450 5, 720, 930 0. 373547 308, 774	0 4, 481 807, 258 8. 181393 50, 990	2, 580, 935 39. 992795 478, 507	0 0 0. 000000 0	0 0 69, 842 45. 768021 1, 025
1. 00 1 ¹ 2. 02 1 ¹ 3. 00 1 ¹ 4. 00 0 ¹ 5. 00 1. 00 2. 00 3. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part	0 84, 450 5, 720, 930 0. 373547	0 4, 481 807, 258 8. 181393 50, 990	2, 580, 935 39. 992795 478, 507	0 0 0	0 0 69, 842 45. 768021
I. 00 11 2. 00 11 2. 02 11 3. 00 11 4. 00 0 0. 00 I. 00 2. 00 4. 00 5. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)	0 84, 450 5, 720, 930 0. 373547 308, 774 0. 020161	0 4, 481 807, 258 8. 181393 50, 990	2, 580, 935 39. 992795 478, 507	0 0 0. 000000 0	0 0 69, 842 45. 768021 1, 025 0. 671691
I. 00 1 ¹ 2. 02 1 ¹ 3. 00 1 ¹ 4. 00 0 5. 00 I. 00 2. 00 4. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) NAHE adjustment amount to be allocated	0 84, 450 5, 720, 930 0. 373547 308, 774 0. 020161	0 4, 481 807, 258 8. 181393 50, 990	2, 580, 935 39. 992795 478, 507	0 0 0. 000000 0	0 0 69, 842 45. 768021 1, 025
I. 00 11 2. 00 11 2. 02 11 3. 00 11 4. 00 0 0. 00 I. 00 2. 00 4. 00 5. 00	9200 PHYSICIANS' PRIVATE OFFICES 9202 MOB 9300 NONPAID WORKERS 7950 LEASED SPACE Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II)	0 84, 450 5, 720, 930 0. 373547 308, 774 0. 020161	0 4, 481 807, 258 8. 181393 50, 990	2, 580, 935 39. 992795 478, 507	0 0 0. 000000 0	0 0 69, 842 45. 768021 1, 025 0. 671691

Heal th	Financial Systems I	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
					rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/28/2019 6:1	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(SQUARE FEET)	(PATIENT DAYS)	(FTE'S)	ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
					(DI RECT NURSI NG HOURS)	(COSTED REQUIS.)	
		9.00	10.00	11.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	101.00		10100	11100	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT - MOB						1.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 7.01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL						7.00 7.01
7.02	00702 OPERATION OF PLANT - MOB						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	60, 788					9.00
10.00	01000 DI ETARY	3, 058	1, 526				10.00
11.00	01100 CAFETERI A	4, 230		7, 415			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	618		892		445 000	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	2,060		(415, 980	
	01600 MEDICAL RECORDS & LIBRARY	1, 957 0	1 1	407		3, 881 0	1
10.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	<u> </u>		<u>и</u> ч	0	10.00
30.00	03000 ADULTS & PEDIATRICS	12, 118	1, 526	1, 471	26, 781	86, 959	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	10, 254		392		45, 492	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 123		853		16, 859	
60.00	06000 LABORATORY	4, 322		755		8, 266	1
66.00	06600 PHYSI CAL THERAPY	2,850		(18, 325 0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 322		75		19	
	06900 ELECTROCARDI OLOGY	0,0	0	, .		0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(58, 249	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0 0	16, 482	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(0 0	0	
73.01	07301 ONCOLOGY DRUGS	0	0)	-	0	73.01
76.00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	2,714	0	810	0 0	11, 964	76.00
90, 00	09000 CLINIC	0	o	(0	0	90.00
	09100 EMERGENCY	4, 985		1, 760		149, 484	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS				1 1		
101.00	10100 HOME HEALTH AGENCY	0	0	(0 0	0	101.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	56, 307	1, 526	7, 415	60, 587	415, 980	110 00
110.00	NONREI MBURSABLE COST CENTERS	50, 307	1, 520	7,41	00, 587	415, 900	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0	0	190. 00
	19100 RESEARCH	0	0	(0 0		191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(0 0		192.00
	2 19202 MOB	0	0	(0 0		192. 02
	19300 NONPAI D WORKERS	0	0	(0		193.00
194.00 200.00	07950 LEASED SPACE	4, 481	0	(0	0	194.00
200.00							200. 00 201. 00
201.00		871, 278	481, 765	584, 989	1, 497, 919	1, 018, 407	
202.00	Part I)	0,1,2/0	101,700	001,70	., ., ., , , , , , , , , , , , , , , ,	., 515, 107	
203.00	Unit cost multiplier (Wkst. B, Part I)	14. 333059	315. 704456	78.892650	24. 723439	2.448211	203.00
204.00		110, 792	91, 805	125, 796	54, 207	71, 976	204.00
205 62	Part II)	1 000503	10 1/0550	1/ 0/503	0.004/07	0 470000	205 22
205.00	Unit cost multiplier (Wkst. B, Part	1. 822597	60. 160550	16. 965071	0. 894697	0. 173028	205.00
206.00							206.00
_00.00	(per Wkst. B-2)						
207.00							207.00
	Parts III and IV)	I	I I				

T ALLOO	CATION - STATISTICAL BASIS		Provider CCN: 15-1		eriod:	Worksheet	B-1
				Fi To	rom 01/01/2018 0 12/31/2018	Date/Time 5/28/2019	
	Cost Center Description	PHARMACY (COSTED REQUIS.) 15.00	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16. 00				
GEN	ERAL SERVICE COST CENTERS	13.00	10.00		<u> </u>		
00 001 01 001 02 001 00 004 00 005 00 007 01 007 02 007 03 007 04 007 05 007 00 008 00 009 00 010 00 011 00 013 00 014	00 CAP REL COSTS-BLDG & FIXT 01 CAP REL COSTS-BLDG & FIXT - HOSPITAL 02 CAP REL COSTS-BLDG & FIXT - MOB 00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL 00 OPERATION OF PLANT 01 OPERATION OF PLANT - HOSPITAL 02 OPERATION OF PLANT - MOB 00 LAUNDRY & LINEN SERVICE 00 HOUSEKEEPING 00 DI ETARY 00 CAFETERIA 00 NURSING ADMINISTRATION 00 CENTRAL SERVICES & SUPPLY 00 PHARMACY	299, 702					1 1 4 5 7 7 7 7 7 8 9 10 11 13 14 15
	00 MEDICAL RECORDS & LIBRARY	0	0				16
	ATLENT ROUTINE SERVICE COST CENTERS	0.070					
	00 ADULTS & PEDIATRICS I LLARY SERVICE COST CENTERS	3, 270	0				30
	00 OPERATI NG ROOM	1, 643	0				50
	00 RADI OLOGY-DI AGNOSTI C	905	0				54
	00 LABORATORY	0	0				60
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	0				66
	00 SPEECH PATHOLOGY	0	0				68
	00 ELECTROCARDI OLOGY	0	0				69
	00 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71
	00 I MPL. DEV. CHARGED TO PATIENTS 00 DRUGS CHARGED TO PATIENTS	0 221, 515	0				72
	01 ONCOLOGY DRUGS	58, 908	0				73
1	60 CARDI OPULMONARY	106	Ö				76
	PATIENT SERVICE COST CENTERS		1				
		0	0				90
	00 EMERGENCY 00 OBSERVATI ON BEDS (NON-DI STI NCT PART)	13, 355	0				91
OTH	ER REIMBURSABLE COST CENTERS						
	OO HOME HEALTH AGENCY	0	0				10
	CIAL PURPOSE COST CENTERS	000 700	0				
3. 00	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	299, 702	0				118
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
. 00 191	00 RESEARCH	0	0				191
	00 PHYSI CLANS' PRI VATE OFFI CES	0	0				19
2.02192	02 MOB 00 NONPAID WORKERS	0	0				192 193
	50 LEASED SPACE	0	0				19
0.00	Cross Foot Adjustments						200
. 00	Negative Cost Centers						201
2. 00	Cost to be allocated (per Wkst. B,	1, 508, 761	0				202
. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	5. 034204	0. 000000				203
. 00	Cost to be allocated (per Wkst. B,	83, 808	0.000000				203
	Part II)	,0	-				
5. 00	Unit cost multiplier (Wkst. B, Part	0. 279638	0. 000000				205
. 00	II) NAHE adjustment amount to be allocated						206
	(per Wkst. B-2)						200

