IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interF@RM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPI RES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION PANDI der CCN: 15-1316 Peri od: Worksheet S From 01/01/2020 Parts I-III SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/13/2021 4: 29 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/13/2021 4: 29 pm use only] Manually prepared cost report 7] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status

PART II - CERTIFICATION

use only

(1) As Submitted

(4) Reopened (5) Amended

(3) Settled with Audit

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 PROVI PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE A FINES AND/OR IMPRISONMENT MAY RESULT.

(2) Settled without Audit 8. [N] Initial Report for this Provider CCN12. [O] If line 5, column 1 is 4: Enter (3) Settled with Audit 9. [N] Final Report for this Provider CCN | number of times reopened = 0-9.

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH FRANKFORT HOSPITAL (15-1316) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 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. further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

> (Si gned) TODD WILLIAMS

> > Officer or Administrator of Provider(s)

11. Contractor's Vendor Code:

number of times reopened = 0-9.

CHIEF FINANCIAL OFFICER

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	390, 952	388, 285	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	155, 502	0		0	5. 00
6.00 Swing Bed - NF	0				0	6.00
9. 00 HOME HEALTH AGENCY I	0	0	0		0	9. 00
200. 00 Total	0	546, 454	388, 285	0	0	200.00
The above amounts represent "due to" or "due from	" the applicab	le program for	the element o	f the above co	omplex indicate	ed.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it dis a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to com and review the information collection is estimated 673 hours per response, including the time to review instructions, search exis 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 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 R Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-1316 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/13/2021 4:29 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1300 SOUTH JACKSON STREET 1.00 PO Box: 1.00 2.00 City: FRANKFORT State: IN Zip Code: 46041 County: CLINTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P. T, 0, or N) Certi fied Number Number Type V XVIII XIX 1.00 2.00 3.00 4.00 5.00 6. 00 7. 00 8. 00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH FRANKFORT 151316 99915 01/21/2003 N 0 3.00 HOSPI TAL 4.00 Subprovider - IPF 4.00 Subprovi der – IRF 5.00 5.00 Subprovider - (Other) 6 00 6 00 Swing Beds - SNF IU HEALTH FRANKFORT 99915 0 N 7.00 15Z316 01/21/2003 Ν 7.00 HOSPI TAL 8.00 Swing Beds - NF 8.00 Hospi tal -Based SNF 9.00 9.00 10.00 Hospi tal -Based NF 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12 00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 15.00 Hospital -Based Health Clinic - RHC 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From. To. 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2020 12/31/2020 21.00 Type of Control (see instructions) 21.00 1.00 2. 00 3. 00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for 22.00 N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost Ν Ν 22.01 reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care N Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or 'N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural Ν 22.03 Ν Ν as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? Ν 23.00 In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Medi cai d 0ther Out-of Medi cai d State Medicai d State HMO days Medi cai d Medi cai d Medi cai d paid days eligible days paid days npaid days eligible npai d day 1.00 2.00 3 00 5. 00 6. 00 4.00 24.00 If this provider is an IPPS hospital, enter the 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

Health Financial Systems IU HEALTH	H FRANKFORT	Γ HOSPITAL			In Lieu	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION		Provi der CO	CN: 15-1316	Peri od:		Worksh	eet S-2	
				From 01/ To 12/	31/2020	Date/T	ime Pre	
	In-State	In-State	Out-of	Out-of	Medi ca		<u>021 4:2</u> ther	29 pm
	Medi cai d	Medi cai d	State	State	HMO da	-	di cai d	
	paid days	eligible unpaid days	Medicaid spaid days	Medicaid eligible			days	
	1.00			unpai d day			/ 00	
25.00 If this provider is an IRF, enter the in-state Medi	1.00 cai d 0	2.00	3.00	4. 00	5. 00	0	6. 00	25. 00
paid days in column 1, the in-state Medicaid eligib unpaid days in column 2, out-of-state Medicaid days								
column 3, out-of-state Medicaid eligible unpaid day								
column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
days in corumn 3.						Date of		
26.00 Enter your standard geographic classification (not	wage) stat	us at the	beai nni na la		00 2	2.	00	26. 00
reporting period. Enter "1" for urban or "2" for ru	ıral .			1	. <u>-</u>			
27.00 Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban					2			27. 00
the effective date of the geographic reclassificati	on in colu	ımn 2.		1				
35.00 If this is a sole community hospital (SCH), enter t in the cost reporting period.	he number	of periods	SCH status	in effect	: 0	1		35. 00
					ni ng:	Endi		
36.00 Enter applicable beginning and ending dates of SCH	status. Su	ıbscript li	ne 36 for n		00	2.	00	36.00
periods in excess of one and enter subsequent dates	S.	·			. ^			
37.00 If this is a Medicare dependent hospital (MDH), ent effect in the cost reporting period.	er the num	iber of peri	IOOS MDH St	atus is ir	n 0	Ί		37. 00
37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"								37. 01
38.00 If line 37 is 1, enter the beginning and ending dat								38. 00
than 1, subscript this line for the number of periodates.	ds in exce	ess of one	and enter s	ubsequent				
uates.					/N	Y,		
39.00 Does this facility qualify for the inpatient hospit	al navment	adiustmen	t for low v		00 N		00 N	39.00
hospitals in accordance with 42 CFR §412.101(b)(2)((i), (ii),	or (iii)?	Enter in co	olumin 1 "Y"		·	•	07.00
for yes or "N" for no. Does the facility meet the m CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in colu					2			
i nstructi ons)		,		`		ļ .		40.00
40.00 Is this hospital subject to the HAC program reducti for no in column 1, for discharges prior to October	1. Enter	"Y" for yes			N	ľ	N	40. 00
column 2, for discharges on or after October 1. (se	e instruct	i ons)			1 1/	I NATE I	VIV	
					1. 00	XVIII 0 2.00		
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital paym	ont for di	sproportio	nato sharo	in accords	nch wilt	th N	IN	45. 00
42 CFR Section §412.320? (see instructions)							"	
46.00 Is this facility eligible for additional payment ex to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt						N	N	46. 00
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	capital?	Enter "Y	for yes or	"N" for no	o. N	N	N	47. 00
48.00 Is the facility electing full federal capital payme Teaching Hospitals	ent? Enter	"Y" for y	es or "N" f	for no.	N	N	N	48. 00
56.00 Is this a hospital involved in training residents i						1"		56. 00
for no in column 1. If column 1 is "Y", are you imp payment reduction? Enter "Y" for yes or "N" for no			r subsequen	it CR), MA	GME			
57.00 If line 56 is yes, is this the first cost reporting	period du	ıring which	residents	in approve	ed GME	.		57. 00
programs trained at this facility? Enter "Y" for y did residents start training in the first month of								
"N" for no in column 2. If column 2 is "Y", comple		et E-4. If	column 2 i	s "N", con	nplete			
Wkst. D, Parts III & IV and D-2, Pt. II, if applica 58.00 If line 56 is yes, did this facility elect cost rei		for physic	cians' serv	rices as de	efinedNi	n		58. 00
CMS Pub. 15-1, chapter 21, §2148? If yes, complete 59.00 Are costs claimed on line 100 of Worksheet A? If y		to Wkst D	2 D+ I		l N			59. 00
37.00 prie costs cramied on trile 100 of worksheet A: 11 y	res, compre	ite wkst. D	NAHE 413.	85 Works	heet A	Pass-T	hrough	37.00
			Y/N	Lir	ne #	Qualifi Criteri		
60.00 Are you claiming nursing and allied health education	n (NAHF) c	osts for a	1. 00 nv N	2.	00	3.	00	60.00
programs that meet the criteria under 42 CFR 413.85	? (see in	structions) _					55. 55
Enter "Y" for yes or "N" for no in column 1. If co impacted by CR 11642 (or subsequent CR) NAHE MA pay								
"Y" for yes or "N" for no in column 2.	,							

		ORT HOSPITAL			of Form CMS-2	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der Co	F	eriod: rom 01/01/2020		
					7/13/2021 4: 2	
	Y/N	IME	Direct GME	I ME	Direct GME	
(1, 00 D)	1.00	2. 00	3. 00	4.00	5. 00	(1.00
61.00 Did your hospital receive FTE slots under ACA secti 5503? Enter "Y" for yes or "N" for no in column 1.	on N (see			0. 00	0.00	61.00
instructions) 61.01 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 car						61. 02
FTE count (excluding OB/GYN, general surgery FTEs, primary care FTEs added under section 5503 of ACA).	and					
<pre>(see instructions) 61.03 Enter the base line FTE count for primary care and/</pre>	or					61. 03
general surgery residents, which is used for						01.03
determining compliance with the 75% test. (see instructions)						
61.04 Enter the number of unweighted primary care/or surg						61. 04
allopathic and/or osteopathic FTEs in the current c reporting period. (see instructions).	ost					
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 (lin	ie					
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being u	rod					61.06
for cap relief and/or FTEs that are nonprimary care						01.00
general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted IME	Unwei ghted	
		3	3		Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents				0.00	0. 00	61. 10
each new program. (see instructions) Enter in colum	n 1,					
the program name. Enter in column 2, the program co Enter in column 3, the IME FTE unweighted count. En						
in column 4, the direct GME FTE unweighted count.				0.00	0.00	61. 20
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE				0.00	0.00	01.20
residents for each expanded program. (see instructi Enter in column 1, the program name. Enter in colum						
the program code. Enter in column 3, the IME FTE						
unweighted count. Enter in column 4, the direct GME unweighted count.	FTE					
jarmor gricou courti					1 00	
ACA Provisions Affecting the Health Resources and S					1. 00	
62.00 Enter the number of FTE residents that your hospital hospital received HRSA PCRE funding (see instruction		ned in this co	st reporting p	eriod for whic	h your 0.00	62. 00
62.01 Enter the number of FTE residents that rotated from	a Teac	•	, ,	to your hospit	al 0.00	62. 01
during in this cost reporting period of HRSA THC pr Teaching Hospitals that Claim Residents in Nonprovi			i ons)			
63.00 Has your facility trained residents in nonprovider	setting	s during this			r "Y" N	63. 00
for yes or "N" for no in column 1. If yes, complete	TITIES	04 till Ougil 67	Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	·		
Section 5504 of the ACA Base Year FTE Residents in	Nonprov	vider Settings	1.00 This base ye	2.00 ear is your cos	3. 00 st	
reporting period that begins on or after July 1, 20 64.00 Enter in column 1, if line 63 is yes, or your facil	009 and	before June 3	0, 2010.			64 00
the base year period, the number of unweighted non-	pri mary	care residen	t	0.00	0.000000	04.00
FTEs attributable to rotations occurring in all non in column 2 the number of unweighted non-primary ca			Enter t			
trained in your hospital. Enter in column 3 the rat						
by (column 1 + column 2)). (see instructions)			I	I		İ

