payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050

EXPLIES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1311 Period: From 01/01/2018 To 12/31/2018 Vorksheet S Parts I-III Date/Time Prepared: 5/29/2019 12: 43 pm

			5/29/2	2019 12: 43 pm
PART I - COST	REPORT STATUS	·		
Provi der	1. [X] Electronically filed cost report		Date: 5/29/2019	Time: 12:43 pm
use only	2. [] Manually submitted cost report			
	3. [0] If this is an amended report enter the 4. [F] Medicare Utilization. Enter "F" for ful	number of times the provider I or "L" for low.	r resubmitted this cost rep	ort
Contractor use only	5. [1] Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Recoived: (3) Settled with Audit 9. [N] Final Report (4) Reopened (5) Amended	1	O.NPR Date: 1.Contractor's Vendor Code: 2.[O]If line 5, column 1 number of times reop	is 4: Enter

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) for the cost reporting period beginning 01/01/2018 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) CARA BREIDSTER
Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
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	139, 710	949, 369	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	-7, 493	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	132, 217	949, 369	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.

	1.00		00		. 00		From 01/01 To 12/31	/2018	Part I Date/Ti 5/29/20		
	1.00		00		5. 00			4. 00			
1.00	Hospital and Hospital Health Care Co Street: 1000 SOUTH MAIN STREET City: TIPTON	PO Box: State: I	N Zi r	Code:	46072	Coun	ty: TIPTON				1. 00 2. 00
		Component Na		CN nber	CBSA Number	Provi dei Type		T,	nt Syst 0, or	N)	
		1.00	2	00	2 00	4.00	F 00	V 00		XIX	-
	Hospital and Hospital-Based Componen	1.00		00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
	Hospi tal	IU HEALTH TIPTON		311	99915	1	11/12/2005	5 N	0	0	3.00
		HOSPI TAL									
1.00	Subprovider - IPF										4.00
	Subprovider - IRF Subprovider - (Other)										5.0
	Swing Beds - SNF	IU HEALTH TIPTON	157	2311	29020		11/12/2005	5 N	0	l N	6. 00 7. 00
. 00	Swifig beds - Swi	HOSPI TAL	132	.511	27020		117 127 2003	"		"	/. 0
. 00	Swing Beds - NF			1							8.0
	Hospital -Based SNF										9. 0
	Hospi tal -Based NF			-							10.0
	Hospi tal -Based OLTC Hospi tal -Based HHA			-							11. 0
	Separately Certified ASC			-							13. 0
	Hospi tal -Based Hospi ce										14. 0
	Hospital-Based Health Clinic - RHC										15. 0
	Hospital-Based Health Clinic - FQHC										16. 0
	Hospital-Based (CMHC) I										17. 0
	Renal Dialysis										18. 0
9.00	0ther						From		To	\·	19. 0
							1. 00		2. (1
	Cost Reporting Period (mm/dd/yyyy)						01/01/2	2018	12/31	/2018	20.0
1. 00	Type of Control (see instructions)						2				21. 0
						1. 00	2. 00	,	3. (20	1
	Inpatient PPS Information					1.00	2.00	,	3. (00	
22. 01	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 § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un	stment, in accord r yes or "N" for 412.106(c)(2)(Pic r yes or "N" for compensated care	dance with 4 no. Is this kle amendme no. payments fo	2 CFR nt r this		N N	N N				22. 00 22. 0°
	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 Is this a newly merged hospital that payments to be determined at cost re	riod occurring pr " for no for the er October 1. (se requires final u	rior to Octo portion of ee instructi uncompensate	ber 1. the co ons) d care	st	N	N				22. 0
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octobor "N" for no, for the portion of th October 1.	" for no, for the er 1. Enter in co e cost reporting	e portion of Dlumn 2, "Y" period on o	the for yer afte	es	N					22.6
	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 delineating olumn 1, "Y" for g period prior to no for the portice er October 1. (see 100 but not more 2.105)? Enter in	ng statistic yes or "N" o October 1. on of the co ee instructi than 499 be column 3, "	al are for no Enter st ons) ds (as Y" for		N	N		N	ı	22.0
	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 da ne days in t ne prior cos	ys, or his co t	st		3 N				23. 0
			In-State Medicaid paid days	In-Sta Medica eligib unpai days 2.00	nid S ole Me d pai			Medicai HMO day 5.00	rs Med	ther di cai d days 5.00	
4. 00	If this provider is an IPPS hospital	, enter the	1.00	2.00	0	3.00	4.00	3.00	0		24.0
	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					9			C	24.0

	Financial Systems IU HEAL AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TH TIPTON F	IOSPITAL Provider CC	N: 15_1211	Peri od:	Ιn			m CMS-2 eet S-2	
	AL AND HOSTITAL HEALTH CARE COMMERCA TOURISTICATION DA				From 01 To 12	/31/20	018 I 018 I	Part I Date/Ti 5/29/20	ime Pre 019 12:	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	HM(di cai O day	s Med	ther di cai d days	
5 00	If this provider is an IRF, enter the in-state	1.00	2. 00	3. 00	4. 00	0 ;	5. 00	0	5. 00	25. 0
J. 00	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.			J	Hobon				Coogn	25. 0
						1. 00	1 3 L	2.	Geogr 00	1
7. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassification is a sole community hospital (SCH), enter the	r rural. age) status r "2" for r ication in	at the end ural. If ap column 2.	l of the cos pplicable,	t		2 2			26. C 27. C
3.00	effect in the cost reporting period.	e number of	perrous 30	ai Status III			- U			35.0
						nni ng 1. 00	j:	Endi 2.		
5. 00	Enter applicable beginning and ending dates of SCH s	tatus. Subs	cript line	36 for numb		1.00		۷.	00	36.
7 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		r of norice	le MDU etatu			0			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t	he MDH tran	sitional pa	yment in	3					37.
. 00	accordance with FY 2016 OPPS final rule? Enter "Y" finstructions) If line 37 is 1, enter the beginning and ending date	s of MDH st	atus. If li	ne 37 is						38.
	greater than 1, subscript this line for the number o enter subsequent dates.	f periods i	n excess of	one and		Y/N		Y/	'N	
	<u> </u>					1. 00		2.		<u> </u>
9. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? Ent	er in colum its in	n	N		N	ı	39.
0. 00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	"Y" for y			N		N		40.
							V 1. 00	2. 00	3. 00	
	Prospective Payment System (PPS)-Capital									
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc	·				ce	N N	N N	N N	45.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I	I and Wkst	. L-1, Pt.	I through	۱				
	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals						N N	N N	N N	47. 48.
. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	? Enter "Y	" for yes	5	N			56.
. 00	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is ""N", complete Wkst. D, Parts III & IV and D-2, Pt. I	r yes or "N th of this Y", complet	' for no in cost report e Worksheet	column 1. ing period?	If column Enter '	'Y"				57.
	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15–1, chapter 21, §2148? If yes,	bursement f complete W	or physicia kst. D-5.		s as		N			58.
. 00	Are costs claimed on line 100 of Worksheet A? If ye	s, complete	wkst. U-2,	Pt. I. NAHE 413.8 Y/N		sheet ne #	C	Qualifi	hrough cation on Code	59.
				1. 00		2. 00		3.	00	

Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1311 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:43 pm Y/N IME Direct GME IME Direct GME 2.00 5.00 1.00 3. 00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 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) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 3.00 1.00 2.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) N 63.00

		Unwei ghted		Ratio (col. 1/	
		FTEs	FTEs in	(col. 1 + col.	
		Nonprovi der	Hospi tal	2))	
		Si te			
ı		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsT	his base year	is your cost r	eporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
(64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0. 00	0. 00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1311 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:43 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems IU HEALTH TIPTON HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider	r CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018		2 epared:
			1.00	-
Long Term Care Hospital PPS				
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for standard standa		g period? Enter	N N	80. 00 81. 00
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? E. 86.00 Did this facility establish a new Other subprovider (excluded unit) unit			N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classification (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	ed under section		N	87. 00
1000(d)(1)(b)(v1): Litter 1 101 yes of N 101 flo.		V	XI X	
Title Ward VIV Comitee		1. 00	2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services	? Enter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column.				
91.00 Is this hospital reimbursed for title V and/or XIX through the cost refull or in part? Enter "Y" for yes or "N" for no in the applicable col		N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certificinstructions) Enter "Y" for yes or "N" for no in the applicable column	cation)? (see		N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes of title V "Y" for yes or "N" for no in the applicable column.	and XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" fo	r no in the	N	N	94. 00
95.00 f line 94 is "Y", enter the reduction percentage in the applicable co 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" fo		0. 00 N	0. 00 N	95. 00 96. 00
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable co 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and stepdown adjustments on What B, Pt. I, col. 25? Enter "Y" for yes or	residents post	0. 00 N	0. 00 Y	97. 00 98. 00
column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and			Y	98. 01
title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for the calculation of the costs of the Vivia No. 1, Pt. IV. IV. IV. IV. IV. IV. IV. IV. IV. IV		N	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 critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for			N	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 CAH reimbursed outpatient services cost? Enter "Y" for yes or "N" for no in column 1		N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for the property of the XIX.			Y	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for tit column 2 for title XIX.		N	Y	98. 06
Rural Providers				105.00
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive	method of paymen	t Y N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 f this facility qualifies as a CAH, is it eligible for cost reimbursed training programs? Enter "Y" for yes or "N" for no in column 1. (see in yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the reimbursed. If yes complete Wkst. D-2, Pt. II.	nstructions) If	N t		107. 00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee some CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			Dani	108. 00
Physical 1.00	0ccupationa 2.00	Speech 3.00	Respiratory 4.00	+
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	Y	109. 00

reimbursed. If yes complete Wkst. D-2, Pt. II.					
108.00 Is this a rural hospital qualifying for an exception to the		108. 00			
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Respi ratory				
	4. 00				
109.00 If this hospital qualifies as a CAH or a cost provider, are	Υ	N	N	Υ	109.00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita	l Demonstratio	on project (§41	OA	N	110.00
Demonstration) for the current cost reporting period? Enter "	Y" for yes or	"N" for no. If	yes,		
complete Worksheet E, Part A, Lines 200 through 218, and Wor	ksheet E-2, li	nes 200 through	h 215, as		
appl i cabl e.		· ·			

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-1311	Perion From To	od: 01/01/2018 12/31/2018		repared:
			1. 00	2.00	\dashv
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this community for yes or "N" for no in column 1. If the response to confine integration prong of the FCHIP demo in which this CAH is participated and that apply: "A" for Ambulance services; "B" for additional for tele-health services.	st reporting period? Ent lumn 1 is Y, enter the ticipating in column 2.		N	2.00	111. 00
			1. 0	00 2.00 3.0	0
Miscellaneous Cost Reporting Information 15.00 s 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 provider: Pub. 15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" in the content of th	If column 2 is "E", ent t for long term care (ir s) based on the definiti	er in c ncludes	ol umn		115. 00
17.00 s this facility legally-required to carry malpractice insurance.		or "N"			117. 00
18.00 is the mal practice insurance a claims-made or occurrence policiaim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the poli	cy is	1		118. 00
	Premi un	ns	Losses	Insurance	
	1.00		2. 00	3.00	
18.01 List amounts of malpractice premiums and paid losses:	58	3, 039		0	0 118. 0
			1. 00	2.00	\dashv
18.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting schedular and amounts contained therein. 19.00 DO NOT USE THIS LINE	ule listing cost centers		N		118. 02
20.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes oalifies for the Outpation	or	N	N	120. 00
21.00 Did this facility incur and report costs for high cost implainments? Enter "Y" for yes or "N" for no.	ntable devices charged 1	:0	Υ		121. 00
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.			Y	5.00	122. 00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	r yes and "N" for no. If	-	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 of this is a Medicare certified kidney transplant center, en		ite			126. 0
in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, enting in column 1 and termination date, if applicable, in column 2	er the certification dat	ie			127. 00
28.00 If this is a Medicare certified liver transplant center, ent- in column 1 and termination date, if applicable, in column 2	er the certification dat	:e			128. 00
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		ein			129. 00
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column					130. 00
31.00 If this is a Medicare certified intestinal transplant center date in column 1 and termination date, if applicable, in column 1.		on			131. 00
32.00 If this is a Medicare certified islet transplant center, entin column 1 and termination date, if applicable, in column 2					132. 00
33.00 f this is a Medicare certified other transplant center, enting in column 1 and termination date, if applicable, in column 2					133.00
34.00 f this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.	e upu number in column 1				134. 00
All Providers 40.00 Are there any related organization or home office costs as do	-£1		Y	15H059	140. 00

					Fr To		/01/2018 2/31/2018		
1.00		2. 00					3.00		
If this facility is part of a chain home office and enter the home office.					ne nam	e and	address	of the	
141. 00 Name: I NDI ANA UNI VERSI TY HEALTH	Contractor's Nar		tractor number		actor'	s Niin	nber: 0810)1	141. 00
142. 00 Street: 340 WEST 10TH STREET	PO Box:	iic. wi 5		COITE	actor	3 Null	iber. oure	, 1	142. 00
143. OOCi ty: INDI ANAPOLI S	State:	ΙN		Zip C	ode:		4620)2	143. 00
	<u>'</u>								
								1.00	
144.00 Are provider based physicians' cos	its included in Works	neet A?						Y	144. 00
							1. 00	2. 00	
145.00 of costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inceperiod? Enter "Y" for yes or "N" openiod? Enter "Y" for yes or "N" for no inception of the services of the serv	for yes or "N" for melude Medicare utilization for no in column 2. The column 1 (See CMS In the properties of the column 1.	no in co ation fo revious!	olumn 1. If one of this cost y filed cost	column 1 i reporting report?	3		N		145. 00
lyes, circi the approval date (iiiii)	107 7 7 7 7 111 001 01111 2.								
								1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for yes	or "N" for	no.				N	147. 00
148.00 Was there a change in the order of								N	148. 00
149.00 Was there a change to the simplifi	ed cost finding metho	od? Ente	er "Y" for ye	es or "N"	for no	o		N	149. 00
			Part A	Part	В	Ti	tle V	Title XIX	
			1.00	2.00			3. 00	4. 00	
Does this facility contain a provi									
or charges? Enter "Y" for yes or '	N" for no for each c	omponen ⁻			B. (S	ee 42			155 00
155.00 Hospital 156.00 Subprovider - IPF			N N	l N I N			N N	N N	155. 00 156. 00
157. 00 Subprovider - TRF			N	N N			N	N N	157. 00
158. OOSUBPROVI DER			IV	1			IN	IN IN	158. 00
159. 00 SNF			N	l N			N	N	159. 00
160.00 HOME HEALTH AGENCY			N	l N			N	N	160.00
161.00 CMHC				N			N	N	161.00
		<u> </u>						1.00	
Multicampus								1. 00	
165.00 s this hospital part of a Multica	imnus hosnital that h	as one o	or more campu	ises in di	fferer	nt CR	SΔs?	N	165. 00
Enter "Y" for yes or "N" for no.	impus nospi tai that ne	as one c	illor e campe	1303 III UI	110101	TE OD.	JAS:	14	103.00
,	Name		County	State	Zip (Code	CBSA	FTE/Campus	
	0		1. 00	2. 00	3. (4. 00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0 166. 00
								1.00	
Health Information Technology (HI) incentive in the A	meri can	Recovery and	d Reinvest	tment	Δct		1.00	
167.00 Is this provider a meaningful user						ACT		Υ	167. 00
168.00 If this provider is a CAH (line 10						enter	the		0168.00
reasonable cost incurred for the H	IIT assets (see instr	uctions)	·		•				
168.01 If this provider is a CAH and is r						hards	shi p		168. 01
exception under §413.70(a)(6)(ii)?									
169.00 If this provider is a meaningful utransition factor. (see instruction) and is	not a CAH ((line 105	is "N'	"), er	nter the	0.0	0169.00
The ansate of the action of th						Bec	ıi nni ng	Endi ng	
							1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	eginning date and end	ding dat	e for the re	eporti ng		01/	01/2018	03/31/2018	170. 00
							1. 00	2.00	
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans r "Y" for yes and "N" for no in column 1876 Medicare days in column 2. (s	eported on Wkst. S-3, umn 1. If column 1 is	, Pt. I,	line 2, col	. 6? Ente			Υ	1	2 171. 00

	n Financial Systems		CN: 15-1311	Period:	worksheet S-2	
	7.2 7.10 7.00 7.71.2 7.2 7.2 7.2 7.2 7.2 7.2 7.2 7.2 7.2 7			From 01/01/2018 To 12/31/2018	Part II	epared
				Y/N	Date	1
	General Instruction: Enter Y for all YES responses. Enter N	for all NO re	esnonses Ente	1.00	2.00 the	
	mm/dd/yyyy format.			arr dates in		
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in co		instructions)			
			1.00	2.00	V/I 3. 00	
00	Has the provider terminated participation in the Medicare P	rogram? If	N N	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in column	n 3, "V" for				
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including	g management	Y			3.
	contracts, with individuals or entities (e.g., chain home o	ffices, drug				
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and othe					
	relationships? (see instructions)			_		
			1. 00	7ype 2. 00	3.00	
	Financial Data and Reports		1.00	2.00	J. 00	
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A	02/28/2019	4. (
	Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	Trable III				
00	Are the cost report total expenses and total revenues diffe		N			5.
	those on the filed financial statements? If yes, submit rec	oncillation.		Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If you is th	no providor i	s N	I	
00	the legal operator of the program?	ii yes, is ti	ie provider is	S IN		6.
. 00	Are costs claimed for Allied Health Programs? If "Y" see in:			N		7. (
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	d during the	N		8. (
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. (
0 00	program in the current cost report? If yes, see instruction		Ll	N.		10.
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in t	the current	N		10. (
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
	Bad Debts				T	1.0
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. (
0. 00	period? If yes, submit copy.	orrey enange c	adi ing tin 5 ct	ost reporting		10.
4. 00	J	nts waived? If	fyes, see ins	structions.	N	14.
5. 00	Bed Complement Did total beds available change from the prior cost reportion	na period? If	ves, see inst	tructions.	N	15.
		Par	rt A	Par	t B	
		Y/N 1.00	2.00	Y/N 3. 00	Date 4. 00	
	PS&R Data	1.00	2.00	3.00	4.00	
6. 00		N		N		16. (
	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)					
	Was the cost report prepared using the PS&R Report for	Υ	04/03/2019	Υ	04/03/2019	17.
7. 00	totals and the provider's records for allocation? If					
7. 00						
7. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		1	N		18.
	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N				
	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	N				
	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N				
	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 cost report? If yes, see instructions.	N N		N		19.

Report data For Other? Describe the other adjustments: Y/N Date	Heal th	Financial Systems IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CM	S-2552-10
1.00 3.00 1.00 3.00 2.00 2.00 1.00 3.00 2.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1311	From 01/01/2018	Part II Date/Time P	repared:
Provided to the provider of			Descr	i pti on	Y/N	Y/N	
Report data for Other? Describe the other adjustments:				0	1. 00	3.00	
21.00 Was the cost report prepared only using the provider's N N 2.00 1.00 2.00 3.00 4.00 records? If yee, see instructions. COMPLETED BY COST RETIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Copital Related Cost 2.00 Have assets been relified for Medicare purposes? If yes, see instructions N 22.00 1.00 No. 20.00 1.00 No. 20.00 No. 20.	20. 00				N	N	20. 00
21.00 Was the cost report prepared only using the provider's N N 21.00			Y/N	Date	Y/N	Date	
records? If yes, see instructions. 1.00			1.00	2.00	3. 00	4. 00	
Completed By COST RELIBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related CoSt Capital Related CoSt Capital Related CoSt 1.00 Have assets been relifed for Medicare purposes? If yes, see instructions. 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or memoments to existing leases entered into during this cost reporting period? If yes, see instructions. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see IN 25.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see IN 26.00 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see Instructions. 28.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 20.00 Has existed a depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 20.01 Has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 20.01 Has deep replaced prior to its scheduled maturity with new debt? If yes, see IN 31.00 20.01 Has existed the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 21.02 Have changes or new agreements occurred in patient care services furnished through contractual IN 32.00 23.00 Have changes or new agreements occurred in patient care services furnished through contractual IN 32.00 24.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? In yes, see Instructions. 25.00 If file 34 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, see Instructions. 26.00 Were home Office Costs 27.00 If file 34	21. 00		N		N		21. 00
Completed By COST RELIBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related CoSt Capital Related CoSt Capital Related CoSt 1.00 Have assets been relifed for Medicare purposes? If yes, see instructions. 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or memoments to existing leases entered into during this cost reporting period? If yes, see instructions. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see IN 25.00 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see IN 26.00 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see Instructions. 28.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 20.00 Has existed a depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 20.01 Has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 20.01 Has deep replaced prior to its scheduled maturity with new debt? If yes, see IN 31.00 20.01 Has existed the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) IN 29.00 21.02 Have changes or new agreements occurred in patient care services furnished through contractual IN 32.00 23.00 Have changes or new agreements occurred in patient care services furnished through contractual IN 32.00 24.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? In yes, see Instructions. 25.00 If file 34 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, see Instructions. 26.00 Were home Office Costs 27.00 If file 34						1 00	
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reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions. 25.00 New there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 New see assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit N 27.00 Nest the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Nest Expense. 28.00 New sets the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Policy provider have a funded depreciation account? If yes, see instructions. 30.00 Nest existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Instructions. 31.00 Has debt been recalled before scheduled maturity with new debt? If yes, see N 31.00 Nest Sebt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Nest Sebt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Nest Sebt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Nest Sebt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Nest Sebt Sebt Sebt Sebt Sebt Sebt Sebt Seb	22. 00					N	22. 00
24.00 Were new Teases and/or amendments to existing Leases entered into during this cost reporting period? N 24.00 If Yeys, see Instructions. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Nere assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, submit N 27.00 (copy. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 (copy. 28.00 Were new Loans, mortgage agreements or Letters of credit entered into during the cost reporting N 28.00 Period? If yes, see Instructions N 29.00 Did the provider have a funded depreciation account? If yes, see Instructions N 29.00 Instructions Instructions N 29.00 Ins	23. 00		due to apprais	sals made dur	ing the cost	N	23. 00
25.00 Navé there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00	24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	porting period?	N	24. 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. 10 Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 treated as a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Has debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Historius of Sec. 2135.2 applied pertaining to competitive bidding? If no, see Instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. Provider-Based Physicians 4.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 His yes, see instructions. 11 In a 3 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 His His 34 is yes, see instructions. 12 In a 3 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 His His 36 is yes, was a home office cost statement been prepared by the home office? Y 36.00 His 36.00 His 10 as is yes, see instructions. 13 In a 3 is yes, see inst	25. 00	Have there been new capitalized leases entered into during	the cost repor	rting period?	If yes, see	N	25. 00
27. 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27. 00 copy. Interest Expense	26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see	N	26. 00
Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 28.00 29.00 10 the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 10 the provider have a funded depreciation account? If yes, see instructions N 29.00 10 the provider have a funded depreciation account? If yes, see instructions N 29.00 10 the provider have a funded depreciation account? If yes, see instructions N 29.00 10 the provider have a funded depreciation account? If yes, see instructions N 29.00 10 the provider have a funded depreciation account? If yes, see N 30.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account? If yes, see instructions. N 20.00 10 the provider have a funded depreciation account and/or have a funded depreciation account? If yes, see instructions. N 20.00 20	27. 00	Has the provider's capitalization policy changed during the	e cost reportin	ng period? If	yes, submit	N	27. 00
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29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions and a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00	28. 00		ntered into dum	ing the cost	reporti ng	N	28. 00
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see	29. 00	Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	N	29. 00
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 14.00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based No. 35.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 1.00 2.00 1.00 1 If line 36 is yes, has a home office cost statement been prepared by the home office? 1.00 2.00 1.00 1 If line 36 is yes, and the provider render services to other chain components? If yes, see instructions. 1.00 2.00 Cost Report Preparer Contact Information 1.00 August Plane 36 Information 1.00 August Plane 37 Information 1.00 August Plane 37 Information 1.00 August Plane 37 Inform	30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30. 00
Bave changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N Date	31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	, see	N	31. 00
arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If no, see instructions. Provider-Based Physicians 33.00 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions. N	32. 00		rvi ces furni she	ed through co	ntractual	N	32. 00
Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00		arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	-			33. 00
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00		Provi der-Based Physi ci ans				.,	
physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00	34.00	If yes, see instructions.	9	·	. ,	Y	
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 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. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	35. 00			nts with the	provi der-based	N	35. 00
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 41.00 Cost Report Preparer Contact Information 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 INDIANA UNIVERSITY HEALTH Preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00							
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 1		Homa Offica Costs			1.00	2.00	
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report Preparer. 41.00 Enter the telephone number and email address of the cost 1.00 RHONDA RHONDA RHONDA RUTTER®I UHEALTH. ORG 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER®I UHEALTH. ORG	36 00				Y		36.00
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 1.00 2.00 Cost Report Preparer Contact Information 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 INDIANA UNIVERSITY HEALTH Preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00		If line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37. 00
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 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 INDIANA UNIVERSITY HEALTH 42.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	38. 00	If line 36 is yes , was the fiscal year end of the home off			N		38. 00
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 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. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 43.00	39. 00	If line 36 is yes, did the provider render services to othe			, Y		39. 00
Cost Report Preparer Contact Information 41.00 Enter the first name, I ast 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 INDI ANA UNI VERSITY HEALTH preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@I UHEALTH. ORG 43.00	40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
Cost Report Preparer Contact Information 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. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 43.00		I NSTRUCTI ONS.					
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. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 43.00			1.	00	2.	00	
respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	41. 00	Enter the first name, last name and the title/position	RHONDA		UTTER		41. 00
preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	42, 00	respecti vel y.	INDIANA UNIVER			42. 00	
		preparer.			DUTTEDALIBEALT	H ODC	
	43.00		317. 902. 1093		KUIIEK@IUHEALII	п. ОКО	43.00

Heal th	Financial Systems IU HEALTH	TI PTOI	N HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der	CCN: 15-		Peri od: From 01/01/2018	Worksheet S-2 Part II	!
							Date/Time Pre 5/29/2019 12:	pared: 43 pm
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	DI	RECTOR OF	GOVERNMEN	NT			41. 00
	held by the cost report preparer in columns 1, 2, and 3,	, PR	OGRAMS					
	respecti vel y.							
42.00	Enter the employer/company name of the cost report							42. 00
	preparer.							
43.00	Enter the telephone number and email address of the cos	t						43.00
	report preparer in columns 1 and 2, respectively.							