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/28/2019 6:1	pared: 7 pm
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description		Therapy Limit	Total Costs		Total Costs	
	(from Wkst. B,	Adj.		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1	1				
30. 00 03000 ADULTS & PEDI ATRI CS	4, 450, 450		4, 450, 45	50 0	0	30.00
ANCI LLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	1, 896, 995		1, 896, 99		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 632, 689		1, 632, 68		0	
60. 00 06000 LABORATORY	1, 395, 659		1, 395, 65		0	
66. 00 06600 PHYSI CAL THERAPY	1, 052, 406		1, 052, 40		0	
67.00 06700 OCCUPATI ONAL THERAPY	436, 387		436, 38		0	
68.00 06800 SPEECH PATHOLOGY	186, 044	0	186, 04	14 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	222, 614		222, 61		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	62, 990		62, 99		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 419, 412		1, 419, 41	12 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	377, 468		377, 46		0	73.01
76.00 03160 CARDI OPULMONARY	1, 413, 559		1, 413, 55	59 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0			0 0	0	
91.00 09100 EMERGENCY	5, 915, 651		5, 915, 65		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,077,420		1, 077, 42	20	0	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	21, 539, 744		21, 539, 74			200. 00
201.00 Less Observation Beds	1,077,420		1, 077, 42			201.00
202.00 Total (see instructions)	20, 462, 324	0	20, 462, 32	24 0	0	202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	2, 510, 369		2, 510, 36	9		30.00
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	77, 103	2, 829, 768	2, 906, 87	1 0. 652590	0.000000	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	246, 392	7,032,768	7, 279, 16	0 0. 224296	0.000000	54.00
60. 00 06000 LABORATORY	347, 580	2, 991, 356	3, 338, 93	6 0. 417995	0.000000	60.00
66. 00 06600 PHYSI CAL THERAPY	436, 400	2,015,350	2, 451, 75			
67.00 06700 OCCUPATI ONAL THERAPY	296, 923	837, 861	1, 134, 78			
68.00 06800 SPEECH PATHOLOGY	154,008	238, 116	392, 12			
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	89	158, 669	158, 75	8 1.402222	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	127, 941	127, 94	1 0. 492336	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	859, 283	1, 534, 317	2, 393, 60	0 0. 593003	0.000000	73.00
73.01 07301 ONCOLOGY DRUGS	0	441, 777	441, 77	7 0. 854431	0.000000	73.01
76.00 03160 CARDI OPULMONARY	320, 529	2, 542, 724	2, 863, 25	3 0. 493690	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS			-			
90. 00 09000 CLINIC	0	0		0 0.000000	0.00000	90.00
91.00 09100 EMERGENCY	233, 149	17, 609, 503	17, 842, 65		0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 990	1, 976, 291	1, 986, 28	1 0. 542431	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS			_			
101.0010100 HOME HEALTH AGENCY	0	0		0		101.00
200.00 Subtotal (see instructions)	5, 491, 815	40, 336, 441	45, 828, 25	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	5, 491, 815	40, 336, 441	45, 828, 25	6		202.00

Health Financial Systems	IU HEALTH FRANKFO	ORT HOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Peri od: From 01/01/2018 To 12/31/2018	
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCI LLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0.000000			50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			54.00
60. 00 06000 LABORATORY	0.000000			60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01 07301 ONCOLOGY DRUGS	0.000000			73.01
76.00 03160 CARDI OPULMONARY	0. 000000			76.00
OUTPATIENT SERVICE COST CENTERS	-i			
90. 00 09000 CLINIC	0.000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018		pared: 7 pm
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1			_		
30. 00 03000 ADULTS & PEDI ATRI CS	4, 450, 450		4, 450, 45	0 0	4, 450, 450	30.00
ANCI LLARY SERVI CE COST CENTERS	1			-		
50. 00 05000 OPERATI NG ROOM	1, 896, 995		1, 896, 99		1, 896, 995	•
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 632, 689		1, 632, 68		1, 632, 689	•
60. 00 06000 LABORATORY	1, 395, 659		1, 395, 65		1, 395, 659	•
66. 00 06600 PHYSI CAL THERAPY	1,052,406	0	1, 052, 40		1, 052, 406	•
67.00 06700 OCCUPATI ONAL THERAPY	436, 387	0	436, 38		436, 387	•
68.00 06800 SPEECH PATHOLOGY	186, 044	0	186, 04	4 0	186, 044	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	222, 614		222, 61		222, 614	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	62, 990		62, 99	0 0	62, 990	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 419, 412		1, 419, 41	2 0	1, 419, 412	73.00
73.01 07301 ONCOLOGY DRUGS	377, 468		377, 46	8 0	377, 468	73.01
76.00 03160 CARDI OPULMONARY	1, 413, 559		1, 413, 55	9 0	1, 413, 559	76.00
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0			0 0	0	, 01 00
91. 00 09100 EMERGENCY	5, 915, 651		5, 915, 65		5, 915, 651	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,077,420		1, 077, 42	0	1, 077, 420	92.00
OTHER REIMBURSABLE COST CENTERS	1					
101.00 10100 HOME HEALTH AGENCY	0			0		101.00
200.00 Subtotal (see instructions)	21, 539, 744	0	,		21/00////11	
201.00 Less Observation Beds	1,077,420		1, 077, 42		1, 077, 420	
202.00 Total (see instructions)	20, 462, 324	0	20, 462, 32	4 0	20, 462, 324	202.00