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH FRANKFORT HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 15-1316 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/13/2021 4:29 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + colFTEs 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 trained 0.000000 0.00 0.00 65.00 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 residert 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 in (col. 1 + col **FTEs** Nonprovi der 2)) Hospi tal 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 66.00 Enter in column 1 the number of unweighted non-primary care resident FT s 0 00 0 00 0.000000 66.00 attributable to rotations occurring in all nonprovider settings. 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 <u>by (column 1 + column 2)). (see instructions)</u> Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ (col. 3 + colFTEs in **FTEs** 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 0.00 0.00 0.000000 67.00 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? N 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 mos 71.00 0 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 progr<mark>a</mark>m in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column s 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 subproved the facility (IRF). 75.00 Enter "Y" for yes and "N" for no. 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the mos 0 76.00 ecent 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)

alth Financial Systems IU HEALTH FRAN OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CCN: 15-13	16 Period: From 01/01/2020	u of Form CMS- Worksheet S- Part I	.2
		To 12/31/2020	Date/Time Pr 7/13/2021 4:	epared 29 pm
			1.00	
Long Term Care Hospital PPS			1	
 Is this a long term care hospital (LTCH)? Enter "Y" for Is this a LTCH co-located within another hospital for particle for yes and "N" for no. TEFRA Providers 		eporting period? En	N ter "Y" N	80. 0 81. 0
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1) 5.00 Did this facility establish a new Other subprovider (exclenter "Y" for yes and "N" for no.				85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hosp Enter "Y" for yes or "N" for no.	oital classified under	section 1886(d)(1)(B)(vi)?N	87. 0
		V	XLX	
Title V and XIX Services		1.00	2. 00	
0.00 Does this facility have title V and/or XIX inpatient hosp	oital services? Enter "	Y" for yes onN	Y	90. 0
"N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX through		er in full omN	N	91. 0
in part? Enter "Y" for yes or "N" for no in the applicable. OO Are title XIX NF patients occupying title XVIII SNF beds	(dual certification)?	(see	N	92. 0
instructions) Enter "Y" for yes or "N" for no in the appl 3.00 Does this facility operate an ICF/IID facility for purpos		Enter "Y" N	N	93. 0
for yes or "N" for no in the applicable column. 1.00 Does title V or XIX reduce capital cost? Enter "Y" for ye column.	es, and "N" for no in t	he applicableN	N	94. 0
5.00 If line 94 is "Y", enter the reduction percentage in the b.00 Does title V or XIX reduce operating cost? Enter "Y" for column.		0.00 he applicableN	0. 00 N	95. 0 96. 0
7.00 If line 96 is "Y", enter the reduction percentage in the B.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y for title V, and in column 2 for title XIX.	e interns and residents		0. 00 Y	97. 0 98. 0
B.01 Does title V and III coldinal 2 for title XVIII) for the Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti XIX.			Y	98. 0
3.02 Does title V or XIX follow Medicare (title XVIII) for the costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes on V, and in column 2 for title XIX.			Y	98.0
B.03 Does title V or XIX follow Medicare (title XVIII) for a creimbursed 101% of inpatient services cost? Enter "Y" for title V, and in column 2 for title XIX.			N	98.0
3.04 Does title V or XIX follow Medicare (title XVIII) for a (services cost? Enter "Y" for yes or "N" for no in column			N	98. 0
title XIX. 3.05 Does title V or XIX follow Medicare (title XVIII) and add (C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colu			Y	98. (
for title XIX. 3.06 Does title V or XIX follow Medicare (title XVIII) when continuous through IV? Enter "Y" for yes or "N" for no in column 1 title XIX.			Y	98. 0
Rural Providers 05.00Does this hospital qualify as a CAH?		l y		105. 0
06.00 of this facility qualifies as a CAH, has it elected the a loutpatient services? (see instructions)	all-inclusive method of	• · · · · ·		106.0
07.00Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in col Column 2: If column 1 is Y and line 70 or line 75 is Y, medical education program in the CAH's excluded IPF and, or "N" for no in column 2. (see instructions)	umn 1. (see instructi do you train I&Rs in a	ons) n approved		107. (
08.00 s this a rural hospital qualifying for an exception to section §412.113(c). Enter "Y" for yes or "N" for no.			Deer's re-	108. C
	Physi cal 0ccupation 1.00 2.0		Respi ratory 4.00	
09.00 If this hospital qualifies as a CAH or a cost provider, a therapy services provided by outside supplier? Enter "Y" yes or "N" for no for each therapy.	for		N N	109. 0

		In Lieu	of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		Period: From 01/01/2020	Worksheet S- Part I	-2
	1	o 12/31/2020	Date/Time Pr 7/13/2021 4:	repared: 29 pm
			1. 00	_
110.00Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "Y" for yes Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200	or "N" for no	If yes, compl	N ete	110.00
		1.00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Integration Project (FCHIP) demonstration for this cost reporting perio or "N" for no in column 1. If the response to column 1 is Y, enter the the FCHIP demo in which this CAH is participating in column 2. Enter al Ambulance services; "B" for additional beds; and/or "C" for tele-health	d? Enter "Y" integration p I that apply:	for yes rong of		111.00
112 OOD d this been tell participate in the Danney Lyapia Dural Health Medel	1. 00	2. 00	3. 00	112.00
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? En "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in co 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information				112.00
115.00 is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no				0115. 00
column 1. If column 1 is yes, enter the method used (A, B, or E only) i column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on definition in CMS Pub.15-1, chapter 22, §2208.1.				
116.00 s this facility classified as a referral center? Enter "Y" for yes or for no.	'N" N			116. 00
117.00 s this facility legally-required to carry malpractice insurance? Enter for yes or "N" for no.	"Y" N			117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy? Enter the policy is claim-made. Enter 2 if the policy is occurrence.	lif :	2		118. 00
	Premi ums	Losses	Insurance	
	1. 00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:	1. 00 27, 98			0118. 01
	27, 98	1. 00		
118.02Are malpractice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing	27, 98 r than the	1. 00 N		0118. 01
118.02Are malpractice premiums and paid losses reported in a cost center othe	27, 98 r than the	1. 00 N		
118.02Are mal practice premiums and paid losses reported in a cost center othe Administrative and General? If yes, submit supporting schedule listing amounts contained therein. 119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless p and applicable amendments? (see instructions) Enter in column 1, "Y" fo Is this a rural hospital with < 100 beds that qualifies for the Outpatien provision in ACA §3121 and applicable amendments? (see instructions) En	27,980 r than the cost centers rovision in Arryes or "N" ent Hold Harm	1.00 N and CA §3121N For no.		118. 02
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				From O	1/01/2020	Part I	
				To 12	2/31/2020	Date/Time Pi 7/13/2021 4:	
					1. 00	2. 00	4
All Providers					1.00	2.00	
0.00 Are there any related organization or home of						15H059	140.
10? Enter "Y" for yes or "N" for no in column enter in column 2 the home office chain numbe			e costs are	claimed	ı		
1.00	2.00				3. 00		
If this facility is part of a chain organization					and addre	ess	
of the home office and enter the home office	contractor nar					\1	
.OdName: INDIANA UNIVERSITY HEALTH Contrac 2.OdStreet:340 WEST 10TH STREET PO Box:			Contrac	tor's Nu	mber:0810)	141. 142.
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Odara provider based physicians' costs included	d in Warkshaat	A2				1. 00 Y	1 4 4
00 Are provider based physicians' costs included	ı iii worksneet	A!				Y	144
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.00 f costs for renal services are claimed on Wk							145.
services only? Enter "Y" for yes or "N" for r							
dialysis facility include Medicare utilization for yes or "N" for no in column 2.	ווע TNIS COS	si reporting	berioa? Ent	reil "A"			
0.00 Has the cost allocation methodology changed f	from the previo	ously filed c	ost report?	Enter "	Y'N	İ	146.
for yes or "N" for no in column 1. (See CMS F							
approval date (mm/dd/yyyy) in column 2.							
						1. 00	-
.00Was there a change in the statistical basis?	Enter "Y" for	yes or "N" f	or no.			N	147
.00Was there a change in the order of allocation	n? Enter "Y" fo	or yes or "N"	for no.	_		N	148
.00Was there a change to the simplified cost fir	nding method? E	<u>Enter "Y" for</u> Part A	yes or "N" Part B		tle V	N Title XIX	149
		1. 00	2. 00		3. 00	4.00	+
Does this facility contain a provider that qu		n exemption f	rom the app	lication	of the	•	
lower of costs or charges? Enter "Y" for yes	or "N" for no	for each com	ponent for I	Part A a	ind Part I	3.	
(See 42 CFR §413.13) 5.00Hospi tal		N	N		N	l N	155
. 00Subprovi der – IPF		N	N	İ	N	N N	156
. 00 Subprovi der – I RF		N	N	ļ	N	N	157
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	tal that has or		·			Enter N	
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Name O. OOIs this hospital part of a Multicampus hospital "Y" for yes or "N" for no. Name O. OOIf line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive OOIs this provider a meaningful user under §188 OOIf this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets (OOIs this provider is a CAH and is not a meanin under §413.70(a)(6)(ii)? Enter "Y" for yes or	e in the America 36(n)? Enter " and is a meanir (see instructic ngful user, doe r "N" for no. (County 1.00 can Recovery 'Y" for yes o ngful user (I ons) es this provie (see instruct	and Reinves: "N" for notine 167 is " der qualify	p Code 3.00 tment Aco. 'Y"), en	CBSA 4.00	FTE/Campus 5.00 0.0 1.00 Y xception	167. 168.
Name Name Name No. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive 1.00 If this provider a meaningful user under §188. Olif this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets (3.01 If this provider is a CAH and is not a meaning under §413. 70(a) (6) (ii)? Enter "Y" for yes or	e in the America 36(n)? Enter " and is a meanir (see instructic ngful user, doe r "N" for no. (County 1.00 can Recovery 'Y" for yes o ngful user (I ons) es this provie (see instruct	and Reinves: "N" for notine 167 is " der qualify	p Code 3.00 tment Ac 5. 'Y"), en for a h is "N")	CBSA 4.00	FTE/Campus 5.00 0.0 1.00 Y xception he 0.0	167.
Name O. OOIs this hospital part of a Multicampus hospital "Y" for yes or "N" for no. Name O. OOIf line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, code in column 3, CBSA in column FTE/Campus in column 5 (see instructions) Health Information Technology (HIT) incentive OOIs this provider a meaningful user under §188 OOIf this provider is a CAH (line 105 is "Y") a reasonable cost incurred for the HIT assets (OOIs this provider is a CAH and is not a meanin under §413.70(a)(6)(ii)? Enter "Y" for yes or	e in the Americ 36(n)? Enter " and is a meanir (see instruction gful user, doe r "N" for no. (167 is "Y") and	County 1.00 can Recovery 'Y" for yes o ngful user (I ons) es this provi (see instruct d is not a CA	and Reinves: r "N" for notine 167 is " der qualify ons) H (line 105	tment Acordinates the second s	CBSA 4.00	FTE/Campus 5.00 0.0 1.00 Y xception he 0.0	167. 168.