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5//9/2019	12:43 pm

							5/29/2019 12:	43 pm
	·						I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00		25				1. 00
	8 exclude Swing Bed, Observation Bed and				,			
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			25	9, 12	58, 656. 00	-	
7.00	beds) (see instructions)			20	/, 12	00, 000. 00	Ĭ	7.00
8. 00	INTENSIVE CARE UNIT							8.00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14. 00	4			25	9, 12	58, 656. 00	0	
15. 00	CAH visits			25	7, 12	36, 636. 00	0	
16. 00	SUBPROVIDER - IPF						0	16.00
17. 00	SUBPROVIDER - IPF							17.00
17.00	4							18.00
	SUBPROVI DER							
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	20.00						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	, ,			25				27. 00
28. 00	Observation Bed Days						0	
29. 00								29. 00
30. 00	Employee discount days (see instruction)							30.00
31. 00	, , ,							31. 00
32. 00	Labor & delivery days (see instructions)			0		0		32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	1							33. 00
33. 01	LTCH site neutral days and discharges							33. 01

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1311

				'	0 12/31/2010	5/29/2019 12:	
		I/P Days	6 / O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7.00	8.00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	1, 441	0	2, 444			1. 00
2.00	HMO and other (see instructions)	361	157				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	375	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 816	0	2, 862			7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	1, 816	0		0.00	176. 55	ł
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00 23. 00	HOME HEALTH AGENCY						22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)			0			24. 00
25. 00	CMHC - CMHC			١			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)	ď	0		0.00	l	
28. 00	Observation Bed Days		1	619		170.33	28. 00
29. 00	Ambul ance Tri ps	0		017			29. 00
30. 00	Employee discount days (see instruction)	Ĭ		1			30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)	0	0				32. 00
32. 01	Total ancillary labor & delivery room		O				32. 01
52.01	outpatient days (see instructions)			I			52.01
33. 00	LTCH non-covered days	l					33. 00
	LTCH site neutral days and discharges	o					33. 01
	,	. '		•	'	•	

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Health Financial Systems IU HEAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1311

					To	12/31/2018	Date/Time Pre 5/29/2019 12:	
		Full Time Equivalents			Di sch	arges	0,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10 p
	Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
	·	Workers					Pati ents	
		11.00	12.00		13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			0	397	0	702	1. 00
2.00	HMO and other (see instructions)				88	34		2. 00
3.00	HMO I PF Subprovi der					0		3. 00
4.00	HMO I RF Subprovi der					O		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							5.00
6.00	Hospital Adults & Peds. Swing Bed NF			-				6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)							7. 00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY							13. 00
14.00	Total (see instructions)	0. 00		0	397	0	702	14. 00
15.00	CAH visits							15. 00
16.00	SUBPROVI DER - I PF							16.00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)							24. 10 25. 00
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00						26. 00
27. 00	Total (sum of lines 14-26)	0.00						27. 00
28. 00	Observation Bed Days	0.00						28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)							32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
	LTCH non-covered days				0			33. 00
33. 01	LTCH site neutral days and discharges				0			33. 01

IOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	vider CCN: 15-131		eri od:	Worksheet S-10	0
				om 01/01/2018		
			To	12/31/2018	Date/Time Pre 5/29/2019 12:	
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 202 co	lumn 8	3)	0. 315773	1.
00	Medicaid (see instructions for each line) Net revenue from Medicaid				706, 496	2.
00	Did you receive DSH or supplemental payments from Medicaid?				N	3.
00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l?		4.		
00	If line 4 is no, then enter DSH and/or supplemental payments from	Medi cai d			0	
00	Medicaid charges Medicaid cost (line 1 times line 6)		10, 016, 598 3, 162, 971			
00	Difference between net revenue and costs for Medicaid program (lir	2 and 5 if	2, 456, 475			
	< zero then enter zero)				_,,	
	Children's Health Insurance Program (CHIP) (see instructions for e	each line)				
.00	Net revenue from stand-allone CHIP				0	
). 00 I. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. 11.
2. 00	,	ne 11 minus line	9; if	< zero then	Ö	
	enter zero)					
	Other state or local government indigent care program (see instruc				0	1 12
3. 00 1. 00	Net revenue from state or local indigent care program (Not include Charges for patients covered under state or local indigent care pr			lines 6 or	0	13. 14.
r. 00	10)	ogram (Not There	ided 11	1 111163 0 01		14.
5. 00	State or local indigent care program cost (line 1 times line 14)		0	15.		
5. 00	15 minus line	0	16.			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/Local i	ndi aer	it care program	ns (see	
	instructions for each line)	ina State/Todai T	nai gei	it care program	(300	
7. 00					-	17.
8.00		•		oum of Lines	0	18.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local ir 8, 12 and 16)	idigent care prog	ii ailis (Sull of Titles	2, 456, 475	19.
		Uni nsu	red	Insured	Total (col. 1	
		pati er		pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)	1.00)	2. 00	3. 00	
0. 00	Charity care charges and uninsured discounts for the entire facili	ty 1, 57	9, 483	72, 846	1, 652, 329	20.
	(see instructions)	. (0 750	72.04/	F71 (04	21
1. 00	Cost of patients approved for charity care and uninsured discounts instructions)	s (see	8, 758	72, 846	571, 604	21.
2. 00		fas	7, 574	7, 220	14, 794	22.
	charity care					
3. 00	Cost of charity care (line 21 minus line 22)	49	1, 184	65, 626	556, 810	23.
					1. 00	
1. 00	Does the amount on line 20 column 2, include charges for patient of	days beyond a Len	gth of	stay limit	N	24.
5. 00	imposed on patients covered by Medicaid or other indigent care pro If line 24 is yes, enter the charges for patient days beyond the i		aram's	lenath of	0	25.
	stay limit			-		
5. 00		,			2, 003, 957	
7. 00 7. 01	Medicare reimbursable bad debts for the entire hospital complex (s Medicare allowable bad debts for the entire hospital complex (see				365, 103 561, 697	
	· · · · · · · · · · · · · · · · · · ·	instructions)			1, 442, 260	•
3. 00	and the second of the second o					•
8. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expens	se (see instructi	ons)		652, 021	27.
9. 00 0. 00	·	•	ons)		1, 208, 831 3, 665, 306	30.

Health Financial Systems	IU HEALTH TIPTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der Co	CN: 15-1311	Peri od:	Worksheet A	
				From 01/01/2018	Doto/Time Dro	narad.
				To 12/31/2018	Date/Time Pre 5/29/2019 12:	
Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cati	Reclassi fi ed	lo piii
Social Social Person	00.000	0 (110)	+ 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 O0100 CAP REL COSTS-BLDG & FLXT		0		0 784, 821	784, 821	1. 00
1.01 O0101 CAP REL COSTS-BLDG & FIXT - INTERES		0		0 742, 787	742, 787	1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		0		0 1, 156, 572	1, 156, 572	2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	88, 952	38, 330			2, 005, 682	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	863, 995	8, 068, 784			7, 211, 566	5. 00
7. 00 00700 OPERATION OF PLANT	766, 614	3, 480, 449			4, 150, 754	7. 00
7. 01 00701 OPERATION OF PLANT - OFFSITE	0	0		0 62, 364	62, 364	7. 01
8. 00 00800 LAUNDRY & LI NEN SERVI CE	51, 210	85, 114	136, 32		111, 418	8. 00
9. 00 00900 HOUSEKEEPI NG	332, 863	217, 220			399, 250	9. 00
10. 00 01000 DI ETARY	463, 926	421, 364	1		244, 464	10.00
11. 00 01100 CAFETERI A	400 104	147 120		0 515, 222	515, 222	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	488, 104	147, 128			660, 291	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	594, 628	11, 144 2, 260, 050			882, 661	14. 00 15. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	394, 020	2, 200, 030	2, 634, 67	8 -1, 695, 595	1, 159, 083	15.00
30. 00 03000 ADULTS & PEDIATRICS	1, 955, 998	1, 273, 312	3, 229, 31	0 -553, 555	2, 675, 755	30. 00
ANCI LLARY SERVI CE COST CENTERS	1, 733, 770	1, 273, 312	3, 227, 31	0 -333, 333	2,073,733	30.00
50. 00 05000 OPERATING ROOM	1, 046, 730	3, 148, 816	4, 195, 54	6 -2, 601, 704	1, 593, 842	50.00
53. 00 05300 ANESTHESI OLOGY	179, 226	344, 173			491, 111	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 078, 157	1, 124, 461	2, 202, 61		1, 292, 522	54.00
60. 00 06000 LABORATORY	0	1, 245, 886			1, 245, 886	
65. 00 06500 RESPIRATORY THERAPY	467, 758	182, 356			534, 583	65. 00
66. 00 06600 PHYSI CAL THERAPY	656, 335	392, 945	1, 049, 28		678, 828	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	166, 082	41, 925			225, 373	67. 00
69. 00 06900 ELECTROCARDI OLOGY	425, 354	158, 252			497, 741	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 292, 896	292, 896	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 506, 110	1, 506, 110	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 1, 706, 703	1, 706, 703	73. 00
73. 01 03480 ONCOLOGY	193, 937	80, 286	274, 22	3 -44, 932	229, 291	73. 01
76. 00 03160 CARDI OPULMONARY	0	0		0 0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	105, 367	55, 971	161, 33	8 -27, 753	133, 585	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	1, 130, 125	1, 792, 587	2, 922, 71	2 -262, 496	2, 660, 216	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 055, 361	24, 570, 553	35, 625, 91	4 225, 463	35, 851, 377	118. 00
NONREI MBURSABLE COST CENTERS	T					l
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	146, 821	222, 362			167, 910	
192. 01 19201 OCCUPATI ONAL MEDI CI NE	36, 121	77, 708	113, 82	9 -24, 190	89, 639	
192. 02 19202 VACANT SPACE	11 220 202	04 070 400	24 100 02	0 0		192. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	11, 238, 303	24, 870, 623	36, 108, 92	이	36, 108, 926	J∠UU. UU

Peri od: Worksheet A From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 12:43 pm

					5/29/2	2019 12:43 pm
	Cost Center Description	Adjustments	Net Expenses			
		(See A-8)	For Allocation			
		6.00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	827, 009	1, 611, 830			1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	-90, 948	651, 839			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	170, 390	1, 326, 962			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	125, 064	2, 130, 746			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-994, 425	6, 217, 141			5. 00
7.00	00700 OPERATION OF PLANT	-247	4, 150, 507			7. 00
7.01	00701 OPERATION OF PLANT - OFFSITE	-47, 625	14, 739			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	O	111, 418			8. 00
9.00	00900 HOUSEKEEPI NG	-27, 381	371, 869			9. 00
10.00	01000 DI ETARY	O	244, 464			10.00
11. 00	01100 CAFETERI A	-142, 925	372, 297			11. 00
13.00	01300 NURSING ADMINISTRATION	-29, 571	630, 720			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	-434	882, 227			14. 00
15. 00	01500 PHARMACY	-409, 493	749, 590			15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	· · · · · ·	<u>'</u>		
30.00		-527, 079	2, 148, 676			30.00
	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u>'</u>		
50.00		-319, 084	1, 274, 758			50.00
53.00	05300 ANESTHESI OLOGY	-429, 472	61, 639			53. 00
54.00		-63, 800	1, 228, 722			54.00
60.00	06000 LABORATORY	ol	1, 245, 886			60.00
65. 00		-498	534, 085			65. 00
66. 00		-298	678, 530			66. 00
67. 00		o	225, 373			67. 00
69. 00	06900 ELECTROCARDI OLOGY	-58, 605	439, 136			69. 00
71. 00	l i	0	292, 896			71. 00
72. 00		0	1, 506, 110			72. 00
73. 00		0	1, 706, 703			73. 00
73. 01		0	229, 291			73. 01
76. 00	l i	o	0			76. 00
76. 97		0	133, 585			76. 97
	OUTPATIENT SERVICE COST CENTERS	-1	,			
91. 00		-957, 634	1, 702, 582			91. 00
92. 00			, . ,			92. 00
	SPECIAL PURPOSE COST CENTERS					
118. 0		-2, 977, 056	32, 874, 321			118. 00
	NONREI MBURSABLE COST CENTERS		. , , .	'		
192. 0	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	167, 910			192. 00
	1 19201 OCCUPATI ONAL MEDI CI NE	o	89, 639			192. 01
	2 19202 VACANT SPACE	l	0			192. 02
200.0	1 1	-2, 977, 056	33, 131, 870			200. 00
				'		

Heal th	Financial Systems		IU HEALTH TIF	PTON HOSPITAL		In Lie	u of Form CMS-	2552-10
	SIFICATIONS			Provi der CCN	N: 15-1311	Peri od:	Worksheet A-6	5
						From 01/01/2018 To 12/31/2018	Date/Time Pro	
		Language				<u> </u>	5/29/2019 12:	43 pm
	Cost Center	Increases Line #	Sal ary	Other				
	2. 00	3.00	4.00	5. 00				
	A - DEPRECIATION		_					
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	540, 364 1, 154, 951				1. 00 2. 00
3. 00	CAF REE COSTS-WVBEE EQUIP	0.00	0	1, 154, 951				3. 00
4.00		0.00	0	0				4. 00
5.00		0. 00	0	0				5. 00
6. 00 7. 00		0. 00 0. 00	0	0				6. 00 7. 00
8. 00		0.00	0	0				8. 00
9. 00		0.00	Ö	Ö				9. 00
10.00		0. 00	0	0				10. 00
11.00		0.00	0	0				11.00
12. 00 13. 00		0. 00 0. 00	0	0				12. 00 13. 00
10.00	TOTALS — — — — —		— — <u> </u>	1, 695, 315				10.00
	B - INTEREST							
1. 00	CAP REL COSTS-BLDG & FIXT -	1. 01	0	742, 787				1. 00
	TOTALS	+	— — ₀	742, 787				
	C - OTHER CAPITAL			1				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	7, 795				1.00
2.00 3.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	48, 822 1, 621				2. 00 3. 00
3.00	TOTALS		— — <u> </u>	58, 238				3.00
	D - EMPLOYEE BENEFITS							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 878, 383				1.00
2. 00 3. 00		0. 00 0. 00	0	0				2. 00 3. 00
4. 00		0.00	Ö	Ö				4. 00
5.00		0. 00	0	0				5. 00
6.00		0.00	0	0				6.00
7. 00 8. 00		0. 00 0. 00	0	0				7. 00 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 13. 00		0.00	0	0				12.00
14. 00		0. 00 0. 00	0	0				13. 00 14. 00
15. 00		0.00	0	0				15. 00
16. 00		0. 00	0	0				16. 00
17. 00		0.00	0	0				17. 00
18. 00 19. 00		0. 00 0. 00	0	0				18. 00 19. 00
20. 00		0.00	0	Ö				20. 00
	TOTALS		0	1, 878, 383				
1. 00	E - CAFETERI A CAFETERI A	11. 00	314, 637	200, 585				1. 00
1.00	TOTALS		314, 637					1.00
	F - MEDICAL SUPPLIES	,						
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	17 160				1. 00 2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	54				3. 00
4.00	CENTRAL SERVICES & SUPPLY	14. 00	0	871, 163				4. 00
5.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	292, 896				5. 00
6. 00	PATIENT I MPL. DEV. CHARGED TO	72. 00	0	1, 506, 110				6. 00
7. 00	PATI ENTS	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
11. 00 12. 00		0. 00 0. 00	0	0				11. 00 12. 00
13. 00		0.00	0	0				13. 00
14.00		0. 00	0	0				14. 00
15.00		0.00	0	0				15. 00
16. 00 17. 00		0. 00 0. 00	0	0				16. 00 17. 00
18. 00		0.00	0	0				18. 00
	TOTALS	†		2, 670, 400				

RECLASSI FI CATIONS

500.00 Grand Total: Increases

Provider CCN: 15-1311

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prep

500.00

Date/Time Prepared: 5/29/2019 12: 43 pm Increases Cost Center Sal ary 0ther Li ne # 2.00 3.00 4.00 5.00 G - DRUGS 1.00 CENTRAL SERVICES & SUPPLY 14.00 597 1.00 15.00 445, 790 2.00 PHARMACY 0 2.00 3.00 DRUGS CHARGED TO PATIENTS 73.00 1, 706, 703 3.00 0.00 4.00 0 4.00 5.00 0.00 0 5.00 0 6.00 0.00 0 6.00 7.00 0.00 0 7.00 8.00 0.00 0 0 0 0 8.00 9.00 0.00 9.00 10.00 0.00 0 10.00 0.00 0 11.00 11.00 0 12.00 0.00 0 12.00 13.00 0.00 0 13.00 TOTALS ō 2, 153, 090 H - ORTHOPEDIC CLERICAL STAFF 1.00 OCCUPATI ONAL THERAPY 67.00 47, 882 1.00 47, 882 ō TOTALS I - VP OF NURSING 94, 899 1.00 NURSING ADMINISTRATION 13. 00 0 1.00 94, 899 J - SURGERY ON-CALL 1.00 OPERATING ROOM 50.00 6<u>5, 2</u>71 1.00 TOTALS ō 65, 271 K - MAINTENANCE & LEASE EXPENSE CAP REL COSTS-BLDG & FIXT 1.00 203, 430 1.00 0 1.00 2.00 ADMINISTRATIVE & GENERAL 5.00 0 1, 027 2.00 3.00 OPERATION OF PLANT 7.00 0 7, 510 3.00 OPERATION OF PLANT - OFFSITE 7. 01 62, 364 4.00 4.00 TOTALS 274, 331