Health Financial Systems	IU HEALTH FRANK	ORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018	Worksheet C Part I	
				To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 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	0.540.040		0.540.07			
30. 00 03000 ADULTS & PEDI ATRI CS	2, 510, 369		2, 510, 36	9		30.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM	77, 103	2, 829, 768				1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	246, 392	7,032,768				54.00
60. 00 06000 LABORATORY	347, 580	2, 991, 356				60.00
66.00 06600 PHYSI CAL THERAPY	436, 400	2,015,350				
67.00 06700 OCCUPATI ONAL THERAPY	296, 923	837, 861				
68.00 06800 SPEECH PATHOLOGY	154,008	238, 116				
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000		69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	89	158, 669			0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	127, 941				
73.00 07300 DRUGS CHARGED TO PATIENTS	859, 283	1, 534, 317				
73.01 07301 ONCOLOGY DRUGS	0	441, 777			0.00000	1
76.00 03160 CARDI OPULMONARY	320, 529	2, 542, 724	2, 863, 25	3 0. 493690	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS				0 0 0 0 0 0 0 0 0	0.00000	
90. 00 09000 CLINIC	0	0		0 0.00000		1
91.00 09100 EMERGENCY	233, 149	17, 609, 503				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9, 990	1, 976, 291	1, 986, 28	0. 542431	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0	15 000 05	0		101.00
200.00 Subtotal (see instructions)	5, 491, 815	40, 336, 441	45, 828, 25	6		200.00
201.00 Less Observation Beds	F 404 04F	40.00/ 444	45 000 05	,		201.00
202.00 Total (see instructions)	5, 491, 815	40, 336, 441	45, 828, 25	6		202.00

Health Financial Systems	IU HEALTH FRANKF	ORT HOSPI TAL	In Lie	u of Form CMS-2552	2-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepare 5/28/2019 6:17 pm	ed: m
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	0. 00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				0. 00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				1.00
60. 00 06000 LABORATORY	0. 000000				0. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				5.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				7.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				3. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			-	9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				I. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				2.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				3.00
73.01 07301 ONCOLOGY DRUGS	0. 000000				3. 01
76.00 03160 CARDI OPULMONARY	0. 000000				5.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0. 000000				0.00
91.00 09100 EMERGENCY	0. 000000				1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92	2.00
OTHER REI MBURSABLE COST CENTERS				101	
101.00 10100 HOME HEALTH AGENCY					1.00
200.00 Subtotal (see instructions)					0.00
201.00 Less Observation Beds					1.00
202.00 Total (see instructions)				202	2.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1316	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part II Date/Time Pre 5/28/2019 6:1	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,			(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	
ANCILLARY SERVICE COST CENTERS	-1		1			
50. 00 05000 OPERATI NG ROOM	326, 793					•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	182, 557	7, 279, 160	0. 02507	79 92, 700	2, 325	54.00
60. 00 06000 LABORATORY	153, 197	3, 338, 936	0. 04588	32 180, 560	8, 284	60.00
66. 00 06600 PHYSI CAL THERAPY	96, 856	2, 451, 750	0. 03950	05 131, 855	5, 209	66.00
67.00 06700 OCCUPATI ONAL THERAPY	43, 001	1, 134, 784	0. 03789	94 82, 849	3, 139	67.00
68.00 06800 SPEECH PATHOLOGY	23, 277	392, 124	0. 05936	51 95, 894	5, 692	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	11, 253	158, 758	0. 07088	31 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 184	127, 941	0. 02488	36 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	66, 410	2, 393, 600	0. 02774	45 464, 828	12, 897	73.00
73.01 07301 ONCOLOGY DRUGS	17, 661	441, 777	0. 03997	77 0	0	73.01
76.00 03160 CARDI OPULMONARY	111, 072	2, 863, 253	0. 03879	92 195, 959	7, 602	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
91.00 09100 EMERGENCY	293, 289	17, 842, 652			158	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	129, 975					92.00
200.00 Total (lines 50 through 199)	1, 458, 525			1, 283, 072		200.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		
				To 12/31/2018		
					5/28/2019 6:1	/pm
			e XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	c c		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	l c		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73.00
73. 01 07301 ONCOLOGY DRUGS	0			0 0	0	73.01
76. 00 03160 CARDI OPULMONARY	0			0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS			1	<u> </u>		/ 01 00
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91. 00 09100 EMERGENCY	0			0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1	0	0	92.00
200.00 Total (lines 50 through 199)	0			0 0	-	200.00
200.00 Total (Thes so through 199)	0		4	0	0	200.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		nared
				10 12/31/2010	5/28/2019 6:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost				(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	1.00	5.00	and 4)	7.00		
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	0	0	1	0 2.00/ 071	0.000000	50.00
	0	0		0 2, 906, 871		
	0	0		0 7, 279, 160		•
60. 00 06600 LABORATORY 66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 338, 936		
	0	0		0 2, 451, 750		•
	0	0		0 1, 134, 784		
	0	0		0 392, 124		•
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			0.000000	
	0	0		0 158, 758		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 127, 941		•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 393, 600		•
73. 01 07301 ONCOLOGY DRUGS	0	0		0 441,777		
76. 00 03160 CARDI OPULMONARY OUTPATI ENT_SERVI CE_COST_CENTERS	0	0		0 2, 863, 253	0.000000	76.00
		0	1	0	0.00000	00.00
90. 00 09000 CLINIC	0	0			0.000000	
91.00 09100 EMERGENCY	0	0		0 17, 842, 652		
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	0		0 1, 986, 281		
200.00 Total (lines 50 through 199)	0	0	1	0 43, 317, 887	1	200.00