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL			of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provi der CCN: 15-1316	Peri od: From 01/01/2020 To 12/31/2020		repared:
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider	have any days for in	dividuals enrolled in se	ection Y		27171. 00
1876 Medicare cost plans reported on Wk	or yes and				
"N" for no in column 1. If column 1 is	re days				
in column 2. (see instructions)					

ealth Financial Systems IU HEALTH FRANK		ON 45 4047		of Form CMS-	
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CCN: 15-1316	Period: From 01/01/2020	Worksheet S- Part I	2
				Date/Time Pr	
			Y/N	7/13/2021 4: Date	29 pm
			1, 00	2. 00	
General Instruction: Enter Y for all YES responses. Enter	N for all NO	responses. E			
the mm/dd/yyyy format.		<u> </u>			
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation	the beat and an	- C + L +			1 00
Has the provider changed ownership immediately prior to period? If yes, enter the date of the change in column 2.			reportingN	I	1.00
The rough the date of the change the condition 2.	. (See Thistruc	Y/N	Date	V/I	
		1.00	2.00	3. 00	
00 Has the provider terminated participation in the Medicare	e Program? If	yes, N			2. 00
enter in column 2 the date of termination and in column 3	3, "V" for vol	ıntary		I	
or "I" for involuntary.		1 ,		I	1
On Is the provider involved in business transactions, include contracts, with individuals or entities (e.g., chain home				I	3.00
medical supply companies) that are related to the provide				I	
medical staff, management personnel, or members of the bo				I	
through ownership, control, or family and other similar				I	
instructions)		•		<u> </u>	
		Y/N	Type	Date	
Elmandal Data and Danasta		1. 00	2. 00	3. 00	
Financial Data and Reports Oo Column 1: Were the financial statements prepared by a Co	ortified Dublic	d Y	I A		4.00
Accountant? Column 2: If yes, enter "A" for Audited, "C"			^	I	4.00
"R" for Reviewed. Submit complete copy or enter date available.				I	
(see instructions) If no, see instructions.				I	
00 Are the cost report total expenses and total revenues di	fferent from t	ose N		I	5.00
on the filed financial statements? If yes, submit reconci	iliation.				
			Y/N	Legal Oper.	
Approved Educational Activities			1. 00	2. 00	
OO Column 1: Are costs claimed for nursing school? Column 2	2. If ves is	the provider	s the N		6.00
legal operator of the program?	z you, .o	o p. ov. do.		I	0.00
00 Are costs claimed for Allied Health Programs? If "Y" see	instructions.		N	I	7.00
00 Were nursing school and/or allied health programs approve	ed and/or rene	wed during th	ne cost N	I	8. 00
reporting period? If yes, see instructions.				I	
Are costs claimed for Interns and Residents in an approve		dical educati	oh N	I	9. 00
program in the current cost report? If yes, see instructi 0.00 Was an approved Intern and Resident GME program initiated		n the current	cost N	I	10.00
reporting period? If yes, see instructions.	a of Tellewed I	ii the current	. 1031 11	I	10.00
1.00 Are GME cost directly assigned to cost centers other than	n I & R in an .	Approved Tead	ching N	I	11. 00
Program on Worksheet A? If yes, see instructions.			Ü	<u> </u>	
				Y/N	
Ded Delde	-			1. 00	
Bad Debts 2.00 Is the provider seeking reimbursement for bad debts? If v	uss soo instr	uctions		Y	12.00
3.00 If line 12 is yes, did the provider's bad debt collection			cost renorting		13.00
If yes, submit copy.	in point by change	c during this	s cost reporting	 	13.00
4.00 If line 12 is yes, were patient deductibles and/or co-pay	yments wai ved?	If yes, see	instructions.	N	14.00
Bed Complement					
5.00 Did total beds available change from the prior cost repo			nstructions.	N	15. 00
		T A		t B	
	Y/N 1.00	2.00	Y/N 3.00	Date 4. 00	
PS&R Data	1.00	2.00	0.00	1. 00	
6.00 Was the cost report prepared using the PS&R Report only?	lf N		N		16. 00
either column 1 or 3 is yes, enter the paid-through date				I	
the PS&R Report used in columns 2 and 4 (see instruction					
7.00 Was the cost report prepared using the PS&R Report for to and the provider's records for allocation? If either colu		04/02/2021	Υ	04/02/2021	17. 00
				I	
	1 ''			Ì	
or 3 is yes, enter the paid-through date in columns 2 and		ŀ	N	I	18.00
or 3 is yes, enter the paid-through date in columns 2 and (see instructions)	port N		IN		1
or 3 is yes, enter the paid-through date in columns 2 and (see instructions)			IN IN		
or 3 is yes, enter the paid-through date in columns 2 and (see instructions) 3.00 If line 16 or 17 is yes, were adjustments made to PS&R Redata for additional claims that have been billed but are included on the PS&R Report used to file this cost report	not		IN IN		
or 3 is yes, enter the paid-through date in columns 2 and (see instructions) 3.00 If line 16 or 17 is yes, were adjustments made to PS&R Reddata for additional claims that have been billed but are included on the PS&R Report used to file this cost report yes, see instructions.	not t? If				
or 3 is yes, enter the paid-through date in columns 2 and (see instructions) 3.00 If line 16 or 17 is yes, were adjustments made to PS&R Redata for additional claims that have been billed but are included on the PS&R Report used to file this cost report yes, see instructions. 9.00 If line 16 or 17 is yes, were adjustments made to PS&R Report used to ps&R Redata to	not t?lf eport N		N		19. 00
or 3 is yes, enter the paid-through date in columns 2 and (see instructions) 3.00 If line 16 or 17 is yes, were adjustments made to PS&R Reddata for additional claims that have been billed but are included on the PS&R Report used to file this cost report yes, see instructions.	not t?lf eport N				19.00

	Financial Systems IU HEALTH FRANKFI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1316		Peri od: From 01/01/2020 To 12/31/2020		5-2
					7/13/2021 4	
			<u>iption</u>	Y/N	Y/N	
20.00	If line 14 or 17 is yes were adjustments made to DCOD Dan		0	1. 00	3. 00 N	20, 00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Rep data for Other? Describe the other adjustments:	ort		N	IN	20. 00
	data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4. 00	
21.00	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					
	COMPLETED BY COST DELMBURGED AND TEEDA HOSDITALS ONLY (EVO	EDT CHILLDDEN	C HOCDLTALC)		1. 00	
-	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDREN	5 HUSPITALS)			
22 00	Have assets been relifed for Medicare purposes? If yes, se	e instructio	ins		N	22. 00
	Have changes occurred in the Medicare depreciation expense			during the cost	N N	23. 00
20.00	reporting period? If yes, see instructions.	ado to appi	a. ca. caac	aarring tilo ooot		20.00
24. 00	Were new leases and/or amendments to existing leases enter	ed into duri	ng this cost	reporting perio	d?lf N	24. 00
	yes, see instructions		0			
25. 00	Have there been new capitalized leases entered into during	the cost re	porting peri	od? If yes, see	N	25. 00
	instructions.					l l
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost repo	rting period	? If yes, see	N	26. 00
27.00	instructions.			1 €alam! +	anni N	27.00
27.00	Has the provider's capitalization policy changed during th	e cost repor	ting period?	ir yes, submit	copy. N	27. 00
28 00	<u>Interest Expense</u> Were new Loans, mortgage agreements or Letters of credit e	ntered into	during the c	ost reporting ne	ciod2 INF	28. 00
20.00	yes, see instructions.	intered Titto	during the c	ost reporting pe	i i od: iii	20.00
29. 00	Did the provider have a funded depreciation account and/or	bond funds	(Debt Servic	e Reserve Fund)	treatedN	29. 00
	as a funded depreciation account? If yes, see instructions					
30.00	Has existing debt been replaced prior to its scheduled mat	urity with n	ew debt? If	yes, see instruc	tions. N	30.00
31.00	Has debt been recalled before scheduled maturity without i	ssuance of n	ew debt? If	yes, see instruc	tions. N	31.00
00.00	Purchased Services					
32.00	Have changes or new agreements occurred in patient care se		shed through	contractual	N	32. 00
33 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap		ning to comp	otitivo bidding?	lf no	33. 00
33.00	see instructions.	pri eu pertar	Tilling to comp	etritive bruding:	TT TIO,	33.00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an a	rrangement w	ith provider	-based physician	s? If Y	34.00
	yes, see instructions.	•	·			
35. 00	If line 34 is yes, were there new agreements or amended ex		ments with t	he provider-base	d N	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.			_	
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
	Were home office costs claimed on the cost report?			Υ		36.00
	If line 36 is yes, has a home office cost statement been p	repared by t	he home offi			37. 00
	yes, see instructions.	. opa. oa 25 c				
07.00						37.00
	If line 36 is yes, was the fiscal year end of the home of	fice differe	nt from that	of the N		38.00
	If line 36 is yes, was the fiscal year end of the home of provider? If yes, enter in column 2 the fiscal year end of	fice differe the home of	nt from that fice.	of the N		
38. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth	the home of	fice.			
38. 00 39. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions.	the home of er chain com	fice. ponents? If	yes, see N		38. 00 39. 00
38. 00 39. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the	the home of er chain com	fice. ponents? If	yes, see N		38. 00
38. 00 39. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions.	the home of er chain com	fice. ponents? If	yes, see N		38. 00 39. 00
38. 00 39. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the	the home of er chain com home office	fice. ponents? If ? If yes, s	yes, see N ee N	00	38. 00 39. 00
38. 00 39. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the	the home of er chain com home office	fice. ponents? If	yes, see N ee N	00	38. 00 39. 00
38. 00 39. 00 40. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the instructions.	the home of er chain com home office	fice. ponents? If ? If yes, s	yes, see N ee N	00	38. 00 39. 00
38. 00 39. 00 40. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	the home of er chain com home office	fice. ponents? If ? If yes, s	yes, see N ee N 2.	00	38. 00 39. 00 40. 00
38. 00 39. 00 40. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position her by the cost report preparer in columns 1, 2, and 3, respectively.	the home of er chain com home office 1.	fice. pponents? If If yes, s	yes, see N ee N 2.	00	38. 00 39. 00 40. 00
38. 00 39. 00 40. 00 41. 00 42. 00	provider? If yes, enter in column 2 the fiscal year end of If line 36 is yes, did the provider render services to oth instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position her by the cost report preparer in columns 1, 2, and 3,	the home of er chain com home office 1.	fice. pponents? If If yes, s	yes, see N ee N 2.		38. 00 39. 00 40. 00

Health Financial Systems	ieu of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Worksheet S-	2		
			From 01/01/2 To 12/31/2	020 Part 11 020 Date/Time Pr 7/13/2021 4:	
	-	2.00			
		3. 00			
Cost Report Preparer Contact Information					
41.00 Enter the first name, last name and the t	itle/position he	GOVERNMENT PROGRAMS DIREC	CTO R		41. 00
by the cost report preparer in columns 1,	2, and 3,				
respecti vel y.					
42.00 Enter the employer/company name of the co	st report prepare	er.			42.00
43.00 Enter the telephone number and email addre	ess of the cost				43.00
report preparer in columns 1 and 2, respec	cti vel v.				

 Health Financial
 Systems
 IU HEALTH F

 HOSPITAL
 AND
 HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Period: Worksheet S-3 From 01/01/2020 Part I Provi der CCN: 15-1316

					To	rom 01/01/2020 o 12/31/2020	Date/Time Pre	
							7/13/2021 4:2 /P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No. of Be	2hc	Bed Days	CAH Hours	Title V	
	Compension	Line Number	110. 01 20	Jus	Avai I abl e	oran noar s	11 110 1	
		1.00	2. 00		3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 an	d 8 30.00		24	8, 448	25, 968. 00	0	1. 00
	exclude Swing Bed, Observation Bed and Hosp	i ce						
	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	0.00
7. 00	Total Adults and Peds. (exclude observation			24	8, 448	25, 968. 00	0	7. 00
0.00	beds) (see instructions)							0.00
8. 00	INTENSIVE CARE UNIT							8.00
9. 00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10. 00 11. 00
11. 00 12. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)							12.00
	NURSERY							13. 00
	Total (see instructions)			24	8, 448	25, 968. 00	0	
15. 00	CAH visits			24	0, 440	23, 900.00	0	15. 00
16. 00	SUBPROVI DER - I PF						O	16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
	SKILLED NURSING FACILITY							19. 00
	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY	101. 00					0	22. 00
23.00	AMBULATORY SURGICAL CENTER (D.P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25. 00
	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
	Total (sum of lines 14-26)			24				27. 00
28. 00	Observation Bed Days						0	28. 00
	Ambul ance Tri ps							29. 00
	Employee discount days (see instruction)							30.00
	Employee discount days - IRF			_				31.00
	Labor & delivery days (see instructions)			0	0			32.00
32.01	Total ancillary labor & delivery room							32. 01
22 00	outpatient days (see instructions)							33. 00
	LTCH non-covered days LTCH site neutral days and discharges							33.00
33. U I	LETON SELE NEUTRAL MAYS AND DESCRIPTIONS							J 33. U I