457, 418

9, 738, 400

Provider CCN: 15-1311

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 12: 43 pm

COST CORNEC LIFE SAME AND OTHER COST AND COST			Doorsoos				5/29/2019 12	: 43 piii
		Cost Contor	Decreases	Calary	Othor	Wks+ A 7 Dof		
A								
ADMAN STRATIVE & CHERNAL 5.00 0			7.00	8.00	7.00	10.00		
2.00 DEFERATION OF PLANT 7.00 0 1.1.342 9 2.00 4.00 PARAMETER 10.00 0 5.900 0 3.000 4.00 PARAMETER 10.00 0 5.900 0 3.000 4.00 PARAMETER 10.00 0 0 12.407 0 0 7.00 4.00 PARAMETER 10.00 0 0 12.407 0 0 7.00 4.00 PARAMETER 10.00 0 0 12.407 0 0 7.00 4.00 PARAMETER 10.00 0 0 12.407 0 0 0 0 4.00 PARAMETER 10.00 0 0 0 0 0 0 0 4.00 PARAMETER 10.00 0 0 0 0 0 0 4.00 PARAMETER 10.00 0 0 0 0 0 4.00 PARAMETER 10.00 0 4.00 PARAMETER 10.00	1 00		5.00	0	756 127	Q		1 00
3.00 DIFFARY 10.00 0 5.900 0 3.00 0 5.900 0 5.		1		-				1
4.00 PARAMANY 15.00 0 39,498 0 4.00 5.00 6		1		- 1				1
ADULTS & PEDIATRICS 30 00				-				1
0.00 OPERATING ROW		1		-				1
7.00 MESTRESI CLOVY 0.00 PAID CLOVY—10 AND STITE 0.01 PAID CLOVY—10 AND STITE 1.00 PAID CLOVY—10 AND		l e		0				1
B.00 B.00 C.00		1		0				1
9.00 Physical Treerapy 66.00 0 44.072 0 9.00 10.00 11.00 11.00 12.00 10.00 10.00 10.00 11.		l e		0				1
10.00 ELECTRICARDIOLOGY		1		0				1
11.00 CARDIAC REMBAL LITATION		1		0				1
12.00		l I		0				
13.00 MINISTRATIVE & GENERAL 5.00 0 742,787 11 10 10 10 10 10 10 1			•	0				1
TOTALS		1		0				1
1.00 ADMINISTRATIVE & CENERAL 5.00 0 742,787 11 11 1.00								
Description Company				-	, , , , , , ,			
TOTALS	1.00		5. 00	0	742, 787	11		1.00
1.00				₀	742, 787			
2.00 ADMINISTRATIVE & GENERAL 5.00 0 48,822 12 3.00 TOTALS 0 0 58,238 11 12 3.00 TOTALS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		C - OTHER CAPITAL						Ī.
ADMINISTRATIVE & GENERAL 5,00 0 1,621 12 12 10 10 10 10 10	1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	7, 795	13		1.00
TOTALS 0 58, 238	2.00	ADMINISTRATIVE & GENERAL	5. 00	0	48, 822	12		2. 00
TOTALS 0 58, 238	3.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 621	12		3. 00
1.00		TOTALS	- $ +$	₀	58, 238			
Depart on or Plant		D - EMPLOYEE BENEFITS						
3.00 LAUNDRY & LINEN SERVICE 8,00 0 24,906 0 4,00 5.00 DIETARY 10,00 0 112,529 0 4,00 5.00 DIETARY 10,00 0 69,894 0 6.00 6.00 NURSIN SAMINI STRATION 13,00 0 69,894 0 6.00 7.00 PHARMACY 15,00 0 82,159 0 8.00 9.00 OPERATING ROOM 50,00 0 318,747 0 9.00 9.00 OPERATING ROOM 50,00 0 7,554 0 10.00 11.00 RADIOLOGY-DIAGNOSTI C 54,00 0 195,076 0 11.00 11.00 RADIOLOGY-DIAGNOSTI C 54,00 0 195,076 0 11.00 13.00 PHYSI CAL THERAPY 65,00 0 124,626 0 13.00 14.00 COLARDATIONAL THERAPY 67,00 0 30,212 0 14.00 15.00 <td>1.00</td> <td>ADMINISTRATIVE & GENERAL</td> <td>5. 00</td> <td>0</td> <td>85, 939</td> <td>0</td> <td></td> <td>1.00</td>	1.00	ADMINISTRATIVE & GENERAL	5. 00	0	85, 939	0		1.00
4.00 HOUSEKEEPING	2.00	OPERATION OF PLANT	7. 00	0	33, 554	0		2. 00
5. 00 DIETARY 10. 00 0 119, 645 0 6. 00 6. 00 NUSIN SAMINI STRATION 13. 00 0 6. 9844 0 6. 00 7. 00 PHARMACY 15. 00 0 82, 159 0 8. 00 9. 00 OPERATING ROM 50. 00 0 31, 872 0 9. 00 9. 00 OPERATING ROM 50. 00 0 198, 747 0 9. 00 11. 00 RADIOLOGY-JI AGNOSTI C 54. 00 0 195, 076 0 11. 00 12. 00 RESPIRATORY THERAPY 65. 00 0 84. 138 0 12. 00 13. 00 PHYSI CAL THERAPY 66. 00 0 32. 21 0 13. 00 15. 00 BELECTROCARDIO LOGY 69. 00 0 37. 746 0 15. 00 15. 00 BELECTROCARDIO LOGY 69. 00 0 57. 746 0 17. 00 16. 00 DICTARY 73. 01 0 33. 401 0 17. 00	3.00	LAUNDRY & LINEN SERVICE	8. 00	0	24, 906	0		3. 00
6. O O NURSI NG ADMINI STRATION 13. 00 0 69,894 0 6. 00 7. 0 O PARMACY 15. 00 0 82,159 0 8. 00 9. 0 O OPERATI ING ROOM 50. 00 0 1371,872 0 9. 00 10. 00 AMESTHESI OLOGY 53. 00 0 7. 554 0 10. 00 11. 00 ROLOGY-DI AGROSTI C 54. 00 0 7. 554 0 11. 00 12. 00 RESPI RATIORY THERAPY 65. 00 0 18. 138 0 12. 00 14. 00 OCUPATI ONAL THERAPY 66. 00 0 12. 46.26 0 13. 00 15. 00 ELECTROCARDI OLOGY 67. 00 0 57. 746 0 15. 00 16. 00 ONCOLOGY 73. 01 0 33. 401 0 16. 00 16. 00 ONCOLOGY 73. 01 0 33. 401 0 16. 00 18. 00 ONCOLOGY 79. 00 0 15. 946 0 17. 00 19. 00 PHSTICLANS PRIVATE OFFICES 192. 00 0 28. 268 <td>4.00</td> <td>HOUSEKEEPI NG</td> <td>9. 00</td> <td>0</td> <td>132, 529</td> <td>0</td> <td></td> <td>4. 00</td>	4.00	HOUSEKEEPI NG	9. 00	0	132, 529	0		4. 00
7. 00 PHARMACY 15. 00 0 82,159 0 8. 00 9. 00 OD FERATING ROOM 50. 00 0 371,872 0 9. 00 9. 00 OPERATING ROOM 50. 00 0 198,747 0 9. 00 11. 00 RADI DLOGY-DJACNOSTI C 54. 00 0 195,076 0 11. 00 12. 00 RESPIRATORY THERAPY 65. 00 0 8. 138 0 12. 00 13. 00 PHYSI CAL. THERAPY 66. 00 0 124,626 0 13. 00 15. 00 PHYSI CAL. THERAPY 67. 00 0 30. 212 0 14. 00 15. 00 PHYSI CAL. THERAPY 67. 00 0 57. 746 0 15. 00 15. 00 BLECTROCARDIOLOGY 73. 01 0 33. 401 0 16. 00 17. 00 CARDI AC REHABI LI TATION 76. 97 0 15. 946 0 17. 00 19. 00 CARDI AC REHABI LI TATION 76. 97 0 15. 946	5.00	DI ETARY	10.00	0	119, 645	0		5. 00
8.00 ADULTS & PEDIATRICS 30.00 0 371, 872 0 9.00	6.00	NURSING ADMINISTRATION	13. 00	0	69, 894	0		6. 00
9.00 OPERATING ROOM 50.00 0 198, 747 0 9.00 11.00 RADIOLOGY 53.00 0 7,554 0 11.00 RADIOLOGY - DIAGNOSTIC 54.00 0 195, 076 0 11.00 RADIOLOGY - DIAGNOSTIC 54.00 0 195, 076 0 13.00 PHYSICAL THERAPY 66.00 0 124, 626 0 13.00 PHYSICAL THERAPY 67.00 0 30, 212 0 15.00 DIAGNOSTIC 73.01 0 33.401 0 17.00 LECTROCARDIOLOGY 73.01 0 33.401 0 17.00 CARDIAC REHABILITATION 76.97 0 15.946 0 19.00 CARDIAC REHABILITATION 76.97 0 15.946 0 19.00 PHYSICIAL SUPPLIES 192.01 0 13.149 0 10.00 PHYSICIAL SUPPLIES 192.01 0 18.78, 383 10.00 PHYSICIAL SUPPLIES 10.00 16.00 10.00 DIAGNOSTIC 10.00 14.637 200, 585 0 10.00 DIAGNOSTIC 10.00 10.00 10.00 10.00 DIAGNOSTIC 10.00 10.00 10.00 10.00 10.00 PHANTAL SERVICES & SUPPLY 10.00 10.00 10.00 10.00 10.00 10.00 DIAGNOSTIC 10.00 10.00 10.00 10.00 10.00 10.00 10.00 DIAGNOSTIC 10.00	7.00	PHARMACY	15. 00	0	82, 159	0		7. 00
10.00 AMESTHESI OLOGY 53.00 0 7.554 0 10.00	8.00	ADULTS & PEDIATRICS	30.00	0	371, 872	0		8. 00
11. 00 RADI OLOGY-DI AGNOSTI C 54. 00 195. 076 0 11. 00 12. 0	9.00	OPERATING ROOM	50.00	0	198, 747	0		9. 00
12 00 RESPIRATORY THERAPY 65.00 0 84,138 0 12,00 14.00 OCCUPATI ONAL THERAPY 67.00 0 30,212 0 15.00 ELECTROCARDI OLOGY 69.00 0 57,7146 0 16.00 ONCOLOGY 73.01 0 33.401 0 17.00 ORGADIAC PERHABILITATION 76.97 0 15,946 0 18.00 EMERGENCY 71.00 0 169,022 0 19.00 PRYSI CLAINS* PRIVATE OFFICES 192.00 0 13,149 0 19.00 PRYSI CLAINS* PRIVATE OFFICES 192.01 0 13,149 0 10.00 ORGANIA MEDICINE 192.01 0 13,14637 200,585 0 10.00 ORGANIA MEDICINE 192.01 0 13,14637 200,585 0 10.00 ORGANIA MEDICINE 10,00 314,637 200,585 0 10.00 ORGANIA MEDICINE 10,00 0 18,904 0 2,00 10.00 ORGANIA MEDICINE 10,00 0 18,904 0 2,00 10.00 ORGANIA MEDICINE 10,00 0 18,904 0 2,00 10.00 ORGANIA MEDICINE 10,00 0 54 0 3,00 10.00 ORGANIA MEDICINE 10,00 0 5,50 0 10.00 ORGANIA MEDICINE 10,00 0 2,735,136 0 6,00 10.00 AULTIS & PEDIATRICS 30,00 0 2,735,136 0 6,00 10.00 ARSTHESIOLOGY 53,00 0 2,735,136 0 10,00 10.00 ORGANIA MEDICINE 10,00 10,00 10,00 10.00 ORGANIA MEDICINE 10,00 10,00 10,00 10,00 10.00 ORGANIA MEDICINE 10,00 10,00 10,00 10,00 10.00 ORGANIA MEDICIN	10.00	ANESTHESI OLOGY	53.00	0	7, 554	0		10.00
13. 00 PHYSICAL THERAPY	11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	195, 076			11. 00
14. 00	12.00	RESPIRATORY THERAPY	65.00	0	84, 138	0		12. 00
15. 00 ELECTROCARDIOLOGY	13.00	PHYSI CAL THERAPY	66. 00	0	124, 626			13. 00
16.00 NOCOLOGY	14.00	OCCUPATI ONAL THERAPY	67. 00	0	30, 212	0		14. 00
17. 00	15.00	ELECTROCARDI OLOGY	69. 00	0	57, 746	0		15. 00
18. 00	16.00	ONCOLOGY	73. 01	0	33, 401	0		16. 00
19.00 PHYSICIANS' PRIVATE OFFICES 192.01 0 13.149 0 0 0 0 0 0 0 0 0	17.00	CARDIAC REHABILITATION	76. 97	0	15, 946	0		17. 00
20.00	18.00	EMERGENCY	91. 00	0	169, 022	0		18. 00
TOTALS	19.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	28, 268	0		19. 00
Color Colo	20.00	OCCUPATI ONAL MEDI CI NE	192. 01					20. 00
1.00 DIETARY 10.00 314,637 200,585 0 1.00 TOTALS		TOTALS		0	1, 878, 383			
TOTALS F - MEDICAL SUPPLIES 1.00 OPERATION OF PLANT 7.00 0 8,923 0 1.00 2.00 HOUSEKEEPING 9.00 0 18,304 0 2.00 3.00 DIETARY 1.00 0 0 54 0 4.00 CENTRAL SERVICES & SUPPLY 14.00 0 243 0 4.00 5.00 PHARMACY 15.00 0 5,300 0 5.00 7.00 OPERATING ROOM 50.00 0 2,373,136 0 7.00 8.00 ANESTHESIOLOGY 53.00 0 765 0 8.00 10.00 RESPIRATORY THERAPY 65.00 0 24,442 0 9.00 10.00 RESPIRATORY THERAPY 66.00 0 13,212 0 10.00 11.00 PHYSICAL THERAPY 66.00 0 12,590 0 13.00 12.00 OCCUPATIONAL THERAPY 67.00 0 888 0 115.00 13.00 ELECTROCARDIOLOGY 73.01 0 9,371 0 14.00 15.00 CARDIA CREHABILITATION 76.97 0 888 0 15.00 16.00 EMERGENCY 91.00 0 5,9341 0 16.00 17.00 PHYSICAL SHARDY 192.00 0 6,608 0 17.00 18.00 EMERGENCY 91.00 0 5,9341 0 16.00 17.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 6,608 0 17.00 18.00 EMERGENCY 91.00 0 5,9341 0 16.00 17.00 PHYSICIANS' PRIVATE OFFICES 192.00 0 6,608 0 17.00 18.00 CCUPATIONAL MEDICINE 192.01 0 2,391 0 18.00 18.00 DIETARY 10.00 0 5,000 0 16,738 0 1.00 18.00 DIETARY 10.00 0 5,000 0 16,738 0 2.00 10.01 THARDY 15.00 0 16,738 0 1.00 11.00 0 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
F - MEDICAL SUPPLIES	1.00		1000					1. 00
1.00 OPERATION OF PLANT				314, 637	200, 585			_
2. 00 HOUSEKEEPING 9. 00 0 18, 304 0 3. 00 3. 00 DI ETARY 10. 00 0 54 0 4. 00 5. 00 PHARMACY 15. 00 0 5, 300 0 5. 00 6. 00 ADULTS & PEDIATRICS 30. 00 0 99, 420 0 6. 00 8. 00 APERATING ROOM 50. 00 0 2, 373, 136 0 7.00 9. 00 RESPIRATORY THERAPY 53. 00 0 765 0 8. 00 11. 00 PHYSICAL THERAPY 66. 00 0 17, 108 0 11. 00 12. 00 OCCUPATIONAL THERAPY 66. 00 0 17, 108 0 11. 00 13. 00 ELECTROCARDIOLOGY 69. 00 0 12, 590 0 13. 00 15. 00 CARDIA C REHABILITATION 76. 97 0 888 0 15. 00 16. 00 EMERGENCY 91. 00 0 2, 391 0 15. 00 17. 00 DETARY OPERATING SILE 192. 00 18. 00 18. 00 AND STREET OF THE STREET								4
3. 00 DI ETARY 10. 00 0 54 0 0 3. 00 4. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 243 0 0 4. 00 5. 00 PHARMACY 15. 00 0 5. 300 0 5. 00 6. 00 ADULTS & PEDI ATRI CS 30. 00 0 99, 420 0 6. 00 7. 00 OPERATI NG ROOM 50. 00 0 2, 373, 136 0 7. 00 8. 00 ANESTHESI OLOGY 53. 00 0 765 0 8. 00 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 24, 442 0 99. 00 10. 00 RESPI RATORY THERAPY 65. 00 0 31, 212 0 10. 00 11. 00 PHYSI CAL THERAPY 66. 00 0 17, 108 0 11. 00 12. 00 OCCUPATI ONAL THERAPY 67. 00 0 304 0 12. 00 13. 00 ELECTROCARDI OLOGY 69. 00 0 12, 590 0 13. 00 14. 00 ONCOLOGY 73. 01 0 9, 371 0 14. 00 15. 00 CARDI AC REHABI LI TATI ON 76. 97 0 888 0 15. 00 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CINE 192. 01 0 2, 391 0 18. 00 17. 00 PHARMACY 15. 00 0 2, 670, 400 6 18. 00 OCCUPATI ONAL MEDI CINE 192. 01 0 2, 670, 400 6 19. 00 OCCUPATI ONAL MEDI CINE 192. 01 0 2, 670, 400 6 19. 00 OCCUPATI ONAL MEDI CINE 192. 01 0 2, 074, 428 0 2. 00 2. 00 PHARMACY 15. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 550 0 0 4. 00				-	1			1
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5. 00 PHARMACY 15. 00 0 5, 300 0 6. 00 6. 00 6. 00 ADULTS & PEDIATRICS 30. 00 0 99, 420 0 6. 00 6. 00 7. 00 OPERATING ROOM 50. 00 0 2,373,136 0 7. 00 8. 00 ANESTHESI OLOGY 53. 00 0 765 0 8. 00 9. 00		1	· · · · · · · · · · · · · · · · · · ·	-				1
6. 00 ADULTS & PEDIATRICS 30. 00 0 99, 420 0 6. 00 7. 00 0 0 0 0 0 0 0 0 0		1	· · · · · · · · · · · · · · · · · · ·	-				1
7. 00 OPERATING ROOM 50. 00 2,373,136 0 7. 00 8. 00 ANESTHESI OLOGY 53. 00 0 765 0 8. 00 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 24,442 0 9. 00 10. 00 RESPIRATORY THERAPY 65. 00 0 31, 212 0 10. 00 11. 00 PHYSI CAL THERAPY 66. 00 0 17, 108 0 11. 00 12. 00 OCCUPATI ONAL THERAPY 67. 00 0 304 0 12. 00 13. 00 ELECTROCARDI OLOGY 69. 00 0 12, 590 0 13. 00 15. 00 CARDI AC REHABI LI TATI ON 76. 97 0 888 0 15. 00 16. 00 EMERGENCY 91. 00 0 59, 341 0 16. 00 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 4. 00 OPERATI NG ROOM 50. 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 0 16, 550 0 4. 00 4. 00 OPERATI NG ROOM 50. 0 16, 738 0 4. 00		1		-				1
8. 00 ANESTHESI OLOGY 53. 00 0 765 0 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 24, 442 0 9. 00 10. 00 RESPIRATORY THERAPY 65. 00 0 31, 212 0 10. 00 11. 00 PHYSI CAL THERAPY 66. 00 0 17, 108 0 111. 00 12. 00 OCCUPATI ONAL THERAPY 67. 00 0 304 0 12. 00 13. 00 ELECTROCARDI OLOGY 69. 00 0 12, 590 0 13. 00 14. 00 ONCOLOGY 73. 01 0 9, 371 0 14. 00 15. 00 CARDI AC REHABI LI TATI ON 76. 97 0 888 0 15. 00 16. 00 EMERGENCY 91. 00 0 99, 371 0 16. 00 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 17. 00 DI ETARY 10. 00 2, 670, 400 18. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 738 0 4. 00				-				1
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12. 00 OCCUPATI ONAL THERAPY 67. 00 0 304 0 12. 00 13. 00 ELECTROCARDI OLOGY 69. 00 0 12, 590 0 13. 00 14. 00 ONCOLOGY 73. 01 0 9, 371 0 14. 00 15. 00 CARDI AC REHABI LI TATI ON 76. 97 0 888 0 15. 00 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 10 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 10 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 670, 400 0 18. 00 10 ODI ETARY 10. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 738 0 4. 00				-				
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14. 00 ONCOLOGY 73. 01 0 9, 371 0 14. 00 15. 00 CARDI AC REHABI LI TATI ON 76. 97 0 888 0 15. 00 16. 00 EMERGENCY 91. 00 0 59, 341 0 16. 00 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 G - DRUGS 1. 00 DI ETARY 10.00 0 5 0 1. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 0 16, 738 0 4. 00		l I	•	0				1
15. 00 CARDI AC REHABI LI TATI ON 76. 97 0 888 0 15. 00 16. 00 EMERGENCY 91. 00 0 59, 341 0 16. 00 17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 G - DRUGS 1. 00 DI ETARY 10. 00 0 5 0 1. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 0 16, 738 0 4. 00				0				
16. 00 EMERGENCY 91. 00 0 59, 341 0 16. 00 17. 00 PHYSICIANS' PRIVATE OFFICES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDICINE 192. 01 0 2, 391 0 18. 00 G - DRUGS 1. 00 DI ETARY 10. 00 0 5 0 1. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDIATRICS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATING ROOM 50. 00 0 16, 738 0 4. 00				0				
17. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 6, 608 0 17. 00 18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 TOTALS 0 2,670,400 18. 00 1. 00 DI ETARY 10. 00 5 0 1. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 16, 738 0 4. 00				-		-		1
18. 00 OCCUPATI ONAL MEDI CI NE 192. 01 0 2, 391 0 18. 00 TOTALS 0 2, 670, 400 1 192. 01 0 2, 670, 400 1 192. 01 1 . 00 1			•					
TOTALS 0 2,670,400 G - DRUGS 1. 00 DI ETARY 10.00 0 5 0 1.00 2. 00 PHARMACY 15. 00 0 2,014,428 0 2. 00 3. 00 ADULTS & PEDIATRICS 30. 00 0 16,550 0 3. 00 4. 00 OPERATING ROOM 50. 00 0 16,738 0 4. 00				-				
G - DRUGS 1. 00 DI ETARY 10. 00 0 5 0 1. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 0 16, 738 0 4. 00	18. 00		1 <u>92.</u> 01					18. 00
1. 00 DI ETARY 10. 00 0 5 0 1. 00 2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDI ATRI CS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATI NG ROOM 50. 00 0 16, 738 0 4. 00				0	2, 670, 400			4
2. 00 PHARMACY 15. 00 0 2, 014, 428 0 2. 00 3. 00 ADULTS & PEDIATRICS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATING ROOM 50. 00 0 16, 738 0 4. 00	<u> </u>							4
3. 00 ADULTS & PEDIATRICS 30. 00 0 16, 550 0 3. 00 4. 00 OPERATING ROOM 50. 00 0 16, 738 0 4. 00								1
4. 00 OPERATING ROOM 50. 00 16, 738 0 4. 00		1		-	,			1
			· · · · · · · · · · · · · · · · · · ·				•	1
5. UU ANESTHESTOLUGY 53. 00 0 11, 562 0 5. 00		1	l	-	1		•	1
	5.00	AINESTHESTULUGY	53.00	0	11, 562	0		5.00

Health Financial Systems RECLASSIFICATIONS IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1311

Peri od: Worksheet A-6
From 01/01/2018
To 12/31/2018 Date/Time Prepared: 5/39/2019 12:43 pm

						5/29/2019 12: 43	pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	50, 317	0		6. 00
7.00	RESPIRATORY THERAPY	65.00	0	181	0		7.00
8.00	PHYSI CAL THERAPY	66.00	0	303	0		8. 00
9.00	ELECTROCARDI OLOGY	69.00	0	11, 731	0		9. 00
10.00	ONCOLOGY	73. 01	0	2, 160	0	10	0.00
11.00	EMERGENCY	91.00	0	20, 401	0	1	1.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	64	0	1:	2.00
13.00	OCCUPATIONAL MEDICINE	192. 01	o	8, 650	0	1:	3.00
	TOTALS			2, 153, 090			
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSI CAL THERAPY	66.00	47, 882	0	0		1.00
	TOTALS		47, 882				
	I - VP OF NURSING						
1.00	ADMINISTRATIVE & GENERAL	5. 00	94, 899	0	0		1.00
	TOTALS		94, 899				
	J - SURGERY ON-CALL						
1.00	ADULTS & PEDIATRICS	30.00		65, 271	0		1.00
	TOTALS		0	65, 271			
	K - MAINTENANCE & LEASE EXPEN	ISE					
1.00	PHYSI CAL THERAPY	66.00	0	136, 461	10		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	137, 870	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
	TOTALS			274, 331			
500.00	Grand Total: Decreases		457, 418	9, 738, 400		500	0. 00

Provider CCN: 15-

	Perion From To	01/01/2018	Worksheet A-7 Part I Date/Time Prepared: 5/29/2019 12:43 pm
uisition:	S		

				1	Го 12/31/2018	Date/Time Pre 5/29/2019 12:	pared: 43 pm
				Acqui si ti ons		0,2,,201,	то р
		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	Γ BALANCES			_		
1.00	Land	0	0	(0	0	1. 00
2.00	Land Improvements	0	0	(0	0	2. 00
3.00	Buildings and Fixtures	0	0	(0	0	3. 00
4.00	Building Improvements	2, 098, 521	773, 936	(773, 936	0	4. 00
5.00	Fixed Equipment	0	0	(0	0	5. 00
6.00	Movable Equipment	10, 180, 402	2, 270, 564	(2, 270, 564	891, 396	6. 00
7.00	HIT designated Assets	964, 363	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	13, 243, 286	3, 044, 500	(3, 044, 500	891, 396	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10. 00	Total (line 8 minus line 9)	13, 243, 286	3, 044, 500	(3, 044, 500	891, 396	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYSIS OF CHANGES IN CARLTAL ASSE	6.00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	0				1 00
1.00	Land	0	0				1.00
2.00	Land Improvements	0	0				2.00
3. 00 4. 00	Buildings and Fixtures	2 072 457	0				3. 00 4. 00
5. 00	Building Improvements	2, 872, 457	0				5.00
6.00	Fixed Equipment	11, 559, 570	0				6.00
7. 00	Movable Equipment HIT designated Assets	964, 363	0				7.00
8.00	Subtotal (sum of lines 1-7)	15, 396, 390	0				8. 00
9. 00	Reconciling Items	15, 390, 390	0				9.00
10.00	Total (line 8 minus line 9)	15, 396, 390	0				10.00
10.00	Tiotal (Title o milius Title 9)	15, 390, 390	V				10.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der (CCN: 15-1311	Peri od:	Worksheet A-7	
				From 01/01/2018		narad.
				To 12/31/2018	Date/Time Prep 5/29/2019 12:	pared: 43 nm
			SUMMARY OF CAP	I TAL	0,2,,201, 12.	, o p
Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
				instructions)		
DADT II. DECONOLILIATION OF AMOUNTS FROM WOR	9.00	10.00	11.00	12. 00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR 1.00 CAP REL COSTS-BLDG & FIXT	KSHEET A, COLUM	IN 2, LINES I	and 2		0	1.00
1.00 CAP REL COSTS-BLDG & FIXT 1.01 CAP REL COSTS-BLDG & FIXT - INTERES	0			0	0	1.00
2.00 CAP REL COSTS-BEDG & TIXT - TWIERES	0				0	2.00
3.00 Total (sum of lines 1-2)	0		0		0	3. 00
cree Total (Sam of Times T.2)	SUMMARY O	F CAPITAL		<u> </u>	Ü	0.00
Cost Center Description	Other	Total (1) (su	m			
	Capi tal -Rel ate					
	d Costs (see	through 14)				
	instructions)	15.00	4			
DART II DECONCILIATION OF AMOUNTS FROM WOR	14. 00	15.00	and 2			
PART II - RECONCILIATION OF AMOUNTS FROM WOR 1.00 CAP REL COSTS-BLDG & FIXT	KSHEET A, CULUM	IN Z, LINES I				1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES					ļ	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0		0		ļ	2. 00
3.00 Total (sum of lines 1-2)			ol .			3.00
	1	•	1		'	