Health Financial Systems	IU HEALTH FRANKF	ORT HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1316	Period: From 01/01/2018	Worksheet D B Part IV	
				To 12/31/2018		
		Title	× XVIII	Hospi tal	Cost	<u>/ piii</u>
Cost Center Description	Outpatient	Inpatient	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	n Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1		1		1	
50.00 05000 OPERATI NG ROOM	0. 000000	26, 643		0 0	0 0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	92, 700		0 0	0 0	54.00
60. 00 06000 LABORATORY	0. 000000	180, 560		0 0	0 0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	131, 855		0 0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	82, 849		0 0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	95, 894		0 0	0 0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0 0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	464, 828		0 0	0 0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 000000	0		0 0	0 0	73.01
76. 00 03160 CARDI OPULMONARY	0. 000000	195, 959		0 0	0 0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0 0	90.00
91.00 09100 EMERGENCY	0. 000000	9, 614		0 0	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	2, 170		0 0	0 0	92.00
200.00 Total (lines 50 through 199)		1, 283, 072		0 0	o 0	200. 00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2018 To 12/31/2018		pared: 7 pm
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 652590		755, 63		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 224296		1, 776, 60		0	
60. 00 06000 LABORATORY	0. 417995	0	805, 61	7 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 429247	0	665, 84	7 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 384555	0	267, 72	5 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 474452	0	48, 95	0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 402222	0	18, 21	6 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 492336	0	22, 40	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 593003	0	338, 99	9 1, 117	0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 854431	0	176, 98	8 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 493690	0	1, 001, 97	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		•	•			1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 331546	0	4, 241, 58	3 720	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 542431	0	707, 89	2 0	0	92.00
200.00 Subtotal (see instructions)		0	10, 828, 43	6 1, 837	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	10, 828, 43	6 1, 837	0	202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/28/2019 6:1	
		Title	XVIII	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			1			4
50.00 05000 OPERATI NG ROOM	493, 120					50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	398, 486	0				54.00
60. 00 06000 LABORATORY	336, 744	0				60.00
66. 00 06600 PHYSI CAL THERAPY	285, 813					66.00
67.00 06700 OCCUPATI ONAL THERAPY	102, 955	0				67.00
68.00 06800 SPEECH PATHOLOGY	23, 224	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 543	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	11,030	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	201, 027	662				73.00
73.01 07301 ONCOLOGY DRUGS	151, 224	0				73.01
76.00 03160 CARDI OPULMONARY	494, 663	0				76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	1, 406, 280	239				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	383, 983					92.00
200.00 Subtotal (see instructions)	4, 314, 092	901				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	4, 314, 092	901				202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2018		norodi
		Component (CCN: 15-Z316	To 12/31/2018	Date/Time Pre 5/28/2019 6:1	pared: 7 pm
		Title	XVIII S	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1				
50.00 05000 OPERATING ROOM	0. 652590			0 0	0	00.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 224296			0 0	0	0 11 00
60. 00 06000 LABORATORY	0. 417995			0 0	0	00.00
66. 00 06600 PHYSI CAL THERAPY	0. 429247	0		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 384555	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 474452	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 402222	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 492336	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 593003	0		0 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	0. 854431	0		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 493690	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0.000000	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 331546	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 542431	0		0 0	0	92.00
200.00 Subtotal (see instructions)	1	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	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1316	Peri od:	Worksheet D	
			001 45 704/	From 01/01/2018	Part V	
		Component (CCN: 15-Z316	To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
		Title	XVIII	Swing Beds - SNF		7 piii
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
73.01 07301 ONCOLOGY DRUGS	0	0				73.01
76.00 03160 CARDI OPULMONARY	0	0				76.00
OUTPATIENT SERVICE COST CENTERS	•					1
90. 00 09000 CLI NI C	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 652590			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 224296			0 0	0	
60. 00 06000 LABORATORY	0. 417995	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 429247	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 384555	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 474452	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 402222	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 492336	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 593003	0		0 0	0	73.00
73.01 07301 ONCOLOGY DRUGS	0.854431	l o		0 0	0	73.01
76.00 03160 CARDI OPULMONARY	0. 493690	l o		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		· · · · ·	1			
90. 00 09000 CLINIC	0.00000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 331546			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 542431	0		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ		0 0	Ű	201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/28/2019 6:1	
		Titl	e XIX	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				50.00
60. 00 06000 LABORATORY	0	0				60.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					73.00
73. 01 07301 ONCOLOGY DRUGS	0					73.00
76. 00 03160 CARDI OPULMONARY	0					76.00
OUTPATIENT SERVICE COST CENTERS	0	0	1			/0.00
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	l				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

	Financial Systems IU HEALTH FRANKFO ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1316	Period:	u of Form CMS-2 Worksheet D-1	
COMIN			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/28/2019 6:1 Cost	7 pm
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS		r		
1.00	Inpatient days (including private room days and swing-bed day			1, 989	
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room davs.	1, 671 0	
	do not complete this line.		······································	-	
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	1, 208 237	4.00 5.00
5.00	reporting period	on days) through becenbe	a si oi the cost	237	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	m davs) through December	31 of the cost	81	7.00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	803	9.00
	newborn days)	0			
10.00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	237	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII c	nly (including private r	room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e		a room days)	0	12.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13.00
14.00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)	am (onor daring om ng bod	aage)	0	
16.00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	es through December 31 d	of the cost		17.00
	reporting period	0			
18.00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost		18.00
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	129.14	19.00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 21 of t	bo cost	0.00	20.00
20.00	reporting period	s alter becenber 31 01 1	the cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			4, 450, 450	
22.00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost report	ing period (line	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00
24.00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 21 of the cost reporti	ng pariod (line	10, 460	24 00
24.00	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			561, 968	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 888, 482	
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation bod ch	argos)	0	28.00
28.00	Private room charges (excluding swing-bed charges)		lai yes)	0	1
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00 36.00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)			0.00	35.00 36.00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 888, 482	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	LISTMENTS			-
38.00	Adjusted general inpatient routine service cost per diem (see			2, 327.04	38.00
	Program general inpatient routine service cost (line 9 x line			1, 868, 613	1
39.00					
40.00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39			0 1, 868, 613	

Heal th	Financial Systems I	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
					rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
						5/28/2019 6:1	7 pm
	Cast Contor Description	Total	Total	XVIII	Hospi tal	Cost	
	Cost Center Description	Total Innatient Cost	Inpatient Days	Average Per Diem (col 1 -	Program Days	Program Cost (col. 3 x col.	
			inputiont buys	col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	cost center bescription					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			624, 358	48.00
49.00	Total Program inpatient costs (sum of lines 4	41 through 48)(<u>(see instructio</u>	ns)		2, 492, 971	49.00
F0 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	annul and (from	What D oum	of Donto L and	0	
50.00	The second	attent routine	services (Irom	WKSL. D, SUM	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 5	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclud		elated, non-phy	sician anesthe	tist, and	0	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operati	ng cost and ta	arget amount (I	ine 56 minus I	ine 53)	0	57.00
	Bonus payment (see instructions)	arting pariod	onding 1004	ndated and com	nounded by the	0.00	58.00 59.00
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	borting period	ending 1996, u	puated and com	pounded by the	0.00	59.00
	Lesser of lines 53/54 or 55 from prior year of					0.00	60.00
61.00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	listi ucti olisj				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	ember 31 of the	cost reportir	g period (See	551, 508	64.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	oer 31 of the c	ost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only). For	551, 508	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31 o	f the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost repor	tina period	0	68.00
	(line 13 x line 20)				51		
69.00	Total title V or XIX swing-bed NF inpatient r					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili		•				70.00
	Adjusted general inpatient routine service co	5					71.00
	Program routine service cost (line 9 x line 7	71)					72.00
	Medically necessary private room cost applica						73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				rt II column		74.00 75.00
75.00	26, line 45)	outine service	COSTS (ITOM W	UIRSHEEL D, Fa	int II, corumn		75.00
76.00	Per diem capital-related costs (line 75 ÷ lir	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	,	rovidor rocord	c)			78.00 79.00
80.00	Total Program routine service costs for compa				s line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82.00	Inpatient routine service cost limitation (li						82.00
	Reasonable inpatient routine service costs (s		is)				83.00
	Program inpatient ancillary services (see ins Utilization review - physician compensation (ns)				84.00 85.00
	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
	Total observation bed days (see instructions)						87.00
88.00 89.00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see					2, 327. 04 1, 077, 420	
57.00						1,077,420	07.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		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	536, 879	4, 450, 450	0. 12063	5 1, 077, 420	129, 975	90.00
91.00 Nursing School cost	0	4, 450, 450	0.00000	0 1, 077, 420	0	91.00
92.00 Allied health cost	0	4, 450, 450	0. 00000	0 1, 077, 420	0	92.00
93.00 All other Medical Education	0	4, 450, 450	0. 00000	0 1, 077, 420	0	93.00