Provi der CCN: 15-1316

Period: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

Title XVIII				I	o 12/31/2020	Date/Time Pre 7/13/2021 4:2	
Note		I/P Days / O/P Visits / Trips			Full Time E		
1.00	Component	Title XVIII	Title XIX				
exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		6.00	7. 00	8. 00	9. 00	10.00	
days)(see instructions for col. 2 for the portion of LDP proma wail table beds) 2.00	1.00 Hospital Adults & Peds. (columns 5, 6, 7 an	d 8 545	11	1, 082			1. 00
Dorition of LDP room available beds)		i ce					
2 00 HM0 and other (see instructions)							
3.00 HMO IPF Subprovider 4.00 MO IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed SNF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 10.00 SUBPROVIDER - IPF 10.00 SUBPROVIDER - IRF 10.00 SUBPROVIDER - IRF 10.00 SUBPROVIDER - IRF 10.00 NURSING FACILITY 10.00 NURSING FACILITY 10.00 ON NURSING FACILITY 10.00 NURSING FACILITY 10.00 ON NURSING FACILITY 10.00 ON NURSING FACILITY 10.00 ON NURSING FACILITY 10.00 SUBPROVIDER - IRF 10.00 SU		221	0.5				2 00
4. 00 HMO IRF Subprovider							
5.00 Hospital Adults & Peds. Swing Bed NF		1 -1	- 1				
6. 00 Hospital Adults & Peds. Swing Bed NF 0 139 6. 000 7. 00 beds) (see instructions) 11 1, 435 3. 00 7. 00 5. 00 10. 00		1 -1	- 1	214			
7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) beds) (see instructions) 8. 00 INTENSIVE CARE UNIT		214	- 1				
BedS) (see instructions)		750					
8. 00 INTENSI VE CARE UNI T 9. 00 10.00 BURN INTENSI VE CARE UNI T 10.00 11. 00 SURGI CAL INTENSI VE CARE UNI T 10.00 11. 00 SURGI CAL INTENSI VE CARE UNI T 11. 00 12. 00 10 11. 00		759	1 1	1, 433			7.00
9. 00 CORONARY CARE UNIT 9. 00 10. 00 BURN INTENSIVE CARE UNIT 11. 00 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00							0 00
10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 CAH visits 17. 00 SUBPROVIDER - IPF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER BEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 O RURAL HEALTH CLINIC 26. 00 O SUBRAL (Sum of lines 14-26) 27. 00 O DOSEPORATION Bed Days 28. 00 O DOSEPORATION Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days - IRF 30. 00 Employee discount days - IRF 30. 00 O O O O O O O O O O O O O O O O O							
11. 00 12. 00 10 OTHER SPECIAL CARE (SPECIFY) 13. 00 10 NURSERY 13. 00 10 NURSERY 15. 00 10 CAH vi sit s 15. 00 10 CAH vi sit s 15. 00 10 CAH vi sit s 15. 00 10 CAH vi sit s 16. 00 17. 00 18 SUBPROVI DER - I PF 17. 00 18 SUBPROVI DER - I RF 18 OS 19 OS 19 OS 19 OS 19 OS 14 LICED NURSI NG FACILITY 20. 00 19 OS 22. 00 19 OS 24. 00 10 HOSPI CE 24. 10 10 HOSPI CE 24. 10 10 HOSPI CE 26. 25 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 28. 00 29. 00 20 OS 20 OS 20 OS 21. 00 22 OS 23 OS 24 OS 25 OS 26 OS 27. 00 28 OS 29 OS 28 OS 29 OS 29 OS 29 OS 20 OS 21 OS 22 OS 23 OS 24 OS 25 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 28. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22 OS 23 OS 24 OS 25 FEDERALLY OUALIFIED HEALTH CENTER 26 OS 27. 00 28 OS 29 OS 29 OS 30 OS 31. 00 31. 00 32 OS 32 OS 33 .00 33 .00 33 .00 33 .00 33 .00 35 OS 35 O							•
12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 17. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 28. 00 Observation Bed Days 30. 00 Empl oyee discount days (see instructions) 33. 00 LTOT hon-covered days 33. 00 LTOT hon-covered days 33. 00 LTOT hon-covered days 33. 00 LTOT hon-covered days 33. 00 LTOT hon-covered days 33. 00 LTOT hon-covered days 30. 00 DO							
13. 00 14. 00 15							•
14.00							•
15. 00 CAH visits 0 0 0 0 15. 00 16. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IPF 17. 00 SUBPROVI DER - IRF 18. 00 18. 00 19. 00 SUBPROVI DER 19. 00 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 OUNGRING	750	11	1 /25	0.00	104 25		
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 SKI LLED NURSI NG FACI LI TY 19. 00 SKI LLED NURSI NG FACI LI TY 20. 00 NURSI NG FACI LI TY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 0 0 0 0 0. 00 0. 00 22. 00 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0. 00 0. 00 26. 25 26. 00 26. 25 CM CANDER OF AMBULATORY SURGI CAL CENTER 0 0 0. 00 0. 00 26. 25 26. 00 26. 25	, ,	737	11	1, 433	0.00	104. 23	•
17. 00 SUBPROVI DER - IRF 17. 00 18. 00 SUBPROVI DER 17. 00 18. 00 SUBPROVI DER 17. 00 18. 00 SUBPROVI DER 17. 00 18. 00 19. 00		i o	U	C			
18.00 SUBPROVI DER 18.00 19.00 SKI LLED NURSI NG FACI LI TY 20.00 NURSI NG FACI LI TY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE		1					
19.00 SKILLED NURSING FACILITY 19.00 20.00 21.00 22.00 22.00 23.00 4MBULATORY SURGICAL CENTER (D.P.) 23.00 4MSULATORY SURGICAL CENTER (D.P.) 24.00 24.00 40.00 40.00 40.00 24.10 25.00 24.00 25.00 26.25 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 26.25 27.00 28.00 29.		1					
20.00 NURSING FACILITY 20.00 21.00 21.00 22.00 21.00 22.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 23.00 40.00 40.00 40.00 22.00 23.00 24.00 40.00 40.00 40.00 20.00 24.00 24.10 25.00 24.10 25.00 26.25 26.00 26.25 27.00 27.00 27.00 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00							
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 44.00 HOSPICE 44.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 20.00 Employee discount days (see instruction) 31.00 Employee discount days (see instructions) 32.00 LTCH non-covered days 33.00 LTCH non-covered days							
22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 33.00 LTCH non-covered days 33.00 LTCH non-covered days 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							•
23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 23.00 24.00 24.00 24.00 25.00 26.00 26.00 27.00 0 0 0.00 0.00 0		0	0	0	0.00	0.00	
24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 24.00 24.10 25.00 26.05 27.00 0 0 0.00 0.00 0.00 26.25 27.00 0 0.00 104.25 27.00 0 0.00 104.25 27.00 0 0 0 0.00 0 0 0 0.00 0 0 0 0 0 0 0		Ŭ	J		0.00	0.00	•
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 26 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 00 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 24. 10					•		
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 O O O O O O O O O O O O O O O O O O				0			•
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 26. 00 0 0 0 0 0. 0				Č			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 104. 25 27. 00 28. 00 Observation Bed Days 1 451 28. 00 29. 00 Ambul ance Trips 0 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 0 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 0 0 0 0 32. 00 33. 00 LTCH non-covered days 0 0 0 0 33. 00 33. 00							•
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0.00 104.25 27.00 28.00 29.00 30.00 0 0 0 30.00 31.00 32.00 33.00		0	0	0	0.00	0.00	
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 1 451 28.00 29.00 30.00 30.00 30.00 31.00 32.00 32.01 33.00		, and the second	Š	· ·			•
29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 29.00 30.00 31.00 0 31.00 0 32.00 32.00			1	451	0.00	101120	•
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 30.00 31.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	,	0	·				
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 31.00 O O O O O O O O O O O O O O O O O O		, and the second		0			
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 32.00 0 0 0 0 0 32.01		İ		O			
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 0 32.01		0	0	0	i		
outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00		Ĭ	ĭ	n			
33.00 LTCH non-covered days 0 33.00							52.01
		0			i		33. 00

Health Financial Systems IU HEALTH F HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Period: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: Provi der CCN: 15-1316

				To	o 12/31/2020	Date/Time Pre 7/13/2021 4:2	
		Full Time	•	Di sch	arges	// 10/ <u>L</u> 0 <u>E</u> 1 11 E]
		Equi val ents		I =			
	Component	onpaid Workers	Title V	Title XVIII	Title XIX	Total All	
		11.00	10.00	10.00	11.00	Pati ents	
1 00	Tu	11.00	12. 00	13. 00	14. 00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 ar		C	166	3	347	1.00
	exclude Swing Bed, Observation Bed and Hosp	n ce					
	days) (see instructions for col. 2 for the						
2 00	portion of LDP room available beds)			7.5	20		2 00
2.00	HMO and other (see instructions)			75	29		2.00
3.00	HMO IPF Subprovi der			}	0		3.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF			}	U		4. 00 5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF			1			6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)	1					7.00
8. 00	INTENSIVE CARE UNIT			1			8.00
9. 00	CORONARY CARE UNIT			1			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
	OTHER SPECIAL CARE (SPECIFY)						12.00
	NURSERY						13. 00
	Total (see instructions)	0.00	(166	3	347	•
	CAH visits	0.00			, i	0.,	15. 00
16. 00							16. 00
17. 00	SUBPROVIDER - IRF	1					17. 00
	SUBPROVI DER	1					18. 00
19.00	SKILLED NURSING FACILITY	1					19. 00
20.00	NURSING FACILITY	1					20.00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC	1					25. 00
	RURAL HEALTH CLINIC	1					26. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
	Total (sum of lines 14-26)	0.00					27. 00
	Observation Bed Days						28. 00
	Ambul ance Tri ps						29. 00
	Employee discount days (see instruction)						30.00
	Employee discount days - IRF			1			31.00
	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges	1 1		0			33. 01

Heal th	Financial Systems IU HEALTH FRANKFORT	HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
HOSPI 7	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC		Peri od:	Worksheet S-1	0
				From 01/01/2020 To 12/31/2020	Date/Time Pre	epared:
					7/13/2021 4: 2	
					1. 00	
	Uncompensated and indigent care cost computation				1. 00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 c	divided by	line 202 col	umn 8)	0. 496262	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				892, 568 N	2.00
3. 00 4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or suppleme	ntal navme	nts from Med	i cai d?	IN	3. 00 4. 00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments			r car a:	0	5.00
6.00	Medi cai d charges				9, 882, 134	6. 00
7.00	Medicaid cost (line 1 times line 6)				4, 904, 128	
8. 00	Difference between net revenue and costs for Medicaid program	n (line 7 m	inus sum of	lines 2 and 5;	f < 4,011,560	8. 00
	zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions	for each li	i no)			
9. 00	Net revenue from stand-alone CHIP	TOT Each I	i ne)		0	9. 00
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00
12.00	Difference between net revenue and costs for stand-alone CHIF	P (line 11	minus line 9	; if < zero the	n enter 0	12. 00
	zero)	-4	6l. 1!	>		ļ
12 00	Other state or local government indigent care program (see in Net revenue from state or local indigent care program (Not in				4 050	13. 00
	Charges for patients covered under state or local indigent ca					
15. 00	State or local indigent care program cost (line 1 times line		(1.01 11.01 44			15. 00
16.00	Difference between net revenue and costs for state or local i	ndi gent ca	re program (line 15 minus I	ne 13; 13,911	16. 00
	if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, (programs (see instructions for each line)	CHIP and sta	ate/local in	digent care		
17 00	Private grants, donations, or endowment income restricted to	fundi na ch	arity care		0	17. 00
	Government grants, appropriations or transfers for support of				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and Loc	cal indigen	t care progr	ams (sum of lin	es 8,4,1 0 25,471	19. 00
	and 16)		Uni nsured	Insured	Total (col. 1	
			pati ents	patients	+ col . 2)	
		Ī	1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
20. 00	Charity care charges and uninsured discounts for the entire	facility (s	ee 1, 485, 96	6 37, 397	1, 523, 363	20. 00
21. 00	instructions) Cost of patients approved for charity care and uninsured disc	nunts (see	737, 42	8 37, 397	774, 825	21 00
21.00	instructions)	Journs (3ee	737, 42	37,377	774,023	21.00
22.00	Payments received from patients for amounts previously writte	en off as		0 0	0	22. 00
	charity care					
23.00	Cost of charity care (line 21 minus line 22)		737, 42	8 37, 397	774, 825	23. 00
					1. 00	
24.00	Does the amount on line 20 column 2, include charges for pati	ent davs b	evond a Leng	th of stav limi	t N	24. 00
	imposed on patients covered by Medicaid or other indigent can					
25.00	If line 24 is yes, enter the charges for patient days beyond	the indige	nt care prog	ram's length of	stay 0	25. 00
2/ 02	limit		-)		2 055 452	2/ 00
26.00	Total bad debt expense for the entire hospital complex (see i Medicare reimbursable bad debts for the entire hospital compl				2, 055, 452 334, 656	
	Medicare allowable bad debts for the entire hospital complex				514, 854	
	Non-Medicare bad debt expense (see instructions)	(555 111511	20110110)		1, 540, 598	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e	expense (se	e instructio	ns)	944, 738	29. 00
	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 719, 563	
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			5, 745, 034	31.00