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 Fo 12/31/2018	5/29/2019 12: 4	
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	3, 836, 820	0	-,,		0	1. 00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	1	0. 000000	0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	11, 559, 569	0	11, 559, 56		0	2. 00
3.00	Total (sum of lines 1-2)	15, 396, 389	0	15, 396, 38		0	3. 00
		ALLOCA	TION OF OTHER (CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other Capi tal -Relate	Total (sum of cols. 5	Depreciation	Lease	
			d Costs	through 7)			
		6. 00	7. 00	8.00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0)	1, 402, 337	168, 466	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	o	0)	418, 982	o	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)	1, 325, 341	0	2.00
3.00	Total (sum of lines 1-2)	0	0)	3, 146, 660	168, 466	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						
1.00	CAP REL COSTS-BLDG & FIXT	0	48, 822	1		1, 611, 830	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	232, 857	0	1	0	651, 839	1. 01
2. 00	CAP REL COSTS-MVBLE EQUIP	0	1, 621		0	1, 326, 962	2. 00
3.00	Total (sum of lines 1-2)	232, 857	50, 443	-7, 79	5 0	3, 590, 631	3. 00

Peri od: Worksher From 01/01/2018 Provider CCN: 15-1311

				T	rom 01/01/2018 o 12/31/2018		
				Expense Classification on		5/29/2019 12:	43 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	1. 00
1. 01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	В	-509, 930	CAP REL COSTS-BLDG & FIXT - INTERES	1. 01	11	1. 01
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4. 00	Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	О	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)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 141, 846		0. 00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	2, 865, 423			0	12. 00
13.00	Laundry and linen service		0		0.00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others		-143, 060 0	CAFETERI A	11. 00 0. 00		
16. 00	Sale of medical and surgical supplies to other than patients		0		0.00	О	16. 00
17. 00	Sale of drugs to other than	В	-417, 390	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	О	22. 00
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	-498	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT	А	855, 830	CAP REL COSTS-BLDG & FIXT	1.00	9	26. 00
26. 01	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1. 01	0	26. 01
27. 00	COSTS-BLDG & FIXT - INTERES Depreciation - CAP REL	А	98, 044	INTERES CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)	,, , ,					
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99

From 01/01/2018
To 12/31/2018 Date/Time Prepared:

					, , , , , , , , , , , , , , , , , , , ,	5/29/2019 12:	43 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
	T	1.00	2. 00	3.00	4. 00	5. 00	
31. 00	Adjustment for speech	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
	pathology costs in excess of						
00.00	limitation (chapter 14)		F7 /7/	OAD DEL COCTO MADI E FOLLID	0.00		00.00
32. 00	CAH HIT Adjustment for	A	-57,676	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32. 00
22.00	Depreciation and Interest	В	/ 20/	EMDLOVEE DENEELTC DEDARTMENT	4.00		33. 00
33. 00	MI SCELLANEOUS I NCOME	B B	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 00	0	33. 00
33. 01	MI SCELLANEOUS I NCOME	1	·	ADMINISTRATIVE & GENERAL		0	
33. 02 33. 03	I NVESTMENT FEES MI SCELLANEOUS I NCOME	A B	·	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	33. 02 33. 03
33. 03	MI SCELLANEOUS I NCOME	В		ANESTHESI OLOGY	53.00	0	33. 03
33. 04	MI SCELLANEOUS I NCOME	В		HOUSEKEEPI NG	9. 00	0	33. 04
33. 06	MI SCELLANEOUS I NCOME	В	·	CAFETERI A	11. 00	0	33. 06
33. 07	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00	0	33. 00
33. 07	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 07
33. 11	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69.00	0	33. 11
33. 12	MEDICALD HOSPITAL ASSESSMENT	B		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 11
33. 12	FEE		-1,043,301	ADMINISTRATIVE & GENERAL	3.00	O	33. 12
33. 13	ASSISTED LIVING DEPRECIATION -	A	-131 829	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 13
00. 10	BLDG		1017027	NEE 00010 BEB0 a 11711		ĺ	00. 10
33. 14	ASSISTED LIVING DEPRECIATION -	A	-807	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 14
	MVBLE						
33. 15	CRNA SALARY EXPENSE	A	-179, 226	ANESTHESI OLOGY	53.00	0	33. 15
33. 16	CRNA BENEFITS EXPENSE	A	-35, 661	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 16
33. 17	PATIENT PHONES - SALARY	A	-2, 366	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	PATIENT PHONES - BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 18
33. 19	EMPLOYEE BENEFITS	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 19
33. 20	CABLE	A		OPERATION OF PLANT	7. 00	0	33. 20
33. 21	CABLE	A		PHYSI CAL THERAPY	66.00	0	33. 21
33. 22	ACCURED PTO	A	·	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 22
33. 23	LEASE DEPRECIATION - CARRY	A	284	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 23
33. 24	FORWARD A EQUIPMENT DEPRECIATION - CARRY	A	15 174	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 24
33. 24	FORWA	A	13, 470	CAP REL COSTS-MVBLE EQUIP	2.00	9	33. 24
33. 25	LEASE REVENUE	В	-34 964	CAP REL COSTS-BLDG & FIXT	1. 00	10	33. 25
33. 28	MI SCELLANEOUS I NCOME	B		PHARMACY	15. 00	0	33. 28
33. 29	TELEPHONE EQUI PMENT	A	, -	CENTRAL SERVICES & SUPPLY	14. 00	ő	33. 29
33. 30	TELEPHONE EQUIPMENT	A		EMERGENCY	91. 00	o o	33. 30
33. 31	UNWONTED SITUATIONS	A		ADMINISTRATIVE & GENERAL	5. 00	o o	33. 31
33. 32	MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	ő	33. 32
33. 33	MARKETING	A	·	ADULTS & PEDIATRICS	30.00	ő	33. 33
33. 34	MARKETING	A		RADI OLOGY-DI AGNOSTI C	54.00	Ö	33. 34
33. 35	MARKETING	A		ELECTROCARDI OLOGY	69. 00	Ö	33. 35
33. 36	MARKETI NG	A		EMERGENCY	91.00	Ō	33. 36
50.00	TOTAL (sum of lines 1 thru 49)		-2, 977, 056				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS

Provider CCN: 15-1311 | Period: From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: From 01/01/2018 | Provider CCN: 15-1311 | Period: From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: From 01/01/2018 | Provider CCN: 15-1311 | Period: From 01/01/2018 | Provider CCN: 15-1311 | Provider CCN: 15-1311 | Period: From 01/01/2018 | Provider CCN: 15-1311 | Period: From 01/01/2018 | Provider CCN: 15-1311 | Provi

					5/29/2019 12:	43 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	ii
	HOME OFFICE COSTS:		_			ì
1. 00		l .	HOME OFFICE ALLOCATION	261, 358		
2.00	1		HOME OFFICE ALLOCATION	1, 161, 769		
3.00			HOME OFFICE ALLOCATION	115, 353		3. 00
4.00		l .	HOME OFFICE ALLOCATION	2, 134, 871	5, 952	4. 00
4. 01	1		HOME OFFICE ALLOCATION	5, 517, 605	5, 376, 411	4. 01
4.02	1	OPERATION OF PLANT	I NTERCOMPANY	654, 477	654, 477	4. 02
4.03	•		I NTERCOMPANY	0	47, 625	
4.04	13. 00	NURSING ADMINISTRATION	I NTERCOMPANY	54, 857	83, 945	4. 04
4.05	30.00	ADULTS & PEDIATRICS	INTERCOMPANY	526, 887	526, 887	4. 05
4.06	50.00	OPERATING ROOM	INTERCOMPANY	37, 137	37, 137	4. 06
4.07	54.00	RADI OLOGY-DI AGNOSTI C	INTERCOMPANY	77, 590	77, 590	4. 07
4.08	60.00	LABORATORY	INTERCOMPANY	1, 216, 091	1, 216, 091	4. 08
4.09	69.00	ELECTROCARDI OLOGY	INTERCOMPANY	193, 970	193, 970	4. 09
4. 10	73. 01	ONCOLOGY	INTERCOMPANY	12, 671	12, 671	4. 10
4. 11	91. 00	EMERGENCY	INTERCOMPANY	1, 460, 026	1, 460, 026	4. 11
4. 12	192. 01	OCCUPATIONAL MEDICINE	INTERCOMPANY	28, 441	28, 441	4. 12
5.00	TOTALS (sum of lines 1-4).			13, 453, 103	10, 587, 680	5.00
	Transfer column 6, line 5 to					ì
	Worksheet A-8, column 2,					in the second
	line 12.					

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	0. 00 I U HEALTH 100. 00	6.00
7.00		0.00	7.00
8.00		0.00	8.00
9.00		0.00	9.00
10.00		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 organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

					10 12/31/2010	5/29/2019 12:	
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO						
1. 00	137, 688						1.00
2.00	418, 982						2.00
3.00	115, 353						3.00
4.00	2, 128, 919						4.00
4. 01	141, 194	0					4. 01
4. 02	0	0					4. 02
4.03	-47, 625						4. 03
4.04	-29, 088	0					4. 04
4. 05	0	0					4. 05
4.06	0	0					4. 06
4.07	0	0					4. 07
4.08	0	0					4. 08
4.09	0	0					4. 09
4. 10	0	0					4. 10
4. 11	0	0					4. 11
4. 12	0	0					4. 12
5.00	2, 865, 423						5.00

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

 	cordinate i dilaret 27 the dimedite difference of cordinate be find out out in cordinate for this parti-	
Related Organization(s)		
and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

| Period: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1311

					1	Γο 12/31/2018	B Date/Time Pre 5/29/2019 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	10
		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	526, 887	526, 887	0	0	0	1. 00
2.00	50.00	OPERATING ROOM	319, 084	319, 084	0	0	0	2.00
3.00		ANESTHESI OLOGY	250, 000			0	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	63, 705			0	0	4.00
5.00	69. 00 E	ELECTROCARDI OLOGY	26, 000		0	0	0	5. 00
6.00	91. 00 E	EMERGENCY	1, 430, 703	956, 170	474, 533	0	0	6.00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00			2, 616, 379				0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		ldenti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	0.00	0.00	Educati on	12 13. 00	14.00	
1 00	1. 00	2.00 ADULTS & PEDIATRICS	8.00	9. 00	12. 00		14.00	1. 00
1. 00 2. 00		OPERATING ROOM		1	_			2. 00
3.00	•	ANESTHESI OLOGY		-	_		0	3. 00
4. 00	•	RADI OLOGY-DI AGNOSTI C			0		0	4. 00
5. 00	•	ELECTROCARDI OLOGY			0		0	5. 00
6. 00		EMERGENCY			0		0	6. 00
7. 00	0.00	LWENGENCT			0			7. 00
8. 00	0.00				0			8. 00
9. 00	0.00				0			9. 00
10. 00	0.00				0		o o	10. 00
200.00	0.00		0	Ö	0		o o	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		_	,		1. 00
2.00		OPERATING ROOM	0	-	_	319, 084		2. 00
3.00		ANESTHESI OLOGY	0	1		250, 000		3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0	0		63, 705		4. 00
5. 00		ELECTROCARDI OLOGY	0	0	0	26, 000		5. 00
6. 00		EMERGENCY	0	0	0	956, 170	1	6. 00
7.00	0.00		0	0	0	0)	7. 00
8.00	0.00		0	1 0	0	0		8.00
9.00	0.00		0	0	0			9. 00
10.00	0.00				0	2 141 044	'	10.00
200.00	I I		0	0	0	2, 141, 846	וי	200. 00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS	FURNI SHED BY	Provider CCN: 15-1311	Period: From 01/01/2018 To 12/31/2018		pared:
			Physical Therapy	Cost	
				1. 00	
PART I - GENERAL INFORMATION					
1.00 Total number of weeks worked (excluding aide	s) (see instruction	ons)		8	1.00
2.00 Line 1 multiplied by 15 hours per week	, ,	•		120	2.00

						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aide	s) (see instruc	tions)			8	1. 00
2.00	Line 1 multiplied by 15 hours per week	oor or thoronic	+	dam ai +a (aaa i	notrusti ana)	120	2.00
3. 00 4. 00	Number of unduplicated days in which supervi: Number of unduplicated days in which therapy					0	3. 00 4. 00
4.00	nor therapist was on provider site (see inst		on provider si	te but her ther	super vi soi	0	4.00
5.00	Number of unduplicated offsite visits - super		apists (see ins	structions)		0	5. 00
6.00	Number of unduplicated offsite visits - there	apy assistants	(include only	visits made by	therapy	0	6. 00
	assistant and on which supervisor and/or the	rapist was not	present during	the visit(s))	(see		
7 00	instructions)					E 4E	7 00
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					5. 45 0. 00	
8.00	optional travel expense rate per illire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	8.00
		1.00	2. 00	3. 00	4. 00	5. 00	
9. 00	Total hours worked	0.00	0.00	49. 75	0.00	0.00	9. 00
10.00	AHSEA (see instructions)	0.00	82. 91	62. 18	0. 00	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	41. 46	41. 46	31. 09			11. 00
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)						
12. 00	Number of travel hours (provider site)	o	o	0			12. 00
12. 01	Number of travel hours (offsite)	l o	o	Ö			12. 01
13.00	Number of miles driven (provider site)	0	О	0			13.00
13. 01	Number of miles driven (offsite)	0	0	0			13. 01
						1.00	
	Down II CALADY FOULVALENCY COMPUTATION					1.00	
14. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				0	14. 00
15. 00	Therapists (column 2, line 9 times column 2,						
16. 00	Assistants (column 3, line 9 times column 3,	,				3, 093	
17. 00	Subtotal allowance amount (sum of lines 14 au		ratory therapy	or lines 14-16	for all		17. 00
	others)	•	, ,				
18. 00	Aides (column 4, line 9 times column 4, line					0	
19.00	Trainees (column 5, line 9 times column 5, li	,	*b	17 10 6-		0	
20. 00	Total allowance amount (sum of lines 17-19 for the sum of columns 1 and 2 for respirators					3, 093	20.00
	occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete				and onto: on	20	
	Weighted eveness rate evaluding sides and the						
21. 00	Weighted average rate excluding aides and tra			m of columns 1	and 2, line 9	62. 17	21. 00
	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)	m of columns 1	and 2, line 9		
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train	line 9 for all	others)	m of columns 1	and 2, line 9	7, 460	22. 00
	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions)	line 9 for all ees (line 2 tim	others) es line 21)			7, 460	22. 00
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22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 35. 00 36. 00 37. 00 38. 00 39. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) 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) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Assistants (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 column 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 ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Optional Travel Allowance and Optional Travel	line 9 for all ees (line 2 tim MANCE AND TRAVEL sum of lines 2 for respirator travel expense of columns 1 and, line 12) sum of lines 2 s 1 and 2, line l expense (sum of lines 2 to 1) and 2 time l expense (sum of lines 2 to 1) and 2 time of lines 5 and 1 times 5 and 1 times columns	others) es line 21) L EXPENSE COMPL 4 and 25 for all y therapy or so at the provide d 2, line 12) 9 and 30 for all 13 for respira 28) of lines 27 and of lines 31 and EXPENSE COMPUT	JTATION - PROVI	DER SITE nd 4 for all lines 26 and r sum of	7, 460 7, 460 7, 460 373 0 373 49 422 0 0 0 0 VI DER SITE 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00
22. 00 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	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) 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) 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 Optional travel allowance and optional travel Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum optional Travel Allowance and Optional Travel Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times columns 1) Assistants (column 3, line 12.01 times columns 1) Subtotal (sum of lines 40 and 41)	Inne 9 for all ees (line 2 tim MANCE AND TRAVEL sum of lines 2 for respirator travel expense Expense of columns 1 and, line 12) sum of lines 2 s 1 and 2, line l expense (sum of lines 2 sum of lines 2 and 2 line l expense (sum of lines 3 and 2 line) l expense (sum of lines 5 and 2 lines 6	others) es line 21) L EXPENSE COMPL 4 and 25 for ally therapy or so at the provide d 2, line 12) 9 and 30 for all 13 for respirate 28) of lines 27 and of lines 31 and EXPENSE COMPUTE d 6) 2, line 10)	JTATION - PROVI	DER SITE nd 4 for all lines 26 and r sum of	7, 460 7, 460 7, 460 373 0 373 49 422 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	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 37. 00 38. 00 40. 00 41. 00 42. 00
22. 00 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	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) 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) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Allowance Travel Optional Travel Allowance and Optional Travel Allowance Travel (line 7 times the sur Optional Travel Allowance and Optional Travel Allowance Travel (line 7 times the sur Optional Travel Allowance and Optional Travel Allowance Travel (line 7 times the sur Optional Travel (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	sum of lines 2 for respirator; travel expense of columns 1 and, line 12) sum of lines 2's 1 and 2, line 1 expense (sum of lines 6 (sum of lines 6 (sum of lines 7 (sum of lines 5 and 1 (sum of lines	others) es line 21) L EXPENSE COMPL 4 and 25 for ally therapy or so at the provide d 2, line 12) 9 and 30 for all 13 for respiral 28) of lines 27 and of lines 31 and EXPENSE COMPUTED d 6) 2, line 10) 3, line 13.01)	JTATION - PROVI	DER SITE nd 4 for all lines 26 and r sum of	7, 460 7, 460 7, 460 373 0 373 49 422 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 37. 00 38. 00 40. 00 41. 00 42. 00
22. 00 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	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) 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) 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 ALLOW Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum Total Travel Allowance and Travel Expense (line 8 times the sum	sum of lines 2 for respirator; travel expense of columns 1 and, line 12) sum of lines 2's 1 and 2, line 1 expense (sum of lines 6 (sum of lines 6 (sum of lines 7 (sum of lines 5 and 1 (sum of lines	others) es line 21) L EXPENSE COMPL 4 and 25 for ally therapy or so at the provide d 2, line 12) 9 and 30 for all 13 for respiral 28) of lines 27 and of lines 31 and EXPENSE COMPUTED d 6) 2, line 10) 3, line 13.01)	JTATION - PROVI	DER SITE nd 4 for all lines 26 and r sum of	7, 460 7, 460 7, 460 373 0 373 49 422 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 37. 00 38. 00 40. 00 41. 00 42. 00
22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) 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) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 3, line 10 times the sum of Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Allowance Travel Optional Travel Allowance and Optional Travel Allowance Travel (line 7 times the sur Optional Travel Allowance and Optional Travel Allowance Travel (line 7 times the sur Optional Travel Allowance and Optional Travel Allowance Travel (line 7 times the sur Optional Travel (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	Inne 9 for all ees (line 2 tim MANCE AND TRAVEL sum of lines 2 for respirator travel expense Expense of columns 1 and line 12) sum of lines 2 s 1 and 2, line l expense (sum of lines 2) and 2 for respirator l expense (sum of lines 3) and 4 for lines 4 l expense (sum of lines 5 and 1 expense (sum of lines 5 and 1 expense 01 times column 1 expense 01 times column 1 offsite Services	others) es line 21) L EXPENSE COMPL 4 and 25 for ally therapy or sit at the provide d 2, line 12) 9 and 30 for all 13 for respirate 28) of lines 27 and of lines 31 and EXPENSE COMPUTED d 6) 2, line 10) 3, line 13.01) s; Complete one	JTATION - PROVI	DER SITE nd 4 for all lines 26 and r sum of ES OUTSIDE PRO	7, 460 7, 460 7, 460 373 0 373 49 422 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 37. 00 38. 00 37. 00 38. 00 37. 00 38. 00 40. 00 41. 00 42. 00

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	IU HEALTH TIPT FURNISHED BY	Provider Co		Period: From 01/01/2018 To 12/31/2018		-3 pared:
					Physical Therapy		43 piii
					nysrear merapy	0031	
						1. 00	
46. 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an	d 43 - see in	structions)	0	46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION						
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	0.0	0.00	0. 00	47. 00
48. 00	Overtime rate (see instructions)	0. 00	0.00	0.0	0.00		48. 00
49. 00	Total overtime (including base and overtime	0. 00	0.00				49.00
47.00	allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0.00		77.00
	CALCULATION OF LIMIT	<u>'</u>			<u> </u>		
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50. 00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount	82. 91	62. 18	0.0	0.00		52.00
32.00	(see instructions)	02. 71	02. 10	0.0	0.00		32.00
53. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53. 00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for 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 EXCESS COST	ADJUSTMENT				
57.00	Salary equivalency amount (from line 23)					7, 460	57.00
58.00	Travel allowance and expense - provider site					422	
59. 00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46)		0	
60.00	Overtime allowance (from column 5, line 56)					0	
61. 00	Equipment cost (see instructions)					0	
62.00	Supplies (see instructions)					0	
63. 00	Total allowance (sum of lines 57-62)					7, 882	
64. 00	Total cost of outside supplier services (from					1, 688	
65. 00	Excess over limitation (line 64 minus line 63	- if negative	, enter zero)			0	65. 00
	LINE 33 CALCULATION						4
	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory				others		100. 00 100. 01

	1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00 Salary equivalency amount (from line 23)	7, 460	57. 00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))	422	58. 00
59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46)	0	59. 00
60.00 Overtime allowance (from column 5, line 56)	0	60.00
61.00 Equipment cost (see instructions)	0	61. 00
62.00 Supplies (see instructions)	0	62. 00
63.00 Total allowance (sum of lines 57-62)	7, 882	63. 00
64.00 Total cost of outside supplier services (from your records)	1, 688	64. 00
65.00 Excess over limitation (line 64 minus line 63 – if negative, enter zero)	0	65. 00
LINE 33 CALCULATION		l
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	373	100. 00
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	49	100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27	422	100. 02
LINE 34 CALCULATION		
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others	49	101. 00
101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	101. 01
101.02 Line 34 = sum of lines 27 and 31	49	101. 02
LINE 35 CALCULATION		l
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others	0	102. 00
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line	0	102. 01
13 for all others		
102.02 Line 35 = sum of lines 31 and 32	0	102. 02

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED I OUTSIDE SUPPLIERS		FURNI SHED BY	Provider CCM	N: 15-1311	Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2019 12:	pared
					Respi ratory Therapy	Cost	то р
						1. 00	
	PART I - GENERAL INFORMATION		,				
00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instructi	ons)			19 285	
00	Number of unduplicated days in which supervis	sor or therapist	was on provid	er site (see	e instructions)	43	1
00	Number of unduplicated days in which therapy		n provider sit	e but neithe	er supervisor	0	4.
00	nor therapist was on provider site (see instr Number of unduplicated offsite visits - super		oists (see ins	tructions)		0	5.
00	Number of unduplicated offsite visits - thera					0	6.
	assistant and on which supervisor and/or ther instructions)	apist was not pr	resent during	the visit(s)) (see		
00	Standard travel expense rate					5. 45	1
00	Optional travel expense rate per mile	Supervi sors	Therapists	Assi stants	Ai des	0.00 Trai nees	8.
		1.00	2. 00	3. 00	4. 00	5. 00	
00	Total hours worked	0. 00	517. 42	0.0		0.00	
0. 00 1. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 32. 59	65. 18 32. 59	0. (0. (0. 00	10. (
	one-half of column 2, line 10; column 3,						
2. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	o		0		12. (
2. 01	Number of travel hours (offsite)						12.
3. 00	Number of miles driven (provider site)	0	0		0		13.
3. 01	Number of miles driven (offsite)						13.
	D					1. 00	
1. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14.
5. 00	Therapists (column 2, line 9 times column 2,	line 10)				33, 725	15.
6. 00 7. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 ar		atory thorany	or lines 14	16 for all	0 33, 725	
7.00	others)	iu is foi respira	атогу тпегару	UI IIIIES 14-	10 101 all	33, 723	17.
3. 00	Aides (column 4, line 9 times column 4, line					0	
9. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo		nerapy or line	s 17 and 18	for all others)	0 33, 725	1
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech patho occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on I						
	the amount from line 20. Otherwise complete	lines 21-23.					
1. 00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			of columns	1 and 2, line 9	0. 00	21.
2. 00	Weighted allowance excluding aides and trained					0	1
3. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	IANCE AND TDAVEL	EVDENSE COMDIT	TATION DDO	N/I DED SITE	33, 725	23.
	Standard Travel Allowance	ANCE AND TRAVEL	EXPENSE COMPO	TATION - FRO	WIDER SITE		1
4. 00	Therapists (line 3 times column 2, line 11)					1, 401	
5. 00 5. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for al	l others)		0 1, 401	1
7. 00	Standard travel expense (line 7 times line 3				and 4 for all	234	1
3. 00	others) Total standard travel allowance and standard	travel expense a	at the provide	r site (sum	of lines 26 and	1, 635	28.
	27)	<u> </u>					
9. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		2 line 12)			0	29.
0.00	Assistants (column 3, line 10 times column 3,		2,2 ,			0	1
1.00	Subtotal (line 29 for respiratory therapy or				, on our of	0	
2. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s I and 2, II ne	is for respira	tory therapy	or sum or	0	32.
3. 00	Standard travel allowance and standard travel			21)		1, 635	1
1. 00 5. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel					0	1
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO	VIDER SITE	
5. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.
7. 00	Assistants (line 6 times column 3, line 11)					0	1
3. 00	Subtotal (sum of lines 36 and 37)	. of Ii " '	4)			0	1
9. 00	Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel		U)			0	39.
0. 00	Therapists (sum of columns 1 and 2, line 12.0	1 times column 2	2, line 10)			0	1
	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	1 3, line 10)				0	
1.00							1 12.
. 00 2. 00 3. 00	Optional travel expense (line 8 times the sum	of columns 1-3,	line 13.01)			0	43.