COMPUT	Financial Systems IU HEALTH FRANKFC ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1316	Peri od:	u of Form CMS-2 Worksheet D-1	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Title XIX	Hospi tal	5/28/2019 6:1 Cost	7 pm
	Cost Center Description		-	1 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS			4.000	1
1.00 2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			1, 989 1, 671	
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
4 00	do not complete this line.		-	1 000	1 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 208 237	
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.00
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	81	7.00
0.00	reporting period			0	
8.00	Total swing-bed NF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	om days) arter December (I OF THE COST	0	8.00
9.00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	12	9.00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato r	soom dave)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		com days)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
	through December 31 of the cost reporting period	<u> </u>	5 /	-	
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)			0	
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.00
17.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost		17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	res after December 31 of	the cost		18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	129.14	19.00
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of 1	the cost	0.00	20.00
21.00	reporting period Total general inpatient routine service cost (see instruction	าร)		4, 450, 450	21.00
22.00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportir	a period (line 6	0	23.00
20.00	x line 18)	ST OF the cost reportin		0	25.00
24.00	Swing-bed cost applicable to NF type services through December 7×1 (ine 19)	er 31 of the cost reporti	ng period (line	10, 460	24.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26.00	x line 20) Total swing-bed cost (see instructions)			561, 968	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 888, 482	
~~ ~~	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u> </u>		
28.00 29.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	ed and observation bed ch	narges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li Drivate room cost differential adjuctment (line 3 x line 25)	ne 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 3, 888, 482	
	27 minus line 36)		、 ···		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	IUSTMENTS			-
38.00	Adjusted general inpatient routine service cost per diem (see			2, 327.04	38.00
39.00	Program general inpatient routine service cost (line 9 x line			27,924	
	Medically necessary private room cost applicable to the Progr			0	
40.00					

Heal th	Financial Systems	U HEALTH FRANK	FORT HOSPITAL		ln Li€	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
					From 01/01/2018 Fo 12/31/2018	Date/Time Pre	pared:
						5/28/2019 6:1	7 pm
	Cast Contor Description	Total	Total	e XIX Average Per	Hospital	Cost	
	Cost Center Description	Total Innatient Cost	Inpatient Days	9	Program Days	Program Cost (col. 3 x col.	
			inputront buys	col . 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1		[43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			16, 637	48.00
	Total Program inpatient costs (sum of lines 4			ons)		44, 561	49.00
	PASS THROUGH COST ADJUSTMENTS					Γ	
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
51.00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	ry services (fr	rom Wkst. D, su	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines §	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclud	ding capital re	elated, non-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line 5	52)					
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operati	ing cost and ta	arget amount (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	ending 1996, t	ipdated and con	pounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year of	cost report, up	dated by the m	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than		ts (lines 54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemh	per 31 of the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)			lost ropor tring			00.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	o5)(title XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	o costs through	Docombor 21 c	of the cost ror	orting poriod	0	67.00
07.00	(line 12 x line 19)	e costs through	i becember 31 c	in the cost rep	or tring period	0	07.00
68.00	Title V or XIX swing-bed NF inpatient routine	e costs after D	December 31 of	the cost repor	ting period	0	68.00
(0.00	(line 13 x line 20)			(0)			(0.00
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili		•				70.00
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
72.00	Program routine service cost (line 9 x line 1		. (1:	25)			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi						73.00 74.00
75.00	Capital -related cost allocated to inpatient i	•			art II, column		75.00
	26, line 45)						
	Per diem capital-related costs (line 75 ÷ lin						76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00 78.00
79.00	Aggregate charges to beneficiaries for excess	,	provider record	ls)			79.00
80.00	Total Program routine service costs for compa				us line 79)		80.00
81.00	Inpatient routine service cost per diem limit						81.00
82.00	Inpatient routine service cost limitation (li						82.00
	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		15/				83.00 84.00
	Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum	of lines 83 th					86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					4/0	07.00
87.00 88.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			463 2, 327. 04	87.00 88.00
	Observation bed cost (line 87 x line 88) (see					1, 077, 420	

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	536, 879	4, 450, 450	0. 12063	5 1, 077, 420	129, 975	90.00
91.00 Nursing School cost	0	4, 450, 450	0.00000	0 1, 077, 420	0	91.00
92.00 Allied health cost	0	4, 450, 450	0.00000	0 1, 077, 420	0	92.00
93.00 All other Medical Education	0	4, 450, 450	0.00000	0 1, 077, 420	0	93.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	;
			From 01/01/2018 To 12/31/2018	Date/Time Pre	nared
			10 12/31/2010	5/28/2019 6: 1	
	Title	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	1, 491, 459		30.00
ANCI LLARY SERVICE COST CENTERS		1	1,471,437		30.00
50. 00 05000 OPERATING ROOM		0. 65259	26, 643	17, 387	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22429			
60. 00 06000 LABORATORY		0. 41799			
66.00 06600 PHYSI CAL THERAPY		0. 42924			
67.00 06700 OCCUPATI ONAL THERAPY		0. 38455	5 82, 849	31, 860	67.00
68.00 06800 SPEECH PATHOLOGY		0. 47445	95, 894	45, 497	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	S	1. 40222	2 0	0	1 11 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49233		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 59300		275, 644	
73.01 07301 ONCOLOGY DRUGS		0.85443		0	
76.00 03160 CARDI OPULMONARY		0. 49369	0 195, 959	96, 743	76.00
OUTPATIENT SERVICE COST CENTERS			-	-	
90. 00 09000 CLI NI C		0.00000		0	
91.00 09100 EMERGENCY		0. 33154			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 54243			92.00
200.00Total (sum of lines 50 through 94 ar201.00Less PBP Clinic Laboratory Services-			1, 283, 072	624, 358	200.00
3			-		201.00
202.00 Net charges (line 200 minus line 201	1)	I	1, 283, 072		1202.00