Health Financial Systems	J HEALTH FRANKFO	ORT HOSPITAL		In Lieu	of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE		Provi der Co		eri od:	Worksheet A	
				rom 01/01/2020	Dota /Time Dies	
			T	o 12/31/2020	Date/Time Pre 7/13/2021 4:2	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		7 DIII
			,	ons (See A-6)		
			Í	, , ,	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FLXT		192, 059	192, 059	-175, 644	16, 415	1. 00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL		0	0	2, 020, 457	2, 020, 457	1. 01
1. 02 00102 CAP REL COSTS-BLDG & FLXT - MOB	1.11 001	40 (51	100 (50	2, 250	2, 250	1. 02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	141, 001	42, 651	183, 652	1, 194, 901	1, 378, 553	4.00
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	532, 297 469, 301	7, 311, 079 1, 975, 372	7, 843, 376 2, 444, 673	-793, 573 -1, 848, 463	7, 049, 803 596, 210	5. 00 7. 00
7. 01 00700 OPERATION OF PLANT 7. 01 00701 OPERATION OF PLANT - HOSPITAL	409, 301	1, 975, 372	2,444,073	1, 190, 983	1, 190, 983	7. 00
7. 02 00702 OPERATION OF PLANT - MOB	0	0	0	1, 170, 703	1, 170, 709	7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE	ő	Ö	0	40, 677	40, 677	8.00
9. 00 00900 HOUSEKEEPI NG	268, 269	196, 663	464, 932	-120, 719	344, 213	9. 00
10. 00 01000 DI ETARY	159, 907	292, 295	452, 202	-278, 761	173, 441	
11. 00 01100 CAFETERI A	0	0	0	215, 559	215, 559	11. 00
13.00 01300 NURSING ADMINISTRATION	908, 569	237, 532	1, 146, 101	-124, 915	1, 021, 186	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	222, 165	222, 165	300, 023	522, 188	14.00
15.00 01500 PHARMACY	400, 313	1, 369, 581	1, 769, 894	-736, 085	1, 033, 809	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	946, 352	756, 635	1, 702, 987	-312, 302	1, 390, 685	30.00
ANCILLARY SERVICE COST CENTERS	0/0 570	1 000 100	1 050 007	(54.504	/0/ 005	F0 00
50. 00 05000 OPERATING ROOM	260, 578	1, 090, 408	1, 350, 986	-654, 591	696, 395	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	681, 784 0	516, 971 1, 818, 684	1, 198, 755 1, 818, 684	-260, 008 -1, 963	938, 747 1, 816, 721	54. 00 60. 00
66. 00 06600 PHYSI CAL THERAPY	55	474, 601	474, 656		454, 123	
67. 00 06700 OCCUPATI ONAL THERAPY	0	192, 297	192, 297	-20, 555	192, 297	67. 00
68. 00 06800 SPEECH PATHOLOGY	76, 156	21, 412	97, 568	-15, 749	81, 819	68. 00
69. 00 06900 ELECTROCARDI OLOGY	46, 447	28, 422	74, 869	-22, 408	52, 461	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	44, 818	44, 818	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	o	0	229, 287	229, 287	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	310, 797	310, 797	73. 00
73.01 07301 ONCOLOGY DRUGS	0	0	0	408, 375	408, 375	73. 01
76.00 03160 CARDI OPULMONARY	686, 918	208, 824	895, 742	-150, 065	745, 677	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	6, 716	6, 716	-6, 716	0	90.00
91. 00 09100 EMERGENCY	957, 161	2, 567, 429	3, 524, 590	-376, 643	3, 147, 947	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	ol .	ام	0		0	101 00
101. OC 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 535, 108	19, 521, 796	26, 056, 904	58, 989	26, 115, 893	110 00
NONREI MBURSABLE COST CENTERS	0, 555, 100	17, 321, 770	20, 030, 704	30, 707	20, 115, 075	1 10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 0019100 RESEARCH	ő	ő	Ö	o		191. 00
192.0019200 PHYSICIANS' PRIVATE OFFICES	o	Ō	0	Ō		192. 00
192. 02 19202 MOB	0	2, 931	2, 931	-58, 989	-56, 058	192. 02
193. OQ19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 LEASED SPACE	0	0	0	0		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 535, 108	19, 524, 727	26, 059, 835	0	26, 059, 835	200. 00

Provi der CCN: 15-1316

| Period: | Worksheet A | From 01/01/2020 | To | 12/31/2020 | Date/Time Prepared:

			To 12/31/2020 Date/Time Pi 7/13/2021 4	
Cost Center Description	Adjustments	Net Expenses	17/13/2021 4	. Z / piii
μ		For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FIXT	0	16, 415		1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL	150, 602	2, 171, 059		1. 01
1.02 O0102 CAP REL COSTS-BLDG & FIXT - MOB	0	2, 250		1. 02
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	125, 845	1, 504, 398		4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	-419, 901	6, 629, 902		5. 00
7.00 00700 OPERATION OF PLANT	-32, 625	563, 585		7. 00
7.01 00701 OPERATION OF PLANT - HOSPITAL	-88, 206	1, 102, 777		7. 01
7.02 00702 OPERATION OF PLANT - MOB	0	0		7. 02
8.00 00800 LAUNDRY & LINEN SERVICE	0	40, 677		8. 00
9. 00 00900 HOUSEKEEPI NG	-234	343, 979		9. 00
10. 00 01000 DI ETARY	0	173, 441		10.00
11. 00 01100 CAFETERI A	-50, 651	164, 908		11. 00
13.00 01300 NURSING ADMINISTRATION	71, 683	1, 092, 869		13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	47, 246	569, 434		14. 00
15. 00 01500 PHARMACY	-257, 297	776, 512		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS	-252, 139	1, 138, 546		30.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	-98, 027	598, 368		50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	938, 747		54.00
60. 00 06000 LABORATORY	-1, 657	1, 815, 064		60.00
66. 00 06600 PHYSI CAL THERAPY	0	454, 123		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	192, 297		67. 00
68.00 06800 SPEECH PATHOLOGY	0	81, 819		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	52, 461		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44, 818		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	229, 287		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	310, 797		73. 00
73. 01 07301 ONCOLOGY DRUGS	0	408, 375	l e e e e e e e e e e e e e e e e e e e	73. 01
76. 00 03160 CARDI OPULMONARY	68, 069	813, 746		76. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0	0		90. 00
91. 00 09100 EMERGENCY	-590, 392	2, 557, 555		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS		_		
101. 00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-1, 327, 684	24, 788, 209		118. 00
NONREI MBURSABLE COST CENTERS	-	_		
190. 0019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 0019100 RESEARCH	0	0	Y .	191.00
192. 0019200 PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192. 02 19202 MOB	0	-56, 058		192. 02
193. 00 19300 NONPALD WORKERS	0	0		193.00
194. 00 07950 LEASED SPACE	1 207 (2)	04 700 151		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-1, 327, 684	24, 732, 151	l	200. 00

Heal th FinancialSystemsIU HEALTH FRANKFORT HOSPITALIn Lieu of Form CMS-2552-10RECLASSIFICATIONSProvider CCN: 15-1316Period: From 01/01/2020Worksheet A-6

12/31/2020 Date/Time Prepared: 7/13/2021 4:29 pm Increases Cost Center Line # 0ther Sal arv 2.00 3.00 4.00 5.00 CAFETERI A 1.00 CAFETERI A 11.00 88, 610 126, 949 1.00 126, 949 88, 610 B - DRUGS 1.00 DRUGS CHARGED TO PATIENTS 73.00 310, 797 1.00 2.00 ONCOLOGY DRUGS 73. 01 408, 375 2.00 3.00 0.00 3.00 4.00 0.00 4.00 5.00 0.00 5.00 6.00 0.00 6.00 7.00 0 00 7 00 8.00 0.00 8.00 9.00 0.00 9.00 TOTALS 719, 172 MEDICAL SUPPLIES 1.00 CENTRAL SERVICES & SUPPLY 14.00 0 308, 536 1.00 2.00 MEDICAL SUPPLIES CHARGED TO 71.00 44, 818 2.00 PATI ENTS IMPL. DEV. CHARGED TO PATIENTS 3.00 72.00 229, 287 3.00 4.00 NURSING ADMINISTRATION 13.00 671 4.00 5.00 192.02 5.00 6.00 0 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 11.00 0.00 11.00 12.00 0.00 12.00 13.00 13.00 0.00 TOTALS 583, 315 LAUNDRY 1.00 LAUNDRY & LINEN SERVICE 8. 00 40, 677 1.00 2.00 0.00 2.00 3.00 0.00 0 3.00 4.00 0.00 4.00 5.00 0.00 5.00 6.00 0.00 6.00 7.00 0.00 7.00 8.00 0.00 8.00 9.00 9.00 0.00 TOTALS 40, 677 DEPRECIATION CAP REL COSTS-BLDG & FLXT 1.00 1. 01 1, 344, 319 1.00 HOSPI TAL 2.00 0.00 2.00 3.00 0.00 3.00 4.00 0.00 4.00 0.00 5.00 5.00 6.00 0.00 6.00 7.00 0.00 7.00 0.00 8 00 8 00 9.00 0.00 9.00 10.00 0.00 10.00 11.00 0.00 11.00 1, 344, 319 TOTALS - OTHER CAPITAL 1.00 CAP REL COSTS-BLDG & FIXT 1. 01 482, 723 1.00 HOSPI TAL 2 00 CAP REL COSTS-BLDG & FIXT 16, 415 1 00 2 00 3.00 CAP REL COSTS-BLDG & FIXT -1.01 1, 356 3.00 HOSPI TAL 4.00 ADMINISTRATIVE & GENERAL 5.00 56, 742 4.00 CAP REL COSTS-BLDG & FIXT 192, 059 5.00 1.01 5.00 HOSPI TAL 749, 295 TOTALS G - OPERATION OF PLANT 1.00 <u> OPERATION OF PLANT - HOSPITA</u> 7.01 1, 19<u>0, 9</u>83 1.00 1, 190, 983 H - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT 1.00 4.00 1, 165, 368 1.00 2.00 0.00 2.00 3.00 0.00 3.00 0 0 0.00 0 0 4.00 4.00 5.00 0.00 5.00

Health Financial Systems

IU HEALTH FRANKFORT HOSPITAL

Provider CCN: 15-1316

Period: From 01/01/2020 To 12/31/2020 Date/Time Prepared:

					To 12/31/2020 Date/Time F 7/13/2021 4	repared: 1·29 nm
		Increases		•	77 107 2021	1 2
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
6. 00		0. 00	0	0	·	6. 00
7.00		0. 00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9.00		0. 00	0	0		9. 00
10.00		0. 00	0	0		10.00
11.00		0. 00	0	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0. 00	0	0		13. 00
14.00		0.00	0	0		14. 00
	TOTALS		0	1, 165, 368		
	I - HOUSEKEEPING					
1.00	HOUSEKEEPI NG	9. 00	0	3, 615		1. 00
2.00		0. 00	0	0		2. 00
3.00		0. 00	0	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0. 00	0	0		5. 00
6. 00		0. 00	0	0		6. 00
7. 00		0. 00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9. 00	oxdot $oxdot$ $oxdot$ $oxdot$ $oxdot$ $oxdot$ $oxdot$ $oxdot$ $oxdot$	<u>0.</u> 00	4	<u> </u>	1	9. 00
	TOTALS		0	3, 615		_
	K - MOB MAINTENANCE AND RENT					4
1.00	CAP REL COSTS-BLDG & FIXT -	1. 02	0	2, 250		1. 00
	MOB	+			-	
	TOTALS		0	2, 250		_
	L - ONCOLOGY					4
1.00	OPERATING ROOM	50.00	9	6, 716		1. 00
	TOTALS		0	6, 716		_
4 00	M - ACCRUED PTO	,	00 =00			4
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	2 <u>9, 5</u> 33			1. 00
F00 00	TOTALS		29, 533	0		
500. 00	Grand Total: Increases		118, 143	5, 932, 659	1	500.00

						To 12/31/2020 Date/Time P 7/13/2021 4	
	Cook Cooker	Decreases	Calami	0+4	Mich A 7 Dof		
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - CAFETERIA	7100	0, 00	7, 00	10100		
1.00	DI ETARY	10.00	8 <u>8, 6</u> 10	<u>126, 949</u>			1. 00
	D - DRUGS		88, 610	126, 949			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	132	0		1.00
2.00	PHARMACY	15. 00	0	682, 000			2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	4, 396	0		3. 00
4. 00 5. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	1, 182 18, 551	0		4. 00 5. 00
6. 00	PHYSI CAL THERAPY	66. 00	ő	110	0		6. 00
7. 00	ELECTROCARDI OLOGY	69. 00	0	17	0		7. 00
8. 00	CARDI OPULMONARY	76. 00	0	2, 710			8. 00
9. 00	EMERGENCY	91.00	— — —	1 <u>0, 0</u> 74 719, 172	<u> </u>		9. 00
	C - MEDICAL SUPPLIES	L	<u> </u>	719, 172			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	17, 310	0		1.00
2.00	OPERATION OF PLANT	7. 00	0	45, 485	0		2. 00
3.00	HOUSEKEEPI NG	9.00	0	10, 361	0		3.00
4. 00 5. 00	DI ETARY PHARMACY	10. 00 15. 00	0	2, 508) 0		4. 00 5. 00
6. 00	ADULTS & PEDIATRICS	30. 00	ő	81, 176	0		6. 00
7.00	OPERATING ROOM	50. 00	0	237, 668	0		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 381	0		8. 00
9. 00 10. 00	LABORATORY PHYSI CAL THERAPY	60. 00 66. 00	0	1, 963 16, 348	0		9. 00 10. 00
11.00	ELECTROCARDI OLOGY	69. 00	o	3, 450			11. 00
12.00	CARDI OPULMONARY	76. 00	0	5, 739			12. 00
13.00	EMERGENCY	91.00	의	14 <u>1, 9</u> 19	<u> </u>		13. 00
	TOTALS D - LAUNDRY		0	583, 315			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	411	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	8, 513	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	6, 803	0		3.00
4. 00 5. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	4, 851 2, 674	0		4. 00 5. 00
6. 00	PHYSI CAL THERAPY	66. 00	ő	3, 309	0		6. 00
7.00	ELECTROCARDI OLOGY	69. 00	0	1, 264	0		7. 00
8. 00	CARDI OPULMONARY	76.00	0	169	0		8. 00
9. 00	TOTALS	91.00	0	1 <u>2, 6</u> 8 <u>3</u> 40, 677	<u> </u>		9. 00
	E - DEPRECIATION		<u> </u>	40, 077			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	751, 529			1. 00
2.00	OPERATION OF PLANT	7. 00	0	10, 113	0		2.00
3. 00 4. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	6, 107 6, 840) 0		3. 00 4. 00
5. 00	ADULTS & PEDIATRICS	30. 00	ő	19, 745	0		5. 00
6.00	OPERATING ROOM	50. 00	0	367, 893	0		6. 00
	RADI OLOGY-DI AGNOSTI C	54. 00 66. 00	0	103, 871	0		7.00
8. 00 9. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	69. 00	0	631 5, 334			8. 00 9. 00
10.00	CARDI OPULMONARY	76. 00	ő	54, 982			10.00
11.00	EMERGENCY	91.00	•	1 <u>7, 2</u> 74			11. 00
	TOTALS F - OTHER CAPITAL		0	1, 344, 319			-
1. 00	OPERATION OF PLANT	7. 00	0	482, 723	10		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	O	16, 415	12		2. 00
3. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 356			3. 00
4. 00 5. 00	MOB CAP REL COSTS-BLDG & FLXT	192. 02 1. 00	0	56, 742 192, 059			4. 00 5. 00
5.00	TOTALS		— — — #	749, 295			5.00
	G - OPERATION OF PLANT		-1				
1.00	OPERATION OF PLANT	7.00	의	<u>1, 190, 983</u>	0		1. 00
	TOTALS H - EMPLOYEE BENEFITS		Ō	1, 190, 983			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	o	32, 993	0		1.00
2. 00	OPERATION OF PLANT	7. 00	Ö	119, 159			2. 00
3. 00	HOUSEKEEPI NG	9. 00	0	113, 973			3. 00
4. 00 5. 00	DIETARY NURSING ADMINISTRATION	10. 00 13. 00	ol O	56, 668 119, 746			4. 00 5. 00
6. 00	PHARMACY	15. 00	0	118, 746 51, 055			6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	ő	199, 732			7. 00
8. 00	OPERATING ROOM	50. 00	o	49, 420			8. 00
9. 00 10. 00	RADI OLOGY-DI AGNOSTI C	54. 00 66. 00	0	115, 382	0		9. 00 10. 00
10.00	PHYSI CAL THERAPY	00.00	U U				10.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-1316	Peri od: Worksheet A-6
		From 01/01/2020
		To 12/31/2020 Date/Time Prepared:

					То	12/31/2020 Date/Time P 7/13/2021 4	repared:
		Decreases				177 107 2021	, 2 / piii
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
11.00	SPEECH PATHOLOGY	68. 00	0	15, 749	0	•	11. 00
12.00	ELECTROCARDI OLOGY	69. 00	0	12, 343	0		12.00
13.00	CARDI OPULMONARY	76. 00	0	86, 396	0		13. 00
14.00	EMERGENCY	<u>91.</u> 00	0_	19 <u>3, 7</u> 50	0		14.00
	TOTALS		0	1, 165, 368			
	I - HOUSEKEEPING						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	636			1. 00
2.00	DI ETARY	10. 00	0	420			2. 00
3.00	PHARMACY	15. 00	0	522	0		3. 00
4.00	ADULTS & PEDIATRICS	30. 00	0	450	0		4.00
5.00	OPERATING ROOM	50. 00	0	293	0		5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	149	1		6. 00
7. 00	PHYSI CAL THERAPY	66. 00	0	133			7. 00
8. 00	CARDI OPULMONARY	76. 00	0	69	0		8. 00
9. 00	EMERGENCY	91. 00	0_	943	0		9. 00
	TOTALS		0	3, 615			
	K - MOB MAINTENANCE AND RENT						
1. 00	MOB	1 <u>92.</u> 02	0_	<u>2, 250</u>			1. 00
	TOTALS		0	2, 250			_
	L - ONCOLOGY						
1. 00	CLINIC	90.00	0_	<u>6, 7</u> 16			1. 00
	TOTALS		0	6, 716			_
	M - ACCRUED PTO						
1. 00	ADMINISTRATIVE & GENERAL	<u>5.</u> 00	<u>29, 5</u> 33	0	<u> </u>		1. 00
	TOTALS		29, 533	0			
500. 00	Grand Total: Decreases		118, 143	5, 932, 659	1		500.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-	10
RECONCILIATION OF CAPITAL COSTS CENTERS		Period: Worksheet A-7 From 01/01/2020 Part I	

12/31/2020 Date/Time Prepared: То 7/13/2021 4:29 pm Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 951, 047 0 1.00 2.00 Land Improvements 16, 117 2.00 0 35, 315 3.00 Buildings and Fixtures 3.00 4.00 Building Improvements 1, 425, 477 4.00 5.00 Fixed Equipment 5.00 6.00 4, 745, 195 6.00 Movable Equipment 1, 456, 842 1, 456, 842 16, 396 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 1, 456, 842 7, 173, 151 1, 456, 842 16, 396 8.00 9.00 Reconciling Items 9.00 0 16, 396 Total (line 8 minus line 9) 7, 173, 151 1, 456, 842 1, 456, 842 10.00 10.00 Endi ng Bal ance Ful I y Depreciated Assets 6.00 7.00 PART CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 951, 047 1.00 2.00 0 2.00 Land Improvements 16, 117 3.00 Buildings and Fixtures 35, 315 0 3.00 4.00 Building Improvements 1, 425, 477 4.00 0 5.00 5.00 Fixed Equipment 6.00 Movable Equipment 6, 185, 641 0 6.00 7.00 HIT designated Assets 7.00 Subtotal (sum of lines 1-7) Reconciling Items 8.00 8, 613, 597 0 8.00 0 9.00 9.00 10.00 Total (line 8 minus line 9) 8, 613, 597 10.00

Heal th	n Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	eriod: rom 01/01/2020 o 12/31/2020		
					0 12/31/2020	7/13/2021 4: 2	9 pm
	SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	nsurance (see instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WO	RKSHEET A, COL	UMN 2, LINES 1	and 2			
1. 00	CAP REL COSTS-BLDG & FIXT	0	0	192, 059	0	0	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	0	0	0	0	0	1. 01
1. 02	CAP REL COSTS-BLDG & FIXT - MOB	0	0	0	0	0	1. 02
3.00	Total (sum of lines 1-2)	0	0	192, 059	0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cook Conton Donorintian	Other	Tatal (1) (a				
	Cost Center Description		Total (1) (sum d of cols. 9				
	'	api tal -Rel ate					
		Costs (see instructions)	through 14)				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WO			l and 2			
1. 00	CAP REL COSTS-BLDG & FIXT	NKKSHELI A, COL	192, 059				1. 00
1. 01	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1 0	1,2,00,				1. 01
1. 02	CAP REL COSTS-BLDG & FIXT - MOB	I	l ő				1. 02
3. 00	Total (sum of lines 1-2)	Ö	192, 059				3. 00