	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider Co		Peri od: From 01/01/2018 To 12/31/2018		pared:	
					Respi ratory Therapy	Cost		
						1. 00		
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see in	structions)	0	45. 00	
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00	
		Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4. 00	Total 5.00		
	PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1. 00	0.00		
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	16. 00	0.00	0.0	0.00	16. 00	47. 00	
48. 00	Overtime rate (see instructions)	97. 77	0.00				48. 00	
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	1, 564. 32	0.00	0.0	0.00		49. 00	
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	100. 00	0. 00	0.0	0.00	100.00	50. 00	
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	2, 080. 00	0.00	O. C	0.00	2, 080. 00	51. 00	
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	65. 18	0.00	0.0	0.00		52. 00	
	(see instructions)							
53. 00	Overtime cost limitation (line 51 times line 52)	135, 574	0		0		53. 00	
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	1, 564	0		0 0		54. 00	
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	1, 043	0		0 0		55. 00	
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	521	0		0 0	521	56. 00	
	respiratory therapy and columns 1 through 3 for all others.)							
						1. 00		
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			1.00		
57. 00	Salary equivalency amount (from line 23)					33, 725		
58. 00 59. 00	Travel allowance and expense - provider site Travel allowance and expense - Offsite service			,		1, 635 0	58. 00 59. 00	
60. 00	Overtime allowance (from column 5, line 56)	es (110m 11nes	44, 45, 01 40)		521	60.00	
61. 00	Equipment cost (see instructions)					0	61. 00	
	Supplies (see instructions)					0		
63. 00 64. 00	Total allowance (sum of lines 57-62)	vour records)				35, 881 36, 379		
	00 Total cost of outside supplier services (from your records) 00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)							
100 00	LINE 33 CALCULATION	oum of Linco 2	4 and DE for a	II othoro		1 401	100. 00	
100. 01	00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION							
101. 01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02	
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01	
102. 02	13 for all others Line 35 = sum of lines 31 and 32					0	102. 02	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I
To 1/21/2019 Part II
To 1/21/2019 Part II Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1311

				Ť.	0 12/31/2018	Date/Time Pre 5/29/2019 12:	
			CAP	TAL RELATED CO	STS	3/24/2014 12.	43 piii
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1.00	1. 01	2. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 611, 830	1, 611, 830				1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	651, 839	0	651, 839			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 326, 962			1, 326, 962		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 130, 746	7, 149			2, 147, 058	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 217, 141	111, 628	l		150, 527	5. 00
7.00	00700 OPERATION OF PLANT	4, 150, 507	395, 480	158, 582	326, 485	150, 041	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	14, 739	0	· ·		0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	111, 418	26, 716			10, 023	8. 00
9.00	00900 HOUSEKEEPI NG	371, 869	15, 930			65, 148	
10.00	01000 DI ETARY	244, 464	22, 197			29, 219	1
11. 00	01100 CAFETERI A	372, 297	46, 777			61, 580	
13. 00	01300 NURSI NG ADMI NI STRATI ON	630, 720		1		114, 105	1
14.00	01400 CENTRAL SERVICES & SUPPLY	882, 227	34, 458			0	14. 00
15. 00	01500 PHARMACY	749, 590	12, 418	5, 665	10, 251	116, 380	15. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 140 (7)	1/0 100	72.044	122 102	202 020	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	2, 148, 676	160, 128	73, 044	132, 192	382, 820	30.00
50. 00	05000 OPERATING ROOM	1, 274, 758	201, 876	92, 088	166, 656	204, 865	50.00
53. 00	05300 ANESTHESI OLOGY	61, 639	3, 809			204, 003	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 228, 722	104, 100			211, 016	54.00
60.00	06000 LABORATORY	1, 245, 886	40, 700			211,010	60.00
65. 00	06500 RESPI RATORY THERAPY	534, 085	2, 457		2, 028	91, 549	
66. 00	06600 PHYSI CAL THERAPY	678, 530	51, 939			119, 086	
67. 00	06700 OCCUPATI ONAL THERAPY	225, 373	16, 029	1		41, 877	67. 00
69. 00	06900 ELECTROCARDI OLOGY	439, 136	27, 334	l		83, 250	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	292, 896	0			0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 506, 110	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 706, 703	0	0	0	0	73. 00
73. 01	03480 ONCOLOGY	229, 291	16, 310	7, 440	13, 464	37, 957	73. 01
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	133, 585	19, 204	8, 760	15, 853	20, 622	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	1, 702, 582	115, 240	52, 568	95, 135	221, 187	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS	1		1			
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	32, 874, 321	1, 468, 283	625, 235	1, 212, 121	2, 111, 252]118. 00
102 0	19200 PHYSICIANS' PRIVATE OFFICES	167, 910	118, 373	15, 120	97, 721	28, 736	102.00
	19200 PHYSICIANS PRIVATE OFFICES	89, 639	20, 738			· ·	192. 00
	2 19202 VACANT SPACE	09,039	4, 436				192. 01
200. 00	· ·		4, 430	2,024		U	200.00
201.00	, ,		0	0	n	Λ	201.00
202.00	1 9	33, 131, 870	1, 611, 830	_	_	2, 147, 058	
0	1 -11 - (110 -110 -100 -100 -100 -1	,, 570	., 5, 500	, 55.,567	., 525, 762	=, , 500	,

Provider CCN: 15-1311

				''	0 12/31/2010	5/29/2019 12:	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	
	'		& GENERAL	PLANT	PLANT -	LINEN SERVICE	
					OFFSI TE		
		4A	5. 00	7. 00	7. 01	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 622, 369	6, 622, 369				5. 00
7.00	00700 OPERATION OF PLANT	5, 181, 095	1, 294, 297	6, 475, 392			7. 00
7.01	00701 OPERATION OF PLANT - OFFSITE	14, 739	3, 682	0	18, 421		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	182, 399	45, 565	168, 550	0	396, 514	8. 00
9.00	00900 HOUSEKEEPI NG	473, 365	118, 252	100, 506	0	0	9. 00
10.00	01000 DI ETARY	324, 329	81, 021	140, 042	0	0	10.00
11.00	01100 CAFETERI A	540, 608	135, 050	295, 119	0	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	827, 888	206, 816	229, 675	0	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	960, 849	240, 031	217, 398	0	0	14. 00
15.00	01500 PHARMACY	894, 304	223, 407	78, 345	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	2, 896, 860	723, 667	1, 010, 260	0	396, 514	30. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	1, 940, 243	484, 694	1, 273, 646	0	0	50. 00
53.00	05300 ANESTHESI OLOGY	70, 331	17, 569	24, 034	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 677, 262	418, 998	656, 773	0	0	54. 00
60.00	06000 LABORATORY	1, 338, 751	334, 435	256, 779	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	631, 240	157, 691	15, 502	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	898, 781	224, 525	86, 772	8, 476	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	298, 449	74, 556	101, 130	2, 615	0	67. 00
69.00	06900 ELECTROCARDI OLOGY	584, 754	146, 078	172, 452	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	292, 896	73, 169	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 506, 110	376, 243	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 706, 703	426, 353	0	0	0	73. 00
73. 01	03480 ONCOLOGY	304, 462	76, 058	102, 899	0	0	73. 01
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	198, 024	49, 469	121, 158	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
91.00	09100 EMERGENCY	2, 186, 712	546, 265	727, 054	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92. 00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	32, 553, 523	6, 477, 891	5, 778, 094	11, 091	396, 514	118. 00
	NONREI MBURSABLE COST CENTERS						1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	427, 860	106, 884	538, 476	7, 330	0	192. 00
192. 01	19201 OCCUPATIONAL MEDICINE	144, 027	35, 980	130, 834			192. 01
	19202 VACANT SPACE	6, 460	· ·				192. 02
200.00	1 1	0					200. 00
201.00	1 1	0	0	0	0	0	201. 00
202.00		33, 131, 870	6, 622, 369	6, 475, 392	18, 421	396, 514	202. 00
	1 (3. 2.)				-,		

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1311

				T	o 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Cost Center Description	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	CENTRAL	43 piii
	, , , , , , , , , , , , , , , , , , ,				ADMINISTRATION	SERVICES &	
						SUPPLY	
		9. 00	10.00	11. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7.00
7. 01	00701 OPERATION OF PLANT - OFFSITE						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG	692, 123	E / O O 0 4 7				9.00
10.00	01000 DI ETARY	14, 625	560, 017	4 004 507			10.00
11.00	01100 CAFETERI A	30, 819	0	1, 001, 596			11.00
13.00	01300 NURSING ADMINISTRATION	23, 985	0	47, 110		4 440 004	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	22, 703	0	0		1, 440, 981	14. 00
15. 00	01500 PHARMACY	8, 182	0	49, 040	0	5, 305	15. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	105, 502	560, 017	254, 920	801, 784	40.055	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	103, 302	360, 017	234, 920	001, 704	49, 855	30.00
50.00	05000 OPERATI NG ROOM	133, 007	ol	105, 585	206, 312	350, 887	50.00
53. 00	05300 ANESTHESI OLOGY	2, 510	Ö	7, 149		405	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	68, 587	o	112, 806		12, 464	1
60.00	06000 LABORATORY	26, 815	o	74, 703		.2, .0.	60.00
65. 00	06500 RESPIRATORY THERAPY	1, 619	o	46, 681		16, 573	
66. 00	06600 PHYSI CAL THERAPY	34, 220	o	64, 195		5, 719	1
67. 00	06700 OCCUPATI ONAL THERAPY	10, 561	o	22, 804		161	1
69. 00	06900 ELECTROCARDI OLOGY	18, 009	o	37, 030		6, 733	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	0	o	155, 039	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	O	o	0	o	797, 228	1
73.00	07300 DRUGS CHARGED TO PATIENTS	O	o	0	O	0	1
73. 01	03480 ONCOLOGY	10, 746	o	19, 158	28, 672	5, 088	73. 01
76. 00	03160 CARDI OPULMONARY	O	o	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	12, 653	o	10, 008	34, 411	498	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	75, 926	0	124, 672	238, 913	30, 192	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		600, 469	560, 017	975, 861	1, 335, 474	1, 436, 147	118. 00
	NONREI MBURSABLE COST CENTERS		_1				
	19200 PHYSI CI ANS' PRI VATE OFFI CES	77, 991	0	18, 801		· ·	192.00
	19201 OCCUPATI ONAL MEDI CI NE	13, 663	0	6, 934	0	· ·	192. 01
	2 19202 VACANT SPACE	0	o	0	0	0	192. 02
200.00	J			^		_	200. 00
201.00		402 122	E40 017	1 001 504	1 225 474		201. 00
202.00	TOTAL (sum lines 118 through 201)	692, 123	560, 017	1, 001, 596	1, 335, 474	1, 440, 981	1202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B
Part I
Date/Time Prepared:
5/29/2019 12: 43 pm Provider CCN: 15-1311 Peri od: From 01/01/2018 To 12/31/2018 Cost Center Description PHARMACY Subtotal Total Intern & Residents Cost & Post Stepdown

			Stepdown		
			Adjustments		
	15. 00	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1. 00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - INTERES					1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					2. 00
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 - OFFSITE					7. 01
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					13. 00
14.00 01400 CENTRAL SERVI CES & SUPPLY					14.00
15. 00 01500 PHARMACY	1, 258, 583				15. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	11, 508	6, 810, 887	0	6, 810, 887	30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	10, 920	4, 505, 294	0	4, 505, 294	50.00
53. 00 05300 ANESTHESI OLOGY	1, 710	123, 708	0	123, 708	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 753	2, 949, 726	0	2, 949, 726	54.00
60. 00 06000 LABORATORY	0	2, 031, 483	0	2, 031, 483	60.00
65. 00 06500 RESPIRATORY THERAPY	128	869, 434	0	869, 434	65. 00
66. 00 06600 PHYSI CAL THERAPY	168	1, 322, 856	0	1, 322, 856	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	510, 276	0	510, 276	67. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 412	993, 767	0	993, 767	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	O	521, 104	0	521, 104	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	2, 679, 581	0	2, 679, 581	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 206, 800	3, 339, 856	0	3, 339, 856	73. 00
73. 01 03480 ONCOLOGY	1, 527	548, 610	0	548, 610	73. 01
76. 00 03160 CARDI OPULMONARY	o	o	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	426, 221	0	426, 221	76. 97
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				
91. 00 09100 EMERGENCY	14, 420	3, 944, 154	0	3, 944, 154	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	,	-, ,	Ö	2, ,	92.00
SPECIAL PURPOSE COST CENTERS			-	<u> </u>	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 253, 346	31, 576, 957	0	31, 576, 957	118. 00
NONREI MBURSABLE COST CENTERS	1,200,010	01,070,707	o _l	01, 070, 707	110.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	45	1, 180, 944	0	1, 180, 944	192. 00
192. 01 19201 OCCUPATI ONAL MEDI CI NE	5, 192	337, 907	0	337, 907	192. 01
192. 02 19202 VACANT SPACE	3, 1,2	36, 062	0	36, 062	192. 02
200.00 Cross Foot Adjustments	١	36, 062	0	30, 002	200. 00
201.00 Negative Cost Centers		0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 258, 583	33, 131, 870		33, 131, 870	201.00
202.00 TOTAL (Suil TITIES TTO THEOUGH 201)	1, 200, 303	33, 131, 670	ı q	33, 131, 070	J202. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

					0 12/31/2018	Date/Time Pre 5/29/2019 12:	
			CAPITAL RELATED COSTS			3/29/2019 12.	43 piii
	Cost Center Description	Di rectly Assi gned New Capi tal Rel ated Costs	BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	Subtotal	
		0	1. 00	1. 01	2. 00	2A	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - INTERES 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 1. 01 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	7, 149			16, 312	4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	0	111, 628			254, 701	5. 00
7.00	00700 OPERATION OF PLANT	0	395, 480			880, 547	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	· -		0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	26, 716			60, 958	8. 00
9.00	00900 HOUSEKEEPI NG	0	15, 930		13, 151	36, 348	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	22, 197			50, 646	10. 00 11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	46, 777 36, 404			106, 731 83, 063	
14. 00	01400 CENTRAL SERVICES & SUPPLY		34, 458			78, 622	1
15. 00	01500 PHARMACY		12, 418			28, 334	
13.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	١	12, 410	3,000	10, 231	20, 334	13.00
30.00	03000 ADULTS & PEDI ATRI CS	0	160, 128	73, 044	132, 192	365, 364	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	201, 876			460, 620	1
53.00	05300 ANESTHESI OLOGY	0	3, 809			8, 692	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	104, 100			237, 524	54.00
60.00	06000 LABORATORY	0	40, 700			92, 865	1
65.00	06500 RESPIRATORY THERAPY	0	2, 457			5, 606	1
66. 00	06600 PHYSI CAL THERAPY	0	51, 939			101, 165	
67. 00 69. 00	06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY	0	16, 029			31, 199 62, 368	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	27, 334 0			02, 308	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0			0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0			0	73.00
73. 01	03480 ONCOLOGY		16, 310	ľ	١	37, 214	73. 01
76. 00	03160 CARDI OPULMONARY	o	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	19, 204	8, 760	15, 853	43, 817	76. 97
	OUTPATIENT SERVICE COST CENTERS			•			
91.00	09100 EMERGENCY	0	115, 240	52, 568	95, 135	262, 943	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 468, 283	625, 235	1, 212, 121	3, 305, 639	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	0	118, 373			231, 214	
	19201 OCCUPATI ONAL MEDI CI NE	0	20, 738			47, 318	
	19202 VACANT SPACE	0	4, 436	2, 024	0		192. 02
200.00	,		_	_	_		200.00
201.00	1 9		1 (11 020	0 451 020			201. 00
202.00	TOTAL (sum lines 118 through 201)	0	1, 611, 830	651, 839	1, 326, 962	3, 590, 631	J2U2. UU

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

				10	0 12/31/2018	5/29/2019 12:	
	Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	ГО РІП
	, , , , , , , , , , , , , , , , , , ,	BENEFITS	& GENERAL	PLANT	PLANT -	LINEN SERVICE	
		DEPARTMENT			OFFSI TE		
		4. 00	5. 00	7. 00	7. 01	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	16, 312					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 144	255, 845				5. 00
7. 00	00700 OPERATION OF PLANT	1, 140	50, 009				7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	142		142		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	76	1, 760		0	87, 045	8. 00
9. 00	00900 HOUSEKEEPI NG	495	4, 568		0	0	9. 00
10. 00	01000 DI ETARY	222	3, 130		0	0	10. 00
11. 00	01100 CAFETERI A	468	5, 217		0	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	867	7, 990		0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	9, 273		0	0	14. 00
15. 00	01500 PHARMACY	884	8, 631	11, 272	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		07.050	445.050		07.045	
30. 00	03000 ADULTS & PEDI ATRI CS	2, 908	27, 958	145, 359	0	87, 045	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1, 556	18, 725	183, 256	0	0	50.00
53. 00	05300 ANESTHESI OLOGY	1, 556	10, 723		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 603	16, 187		0	0	54.00
60.00	06000 LABORATORY	1,003	12, 920		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	696	6, 092		0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	905	8, 674		65	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	318	2, 880		20	0	67.00
69. 00	06900 ELECTROCARDI OLOGY	633	5, 643		0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	033	2, 827		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 535		0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	16, 471		0	o o	73.00
73. 01	03480 ONCOLOGY	288	2, 938		0	0	73. 01
76. 00	03160 CARDI OPULMONARY	0	2, 730		0	Ö	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	157	1, 911	17, 433	0	0	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	107	1, 711	17, 100	<u> </u>		70.77
91. 00	09100 EMERGENCY	1, 680	21, 104	104, 610	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		16, 040	250, 264	831, 367	85	87, 045	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	218	4, 129		57		192. 00
	19201 OCCUPATIONAL MEDICINE	54	1, 390		0		192. 01
	2 19202 VACANT SPACE	0	62	4, 027	0	0	192. 02
200.00	1						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	16, 312	255, 845	931, 696	142	87, 045	202. 00

| Period: | Worksheet B | From 01/01/2018 | Part II | To | 12/31/2018 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

				Т	o 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	Jo piii
					ADMINI STRATTON	SUPPLY	
		9.00	10. 00	11. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE						7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG	55, 872					9. 00
10. 00	01000 DI ETARY	1, 181	75, 329				10. 00
11. 00	01100 CAFETERI A	2, 488	0	157, 366	1		11. 00
13. 00	01300 NURSING ADMINISTRATION	1, 936	0	7, 402	1		13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 833	0	C	1	121, 008	
15. 00	01500 PHARMACY	660	0	7, 705	0	446	15. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	0.547	75 000	40.050	00 (00	4 407	00.00
30. 00	03000 ADULTS & PEDI ATRI CS	8, 517	75, 329	40, 053	80, 633	4, 187	30.00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	10.72/	ol	1/ 500	20.740	20. 444	50.00
53. 00	05300 ANESTHESI OLOGY	10, 736 203	0	16, 589 1, 123		29, 466 34	53.00
54. 00	05400 RADI OLOGY – DI AGNOSTI C	5, 537	0	17, 723	1	1, 047	54.00
60.00	06000 LABORATORY	2, 165	0	11, 723	1	1, 047	60.00
65. 00	06500 RESPI RATORY THERAPY	131	0	7, 334	I	1, 392	65.00
66. 00	06600 PHYSI CAL THERAPY	2, 762	0	10, 086	I	480	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	853	0	3, 583	I	14	67.00
69. 00	06900 ELECTROCARDI OLOGY	1, 454	0	5, 818		565	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 434	0	3, 616	1	13, 020	1
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	1	66, 947	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0			00, 747	73.00
73. 00	03480 ONCOLOGY	867	0	3, 010	1	427	73. 00
76. 00	03160 CARDI OPULMONARY	007	0	3, 010	1	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 021	0	1, 572	1	42	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	1,021	<u> </u>	1, 372	. 3, 401	42	70. 77
91. 00	09100 EMERGENCY	6, 129	ol	19, 588	24, 027	2, 535	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 127	Ÿ	17, 300	24,027	2, 555	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		48, 473	75, 329	153, 323	134, 304	120, 602	118. 00
	NONREI MBURSABLE COST CENTERS	107 170	707027	100,020	1017001	120,002	
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 296	0	2, 954	O	299	192. 00
	19201 OCCUPATI ONAL MEDI CI NE	1, 103	o	1, 089	1		192. 01
	19202 VACANT SPACE	0	o	., 55,	1		192. 02
200.00			Ĭ	_		· ·	200. 00
201. 00	1 1	l	o	C	ol ol	0	201. 00
202.00		55, 872	75, 329	157, 366	134, 304	121, 008	
					. '		•

Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311 Peri od: Worksheet B From 01/01/2018 Part II 12/31/2018 Date/Time Prepared: 5/29/2019 12:43 pm Cost Center Description **PHARMACY** Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 15.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT - OFFSITE 7.01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 57, 932 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 837, 883 0 837, 883 30.00 530 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 503 742, 199 0 742, 199 50.00 05300 ANESTHESI OLOGY 0 53.00 79 14, 268 14, 268 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 374, 254 54 00 127 374, 254 54 00 06000 LABORATORY 0 60.00 0 156, 633 156, 633 60.00 65.00 06500 RESPIRATORY THERAPY 6 23, 488 23, 488 65.00 06600 PHYSI CAL THERAPY 0 66.00 8 136, 630 136, 630 66.00 06700 OCCUPATIONAL THERAPY 0 53, 418 0 53, 418 67 00 67 00 06900 ELECTROCARDI OLOGY 69.00 157 103, 995 103, 995 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15, 847 0 15, 847 71.00 71.00 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 81, 482 81, 482 72.00 72.00 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 72, 018 72, 018 55.547 73.00 0 73. 01 03480 ONCOLOGY 70 62, 502 62, 502 73.01 03160 CARDI OPULMONARY 0 76.00 0 76.00 07697 CARDIAC REHABILITATION 76. 97 69, 414 0 69.414 76.97 0 OUTPATIENT SERVICE COST CENTERS 443, 280 91.00 09100 EMERGENCY 0 91.00 664 443, 280 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 SPECIAL PURPOSE COST CENTERS 3, 187, 311 3, 187, 311 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 57, 691 0 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 322, 646 0 322, 646 192.00

239

57, 932

0

70, 125

10, 549

3, 590, 631

0

0

0

0

70, 125

10, 549

3, 590, 631

0

0

192. 01

192.02

200.00

201.00

202. 00

192. 01 19201 OCCUPATI ONAL MEDI CI NE

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

192. 02 19202 VACANT SPACE

200.00

201.00

202.00

| Peri od: | Worksheet B-1 | To | 12/31/2010 | From 01/01/2018 | To | 12/31/2010 | From CMS-2552-10 Provider CCN: 15-1311