Health Financial Systems IU HEALTH FRANKFO				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1316	Peri od:	Worksheet D-3	3
	Component	CCN: 15-Z316	From 01/01/2018 To 12/31/2018	Date/Time Pre	narod
	component	CON. 13-2310	10 12/31/2010	5/28/2019 6:1	
	Title	e XVIII	Swing Beds - SNF		•
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			0		30.0
ANCI LLARY SERVICE COST CENTERS		0.65259		0	50.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0525		0 2.990	
54. 00 06000 LABORATORY		0. 2242			
66. 00 06600 PHYSICAL THERAPY		0. 42924			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 38455			
68. 00 06800 SPEECH PATHOLOGY		0. 4744			
69. 00 06900 ELECTROCARDI OLOGY		0.00000			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 40222			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 49233			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 59300	03 87, 197	51, 708	73.0
73.01 07301 ONCOLOGY DRUGS		0.85443	31 0	0	73.0
76. 00 03160 CARDI OPULMONARY		0. 4936	90 5, 692	2, 810	76.0
OUTPATIENT SERVICE COST CENTERS		_		_	
90. 00 09000 CLINIC		0.0000	0 00	C	90.0
91. 00 09100 EMERGENCY		0. 33154		0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 54243		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			462, 667	205, 974	
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			462, 667		202.0

Health Financial Systems IU HEALTH FRANKFOR	T HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-13		eriod:	Worksheet D-3	3
			rom 01/01/2018 o 12/31/2018	Date/Time Pre	narod
			0 12/31/2010	5/28/2019 6:1	
	Title XIX		Hospi tal	Cost	
Cost Center Description	Ratio o	f Cost	Inpati ent	Inpati ent	
	To Cha	arges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
	1.0	00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			24, 215		30.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		652590		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		224296		1, 635	
60. 00 06000 LABORATORY		417995		2, 308	
66. 00 06600 PHYSI CAL THERAPY		429247		1, 198	
67. 00 06700 OCCUPATI ONAL THERAPY		384555		202	
68. 00 06800 SPEECH PATHOLOGY		474452	-	0	00.00
69. 00 06900 ELECTROCARDI OLOGY		000000	-	0	07.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		402222	-	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS		492336		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		593003	8, 686	5, 151	
73. 01 07301 0NCOLOGY DRUGS 76. 00 03160 CARDI OPULMONARY		854431 493690	2 420	0	
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0.	493690	2, 438	1, 204	/0.00
90. 00 09000 CLINIC	0	000000	0	0	90.00
91. 00 09100 EMERGENCY		331546		4, 939	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		542431	14, 090	4, 939	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	0.	542451	42, 152	-	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		42, 102	10, 037	200.00
202.00 Net charges (line 200 minus line 201)			42, 152		201.00
202.00 met charges (The 200 minus the 201)	I		42, 102		1202.00

ALCUL	ATI ON OF REIMBURSEMENT SETTLEMENT P	rovider CCN: 15-1316	Period: From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	Cost	/ pili
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			4, 314, 993	1.0
. 00	Medical and other services reimbursed under OPPS (see instruction	ons)		0	2.0
. 00	OPPS payments			0	3.0
. 00 . 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instructi	ons)		0.000	
. 00	Line 2 times line 5			0	
. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. C
. 00	Transitional corridor payment (see instructions)			0	
. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9.0
0.00 1.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 4, 314, 993	10. C
1.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 011, 770	1
	Reasonabl e charges				
2.00	Ancillary service charges			0	
3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	
4. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14. C
5.00	Aggregate amount actually collected from patients liable for pay	vment for services on	a charge basis	0	15.0
6.00	Amounts that would have been realized from patients liable for p		0	0	
	had such payment been made in accordance with 42 CFR §413.13(e)		-		
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1
8.00 9.00	Total customary charges (see instructions)	if line 10 evenede li	n_{0} (coo	0	18. C
9.00	Excess of customary charges over reasonable cost (complete only instructions)	IT THE TO EXCEEDS IT	lie II) (See	0	19.0
0. OO	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.0
	instructions)				
1.00	Lesser of cost or charges (see instructions)			4, 358, 143	
2.00 3.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruc	stions)		0	22.0
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	.trons)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1 2 11 3
5.00	Deductibles and coinsurance amounts (for CAH, see instructions)			24, 307	
6.00	Deductibles and Coinsurance amounts relating to amount on line 2			1, 966, 646	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu instructions)	us the sum of lines 22	and 23] (see	2, 367, 190	27.0
8. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28.0
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36))		0	29.0
0. 00	Subtotal (sum of lines 27 through 29)			2, 367, 190	
1.00	Primary payer payments			3, 125	
2. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	3)		2, 364, 065	32.0
3. 00	· · · · · · · · · · · · · · · · · · ·)		0	33.0
4.00	Allowable bad debts (see instructions)			326, 123	
5.00	Adjusted reimbursable bad debts (see instructions)			211, 980	
6.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		326, 393	
7.00 8.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 576, 045 0	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instructions)			-	39.
9. 97	Demonstration payment adjustment amount before sequestration			0	39.9
9. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	39. 9
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.
0. 00 0. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 576, 045 51, 521	
0. 01 0. 02	Demonstration payment adjustment amount after sequestration			0 0	
1.00	Interim payments			2, 673, 750	
2. 00	Tentative settlement (for contractors use only)			0	42.0
3.00	Balance due provider/program (see instructions)		-h	-149, 226	
4. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	cnapter 1,	168, 810	44. (
	§115.2 TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	90. (
0. 00					1
0. 00 1. 00	Outlier reconciliation adjustment amount (see instructions)			0	
				0.00	91. 92. 93.

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC		Period: From 01/01/2018 To 12/31/2018		
			XVIII	Hospi tal	Cost	-
		I npati ent	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	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		2, 677, 74	1 0	1, 680, 750 0	1.00 2.00
3.00	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					3.00
3.01	ADJUSTMENTS TO PROVIDER	03/23/2018	236, 00	0 03/23/2018	44, 400	3. 01
3.02		08/24/2018	609, 80		948, 600	3.02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program	II			0	5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		845, 80	-	993,000	3.99
	3. 50-3. 98)		,	-	,	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 523, 54	1	2, 673, 750	4.00
	TO BE COMPLETED BY CONTRACTOR	I I				
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
F F 0	Provider to Program	I I		0	0	E E .
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.99
6. 00 6. 01	Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER			0	о	6.00 6.01
6.01	SETTLEMENT TO PROVIDER		1, 309, 06	0	149, 226	6. 02
7.00	Total Medicare program liability (see instructions)		2, 214, 47		2, 524, 524	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/20 To 12/31/20		
		component c	CCN: 15-Z316	10 12/31/20	5/28/2019 6:1	
			XVIII	Swing Beds - S		
		Inpatien	t Part A	F	Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		811, 2	58	0	
00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.0
00	amount based on subsequent revision of the interim rate					0.1
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	08/24/2018	328, 3		0	
02				0	0	
03				0	0	
04 05				0	0	
05	Provider to Program			0	0	- S.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3
52				0	0	3.
53				0	0	3.
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		328, 3	00	0	3.
00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		1, 139, 5	58	0	4.
00	(transfer to Wkst. E or Wkst. E-3, line and column as		1, 137, 3	50		4.
	appropri ate)					
	TO BE COMPLÉTED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	
)3				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtatal (cum of lines E 01 E 40 minus cum of line-			0	0	
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	Determined net settlement amount (balance due) based on					6.
	the cost report. (1)					.
D1	SETTLEMENT TO PROVIDER			0	0	6.
)2	SETTLEMENT TO PROGRAM		389, 8	02	0	6.
00	Total Medicare program liability (see instructions)		749, 7		0	7.
				Contractor		
		0)	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
		L L	,	1.00	2.00	