Health Financial Systems	U HEALTH FRANKF	FORT HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1316	Period: From 01/01/2020	Worksheet A-7	
				Γο 12/31/2020	Date/Time Pre	pared:
	COMP	<u> </u>	TINS	ALLOCATION OF	7/13/2021 4: 2	9 pm
	COM	OTATION OF TAX	1105	ALLOGATI ON O	OTHER ON TIME	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col	i nstructi ons)		
			2)			
DART III DECONCLITATION OF CARLTAL COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS 1.00 CAP REL COSTS-BLDG & FIXT	CENTERS	0	(0. 000000	0	1. 00
1. 01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	8, 613, 597	0	8, 613, 59		-	1. 01
1. 02 CAP REL COSTS-BLDG & FIXT - MOB	0	0	(0. 000000		1. 02
3.00 Total (sum of lines 1-2)	8, 613, 597	O I ON OF OTHER (8, 613, 59		OF CAPITAL	3. 00
	ALLOCAT	TON OF OTHER (CAPITAL	SUIVIIVIART	r CAPITAL	
Cost Center Description	Taxes			Depreciation	Lease	
		Capi tal -Rel ate				
	6. 00	d Costs 7.00	through 7) 8.00	9.00	10. 00	
PART III - RECONCILIATION OF CAPITAL COSTS		7.00	0.00	7. 00	10.00	
1. 00 CAP REL COSTS-BLDG & FIXT	0	0	(0	0	1.00
1. 01 CAP REL COSTS-BLDG & FLXT - HOSPITAL 1. 02 CAP REL COSTS-BLDG & FLXT - MOB	0	0	(1, 289, 383	482, 723 2, 250	1. 01 1. 02
3.00 Total (sum of lines 1-2)		0		1, 289, 383	484, 973	
, , , , , , , , , , , , , , , , , , , ,		SU	MMARY OF CAPI			
Cost Center Description	Interest	nsurance (see	Tayon (con	Other	Total (2) (sum	
cost center bescription				Capi tal -Relate		
				d Costs (see	through 14)	
				instructions)		
PART III - RECONCILIATION OF CAPITAL COSTS	11. 00	12. 00	13. 00	14. 00	15. 00	
1.00 CAP REL COSTS-BLDG & FIXT	OLIVIERS O	16, 415		0	16, 415	1. 00
1.01 CAP REL COSTS-BLDG & FIXT - HOSPITAL	397, 597	1, 356		0	2, 171, 059	1. 01
1. 02 CAP REL COSTS-BLDG & FIXT - MOB	0	0	(0	2, 250	1. 02
3.00 Total (sum of lines 1-2)	397, 597	17, 771	(이	2, 189, 724	3. 00

	Financial Systems MENTS TO EXPENSES	10	TIERETTI TRANS		eri od:	of Form CMS-2 Worksheet A-8	
					rom 01/01/2020 o 12/31/2020	Date/Time Pre	epared:
				Expense Classification on To/From Which the Amount is			2 / piii
				10/11 om will on the rundant 13	to be haj ustee		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2. 00 0	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00 0	1.00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - HOSPITAL	В	216, 118	CAP REL COSTS-BLDG & FIXT - HOSPITAL	1. 01	11	1. 01
1. 02	(chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - MOB (chapter 2)		C	CAP REL COSTS-BLDG & FIXT - MOB	1. 02	0	1. 02
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	*** Cost Center Deleted ***	2. 00	0	2.00
3. 00	Investment income - other (chapter 2)		C		0. 00	0	3.00
4. 00	Trade, quantity, and time discounts (chapter 8)		C		0. 00	0	4.00
5. 00	Refunds and rebates of expension (chapter 8)	es	C		0. 00	0	5.00
6. 00	Rental of provider space by suppliers (chapter 8)		C		0. 00	0	6.00
7. 00	Tel ephone services (pay stations excluded) (chapter 2	1)	C		0. 00	0	7. 00
8. 00	Tel evision and radio service (chapter 21)	')	C		0. 00	0	8.00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 094, 747		0. 00	0	
	adjustment Sale of scrap, waste, etc.	A-0-2	-1,094,747		0.00		11.00
	(chapter 23) Related organization	A-8-1	2, 556, 379		0.00		12.00
	transactions (chapter 10) Laundry and Linen service	A-0-1	2, 550, 577		0.00		13.00
14.00	Cafeteria-employees and guest: Rental of quarters to employe and others	В	-50, 651 0	CAFETERI A	11. 00 0. 00		14. 00
16. 00	Sale of medical and surgical	to	C		0. 00	0	16. 00
17. 00	supplies to other than patien Sale of drugs to other than	is	C		0. 00	0	17. 00
18. 00	patients Sale of medical records and		C		0. 00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees, books, etc.)		C		0. 00	0	19. 00
	Vending machines Income from imposition of		C		0. 00 0. 00		20. 00 21. 00
22. 00	interest, finance or penalty charges (chapter 21) Interest expense on Medicare		C		0. 00	0	22. 00
23. 00	overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory	A-8-3	C	*** Cost Center Deleted ***	65. 00		23. 00
24. 00	therapy costs in excess of limitation (chapter 14) Adjustment for physical thera	oy A-8-3	C	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	costs in excess of limitation (chapter 14) Utilization review -		C	*** Cost Center Deleted ***	114. 00	1	25. 00
26. 00	physicians' compensation (chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL	А	-116, 846	CAP REL COSTS-BLDG & FIXT -	1. 01	9	26. 01
26. 02	COSTS-BLDG & FIXT - HOSPITAL Depreciation - CAP REL		C	HOSPITAL CAP REL COSTS-BLDG & FIXT -	1. 02	0	26. 02
27. 00	COSTS-BLDG & FIXT - MOB Depreciation - CAP REL		C	MOB *** Cost Center Deleted ***	2. 00	0	27. 00
	COSTS-MVBLE EQUIP				1		l

	Financial Systems	11	U HEALTH FRANK	FORT HOSPITAL	In Lieu	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				eri od:	Worksheet A-8	3
					rom 01/01/2020	Date/Time Pre	enared:
					0 12/31/2020	7/13/2021 4: 2	
				Expense Classification on			
				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	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
	instructions)		_				
31. 00	Adjustment for speech patholo		0	SPEECH PATHOLOGY	68. 00		31.00
	costs in excess of limitation						
22.00	(chapter 14)	•			0.00		22 22
32.00	CAH HIT Adjustment for		0		0. 00	0	32. 00
22 00	Depreciation and Interest EMPLOYEE BENEFITS	A	1 147 111	EMPLOYEE BENEFITS DEPARTMEN	4.00	0	33. 00
	MEDICALD HAF FEES	A		ADMINISTRATIVE & GENERAL	5. 00		33. 00
	MI SCELLANEOUS I NCOME	B		ADMINISTRATIVE & GENERAL	5. 00		33. 01
	MISCELLANEOUS INCOME	B		HOUSEKEEPI NG	9. 00		33. 03
	MISCELLANEOUS INCOME	В		NURSING ADMINISTRATION	13. 00		33. 04
	MISCELLANEOUS INCOME	В		LABORATORY	60. 00		33. 05
	MISCELLANEOUS INCOME	В		CARDI OPULMONARY	76. 00		33. 06
33.07	CONTRIBUTION EXPENSE	A	-600	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33.08	DEPRECIATION ON CAPITALIZED	A	61, 910	CAP REL COSTS-BLDG & FIXT -	1. 01	9	33. 08
	ASSETS			HOSPI TAL			1
	START UP COST NEW HOSPITAL	A		ADMINISTRATIVE & GENERAL	5. 00	0	00.07
	ARNETT BUILDING REPAIR OFFSET			OPERATION OF PLANT - HOSPITA		0	33. 10
33. 11	AMORTIZED START UP COSTS 2020	A	46, 104	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
	HOSP						
	FRANKFORT AOB	Α .	-2, 680	ADMINISTRATIVE & GENERAL	5. 00		00
	OTHER ADJUSTMENTS (SPECIFY) (0		0. 00	0	33. 13
50.00	TOTAL (sum of lines 1 thru 49	P	-1, 327, 684				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.

Line No. Cost Center Expense I tems Amount of Amount Included Allowable Cost in Wks. A, col umn 5					To 12/31/2020	Date/Time Pro 7/13/2021 4::	epared:
1.00 2.00 3.00 4.00 5.00		Li ne No.	Cost Center	Expense Items	Amount of A		
1.00 2.00 3.00 4.00 5.00 5.00				'	Allowable Cost	in Wks. A,	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 2.00 3.00 3.00 5.00 ADMINISTRATIVE & GENERAL HOME OFFICE 1, 293, 289 0 2.00 3.01 5.00 ADMINISTRATIVE & GENERAL RELATED PARTY 907, 099 502, 768 3.01 3.01 7.00 OPERATION OF PLANT RELATED PARTY 53, 892 86, 517 3.02 3.03 7.01 OPERATION OF PLANT RELATED PARTY 552, 191 101, 088 3.03 4.00 13.00 NURSING ADMINISTRATION RELATED PARTY 71, 833 0 4.00 4.00 4.01 4.02 15.00 PHARMACY RELATED PARTY 185, 198 137, 952 4.01 4.02 4.03 3.04 4.05 4.04 5.00 OADULTS & PEDIATRICS RELATED PARTY 322, 609 579, 906 4.02 4.05 4.06 91.00 CARDIOPULMONARY RELATED PARTY 192, 216 92, 266 4.04 4.05 4.07 7.08 PHARMACY RELATED PARTY 95, 069 0 4.05 4.08 4.09 4.00 4.00 4.00 4.00 4.00 4.00 4.00							
CLAIMED HOME OFFICE COSTS: 1.00							
1. 00			ΓMENTS REQUIRED AS A RESULT (OF TRANSACTIONS WITH RELATED	ORGANI ZATI ONS	OR	
2. 00 3. 00 3. 00 3. 00 3. 00 3. 01 3. 01 3. 01 3. 01 3. 02 3. 01 3. 02 3. 02 3. 03 4. 00 4. 00 OPERATION OF PLANT RELATED PARTY PO7, 099 S02, 768 3. 01 S183 S189 S2 S1							
3. 00 3. 01 3. 00 3. 01 3. 02 3. 02 3. 02 3. 03 3. 02 3. 03 3. 04 3. 05 3. 05 3. 06 3. 07 3. 06 3. 07 3. 08 3. 09 3. 09 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 3. 00 4. 00 4. 00 4. 01 4. 00 4. 01 4. 00 4. 01 4. 00 4. 01 4. 00 4. 01 4. 00 4. 03 4. 03 4. 04 4. 03 4. 04 4. 05 4. 06 4. 05 4. 06 4. 07 4. 06 4. 07 4. 06 4. 07 4. 08 4. 08 4. 08 4. 09 4. 09 4. 00							
3. 01				1			
3. 02 7. 00 OPERATION OF PLANT RELATED PARTY 53, 892 86, 517 3. 02 3. 03 7. 01 OPERATION OF PLANT - HOSPITA RELATED PARTY 52, 191 101, 088 3. 03 4. 00 13. 00 NURSI NG ADMINI STRATION RELATED PARTY 71, 833 0 4. 00 4. 00 4. 01 14. 00 CENTRAL SERVI CES & SUPPLY RELATED PARTY 71, 833 0 4. 00 4. 00 4. 02 15. 00 PHARMACY RELATED PARTY 71, 833 0 6. 00 4. 00 4. 00 4. 03 30. 00 ADULTS & PEDI ATRI CS RELATED PARTY 71, 833 0 7. 00 4. 00 7. 00 OPERATING ROOM 76. 00 CARDI OPULMONARY 76. 00 CARDI OPULMONARY 76. 00 CARDI OPULMONARY 76. 00 EMERGENCY 76. 00 EME							
3. 03							
4. 00							
4. 01				l e e e e e e e e e e e e e e e e e e e			
4. 02							
4. 03							
4. 04				l e e e e e e e e e e e e e e e e e e e			
4. 05							
4. 06				l .			
4. 07 4. 08 4. 09 4. 10 4. 10 4. 11 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, lire 1. 01 CAP REL COSTS-BLDG & FIXT - SHARED EMPLOYEES SHARED EMPLOYEES SHARED EMPLOYEES SHARED EMPLOYEES SHARED EMPLOYEES 17, 723 17, 723 4. 07 SHARED EMPLOYEES 235, 881 235, 881 235, 881 1, 798, 365 1, 798, 365 1, 798, 365 10, 699, 008 8, 142, 629 5. 00							
4. 08				l e e e e e e e e e e e e e e e e e e e			
4. 09				1			
4. 10		Discourage of the control of the con					
4.11 0.00 0 4.11 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line						·	
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line				STARLE EMILECTEES	1, 770, 303	1, 770, 303	
Transfer column 6, line 5 to Worksheet A-8, column 2, line					10 699 008	8 142 629	
Worksheet A-8, column 2, line	5.00				10, 077, 000	0, 172, 027	3.00
		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 look 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 RELA	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 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 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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under tit XVIII.