				T	rom 01/01/2018 o 12/31/2018	Date/Time Pre 5/29/2019 12:	pared:
		CAPI	TAL RELATED CO	OSTS		372472014 12.	43 piii
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	BLDG & FIXT - INTERES (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT	Reconciliation	
					(GROSS SALARI ES)		
		1.00	1. 01	2.00	4. 00	5A	
	GENERAL SERVICE COST CENTERS						
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 CAP REL COSTS-BLDG & FIXT - INTERES	195, 479 0	172 202				1. 00 1. 01
2. 00	00200 CAP REL COSTS-BLDG & FIXT - THIERES		173, 302	194, 941			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	867	867		10, 970, 126		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	13, 538	13, 538				5. 00
7.00	00700 OPERATION OF PLANT	47, 963	42, 162				7. 00
7. 01 8. 00	OO701 OPERATION OF PLANT - OFFSITE OO800 LAUNDRY & LINEN SERVICE	3, 240	0 3, 240		-	1	7. 01 8. 00
9. 00	00900 HOUSEKEEPING	1, 932	1, 932				9. 00
10. 00	01000 DI ETARY	2, 692	2, 692				10.00
11. 00	01100 CAFETERI A	5, 673	5, 673	5, 673		0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	4, 415			-		13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	4, 179 1, 506				-	14. 00 15. 00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 500	1, 500	1, 500	394, 020		15.00
30.00	03000 ADULTS & PEDI ATRI CS	19, 420	19, 420	19, 420	1, 955, 998	0	30. 00
	ANCILLARY SERVICE COST CENTERS	1				I -	
50.00	05000 OPERATI NG ROOM 05300 ANESTHESI OLOGY	24, 483			1, 046, 730 0		50.00
53. 00 54. 00	05400 RADI OLOGY-DI AGNOSTI C	462 12, 625	462 12, 625		-		53. 00 54. 00
60.00	06000 LABORATORY	4, 936	4, 936			Ö	60.00
65.00	06500 RESPIRATORY THERAPY	298	298			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	6, 299	1, 688				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 944	515				67.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	3, 315	3, 315 0				69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01	03480 ONCOLOGY	1, 978	1, 978	1, 978			73. 01
76. 00	03160 CARDI OPULMONARY	0	0	0	105 247		76. 00
76. 97	O7697 CARDI AC REHABILITATION OUTPATIENT SERVICE COST CENTERS	2, 329	2, 329	2, 329	105, 367	0	76. 97
91. 00	09100 EMERGENCY	13, 976	13, 976	13, 976	1, 130, 125	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
440.00	SPECIAL PURPOSE COST CENTERS	470.070	4// 000	170 070	40 707 404		140 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	178, 070	166, 229	178, 070	10, 787, 184	-6, 622, 369	118.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	14, 356	4, 020	14, 356	146, 821	0	192. 00
	19201 OCCUPATIONAL MEDICINE	2, 515	2, 515		-		192. 01
	19202 VACANT SPACE	538	538	0	0		192. 02
200.00	, , , , , , , , , , , , , , , , , , , ,						200. 00
201.00 202.00		1, 611, 830	651, 839	1, 326, 962	2, 147, 058		201. 00 202. 00
202.00	Part I)	1,011,030	051, 639	1, 320, 902	2, 147, 030		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 245540	3. 761290	6. 806993	0. 195719		203. 00
204.00					16, 312		204. 00
205 00	Part II)				0 001407		205 00
205. 00	Unit cost multiplier (Wkst. B, Part				0. 001487		205. 00
206. 00							206. 00
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)			l		l	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1311

					o 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	, , , , , , , , , , , , , , , , , , ,
	·	& GENERAL	PLANT	PLANT -	LINEN SERVICE	(SQUARE FEET)	
		(ACCUM. COST)	(SQUARE FEET)	OFFSI TE	(TOTAL PATIENT		
		F 00	7.00	(SQUARE FEET)	DAYS)	0.00	
	CENEDAL CEDVICE COST CENTEDS	5. 00	7.00	7. 01	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 00	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	26, 509, 501					5. 00
7.00	00700 OPERATION OF PLANT	5, 181, 095	124, 475				7. 00
7.01	00701 OPERATION OF PLANT - OFFSITE	14, 739		,			7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	182, 399					8. 00
9.00	00900 HOUSEKEEPI NG	473, 365				127, 401	
10.00	01000 DI ETARY	324, 329			0	2, 692	
11.00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	540, 608			0	5, 673	
13. 00 14. 00	01400 CENTRAL SERVICES & SUPPLY	827, 888 960, 849				4, 415 4, 179	
15. 00	01500 PHARMACY	894, 304				1, 506	1
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	074, 304	1, 300	·	<u> </u>	1, 300	13.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 896, 860	19, 420	0	2, 444	19, 420	30. 00
	ANCILLARY SERVICE COST CENTERS		<u> </u>	•			
50.00	05000 OPERATI NG ROOM	1, 940, 243	24, 483	0	0	24, 483	
53.00	05300 ANESTHESI OLOGY	70, 331	462			462	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 677, 262				12, 625	
60. 00	06000 LABORATORY	1, 338, 751	4, 936			4, 936	1
65. 00	06500 RESPI RATORY THERAPY	631, 240				298	1
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	898, 781	1, 668			6, 299	1
67. 00 69. 00	06900 ELECTROCARDI OLOGY	298, 449 584, 754				1, 944 3, 315	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	292, 896		1		0, 313	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 506, 110			0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 706, 703			0	0	1
73. 01	03480 ONCOLOGY	304, 462	1, 978	0	0	1, 978	73. 01
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	198, 024	2, 329	0	0	2, 329	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	2, 186, 712	13, 976	0	0	13, 976	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	25, 931, 154	111, 071	6, 060	2, 444	110, 530	110 00
110.00	NONREI MBURSABLE COST CENTERS	25, 931, 154	111,0/1	0,000	2, 444	110, 530	1116.00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	427, 860	10, 351	4, 005	0	14 356	192. 00
	19201 OCCUPATIONAL MEDICINE	144, 027					192. 01
	19202 VACANT SPACE	6, 460					192. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	1 1	6, 622, 369	6, 475, 392	18, 421	396, 514	692, 123	202. 00
	Part I)				1.0		
203.00		0. 249811	52. 021627			5. 432634	
204.00		255, 845	931, 696	142	87, 045	55, 872	204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	0. 009651	7. 485005	0. 014108	35. 615794	0. 438552	205 00
200.00		0.007031	7. 403003	0.014100	33.013794	0. 430332	200.00
206.00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	-					207. 00
207.00	Parts III and IV)						207.00

	Financiai Systems	TO HEALTH TIPIC				U OT FORM CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
					om 01/01/2018	D-+- /T: D	
				To	12/31/2018		
	Cost Contan Decemintion	DIETADY	CAFETERIA	MIDCLNC	CENTRAL	5/29/2019 12:	43 piii
	Cost Center Description	DIETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(FTE' S)	ADMI NI STRATI ON	SERVICES &	(COSTED	
				(0) 0507	SUPPLY	REQUIS.)	
				(DI RECT	(COSTED		
				NURSING HOURS)	REQUIS.)		
		10.00	11. 00	13. 00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT					l	1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES					ļ	1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP					I	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					l	5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE					ļ	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE					ļ	8. 00
9. 00	00900 HOUSEKEEPI NG					l	9. 00
		0.50/				l	1
10.00	01000 DI ETARY	8, 586				l	10.00
11. 00	01100 CAFETERI A	0	14, 011			l	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	659			l	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	C	0	2, 722, 273	l	14. 00
15.00	01500 PHARMACY	0	686	0	10, 023	1, 779, 936	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	8, 586	3, 566	67, 757	94, 185	16, 275	30.00
	ANCILLARY SERVICE COST CENTERS	.,,	-,				
50.00	05000 OPERATI NG ROOM	0	1, 477	17, 435	662, 888	15, 443	50.00
53. 00	05300 ANESTHESI OLOGY		100		765	2, 418	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1, 578		23, 546	3, 893	
	06000 LABORATORY	0			23, 540		1
60.00		0	1, 045		-1	0	
65. 00	06500 RESPI RATORY THERAPY	0	653		31, 309	181	1
66. 00	06600 PHYSI CAL THERAPY	0	898		10, 804	237	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	319		304	0	
69. 00	06900 ELECTROCARDI OLOGY	0	518	2, 138	12, 720	4, 825	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0	292, 896	0	71. 00
72.00	07200 MPL. DEV. CHARGED TO PATIENTS	0	C	0	1, 506, 110	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	0	0	1, 706, 703	73. 00
73. 01	03480 ONCOLOGY	0	268	2, 423	9, 613	2, 160	73. 01
76.00	03160 CARDI OPULMONARY	0	C	o	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	140	2, 908	941	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	· ·		· · · · ·			1
91.00	09100 EMERGENCY	0	1, 744	20, 190	57, 038	20, 394	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1	.,		21,7000	,	92. 00
, 2. 00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		8, 586	13, 651	112, 858	2, 713, 142	1, 772, 529	118 00
110.00	NONREI MBURSABLE COST CENTERS	0, 300	13, 031	112,000	2, 713, 142	1, 112, 327	1110.00
102.00	19200 PHYSI CLANS' PRI VATE OFFI CES	O	263	8 0	6, 719	4.1	192. 00
							1
	19201 OCCUPATI ONAL MEDICINE		97		2, 412		192. 01
	19202 VACANT_SPACE	0	C	0	0		192. 02
200.00							200. 00
201.00							201. 00
202.00		560, 017	1, 001, 596	1, 335, 474	1, 440, 981	1, 258, 583	202. 00
	Part I)	1				ļ	
203.00	Unit cost multiplier (Wkst. B, Part I)	65. 224435	71. 486404	11. 833224	0. 529330	0. 707095	
204.00	Cost to be allocated (per Wkst. B,	75, 329	157, 366	134, 304	121, 008	57, 932	204. 00
	Part II)					l	
205.00	Unit cost multiplier (Wkst. B, Part	8. 773468	11. 231604	1. 190026	0. 044451	0. 032547	205. 00
						ļ	
206.00						ļ	206. 00
	(per Wkst. B-2)					ļ	
207.00		1				ļ	207. 00
	Parts III and IV)					ļ	
		,		'	,	,	

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1311	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

					To 12/31/2018		pared: 43 pm
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30.00	03000 ADULTS & PEDI ATRI CS	6, 810, 887		6, 810, 88	7 0	0	30.00
	ANCILLARY SERVICE COST CENTERS			., ,			
50.00	05000 OPERATI NG ROOM	4, 505, 294		4, 505, 294	1 0	0	50.00
53.00	05300 ANESTHESI OLOGY	123, 708		123, 708	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 949, 726		2, 949, 720	0	0	54.00
60.00	06000 LABORATORY	2, 031, 483		2, 031, 483	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	869, 434	0	869, 434	1 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 322, 856	0	1, 322, 856	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	510, 276	0	510, 27	6 0	0	67. 00
	06900 ELECTROCARDI OLOGY	993, 767		993, 76	7 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	521, 104		521, 104	1 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 679, 581		2, 679, 58	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	3, 339, 856		3, 339, 856	6 0	0	73. 00
73. 01	03480 ONCOLOGY	548, 610		548, 610	0	0	73. 01
76.00	03160 CARDI OPULMONARY	0			0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	426, 221		426, 22	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				_		
	09100 EMERGENCY	3, 944, 154		3, 944, 154		0	1 , 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 225, 273		1, 225, 27		0	1 /2.00
200.00	,	32, 802, 230		32, 802, 230			200. 00
201.00		1, 225, 273		1, 225, 27			201. 00
202.00	Total (see instructions)	31, 576, 957	0	31, 576, 95	7 0	0	202. 00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 12:	pared: 43 pm
		Ti tl e	2 XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
·	·	·	+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30 00 03000 ADULTS & PEDLATRICS	5 094 591		5 094 59	1		1 30 00

		Charges					
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	5, 094, 591		5, 094, 591			30. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	8, 924, 389				0. 000000	
53. 00	05300 ANESTHESI OLOGY	408, 146				0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	379, 320	8, 465, 799				
60.00	06000 LABORATORY	768, 987	4, 462, 935			0. 000000	
65. 00	06500 RESPI RATORY THERAPY	476, 023	528, 880			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	844, 966	1, 654, 123			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	397, 983	477, 473	· ·		0. 000000	
	06900 ELECTROCARDI OLOGY	219, 494	4, 116, 069				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 559, 341	2, 000, 504			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	10, 941, 173	4, 163, 462	15, 104, 635	0. 177401	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	2, 343, 412	7, 964, 299			0. 000000	
	03480 ONCOLOGY	0	1, 110, 522	1, 110, 522		0. 000000	
	03160 CARDI OPULMONARY	0	0	0	0. 000000	0. 000000	
76. 97	07697 CARDIAC REHABILITATION	0	667, 147	667, 147	0. 638871	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	374, 102	11, 102, 426			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 256	3, 095, 805	3, 107, 061	0. 394351	0. 000000	
200.00	Subtotal (see instructions)	32, 743, 183	67, 255, 752	99, 998, 935			200. 00
201.00	l l						201. 00
202.00	Total (see instructions)	32, 743, 183	67, 255, 752	99, 998, 935			202. 00

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL	In Lie	u of Form CMS	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1311	Peri od: From 01/01/2018 To 12/31/2018		
Title XVIII					Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS					30.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
60.00	06000 LABORATORY	0. 000000				60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1311	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

					Γο 12/31/2018		pared: 43 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30.00	03000 ADULTS & PEDIATRICS	6, 810, 887		6, 810, 88	7 0	6, 810, 887	30.00
	ANCILLARY SERVICE COST CENTERS			., ,			
50.00	05000 OPERATI NG ROOM	4, 505, 294		4, 505, 294	1 0	4, 505, 294	50.00
53.00	05300 ANESTHESI OLOGY	123, 708		123, 708	0	123, 708	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 949, 726		2, 949, 720	5 0	2, 949, 726	54.00
60.00	06000 LABORATORY	2, 031, 483		2, 031, 483	3 0	2, 031, 483	60.00
65.00	06500 RESPI RATORY THERAPY	869, 434	0	869, 434	1 0	869, 434	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 322, 856	0	1, 322, 856	6 0	1, 322, 856	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	510, 276	0	510, 27	6 0	510, 276	67. 00
69.00	06900 ELECTROCARDI OLOGY	993, 767		993, 76	7 0	993, 767	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	521, 104		521, 104	4 O	521, 104	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 679, 581		2, 679, 58	1 0	2, 679, 581	72. 00
	07300 DRUGS CHARGED TO PATIENTS	3, 339, 856		3, 339, 856	6 0	3, 339, 856	73. 00
73. 01	03480 ONCOLOGY	548, 610		548, 610	0	548, 610	73. 01
76.00	03160 CARDI OPULMONARY	0			0	0	70.00
76. 97	07697 CARDI AC REHABI LI TATI ON	426, 221		426, 22	1 0	426, 221	76. 97
	OUTPATIENT SERVICE COST CENTERS				_		
	09100 EMERGENCY	3, 944, 154		3, 944, 154		3, 944, 154	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 225, 273		1, 225, 27		1, 225, 273	
200.00	,	32, 802, 230		32, 802, 230		,,	
201.00	1 1	1, 225, 273		1, 225, 27		1, 225, 273	
202.00	Total (see instructions)	31, 576, 957	0	31, 576, 95	7 0	31, 576, 957	202. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 12:	pared: 43 pm
		Ti tl	e XIX	Hospi tal	Cost	
·		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6, 00	7.00	8.00	9, 00	10.00	

		Ti tl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	5, 094, 591		5, 094, 591			30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	8, 924, 389	16, 824, 256	25, 748, 645	0. 174972	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	408, 146	622, 052	1, 030, 198	0. 120082	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	379, 320	8, 465, 799	8, 845, 119	0. 333486	0.000000	54.00
60. 00 06000 LABORATORY	768, 987	4, 462, 935	5, 231, 922	0. 388286	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	476, 023	528, 880	1, 004, 903	0. 865192	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	844, 966	1, 654, 123	2, 499, 089	0. 529335	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	397, 983	477, 473	875, 456	0. 582869	0.000000	67.00
69. 00 06900 ELECTROCARDI OLOGY	219, 494	4, 116, 069	4, 335, 563	0. 229213	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 559, 341	2, 000, 504	3, 559, 845	0. 146384	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 941, 173	4, 163, 462	15, 104, 635	0. 177401	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 343, 412	7, 964, 299	10, 307, 711	0. 324015	0.000000	73.00
73. 01 03480 ONCOLOGY	0	1, 110, 522	1, 110, 522	0. 494011	0.000000	73. 01
76. 00 03160 CARDI OPULMONARY	o	0	0	0.000000	0.000000	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	o	667, 147	667, 147	0. 638871	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	374, 102	11, 102, 426	11, 476, 528	0. 343671	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 256	3, 095, 805	3, 107, 061	0. 394351	0.000000	92.00
200.00 Subtotal (see instructions)	32, 743, 183	67, 255, 752	99, 998, 935			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	32, 743, 183	67, 255, 752	99, 998, 935			202. 00
	,				'	•

Health Fin	nancial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-	2552-10
	ON OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1311	Period: From 01/01/2018	Worksheet C Part I	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	ATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS					30.00
	ILLARY SERVICE COST CENTERS					
50.00 050	OOO OPERATING ROOM	0. 000000				50.00
53.00 053	300 ANESTHESI OLOGY	0. 000000				53. 00
54.00 054	OO RADI OLOGY-DI AGNOSTI C	0. 000000				54. 00
60.00 060	000 LABORATORY	0. 000000				60.00
65.00 065	000 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 066	000 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 067	OO OCCUPATIONAL THERAPY	0. 000000				67.00
69. 00 069	000 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 071	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71. 00
72.00 072	00 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72. 00
73.00 073	OO DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
73. 01 034	80 ONCOLOGY	0. 000000				73. 01
76. 00 031	60 CARDI OPULMONARY	0. 000000				76. 00
76. 97 076	97 CARDIAC REHABILITATION	0. 000000				76. 97

0. 000000

0. 000000

91.00

92.00

200. 00

201. 00 202. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

201. 00 202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Subtotal (see instructions) Less Observation Beds

	52-10
Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-25	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-1311 Period: Worksheet D From 01/01/2018 Part II	
To 12/31/2018 Part 11	ared.
5/29/2019 12: 4	
Title XVIII Hospital Cost	
Cost Center Description Capital Total Charges Ratio of Cost Inpatient Capital Costs	
Related Cost (from Wkst. C, to Charges Program (column 3 x	
(from Wkst. B, Part I, col. (col. 1 ÷ col. Charges column 4)	
Part II, col. 8) 2)	
26)	
1.00 2.00 3.00 4.00 5.00	
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 0PERATI NG ROOM 742, 199 25, 748, 645 0. 028825 3, 743, 326 107, 901	50. 00
53. 00 05300 ANESTHESI OLOGY 14, 268 1, 030, 198 0. 013850 169, 716 2, 351	53. 00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 374, 254 8, 845, 119 0. 042312 156, 093 6, 605	54. 00
60. 00 06000 LABORATORY 156, 633 5, 231, 922 0. 029938 389, 757 11, 669	60.00
65. 00 06500 RESPI RATORY THERAPY 23, 488 1, 004, 903 0. 023373 279, 316 6, 528	65.00
66. 00 06600 PHYSI CAL THERAPY 136, 630 2, 499, 089 0. 054672 368, 003 20, 119	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 53, 418 875, 456 0. 061017 196, 799 12, 008	67. 00
69. 00 06900 ELECTROCARDI OLOGY 103, 995 4, 335, 563 0. 023987 120, 540 2, 891	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15, 847 3, 559, 845 0. 004452 603, 330 2, 686	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 81,482 15,104,635 0.005395 4,807,947 25,939	72.00
73. 00 07300 DRUGS CHARGED TO PATLENTS 72, 018 10, 307, 711 0. 006987 1, 075, 106 7, 512	73.00
73. 01 03480 0NCOLOGY 62, 502 1, 110, 522 0. 056282 0 0	73. 01
76. 00 03160 CARDI OPULMONARY 0 0 0. 000000 0 0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON 69, 414 667, 147 0. 104046 0 0	76. 97

443, 280 150, 734 2, 500, 162

11, 476, 528 3, 107, 061 94, 904, 344

0. 038625

0.048513

15, 252 0

11, 925, 185

91. 00 92. 00

589

0

206, 798 200. 00

OUTPATIENT SERVICE COST CENTERS
91. 00 O9100 EMERGENCY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)

Health Financial Systems	IU HEALTH TIPTON	I HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1311		Worksheet D Part IV Date/Time Prepared: 5/29/2019 12:43 pm

						5/29/2019 12:	43 pm_
			Titl∈	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	C	0	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	O C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	O C	0	0	54.00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	o c	0	0	67.00
69.00	06900 ELECTROCARDI OLOGY	0	0	o c	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	o c	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	o c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	ol c	0	0	73. 00
73. 01	03480 ONCOLOGY	0	0	ol c	0	0	73. 01
76. 00	03160 CARDI OPULMONARY	0	0	ol c	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	ol c	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	*		•			
91.00	09100 EMERGENCY	0	0	C	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0)	0	92. 00
200.00	Total (lines 50 through 199)	0	0	o c	0	0	200. 00

Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1311 Period: Worksheet D From 01/01/2018 Part IV			
Through Costs To 12/31/2018 Date/Time P			
Title XVIII Hospital Cost	•		
Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost Medical Course of color Outputient (from What Color Charges			

			'		5/29/2019 12:	43 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(25, 748, 645	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	0	0	(1, 030, 198		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(8, 845, 119		
60. 00 06000 LABORATORY	0	0	(5, 231, 922	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	(1, 004, 903	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(2, 499, 089	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(875, 456	0.000000	67. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(4, 335, 563	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	3, 559, 845	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	15, 104, 635	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C	10, 307, 711	0.000000	73. 00
73. 01 03480 ONCOLOGY	0	0	C	1, 110, 522	0.000000	73. 01
76. 00 03160 CARDI OPULMONARY	0	0	C	0	0.000000	76. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	(667, 147	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0	(11, 476, 528	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(3, 107, 061	0.000000	92. 00
200.00 Total (lines 50 through 199)	0	0	(94, 904, 344		200. 00
	•	•	•	*	•	

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS				Period: From 01/01/2018 To 12/31/2018	Worksheet D Part IV	pared:
-		Title	XVIII	Hospi tal	Cost	то ріп
Cost Center Description	Outpatient Ratio of Cost to Charges	Inpatient Program Charges	Inpatient Program Pass-Through	Outpatient Program Charges	Outpati ent Program Pass-Through	
	(col . 6 ÷ col . 7)		Costs (col. 8 x col. 10)		Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS				1 12:00		
50. 00 05000 OPERATING ROOM	0. 000000	3, 743, 326		0 0	0	50. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	169, 716		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	156, 093		0	0	54. 00
60. 00 06000 LABORATORY	0. 000000	389, 757		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	279, 316		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	368, 003		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	196, 799		0	0	67. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	120, 540		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	603, 330		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 807, 947		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 075, 106		0	0	73. 00
73. 01 03480 ONCOLOGY	0. 000000	0		0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
91. 00 09100 EMERGENCY	0. 000000	15, 252		0		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92. 00
200.00 Total (lines 50 through 199)	1	11, 925, 185	l	0	0	200. 00

Heal th F	inancial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI (ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C			Date/Time Pre 5/29/2019 12:	pared: 43 pm
			Titl∈	XVIII	Hospi tal	Cost	
				Charges	1	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Servi ces (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
ΙΔΙ	NCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	5000 OPERATING ROOM	0. 174972		3, 894, 12	5 0	0	50.00
	5300 ANESTHESI OLOGY	0. 174772		113, 44		0	
	5400 RADI OLOGY-DI AGNOSTI C	0. 120082		2, 767, 97		0	1
	6000 LABORATORY	0. 388286		1, 436, 21		o n	1
	6500 RESPI RATORY THERAPY	0. 865192		199, 06		o n	1
	6600 PHYSI CAL THERAPY	0. 529335		699, 23		o o	1
	6700 OCCUPATI ONAL THERAPY	0. 582869		187, 30		0	1
	6900 ELECTROCARDI OLOGY	0. 229213		1, 509, 39		,	1
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 146384		342, 19		,	1
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 177401		762, 03		o o	1
	7300 DRUGS CHARGED TO PATIENTS	0. 324015		3, 693, 39		Ō	1
	3480 ONCOLOGY	0. 494011		605, 57		0	1
76.00 0	3160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
76. 97 0	7697 CARDI AC REHABI LI TATI ON	0. 638871	l c	277, 08	0 0	0	76. 97
OI	UTPATIENT SERVICE COST CENTERS						1
91.00 0	9100 EMERGENCY	0. 343671	0	3, 261, 20	0 0	0	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 394351	0	1, 254, 15	8 0	0	92.00
200.00	Subtotal (see instructions)		0	21, 002, 40	4 9, 221	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	21, 002, 40	4 9, 221	0	202. 00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1311	Peri od:	Worksheet D