Heal th	Financial Systems IU HEALTH FR/	ANKFORT HOSPITAL	In Lie	u of Form CMS-	-2552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1316	Period: From 01/01/2018 To 12/31/2018	Date/Time Pr 5/28/2019 6:	epared:	
		Title XVIII	Hospi tal	Cost		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	TS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL	ATION				
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 24	00			5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col.	. 3 line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instruction	ns)			8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		· · · · · · · · · · · · · · · · · · ·			
30.00	Initial/interim HIT payment adjustment (see instructions))			30.00	
31.00	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 a	and line 31) (see instructior	is)		32.00	

ALCULA		rovider CCN: 15-1316 component CCN: 15-Z316	Period: From 01/01/2018 To 12/31/2018	Worksheet E-2 Date/Time Pre	parec
		Title XVIII	Swing Beds - SNF	5/28/2019 6:1 Cost	/pm
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		557, 023	0	1. (
	Inpatient routine services - swing bed-NF (see instructions)				2.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part.		208, 034	0	3. (
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst			0.00	
	Per diem cost for interns and residents not in approved teachin instructions)	g program (see		0.00	4.
	Program days		237	0	5.
	Interns and residents not in approved teaching program (see ins	tructions)	207	0	6.
	Utilization review - physician compensation - SNF optional meth		0		7.
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		765, 057	0	8.
	Primary payer payments (see instructions)		0	0	
1	Subtotal (line 8 minus line 9)		765, 057	0	
	Deductibles billed to program patients (exclude amounts applica	ole to physician	0	0	11.
	professional services) Subtotal (line 10 minus line 11)		765, 057	0	12.
	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	765, 057	0	
	for physician professional services)	(exclude confisul ance	0	0	13.
	80% of Part B costs (line 12 x 80%)			0	14.
5.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	765, 057	0	15.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.
	Pioneer ACO demonstration payment adjustment (see instructions)				16.
	Rural community hospital demonstration project (§410A Demonstra	tion) payment	0		16.
1	adjustment (see instructions)			0	
1	Demonstration payment adjustment amount before sequestration Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	
	Total (see instructions)		765, 057	0	
	Sequestration adjustment (see instructions)		15, 301	0	19.
0. 02	Demonstration payment adjustment amount after sequestration)		0	0	19.
	Interim payments		1, 139, 558	0	
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, an	-	-389, 802	0	22.
	Protested amounts (nonallowable cost report items) in accordanc	e with CMS Pub. 15-2,	29, 677	0	23.
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstra	tion) Adjustment			-
	Is this the first year of the current 5-year demonstration peri-				200.
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				1
	Medicare swing-bed SNF inpatient routine service costs (from Wk	st. D-1, Pt. II, line			201.
1	66 (title XVIII hospital))				000
	Medicare swing-bed SNF inpatient ancillary service costs (from ' 200 (title XVIII swing-bed SNF))	WKST. D-3, COL. 3, IIN	e		202.
	Total (sum of lines 201 and 202)				203.
	Medicare swing-bed SNF discharges (see instructions)				204.
	Computation of Demonstration Target Amount Limitation (N/A in f	rst year of the curre	nt 5-year demonst	ration	
	period)	5			
	Medicare swing-bed SNF target amount				205.
	Medicare swing-bed SNF inpatient routine cost cap (line 205 tim				206.
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburser				207
	Program reimbursement under the §410A Demonstration (see instru		1		207.
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	cor. r, sum or rines	1		208.
	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruct	ons)			209.
	Reserved for future use	0			210.
	Comparision of PPS versus Cost Reimbursement				1
	Total adjustment to Medicare swing-bed SNF PPS payment (line 20	9 plus line 210) (see			215.

	Financial Systems IU HEALTH FRA ATION OF REIMBURSEMENT SETTLEMENT	ANKFORT HOSPITAL Provider CCN: 15-1316	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF RELMBORSEMENT SETTLEMENT		From 01/01/2018 To 12/31/2018	Part V Date/Time Pre 5/28/2019 6:1	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
. 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDI Inpatient services	CARE PART A SERVICES - CUST	REIMBURSEMENT	2, 492, 971	1 1.
. 00	Nursing and Allied Health Managed Care payment (see instr	cuctions)		2,492,971	
00	Organ acquisition			0	
. 00	Subtotal (sum of lines 1 through 3)			2, 492, 971	
. 00	Primary payer payments			1, 715	
. 00	Total cost (line 4 less line 5). For CAH (see instruction	าร)		2, 516, 186	6.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				-
00	Routine service charges			0	
00	Ancillary service charges			0	-
00	Organ acquisition charges, net of revenue			0	
0. 00	Total reasonable charges Customary charges			0	
I. 00	Aggregate amount actually collected from patients liable	for navment for services on	a charge basis	0	11
2.00	Amounts that would have been realized from patients liable	1 5	5	0	
	had such payment been made in accordance with 42 CFR 413.	1 5	in a onargo baoro	Ū	
8. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13
. 00	Total customary charges (see instructions)			0	14
5.00	Excess of customary charges over reasonable cost (complet	te only if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
5.00	Excess of reasonable cost over customary charges (complet	te only if line 6 exceeds lin	e 14) (see	0	16
7.00	instructions) Cost of physicians' services in a teaching hospital (see	instructions)		0	17
1.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	- ''
3. 00	Direct graduate medical education payments (from Workshee	et E-4 line 49)		0	1 18
9.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 516, 186	
0. 00	Deductibles (exclude professional component)			265, 296	
. 00	Excess reasonable cost (from line 16)			0	
. 00	Subtotal (line 19 minus line 20 and 21)			2, 250, 890	22
3.00	Coinsurance			0	
1.00	Subtotal (line 22 minus line 23)			2, 250, 890	
6.00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		13, 508	
b. 00	Adjusted reimbursable bad debts (see instructions)			8, 780	
. 00	Allowable bad debts for dual eligible beneficiaries (see	Instructions)		13, 508	
8.00 9.00	Subtotal (sum of lines 24 and 25, or line 26) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 259, 670 0	
9. 00 9. 50	Pioneer ACO demonstration payment adjustment (see instructions)	ctions)		0	
. 99	Demonstration payment adjustment amount before sequestrat			0	
. 00	Subtotal (see instructions)			2, 259, 670	
). 01	Sequestration adjustment (see instructions)			45, 193	
0. 02	Demonstration payment adjustment amount after sequestrati	on		0	
1.00	Interim payments			3, 523, 541	
2.00	Tentative settlement (for contractor use only)			0	
3.00	Balance due provider/program (line 30 minus lines 30.01,			-1, 309, 064	
4.00	Protested amounts (nonallowable cost report items) in acc	cordance with CMS Pub. 15-2,	chapter 1,	97, 681	34

	E SHEET (If you are nonproprietary and do not maintain	Provider C		Period: From 01/01/2018	Worksheet G	
na-t Iy)	ype accounting records, complete the General Fund column			To 12/31/2018	Date/Time Pre 5/28/2019 6:1	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
00	CURRENT ASSETS Cash on hand in banks	-725, 004		0 0	0	1 1
00	Temporary investments	723,004		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	1, 308, 232		0 0	0	4
00	Other receivable	C		0 0	0	5
00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
00	Inventory	208, 944		0 0	0	
00	Prepaid expenses	51, 826		0 0	0	
00	Other current assets	0		0 0	0	
00	Due from other funds Total current assets (sum of lines 1-10)	843, 998		0 0	0	
00	FIXED ASSETS	043, 990		0 0	0	
00	Land	807, 164		0 0	0	1 12
00	Land improvements	0		0 0	0	
00	Accumul ated depreciation	0		0 0	0	
00	Bui I di ngs	35, 315		0 0	0	15
00	Accumulated depreciation	-3, 665		0 0	0	
. 00	Leasehold improvements	496, 826		0 0	0	
. 00	Accumulated depreciation	-173, 010		0 0	0	
. 00	Fixed equipment	0		0 0	0	1
. 00	Accumulated depreciation	0		0 0	0	
. 00 . 00	Automobiles and trucks Accumulated depreciation			0 0	0	
. 00	Major movable equipment	5, 350, 980			0	
. 00	Accumulated depreciation	-1, 380, 099		0 0	0	
. 00	Mi nor equipment depreciable	1,000,077		0 0	0	
. 00	Accumulated depreciation	0		0 0	0	
. 00	HIT designated Assets	C		0 0	0	27
. 00	Accumulated depreciation	C		0 0	0	28
. 00	Mi nor equi pment-nondepreci abl e	C		0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	5, 133, 511		0 0	0	30
~~	OTHER ASSETS		1			
. 00	Investments	0		0 0	0	
. 00	Deposits on Leases Due from owners/officers			0 0	0	
. 00	Other assets	762, 236		0 0	0	
. 00	Total other assets (sum of lines 31-34)	762, 236		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	6, 739, 745		0 0	0	
	CURRENT LI ABI LI TI ES					
. 00	Accounts payable	14, 962, 340		0 0	0	37
00	Salaries, wages, and fees payable	615, 165		0 0	0	38
00	Payroll taxes payable	34, 220		0 0	0	
. 00	Notes and Loans payable (short term)	C		0 0	0	
. 00	Deferred income	0		0 0	0	
. 00	Accel erated payments	2 001 704		0	0	42
. 00	Due to other funds Other current liabilities	2, 981, 704		0 0 0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	18, 593, 429		0 0	0	
. 00	LONG TERM LIABILITIES	10, 373, 427		0 0	0	4.
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	0		0 0	0	
00	Unsecured Loans	0		0 0	0	
. 00	Other long term liabilities	C		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49)	0		0 0	0	
00	Total liabilities (sum of lines 45 and 50)	18, 593, 429		0 0	0	51
~ ~	CAPI TAL ACCOUNTS	44.050.404	1			1
00	General fund balance	-11, 853, 684		0		52
00	Specific purpose fund			0		53
00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted					54
00	Governing body created - endowment fund balance - unrestricted			0		56
. 00	Plant fund balance - invested in plant				0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
	Total fund balances (sum of lines 52 thru 58)	-11, 853, 684	1	0 0	0	59
. 00				0 0	0	

Heal th	Financial Systems	U HEALTH FRANKF	ORT HOSPITAL			In Lie	eu of Form CMS	-25	52-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1316		riod: om 01/01/2018 12/31/2018		epa	red:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund		<u>piii</u>
1 00	Fund half and at hand and an of manifold	1.00	2.00	3.00		4.00	5.00	-	1 00
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 12.00\\ 10.0$	Fund balances at beginning of period 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) Deductions (debit adjustments) (specify)	1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-6, 857, 001 -4, 996, 684 -11, 853, 685 -11, 853, 684 -11, 853, 684		0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0			1.00 2.00 3.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00
18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		-11, 853, 684			0 0			18.00 19.00
		Endowment Fund	PI 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	7.00 0 0 0 0 0 0	0.00	0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	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

STATEM	Financial Systems IU HEALTH FRANKFO	RT HOSPITAL Provider CO	N. 15 1214	Peri od:	eu of Form CMS- Worksheet G-2	
STATE				From 01/01/201 To 12/31/201	8 Parts I & II 8 Date/Time Pre 5/28/2019 6:1	epared:
	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, 251, 3	241	2, 251, 341	1.00
2.00	SUBPROVIDER - IPF		2,201,0	941	2, 231, 341	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		259, 0	28	259, 028	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 510, 3	69	2, 510, 369	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 INTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines		0	0	16.00
17 00	11-15)	、 、	2 510 2		2 510 2/0	17 00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 16 Ancillary services)	2, 510, 3 2, 738, 3		2, 510, 369 7 23, 488, 954	
18.00	Outpatient services		2, 738, 3			
20.00	RURAL HEALTH CLINIC		243, 1		0 19, 020, 933	
20.00	FEDERALLY QUALIFIED HEALTH CENTER					
22.00	HOME HEALTH AGENCY			-	0 0	
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	OTHER (SPECIFY)			0	o o	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	5, 491, 8	40, 336, 44	1 45, 828, 256	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES				1	
29.00	Operating expenses (per Wkst. A, column 3, line 200)			21, 740, 72	8	29.00
30.00	ADD (SPECI FY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00 34.00				0		33.00 34.00
34.00 35.00				0		34.00
36.00	Total additions (sum of lines 30-35)			-	0	36.00
37.00	DEDUCT (SPECIFY)			0		37.00
37.00				0		37.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			-	o	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4	2)(transfer		21, 740, 72	8	43.00
	to Wkst. G-3, line 4)					1

	Financial Systems IU HEALTH FRANKFO			u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1316	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	bared [.]
			10 12/01/2010	5/28/2019 6:1	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			45, 828, 256	1.00
2.00	Less contractual allowances and discounts on patients' accoun	ts		29, 120, 530	2.00
3.00	Net patient revenues (line 1 minus line 2)			16, 707, 726	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		21, 740, 728	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-5, 033, 002	5.00
	OTHER INCOME		1		
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			36, 318	24.00
25.00	Total other income (sum of lines 6-24)			36, 318	25.00
26.00	Total (line 5 plus line 25)			-4, 996, 684	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29 00	Net income (or loss) for the period (line 26 minus line 28)			-4, 996, 684	29 00