From 01/01/2018 Part V To 12/31/2018 Date/Time Prepared: 5/29/2019 12:43 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 681, 363 0 50.00 53.00 05300 ANESTHESI OLOGY 13, 622 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 923, 082 0 54.00 06000 LABORATORY 557, 663 0 60.00 60.00 65. 00 06500 RESPIRATORY THERAPY 172, 228 65.00 06600 PHYSI CAL THERAPY 0 66.00 370, 132 66.00 06700 OCCUPATI ONAL THERAPY 109, 177 0 67.00 67.00 69.00 06900 ELECTROCARDI OLOGY 345, 973 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 50, 092 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72 00 135, 185 0 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 196, 716 2, 988 73.00 73.01 03480 ONCOLOGY 299, 160 0 73.01 03160 CARDI OPULMONARY 76.00 0 76.00 177, 018 07697 CARDIAC REHABILITATION 76. 97 0 76.97 OUTPAȚIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 1, 120, 780 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 494, 578 92.00 200.00 Subtotal (see instructions) 6, 646, 769 2, 988 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges

6, 646, 769

2, 988

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1311	Peri od:	Worksheet D

near th Frhancial Systems	TO HEALTH HE	UN HUSFITAL		III LI E	u or rorm cws	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Peri od:	Worksheet D	
				From 01/01/2018		
		Component	CCN: 15-Z311	To 12/31/2018	Date/Time Pre	
		Title	XVIII	Swing Beds - SNF	5/29/2019 12: Cost	43 piii
		11110	Charges	Swifing beds Sivi	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(, , , , , , , , , , , , , , , , , , ,	
	Part I, col. 9	,	Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 174972	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 120082	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 333486	0		0	0	54.00
60. 00 06000 LABORATORY	0. 388286	0		0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 865192	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 529335	0		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 582869	0		0 0	0	67. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 229213	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 146384	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 177401	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 324015	0		0 0	0	73. 00
73. 01 03480 ONCOLOGY	0. 494011	0		0 0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 638871	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						Ī
91. 00 09100 EMERGENCY	0. 343671	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 394351	0		0	0	92.00
200.00 Subtotal (see instructions)		0		0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0	I	201.00
Only Charges					I	
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	AND VACCINE COST	Provider Component (CN: 15-1311 CCN: 15-Z311	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prep 5/29/2019 12:4	
		Title	: XVIII	Swing Beds - SNF	Cost	-
	Co	sts				
Cost Center Description	Cost Reimbursed Services	Cost Reimbursed Services Not				

			l litle	XVIII Swin	ig Beds - SNF	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0				0. 00
	05300 ANESTHESI OLOGY	0	0				3. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				. 00
	06000 LABORATORY	0	0				0. 00
65.00	06500 RESPI RATORY THERAPY	0	0			65.	6. 00
66.00	06600 PHYSI CAL THERAPY	0	0			66	. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0			67.	. 00
69.00	06900 ELECTROCARDI OLOGY	0	0			69.	0. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.	. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.	2. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.	3. 00
73. 01	03480 ONCOLOGY	0	0			73.	3. 01
76.00	03160 CARDI OPULMONARY	0	0			76.	. 00
76. 97	07697 CARDIAC REHABILITATION	0	0			76.	. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	0			91.	. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92	2. 00
200.00		0	0			200	0. 00
201.00	1 1	0				201.	. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0			202	2. 00

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co			Date/Time Pre 5/29/2019 12:	
			Ti tl	e XIX	Hospi tal	Cost	
			200 0 1 1	Charges	1 .	Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Services	Services Not		
		Part I, col. 9		Subject To Ded. & Coins.	Subject To Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50 00	05000 OPERATI NG ROOM	0. 174972	0	153, 31	5 0	0	50.00
	05300 ANESTHESI OLOGY	0. 120082	0	11, 80		0	1
	05400 RADI OLOGY-DI AGNOSTI C	0. 333486		54, 24		0	
	06000 LABORATORY	0. 388286	0	42, 20		0	1
65. 00	06500 RESPIRATORY THERAPY	0. 865192		2, 09		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 529335	0	1, 44	8 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 582869	O	2, 27		0	67. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 229213	0	39, 60		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 146384	0	11, 69	9 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 177401	0	18, 17	6 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 324015	0	21, 65	0 0	0	73. 00
73. 01	03480 ONCOLOGY	0. 494011	0	46	1 0	0	73. 01
76.00	03160 CARDI OPULMONARY	0. 000000	0		0	0	76. 00
76. 97	07697 CARDI AC REHABILITATION	0. 638871	0	5, 86	8 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	_					
	09100 EMERGENCY	0. 343671	0	241, 01		0	, , , , , ,
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 394351	0	4, 31		0	1 ,2.00
200.00			0	610, 18	3 0	0	200. 00
201.00					0		201. 00
	Only Charges		_		-	_	
202.00	Net Charges (line 200 - line 201)) 0	610, 18	3 0	0	202. 00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1311	Peri od: From 01/01/2018	

					To 12/31/2018	Date/Time Pro 5/29/2019 12:	
			Ti tl	e XIX	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
	ANOLULARY OFRICAS COOT OFFITTED	6.00	7. 00				
F0 00	ANCI LLARY SERVI CE COST CENTERS	0/ 00/		1			
50.00	05000 OPERATI NG ROOM	26, 826	0				50.00
	05300 ANESTHESI OLOGY	1, 418	0				53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	18, 089	0				54. 00
	06000 LABORATORY	16, 386	0				60.00
	06500 RESPIRATORY THERAPY	1, 813	0				65. 00
	06600 PHYSI CAL THERAPY	766	0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 328	0				67. 00
	06900 ELECTROCARDI OLOGY	9, 079	0				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 713	0				71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 224	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	7, 015	0				73. 00
	03480 ONCOLOGY	228	0				73. 01
	03160 CARDI OPULMONARY	0	0				76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 749	0				76. 97
01 00	OUTPATIENT SERVICE COST CENTERS	02.020	0	I			01.00
	09100 EMERGENCY	82, 830	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 702	0				92.00
200.00		176, 166	0				200.00
201.00		0					201. 00
202.00	Only Charges (Line 200 Line 201)	174 144	_				202 00
202. 00	Net Charges (line 200 - line 201)	176, 166	0	Ί			202. 00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1311	Peri od: From 01/01/2018	Worksheet D-1	
		To 12/31/2018	Date/Time Prepared: 5/29/2019 12:43 pm	
	Title XVIII	Hospi tal	Cost	

		Title XVIII	Hospi tal	5/29/2019 12: Cost	43 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days).	vate room days,	3, 481 3, 063 0	1. 00 2. 00 3. 00	
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	2, 444 375	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December :	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	43	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	0 1		1, 441	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct	tions)	,	375	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nter O on this line)	, ,	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)	3	,	0	12.00
13. 00 14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter O on this line	e)	0	13. 00 14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	an (excluding swing-bed to	uays)	0	15. 00 16. 00
	SWI NG BED ADJUSTMENT			0	
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	3			17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period				18. 00
19. 00	Medical drate for swing-bed NF services applicable to services reporting period	9		129. 14	
20. 00	Medical drate for swing-bed NF services applicable to services reporting period		ne cost	0.00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions $Swing$ -bed cost applicable to SNF type services through $December 5 ext{ x line } 17$)		ng period (line	6, 810, 887 0	21. 00 22. 00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reporti	ng period (line	5, 553	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		747, 847 6, 063, 040	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	Line 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	FITTHE 28)		0. 000000 0. 00	31. 00 32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	,	0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	6, 063, 040	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	IOTUENTO			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			4 070 15	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 979. 45	
39. 00 40. 00	Medically necessary private room cost applicable to the Progra	•		2, 852, 387 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39)	,		2, 852, 387	

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH TIPT		CN: 15-1311	Period:	u of Form CMS- Worksheet D-1	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1311	From 01/01/2018 To 12/31/2018	Date/Time Pre	epared:
			Title	e XVIII	Hospi tal	5/29/2019 12: Cost	43 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost		col . 2)		(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 0
.2. 00	Intensive Care Type Inpatient Hospital Unit	S					1 .2.0
	INTENSIVE CARE UNIT						43.0
44. 00	CORONARY CARE UNIT						44. 0
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	kst D-3 col 3	line 200)			1. 00 2, 752, 390	48. 0
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		5, 604, 777	
50. 00	Pass through costs applicable to Program in	patient routine :	services (from	n Wkst. D, su	m of Parts I and	0	50.0
51. 00	Pass through costs applicable to Program in and IV)	patient ancillar	y services (fr	rom Wkst. D,	sum of Parts II	0	51.0
52. 00	Total Program excludable cost (sum of lines					0	1
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line	9 1	lated, non-phy	sician anest	hetist, and	0	53. 0
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 0
55. 00	Target amount per discharge						55. 0
56. 00	Target amount (line 54 x line 55)				>	0	
57. 00 58. 00	Difference between adjusted inpatient opera	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0 0	
59. 00							
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the r	narket basket		0.00	60.0
61. 00	If line 53/54 is less than the lower of lin					0	61.0
	which operating costs (line 53) are less th amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	riisti detroiis)				0	62.0
63. 00	Allowable Inpatient cost plus incentive pay	ment (see instru	ctions)			0	63. 0
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	cost report	ing period (See	742, 294	64. 0
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	sts after Decembe	er 31 of the d	cost reportin	g period (See	0	65. 0
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line 6	55)(title XVI	ll only). For	742, 294	66.0
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routi				•	0	
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routi	· ·				0	68. 0
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0	69. 0
70.00	PART III - SKILLED NURSING FACILITY, OTHER						70.0
70. 00 71. 00	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service)		70.00
72. 00	Program routine service cost (line 9 x line		2 .0 . 11110	,			72. 0
73. 00	Medically necessary private room cost appli						73.0
74. 00 75. 00	Total Program general inpatient routine ser Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 0
77. 00	Program capital -related costs (line 9 x lin	,					77. 0
	Inpatient routine service cost (line 74 min						78. 0
79. 00 30. 00	Aggregate charges to beneficiaries for exce				nus line 70)		79. 0 80. 0
30.00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	ost iimitatiOf	. (/0 1111	1143 1116 <i>17)</i>		81.0
32. 00	Inpatient routine service cost limitation (line 9 x line 81					82. 0
33. 00	Reasonable inpatient routine service costs		s)				83. 0
84. 00 85. 00	Program inpatient ancillary services (see i Utilization review - physician compensation		ns)				84. 0 85. 0
	Total Program inpatient operating costs (su						86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PA	SS THROUGH COST					
87. 00	Total observation bed days (see instruction						87. 0
88. 00	Adjusted general inpatient routine cost per	diam /lina 27	lino 2)			1, 979. 44	88. 0

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 12:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	837, 883	6, 810, 887	0. 12302	1 1, 225, 273	150, 734	90.00
91.00 Nursing School cost	0	6, 810, 887	0.00000	0 1, 225, 273	0	91.00
92.00 Allied health cost	0	6, 810, 887	0.00000	0 1, 225, 273	0	92.00
93.00 All other Medical Education	0	6, 810, 887	0. 00000	0 1, 225, 273	0	93. 00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1311	Peri od: From 01/01/2018	Worksheet D-1
			Date/Ti me Prepared: 5/29/2019 12:43 pm
	Title XIX	Hospi tal	Cost

			12,01,2010	5/29/2019 12:	43 pm	
	Coat Contan Decement on	Title XIX	Hospi tal	Cost		
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			3, 481 3, 063	1. 00 2. 00	
2.00						
3. 00	do not complete this line.	vate room days,	0	3. 00		
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 444	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	375	5. 00	
	reporting period	3 , 3		 -		
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00	
7 00	reporting period (if calendar year, enter 0 on this line)		24 -6	42	7 00	
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	43	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private roor	n davs) after December 3	1 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)			- I		
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	0	9. 00	
10.00	newborn days)			075	40.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruc-		oom days)	375	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11.00	
	December 31 of the cost reporting period (if calendar year, er			- I		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00	
40.00	through December 31 of the cost reporting period				40.00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00	
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00	
15. 00	Total nursery days (title V or XIX only)	(0	15. 00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
	SWING BED ADJUSTMENT					
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	r the cost	 -	17. 00	
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	 -	18. 00	
	reporting period					
19. 00	00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period				19. 00	
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0. 00	20. 00	
	reporting period					
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ng poriod (line	6, 810, 887 0	21. 00 22. 00	
22.00	5 x line 17)	er 31 of the cost report	riig perrou (Triie	U	22.00	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00	
	x line 18)					
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reporti	ng period (line	0	24. 00	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00	
27.00	x line 20)			742.000	27 00	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	Tine 21 minus line 26)		742, 898 6, 067, 989		
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trite 21 millias Trite 20)		0,007,707	27.00	
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00	
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	31.00	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (0.00		
34. 00	Average per diem private room charge differential (line 32 min		tions)	0.00		
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ie 31)		0. 00 0	35. 00 36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	6, 067, 989	37.00	
57.00	27 minus line 36)	p	5. 5 (11116	5,001,707	57.50	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		,			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU					
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 981. 06		
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		0	39. 00 40. 00	
	Total Program general inpatient routine service cost (line 39			0	41.00	
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	,	ı	٥١		

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		<u> In_</u> Lie	u of Form CMS-2	<u> 2552-</u> 1
COMPUTATION OF INPATIENT OPERATING COST		Provi der C	CN: 15-1311	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre	
					5/29/2019 12:	
Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
oost canter bescription	Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
Intensive Care Type Inpatient Hospital Ur	ni ts		l			42.00
43. 00 INTENSIVE CARE UNIT						43.00
44. 00 CORONARY CARE UNIT 45. 00 BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 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	(Wkst. D-3, col. 3	, line 200)			0	
49.00 Total Program inpatient costs (sum of line PASS THROUGH COST ADJUSTMENTS	, ,				0	
50.00 Pass through costs applicable to Program	inpatient routine	services (from	n Wkst. D, sui	m of Parts I and	0	50.00
51.00 Pass through costs applicable to Program and IV)	inpatient ancillar	y services (fr	om Wkst. D,	sum of Parts II	0	51.00
52.00 Total Program excludable cost (sum of li					0	
53.00 Total Program inpatient operating cost emedical education costs (line 49 minus l		lated, non-phy	sician anestl	hetist, and	0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0] 54. 00
55.00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)					0	
57.00 Difference between adjusted inpatient op 58.00 Bonus payment (see instructions)	erating cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59.00 Lesser of lines 53/54 or 55 from the cos	t reporting period	endi ng 1996, u	pdated and c	ompounded by the	0.00	
market basket		datad by the m	arkat baakat		0.00	(0.00
60.00 Lesser of lines 53/54 or 55 from prior you 61.00 If line 53/54 is less than the lower of				the amount by	0. 00 0	
which operating costs (line 53) are less	than expected cost					
amount (line 56), otherwise enter zero (62.00 Relief payment (see instructions)	see instructions)				0	62.00
63.00 Allowable Inpatient cost plus incentive	payment (see instru	ctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine	costs through Dace	mhar 31 of the	cost report	ing period (See	742, 898	64. 00
instructions) (title XVIII only)	costs through bece	iliber 31 of the	cost report	ing perrod (see	742,070	04.00
65.00 Medicare swing-bed SNF inpatient routine instructions) (title XVIII only)	costs after Decemb	er 31 of the c	ost reportin	g period (See	0	65.00
66.00 Total Medicare swing-bed SNF inpatient re	outine costs (line	64 plus line 6	5)(title XVI	II only). For	742, 898	66. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient ro	utine costs through	December 31 c	of the cost r	eporting period	0	67. 00
(line 12 x line 19)	ŭ					
68.00 Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)				orting period	0	
69.00 Total title V or XIX swing-bed NF inpation PART III - SKILLED NURSING FACILITY, OTHE	•				0	69.00
70.00 Skilled nursing facility/other nursing facility	acility/ICF/IID rou	tine service c	cost (line 37)		70.00
71.00 Adjusted general inpatient routine servi		ine 70 ÷ line	2)			71.00
72.00 Program routine service cost (line 9 x l 73.00 Medically necessary private room cost ap	,	(line 14 x li	ne 35)			72.00
74.00 Total Program general inpatient routine		•	,			74.00
75.00 Capital-related cost allocated to inpation 26, line 45)	ent routine service	costs (from W	lorksheet B, I	Part II, column		75. 00
76.00 Per diem capital-related costs (line 75						76.00
77.00 Program capital-related costs (line 9 x 78.00 Inpatient routine service cost (line 74)						77.00
79.00 Aggregate charges to beneficiaries for ex		rovi der record	ls)			79.00
80.00 Total Program routine service costs for			*.	nus line 79)		80.00
81.00 Inpatient routine service cost per diem		`				81.00
82.00 Inpatient routine service cost limitation 83.00 Reasonable inpatient routine service cost	* .	•				82.00
84.00 Program inpatient ancillary services (se		٠,				84.00
85.00 Utilization review - physician compensat		ns)				85. 00
86.00 Total Program inpatient operating costs		rough 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED 87.00 Total observation bed days (see instruct					619	 87. 00
88.00 Adjusted general inpatient routine cost	per diem (line 27 ÷	line 2)			1, 981. 06	88. 00
89.00 Observation bed cost (line 87 x line 88)	(see instructions)				1, 226, 276	1 89.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 12:	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	837, 883	6, 810, 887	0. 12302	1 1, 226, 276	150, 858	90.00
91.00 Nursing School cost	0	6, 810, 887	0.00000	0 1, 226, 276	0	91.00
92.00 Allied health cost	0	6, 810, 887	0.00000	0 1, 226, 276	0	92.00
93.00 All other Medical Education	0	6, 810, 887	0. 00000	1, 226, 276	0	93. 00

Health Financial Systems	Health Financial Systems	ALTIL TIDTON HOCDITAL		ما ا ما	u of Form CMC	2552 10
Title XVIII			^N· 15_1311			
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00	THE ATTENT AND LEART SERVICE GOST ATTONION IN			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3		Title				
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	Cost Center Description					
INPATI ENT ROUTI NE SERVI CE COST CENTERS			To Charges			
INPATI ENT ROUTI NE SERVI CE COST CENTERS 2,812,204 30.00 30.00 ADULTS & PEDI ATRI CS 2,812,204 30.00 ADULTS & PEDI ATRI CS 3,743,326 654,977 50.00 ADULTS & PEDI ATRI CS 0.120082 169,716 20.380 53.00 ADULTS & PEDI AGNOSTI C 0.333486 156,093 52.055 54.00 60.00 60.00 LABORATORY 0.388286 389,757 151,337 60.00 60.00 CABORATORY 0.865192 279,316 241,662 65.00 66.00 CABORATORY 0.529335 368,003 194,797 66.00 60.00 CCUPATI (DNAL THERAPY 0.52935 368,003 194,797 66.00 69.00 CCUPATI (DNAL THERAPY 0.52935 368,003 194,797 66.00 69.00 CEUPATI (DNAL THERAPY 0.29213 120,540 27,629 69.00 71.00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.146384 603,330 88,318 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.324015 1,075,106 348,350 73.00 73.01 03480 ONCOLOGY 0.494011 0 0.324015 1,075,106 348,350 73.00 73.01 03480 ONCOLOGY 0.494011 0 0.494011 0 0.73.01 76.00 07697 CARDI AC REHABI LI TATI ON 0.638871 0 0.73.01 76.97 070797 CARDI AC REHABI LI TATI ON 0.638871 0 0.638871 0 0.75.97 0.7097 0.7097 CARDI AC REHABI LI TATI ON 0.638871 0 0.92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.394351 0 0.92.00 09200 ODSERVATI ON BEDS (NON-DISTINCT PART 0.394351 0 0.92.00 09200 ODSERVATI ON BEDS (NON-DISTINCT PART 0.394351 0 0.92.00 09200 ODSERVATION BEDS (NON-DISTINCT PART 0.994050 0.904050 0.904050 0.904050 0.904050 0.904050				Charges		
NPATIENT ROUTINE SERVICE COST CENTERS 2,812,204 30.00 3000 ADULTS & PEDIATRICS 2,812,204 30.00 3000 ADULTS & PEDIATRICS 30.00 30.00 ADULTS & 30.00 30.00 30.00 ADULTS & 30.			4.00	0.00		
30. 00	INDATION DOUTING CODY OF COCT CONTEDC		1.00	2.00	3.00	
ANCI LLARY SERVI CE COST CENTERS			1	2 912 204		20.00
50.00 05000 0PERATI NG ROOM 0.174972 3,743,326 654,977 50.00 53.00 05300 ANESTHESI OLOGY 0.120082 169,716 20,380 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.333486 156,093 52,055 54.00 05400 LABORATIORY 0.388286 389,757 151,337 60.00 65.00 06500 RESPI RATORY THERAPY 0.865192 279,316 241,662 65.00 66.00 06600 PHYSI CAL THERAPY 0.529335 368,003 194,797 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.582869 196,799 114,708 67.00 69.00 06900 ELECTROCARDI OLOGY 0.229213 120,540 27,629 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.146384 603,330 88,318 71.00 73.01 03480 0NCOLOGY 0.324015 1,075,106 348,350 73.00 73.01 03480 0NCOLOGY 0.3480 0NCOLOGY 0.494011 0 0.73.01 76.00 03160 CARDI OPULMONARY 0.638871 0 0.76.00 76.97 076.70 CARDI AC REHABI LI TATI ON 0.638871 0 0.76.97 076.97 076.70 0BSERVATI ON BEDS (NON-DI STI NCT PART 0.343671 0.394351 0 0.90200 0 0 0.90200 0 0 0 0 0 0 0 0 0				2,012,204		30.00
53.00 05300 ANESTHESI OLOGY 0.120082 169, 716 20, 380 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.333486 156, 093 52, 055 54.00 60.00 06000 LABORATORY 0.388286 389, 757 151, 337 60.00 65.00 06500 RESPI RATORY THERAPY 0.865192 279, 316 241, 662 65.00 66.00 06600 PHYSI CAL THERAPY 0.529335 368, 003 194, 797 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.582869 196, 799 114, 708 67.00 69.00 06900 ELECTROCARDI OLOGY 0.229213 120, 540 27, 629 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.146384 603, 330 88, 318 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.177401 4, 807, 947 852, 935 72.00 73.01 03480 ONCOLOGY 0.249011 0 0 73.01 76.00 03160 CARDI OPULMONARY 0.000000 0 0 76.07 76.97 07697 CARDI AC REHABI LI TATI ON 0.638871 0 0 76.97 07100 OP100 EMERGENCY 0.343671 15, 252 5, 242 91.00 92.00 09200 OSSERVATI ON BEDS (NON-DISTINCT PART 0.394351 0 0 92.00 200.00 0 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 001.00 201.00 EMERGENCY 0.1790 0.000000 0 0.000000 0 0.000000 0			0 17497	2 3 743 326	654 977	50.00
St. 00						
60. 00 06000 LABORATORY 0. 388286 389, 757 151, 337 60. 00 65. 00 06500 RESPIRATORY THERAPY 0. 865192 279, 316 241, 662 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 529335 368, 003 194, 797 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 582869 196, 799 114, 708 67. 00 67. 00 06900 ELECTROCARDI OLOGY 0. 292213 120, 540 27, 629 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 146384 603, 330 88, 318 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATI ENTS 0. 177401 4, 807, 947 852, 935 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 324015 1, 075, 106 348, 350 73. 00 73. 01 03480 ONCOLOGY 0. 494011 0 0 0 76. 00 76. 00 03160 CARDI OPULMONARY 0. 000000 0 0 76. 00 000000 0 0 0 0 0 0						
65. 00			•		· ·	
66. 00			•		· ·	
67. 00	66, 00 06600 PHYSI CAL THERAPY		•		· ·	
71. 00	67. 00 06700 OCCUPATI ONAL THERAPY		0. 58286	9 196, 799	114, 708	67. 00
72. 00	69. 00 06900 ELECTROCARDI OLOGY		0. 22921	3 120, 540	27, 629	69. 00
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 14638	4 603, 330	88, 318	71. 00
73. 01	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 17740	1 4, 807, 947	852, 935	72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32401	5 1, 075, 106	348, 350	73. 00
76. 97 O7697 CARDIAC REHABILITATION 0. 638871 0 0 76. 97 OUTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0. 343671 15, 252 5, 242 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART 0. 394351 0 0 92. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00	73. 01 03480 ONCOLOGY		0. 49401	1 0	0	73. 01
OUTPATIENT SERVICE COST CENTERS O. 343671 15, 252 5, 242 91. 00 92. 00 OBSERVATION BEDS (NON-DISTINCT PART O. 394351 O 0.	76. 00 03160 CARDI OPULMONARY		0.00000	0 0	0	76. 00
91. 00	76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 63887	1 0	0	76. 97
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.394351 0 92. 00 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201.						
200.00 Total (sum of lines 50 through 94 and 96 through 98) 11,925,185 2,752,390 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00					5, 242	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			0. 39435		-	
				11, 925, 185		
202.00 Net charges (line 200 minus line 201) 11,925,185 202.00		nly charges (line 61)		0		
	202.00 Net charges (line 200 minus line 201)			11, 925, 185		202. 00

	Financial Systems	IU HEALTH TIPTON				u of Form CMS-2	
INPATII	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CO	CN: 15-1311	Peri od:	Worksheet D-3	
			Component (CCN: 15-Z311	From 01/01/2018 To 12/31/2018		narad.
			Component	JCIN. 13-Z311	10 12/31/2010	5/29/2019 12:	
			Title	XVIII	Swing Beds - SNF		то рііі
	Cost Center Description			Ratio of Cos	t Inpatient	Inpatient	
	'			To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
				1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS				0		30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM			0. 17497	72 4, 702	823	50.00
53.00	05300 ANESTHESI OLOGY			0. 12008	32 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 33348	15, 015	5, 007	54.00
60. 00	06000 LABORATORY			0. 38828	56, 778	22, 046	60.00
65. 00	06500 RESPI RATORY THERAPY			0. 86519	51, 672	44, 706	65. 00
66. 00	06600 PHYSI CAL THERAPY			0. 52933	135, 330	71, 635	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY			0. 58286	65, 670	38, 277	67. 00
69. 00	06900 ELECTROCARDI OLOGY			0. 2292	4, 196	962	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 14638	1, 848	271	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 17740	01 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS			0. 32401	158, 753	51, 438	73. 00
73. 01	03480 ONCOLOGY			0. 49401	11 0	0	73. 01
76. 00	03160 CARDI OPULMONARY			0. 00000	00	0	76. 00
76. 97	07697 CARDIAC REHABILITATION			0. 63887	71 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
91. 00	09100 EMERGENCY			0. 34367	71 0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 39435	51 0	0	92. 00
200.00	Total (sum of lines 50 through 94 and 9	96 through 98)			493, 964	235, 165	200. 00
201.00	Less PBP Clinic Laboratory Services-Pro	ogram only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)	- , ,			493, 964		202. 00
			'	•	•	•	•

Health Financial Systems IU HEALTH TIPTON HO INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1311	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTENT AND LEAR OF SERVICE SOST ATTORT ON MENT	ovider o		From 01/01/2018		
			To 12/31/2018	Date/Time Pre	pared:
	T: ±1	- VIV	11: 4-1	5/29/2019 12:	43 pm
Cost Center Description	11 11	e XIX	Hospi tal t Inpati ent	Cost Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		10 Charges		(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
ANCILLARY SERVICE COST CENTERS		'			1
50. 00 05000 OPERATI NG ROOM		0. 17497	72 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0. 12008	32 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33348	86 0	0	54.00
60. 00 06000 LABORATORY		0. 38828	86 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 86519	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 52933	35 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 58286	0	0	67. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 22921		0	1 0 / 1 0 0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 14638		0	1 / 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 17740		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 32401		0	1 , 0, 00
73. 01 03480 0NC0L0GY		0. 49401		0	
76. 00 03160 CARDI OPULMONARY		0.00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 63887	71 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS		1			
91. 00 09100 EMERGENCY		0. 34367			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 39435	0		92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			0		200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		[0		202. 00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1311		Worksheet E Part B Date/Time Prepared: 5/29/2019 12:43 pm

			12/01/2010	5/29/2019 12:	
		Title XVIII	Hospi tal	Cost	
			<u> </u>		
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 649, 757	1.00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		0	2. 00
3.00	OPPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 649, 757	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(6	e)			
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	•
18. 00	Total customary charges (see instructions)			0	
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19. 00
00.00	instructions)		40) (00.00
20. 00	Excess of reasonable cost over customary charges (complete onlinstructions)	y IT line II exceeds II	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			6, 716, 255	21 00
21.00	Interns and residents (see instructions)			0, 710, 255	ı
23. 00	Cost of physicians' services in a teaching hospital (see instr	suctions)		0	1
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	uctions)		0	•
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	=)		29, 776	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	3, 873, 411	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			2, 813, 068	
27.00	instructions)	51 43 the 34m of 111163 22	una 20] (300	2,010,000	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	,		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 813, 068	30.00
31.00	Pri mary payer payments			318	31.00
32.00	Subtotal (line 30 minus line 31)			2, 812, 750	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			515, 188	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			334, 872	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		343, 021	36. 00
37. 00	Subtotal (see instructions)			3, 147, 622	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	•
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00	Subtotal (see instructions)			3, 147, 622	1
40. 01	Sequestration adjustment (see instructions)			62, 952	
40. 02	Demonstration payment adjustment amount after sequestration			0	
41. 00	Interim payments			2, 135, 301	1
42. 00	Tentative settlement (for contractors use only)			0	
43. 00	Balance due provider/program (see instructions)	' II ONG D.I. 4E O		949, 369	1
44. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	207, 328	44. 00
	§115. 2				
00 00	TO BE COMPLETED BY CONTRACTOR			^	00.00
90.00	Original outlier amount (see instructions)			0	ı
91.00	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	
92. 00 93. 00	The rate used to calculate the Time Value of Money			0.00	•
	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			-	94.00
74. UU	Total (Suii Ol 111163 71 dilu 73)			1	74.00

| Peri od: | Worksheet E-1 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Health Financial Systems 10 F ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1311

submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 3. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER	mm/dd/yyyy 3.00	5/29/2019 12: 4 Cost Tt B Amount 4.00 2,010,601 0 124,700 0 0 0	1.00 2.00
Total interim payments paid to provider 1.00 2.00 1.00 2.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.00 1.00 2.00 2.00 1.00 2.00 2.00 1.00 2.00 2.00 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 3.00	mm/dd/yyyy 3.00	Amount 4. 00 2, 010, 601 0 124, 700 0 0	2. 00
1.00 2.00 1.00 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 2.00 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 3.01 ADJUSTMENTS TO PROVIDER 05/16/2018 94,90 08/22/2018 62,10 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER	3.00	4. 00 2, 010, 601 0	2. 00
1.00 2.00 1.00 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 2.00 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 3.01 ADJUSTMENTS TO PROVIDER 05/16/2018 94,90 08/22/2018 62,10 3.02 3.03 3.04 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER	3.00	4. 00 2, 010, 601 0	2. 00
1.00 2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 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 ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER	08/22/2018	2, 010, 601 0 124, 700 0 0	2. 00
submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 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. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 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) To BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER	08/22/2018	124, 700 0 0	
services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program ADJUSTMENTS TO PROVIDER O5/16/2018 94, 90 08/22/2018 62, 10 8. 20 98/22/2018 62, 10 98/22/2018 62, 10 ADJUSTMENTS TO PROGRAM 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER		0 0	3. 00
write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05 3. 50 ADJUSTMENTS TO PROVIDER Provider to Program ADJUSTMENTS TO PROGRAM 3. 51 3. 52 3. 53 3. 54 3. 59 3. 59 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER		0 0	3. 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 3.01 ADJUSTMENTS TO PROVIDER 3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER		0 0	3. 00
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 TENTATIVE TO PROVIDER		0 0	3.00
for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3. 99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5. 01 5. 01 FENTATIVE TO PROVIDER		0 0	
payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3. 01 3. 02 3. 03 3. 04 3. 05 Provider to Program ADJUSTMENTS TO PROVIDER 3. 50 ADJUSTMENTS TO PROGRAM 3. 50 Provider to Program ADJUSTMENTS TO PROGRAM 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER		0 0	
Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 05/16/2018 94, 90 08/22/2018 62, 10 3.03 3.04 3.05		0 0	,
3.02 3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER		0 0	
3.03 3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER		0	3. 01
3.04 3.05 Provider to Program ADJUSTMENTS TO PROGRAM 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER		1	3. 02
3. 50 Provider to Program ADJUSTMENTS TO PROGRAM 3. 50 3. 51 3. 52 3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER			3. 03
Provider to Program 3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER		0	3. 04
3.50 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER		0	3. 05
3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER		1 0	2 50
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02		0	3. 50 3. 51
3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER)	0	3. 52
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 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) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02)		3. 53
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) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.02		o	3. 54
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) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER)	124, 700	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER			l
appropriate) TO BE COMPLETED BY CONTRACTOR 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 TENTATIVE TO PROVIDER	•	2, 135, 301	4. 00
TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER			l
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 5.01 5.02			
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02			5. 00
write "NONE" or enter a zero. (1) Program to Provider 5. 01 TENTATI VE TO PROVI DER 5. 02			J. 00
Program to Provider 5. 01 TENTATI VE TO PROVIDER 5. 02			l
5. 02		_	l
)	0	5. 01
)	0	5. 02
)	0	5. 03
Provi der to Program 5.50 TENTATI VE TO PROGRAM		0	5. 50
)		5. 51
)		5. 52
		o	5. 99
5. 50-5. 98)			l
6.00 Determined net settlement amount (balance due) based on			6. 00
the cost report. (1)			٠
6. 01 SETTLEMENT TO PROVIDER 139, 71		949, 369	6. 01
		0 2 094 470	6. 02
7.00 Total Medicare program Liability (see instructions) 5,161,84) i	3, 084, 670 NPR Date	7. 00
		(Mo/Day/Yr)	
0	Contractor	2.00	
8.00 Name of Contractor			8. 00

Health Financial Systems IU FANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	CCN. 13-Z311 1	0 12/31/2016	5/29/2019 12:	
		Title	XVIII Si	wing Beds - SNF		•
		I npati en	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		761, 862		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
3. 01	ADJUSTMENTS TO PROVIDER	08/22/2018	198, 700		0	0.0.
3. 02			0		0	
3.03			0		0	
3.04			0		0	
3.05			0		0	3.05
	Provi der to Program		1	1	1	
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	0.02
3.53			0		0	
3.54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		198, 700		0	3. 99
4.00	3.50-3.98)		0/0 5/3		0	4.00
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		960, 562		0	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					1
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,] 3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		1			1
5. 01	TENTATI VE TO PROVI DER		1 0		0	5. 01
5.02			1 0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					1
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	
6. 02	SETTLEMENT TO PROGRAM		7, 493		0	
7. 00	Total Medicare program liability (see instructions)		953, 069		0	7. 00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		U	1. 00	2.00	8.00
0.00	Inalie of collector	I			I	J 6.00

Heal th	Financial Systems IU HEALTH TIPTON	N HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1311	Peri od: From 01/01/2018 To 12/31/2018		pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		2 14		1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
22 00	Polones due provider (line 0 (er line 10) minus line 20 and l	ina 21) (aaa imatmustian)		22.00

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

30. 00 31. 00 32. 00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1311	Peri od:	Worksheet E-2
			From 01/01/2018	
		Component CCN: 15-Z311	To 12/31/2018	Date/Time Prepared:
				5/29/2019 12:43 pm

		Component CCN: 15-Z311	To 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Title XVIII S		Swing Beds - SNF		10 рііі
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		749, 717	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		237, 517	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
4.00	Per diem cost for interns and residents not in approved teachi	ing program (see		0. 00	4. 00
	instructions)			_	
5.00	Program days		375	0	
6.00	Interns and residents not in approved teaching program (see in			0	
7.00	Utilization review - physician compensation - SNF optional met	thod only	007 224	0	7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		987, 234	0	8. 00 9. 00
10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		987, 234	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	907, 234	0	11.00
11.00	professional services)	cable to physician		O	11.00
12. 00	Subtotal (line 10 minus line 11)		987, 234	0	12. 00
13. 00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	16, 888	0	13. 00
	for physician professional services)	, (5,6, 445 55, 1,54, 4,155	10,000	Ü	10.00
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	970, 346	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		3, 343	0	17. 00
	Adjusted reimbursable bad debts (see instructions)		2, 173	0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	072 510	0	18.00
	Total (see instructions) Sequestration adjustment (see instructions)		972, 519	0	19. 00 19. 01
	Demonstration payment adjustment amount after sequestration)		19, 450	0	19.01
	Interim payments		960, 562	0	20.00
	Tentative settlement (for contractor use only)		700, 302	0	21. 00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	-7, 493	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordan	•	30, 488	0	1
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201. 00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	m Wko+ D 2 col 2 line			202. 00
202.00	200 (title XVIII swing-bed SNF))	II WKSt. D-3, COI. 3, TIME			202.00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204. 00
201100	Computation of Demonstration Target Amount Limitation (N/A in	first year of the current	t 5-vear demonst	ration	
	peri od)		,		
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr	*			207. 00
208. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines 1			208. 00
000 00	and 3)				000 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	CTIONS)			209. 00
∠10.00	Reserved for future use Comparision of PPS versus Cost Reimbursement		1		210. 00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (soo			215. 00
215.00	instructions)	20, p. 43 11110 210, (366			2 13.00
			, ,		•

Heal th Financi	al Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-2552-10
CALCULATION O	F REIMBURSEMENT SETTLEMENT		Provi der Co	CN: 15-1311	From 01/01/2018	Worksheet E-3 Part V Date/Time Prepared: 5/29/2019 12:43 pm
			Title	e XVIII	Hospi tal	Cost

			10 12/31/2016	5/29/2019 12:	
		Title XVIII	Hospi tal	Cost	
	· · · · · · · · · · · · · · · · · · ·				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			5, 604, 777	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructio	ns)		0	2.00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			5, 604, 777	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			5, 660, 825	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete onl	y if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete onl	y if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	17. 00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				40.00
18.00	Direct graduate medical education payments (from Worksheet E-4	., IIne 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			5, 660, 825	
20.00	Deductibles (exclude professional component)			419, 348	20.00
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			5, 241, 477	22. 00
23. 00	Coinsurance			2, 345	
24. 00	Subtotal (line 22 minus line 23)			5, 239, 132	
25. 00	Allowable bad debts (exclude bad debts for professional servic	es) (see instructions)		43, 166	
26. 00	Adjusted reimbursable bad debts (see instructions)			28, 058	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		27, 165	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			5, 267, 190	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			5, 267, 190	30.00
30. 01	Sequestration adjustment (see instructions)			105, 344	
30. 02	Demonstration payment adjustment amount after sequestration			0 5 022 124	30. 02
31.00	Interim payments			5, 022, 136	
32.00	Tentative settlement (for contractor use only)	21 and 22)		120 710	32.00
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02		chantar 1	139, 710	33.00
34. 00	Protested amounts (nonallowable cost report items) in accordan §115.2	ice with CMS Pub. 15-2,	chapter I,	174, 798	34. 00
	3110. 4		ļ		

Health Financial Systems

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

Provider CCN: 15-1311 Pe Fr

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 12: 43 pm

——————————————————————————————————————					5/29/2019 12:	43 pm
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	I	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	25, 396, 638	8 0	0	0	1.00
2. 00	Temporary investments	25, 390, 030		_	-	
3.00	Notes recei vabl e		o o		Ö	3.00
4.00	Accounts recei vable	5, 370, 243	0	0	0	4. 00
5.00	Other recei vabl e	-1, 430, 890	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	617, 266		0	0	
8. 00 9. 00	Prepaid expenses Other current assets	178, 412	0	0	0	
10.00	Due from other funds			_	0	10.00
11. 00	Total current assets (sum of lines 1-10)	30, 131, 669	1	_	1	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12. 00
13. 00	Land improvements	0	0	_		13. 00
14. 00	Accumulated depreciation	0	0	0	1	14. 00
15. 00	Buildings	9, 019, 573	0	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leaseholdimprovements	2, 872, 457	'	0	0	16. 00 17. 00
18. 00	Accumulated depreciation	-1, 115, 535		_	0	18.00
19. 00	Fi xed equipment	1,113,333		_	0	19.00
20. 00	Accumulated depreciation	0	Ö	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumul ated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	12, 518, 097	1	0	0	23. 00
24. 00	Accumulated depreciation	-9, 333, 892	. 0	0	0	24. 00
25. 00	Mi nor equipment depreciable	0	0	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e			_	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	13, 960, 700	1	_		30.00
	OTHER ASSETS		•	'		1
31. 00	Investments	424, 983	0	0	-	1
32. 00	Deposits on Leases	0	0	_	-	32. 00
33. 00	Due from owners/officers	0	0	_	0	33. 00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	14, 177, 673 14, 602, 656		-	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	58, 695, 025	1	_	0	36.00
30. 00	CURRENT LIABILITIES	30, 073, 023	,			30.00
37.00	Accounts payable	1, 451, 261	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	1, 093, 366	0	0		38. 00
39. 00	Payroll taxes payable	0	0	0	0	1
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41. 00	Deferred income	0	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	0		0	0	42. 00 43. 00
44. 00	Other current liabilities	4, 149, 467	,	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 694, 094	1	_		1
	LONG TERM LIABILITIES		,			
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	14, 775, 000	1		-	
48. 00	Unsecured Loans	0	0			1
49. 00	Other long term liabilities	377, 222			-	49. 00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	15, 152, 222 21, 846, 316			1	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	21,040,310	,, 0	0	0	31.00
52. 00	General fund balance	36, 848, 709				52. 00
53.00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	36, 848, 709)	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	58, 695, 025		0	0	
	59)					
		•	•	•	•	•

Provider CCN: 15-1311

					То	12/31/2018	Date/Time Prep 5/29/2019 12:4	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	ТО ріп
		1.00	2.00	3.00		4. 00	5. 00	
1.00	Fund balances at beginning of period		32, 770, 675			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		3, 390, 801					2. 00
3.00	Total (sum of line 1 and line 2)	_	36, 161, 476			0	_	3. 00
4.00	Additions (credit adjustments) (specify)	0			0		0	4. 00
5.00	TEMP RESTRICTED	686, 818			0		0	5. 00
6. 00 7. 00	PERM RESTRICTED	13, 927			0		0	6. 00 7. 00
8.00					0			8. 00
9. 00					0			9. 00
10.00	Total additions (sum of line 4-9)		700, 745		J	0	Ü	10. 00
11. 00	Subtotal (line 3 plus line 10)		36, 862, 221			0		11. 00
12. 00	Deductions (debit adjustments) (specify)	o	00,000,000		0		0	12. 00
13.00	UNRESTRICTED FUND BALANCE	13, 506			0		0	13. 00
14.00	ROUNDI NG	6			0		0	14.00
15.00		0			0		0	15. 00
16. 00		0			0		0	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		13, 512			0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36, 848, 709			0		19. 00
	Islieet (Title II IIIIIlus IIIIe 10)	Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0	0		0			3. 00 4. 00
4. 00 5. 00	Additions (credit adjustments) (specify) TEMP RESTRICTED		0					4. 00 5. 00
6. 00	PERM RESTRICTED		0					6. 00
7. 00	TERW RESTRICTED		0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	o			0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00	UNRESTRICTED FUND BALANCE		0					13. 00
14.00	ROUNDI NG		0					14.00
15.00			0					15. 00
16. 00 17. 00			0					16. 00 17. 00
18.00	Total deductions (sum of lines 12-17)		U U		0			17.00
19. 00	Fund balance at end of period per balance				0			19. 00
	sheet (line 11 minus line 18)							
	•			-				

Health Financial Systems I STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1311

				To 12/3	31/2018	Date/Time Prep 5/29/2019 12:	pared: 43 pm
	Cost Center Description		Inpatient	Outpat	tient	Total	то р
			1. 00	2. (3. 00	
	PART I - PATIENT REVENUES					2. 22	
	General Inpatient Routine Services						
1.00	Hospi tal		4, 768, 73	7		4, 768, 737	1. 00
2.00	SUBPROVI DER - I PF						2. 00
3.00	SUBPROVI DER - I RF						3. 00
4.00	SUBPROVI DER						4. 00
5.00	Swing bed - SNF		325, 85	4		325, 854	5. 00
6.00	Swing bed - NF			0		0	6. 00
7.00	SKILLED NURSING FACILITY						7. 00
8.00	NURSING FACILITY						8. 00
9.00	OTHER LONG TERM CARE						9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		5, 094, 59	1		5, 094, 591	10. 00
	Intensive Care Type Inpatient Hospital Services	· ·		1			
11. 00	INTENSIVE CARE UNIT						11. 00
12.00	CORONARY CARE UNIT						12. 00
13.00	BURN INTENSIVE CARE UNIT						13. 00
14.00	SURGICAL INTENSIVE CARE UNIT						14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)						15. 00
16.00	Total intensive care type inpatient hospital services (sum of I	i nes		0		0	16. 00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		5, 094, 59	1		5, 094, 591	17. 00
18.00	Ancillary services		27, 263, 23	3 53, 0	057, 441	80, 320, 674	18. 00
19.00	Outpati ent servi ces		385, 35	8 14, 1	198, 311	14, 583, 669	19.00
20.00	RURAL HEALTH CLINIC			0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULANCE SERVICES						23.00
24.00	CMHC						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00
26.00	HOSPI CE						26.00
27. 00	NON-ALLOWABLE REVENUE			0 2, 6	511, 629	2, 611, 629	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	to Wkst.	32, 743, 18	2 69, 8	367, 381	102, 610, 563	28. 00
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)				108, 926		29. 00
30. 00	ADD (SPECIFY)			0			30. 00
31. 00				0			31. 00
32. 00				0			32. 00
33. 00				0			33. 00
34. 00				0			34. 00
35. 00				0	_		35. 00
36. 00	Total additions (sum of lines 30-35)				0		36. 00
37. 00	DEDUCT (SPECIFY)			0			37. 00
38. 00				0			38. 00
39. 00				0			39. 00
40.00				0			40. 00
41.00	7			U	_		41.00
42. 00	Total deductions (sum of lines 37-41)				0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		36, 1	108, 926		43. 00
	to Wkst. G-3, line 4)	ļ		1	l		

Heal th	Financial Systems IU HEALTH TI	PTON_HOSPITAL		u of Form CMS-2	2552-10
STATEM	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1311 Period:		Worksheet G-3		
			From 01/01/2018 To 12/31/2018	Date/Time Pre	
				5/29/2019 12:	43 pm
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		102, 610, 563	1. 00
2.00	Less contractual allowances and discounts on patients' ac			64, 466, 512	1
3.00	Net patient revenues (line 1 minus line 2)			38, 144, 051	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, I	ine 43)		36, 108, 926	4.00
5.00	Net income from service to patients (line 3 minus line 4)	•		2, 035, 125	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments	0	7. 00		
8.00	Revenues from telephone and other miscellaneous communica	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 oth	er than 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			1, 355, 676	24. 00
25.00	Total other income (sum of lines 6-24)			1, 355, 676	1
	Total (line 5 plus line 25)			3, 390, 801	1
	OTHER EVENISES (SDECLEV)		27 00		

0 27. 00

3, 390, 801 | 29. 00

28. 00

27. 00 OTHER EXPENSES (SPECIFY)

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