		-		 	
6. 00	В	IU HEALTH	100.00	0.00	6. 00
7.00	В	IUH ARNETT	1. 00	0.00	7. 00
8.00			0. 00	0.00	8. 00
9. 00			0. 00	0.00	9. 00
10.00			0. 00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Heal th	Financial Syst	ems	IU HEALTH	FRANKFOR	RT HOSPITAL	In Lieu	of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	M RELATED ORGANIZATIONS	AND HOME	Provider CCN: 15-1316	Peri od:	Worksheet A-	8-1
OFFI CE	COSTS					From 01/01/2020	Doto /T: Dia	
						To 12/31/2020	Date/Time Pr 7/13/2021 4:	
	let Adjustments	Wkst. A-7 Ref.					77 107 2021 1.	2 7 pm
	(col. 4 minus							
	col. 5)*							
	6. 00	7. 00						
	A. COSTS INCUR	RED AND ADJUST	TMENTS REQUIRED AS A RES	SULT OF T	RANSACTIONS WITH RELATE	D ORGANIZATIONS	OR	
	CLAIMED HOME C	FFICE COSTS:						
1.00	-10, 580	11	1					1. 00
2.00	1, 293, 289	0						2. 00
3.00	839, 821	0						3.00
3. 01	404, 331	0						3. 01
3.02	-32, 625	0						3. 02
3.03	-48, 897	0						3. 03
4.00	71, 833	0						4.00
4.01	47, 246	0						4. 01
4.02	-257, 297	0						4. 02
4.03	54, 893	0						4. 03
4.04	99, 950	0						4. 04
4.05	95, 069	0						4. 05
4.06	-654	0)					4.06
4.07	0	10) 					4. 07
4.08	0	0)					4. 08
4.09	0	0) 					4. 09
4. 10	0	0)					4. 10
4. 11	0	0	ol					4. 11

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 not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part

110 0	on posted to worksheet 11, con	dilling 1 dildrei 2, the dilloure di oliubi e should be mareated in cordilli i er this part.	
F	Related Organization(s) and/o		
	Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	ATED 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 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

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 request information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

6.00		6. 00
7. 00		7. 00
8.00		8. 00 9. 00
9. 00		9. 00
10.00		10. 00
6. 00 7. 00 8. 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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

2, 556, 379

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2 From 01/01/2020 Provi der CCN: 15-1316

						To 12/31/202	Date/Time Pr 7/13/2021 4:	epared: 29 pm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Provi	
		l denti fi er	Remuneration	Component	Component		der Component	
							Hours	
1 00	1. 00	2.00	3.00	4. 00	5. 00	6. 00	7. 00	1 00
1.00		ADULTS & PEDIATRICS	307, 032			C	0	
2.00		OPERATING ROOM	197, 977			1		2.00
3.00	0.00	EMERGENCY	1, 873, 238	589, 738	1, 283, 500			3.00
4. 00	0.00		0					4.00
5. 00 6. 00	0.00							5. 00 6. 00
7. 00	0.00							
7. 00 8. 00	0.00							7. 00 8. 00
9. 00	0.00							
10.00	0.00							
200. 00	0.00		2, 378, 247	1, 094, 747	1, 283, 500		1	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
	intot. A Line "	I denti fi er					of Malpractice	
		T deliter i i e i	2,	Li mi t	Continuing	of col. 12	Insurance	1
				27 1111 C	Education	01 001. 12	Tribui dilec	
	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00	30.00	ADULTS & PEDIATRICS	0	() (0	0	1.00
2.00	50.00	OPERATING ROOM	0	() (0	2. 00
3.00	91.00	EMERGENCY	0	() (0	3. 00
4.00	0.00		0	(0) (0	4.00
5.00	0.00		0	(0	0	0	5.00
6.00	0.00		0	(0	0	6. 00
7. 00	0.00		0	(0) C	0	
8. 00	0.00		0	(0	0	0	
9. 00	0. 00		0	(0	0	0	
10.00	0. 00		0	(0	
200. 00		0 1 0 1 (B)	0	(0	0	0	200.00
	Wkst. A Line #		Provi der	Adjusted RCE		Adjustment		
		raentrirer	Component Share of col. 14	Limit	Di sal I owance			
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	15.00					1.00
2. 00		OPERATING ROOM	1 0	1		197, 977		2.00
3. 00		EMERGENCY	1 0			589, 738		3. 00
4. 00	0.00		0					4. 00
5. 00	0.00		0	Ì				5. 00
6. 00	0.00		0)	6.00
7.00	0.00		0)	7. 00
8.00	0.00		0			0		8.00
9.00	0.00		0) ()	9. 00
10.00	0.00		0	() () ()	10.00
200. 00			0	()	1, 094, 747	1	200.00

	Financial Systems I	U HEALTH FRANK		ON 15 101/ ID	In Lieu eriod:	of Form CMS-2 Worksheet A-8	
SUPPLI		ס דטאווו אחבט פז	Outsi Dei dei C	CN: 15-1316 Fi	om 01/01/2020		
					ysi cal Therapy	7/13/2021 4: 2	
					ysrear merap		
	PART I - GENERAL INFORMATION					1. 00	
1. 00 2. 00	Total number of weeks worked (excluding aid Line 1 multiplied by 15 hours per week	es) (see instr	ructi ons)			52 780	1. 00 2. 00
3.00	Number of unduplicated days in which superv			,		s) 300	3. 00
4. 00	Number of unduplicated days in which therap therapist was on provider site (see instruc		s on provider	site but neith	ner supervi sor	nor 2	4. 00
5.00	Number of unduplicated offsite visits - sup				hu thorony oo	0 sistant 0	5.00
6. 00	Number of unduplicated offsite visits - the and on which supervisor and/or therapist wa					SISTAIIT U	6. 00
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					5. 75 0. 00	
0.00	Topt: Share traver expenses rate per	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.00
9. 00	Total hours worked	1.00	2. 00 5, 926. 44	3. 00 3. 50	4. 00 912. 03	5. 00	9. 00
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 43. 41	86. 81 43. 41		33. 91	0. 00	10. 00 11. 00
11.00	one-half of column 2, line 10; column 3,	43. 41	43. 41	20. 22			11.00
12 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0	0			12. 00
12.01	Number of travel hours (offsite)	Ö	0	O			12. 01
13. 00 13. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	0			13. 00 13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
	Supervisors (column 1, line 9 times column Therapists (column 2, line 9 times column 2					0 514, 474	
16.00	Assistants (column 3, line 9 times column 3	, line10)			. 17 6	198	16. 00
	Subtotal allowance amount (sum of lines 14 Aides (column 4, line 9 times column 4, lin		spiratory thera	apy or lines 12	1-16 for all o	30,927	
	Trainees (column 5, line 9 times column 5, Total allowance amount (sum of lines 17-19		ny thorony or l	inos 17 and 19) for all othe	0 rs) 545,599	19. 00 20. 00
20.00	If the sum of columns 1 and 2 for respirato	ry therapy or	columns 1-3 fo	or physical the	erapy, speech		20.00
	pathology or occupational therapy, line 9, and enter on line 23 the amount from line 2	0. Otherwise	complete lines	3 21-23.			
21. 00	Weighted average rate excluding aides and t respiratory therapy or columns 1 thru 3, li			sum of columns	s 1 and 2, lin	e 9 for 0.00	21. 00
	Weighted allowance excluding aides and trai Total salary equivalency (see instructions)	nees (line 2 t				0 545, 599	
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALL		VEL EXPENSE CO	OMPUTATION - PR	OVIDER SITE	343, 377	23.00
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					13, 023	24. 00
25.00	Assistants (line 4 times column 3, line 11)		04 05 -6	11 -46		56	25. 00
26. 00 27. 00	Subtotal (line 24 for respiratory therapy o Standard travel expense (line 7 times line	r sum of lines 3 for respirat	s 24 and 25 for ory therapy or	sum of lines	3 and 4 for a	13, 079 I I 1, 737	26. 00 27. 00
28 00	others) Total standard travel allowance and standar	d travel evner	use at the nrow	vidar sita (sum	of lines 26	and 27) 1/ 816	28 00
	Optional Travel Allowance and Optional Trav	el Expense		•	1 01 111163 20	•	
	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column		and 2, line 12	2)		0	29. 00 30. 00
	Subtotal (line 29 for respiratory therapy o				w or sum of s	0 olumns 0	
	Optional travel expense (line 8 times colum 1-3, line 13 for all others)			orratory therap	by or Sum or C	or units 0	32.00
	Standard travel allowance and standard trav Optional travel allowance and standard trav			and 31)		14, 816 0	
	Optional travel allowance and optional trav	el expense (su	m of lines 31	and 32)		0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLO PROVIDER SITE	WANCE AND IRAV	EL EXPENSE CON	MPUTATION - SEF	RVICES OUTSIDE		
36 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36. 00
37.00	Assistants (line 6 times column 3, line 11)						37. 00
	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the s	um of lines 5	and 6)			0	38. 00 39. 00
	Optional Travel Allowance and Optional Trav	el Expense					
	Therapists (sum of columns 1 and 2, line 12 Assistants (column 3, line 12.01 times colu)		0	40. 00 41. 00
42.00	Subtotal (sum of lines 40 and 41)	·		21)		0	42. 00 43. 00
43.00	Optional travel expense (line 8 times the s Total Travel Allowance and Travel Expense -				lowing three		43.00
44 00	lines 44, 45, or 46, as appropriate. Standard travel allowance and standard trav	el expense (su	m of lines 38	and 39 - see i	nstructions)	0	44. 00
45.00	Optional travel allowance and standard trav	el expense (su	m of lines 39	and 42 - see i	nstructions)	0	45. 00
46.00	Optional travel allowance and optional trav	ei expense (su	uu oi iines 42	anu 43 - See i	nstructions)	0	46. 00

lealth Financial Systems IU REASONABLE COST DETERMINATION FOR THERAPY SERVICES	HEALTH FRANKF		N: 15-1316 Po	eriod:	of Form CMS-2 Worksheet A-8	
SUPPLI ERS		, , , , , , , , , , , , , , , , , , ,	To	rom 01/01/2020	Parts I-VI Date/Time Pre 7/13/2021 4:2	epared:
			Ph	ysi cal Therapy		.9 piii
	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		0. 00	0. 00	0. 00	0. 00	47. 00
(if column 5, line 47, is zero or equal to pr	·					
greater than 2,080, do not complete lines 48-55 and enter zero in each column of line						
56)						
48.00 Overtime rate (see instructions)	0. 00	0.00	0. 00	0. 00		48. 00
49.00 Total overtime (including base and overtime	0.00	0.00	0.00	0.00		49. 00
allowance) (multiply line 47 times line 48)	0.00	0.00	0.00	0.00		17.00
CALCULATION OF LIMIT						
50.00 Percentage of overtime hours by category	0.00	0. 00	0. 00	0. 00	0. 00	50.00
(divide the hours in each column on line 47 b						
the total overtime worked - column 5, line 47						
51.00 Allocation of provider's standard work year	0. 00	0. 00	0. 00	0. 00	0. 00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount (se	ee 86.81	56. 43	33. 91	0. 00		52. 00
instructions)	00.01	50. 43	33. 71	0.00		32.00
53.00 Overtime cost limitation (line 51 times line	0	0	0	0		53. 00
52)						
54.00 Maximum overtime cost (enter the lesser of	O	0	0	0		54.00
line 49 or line 53)						
55.00 Portion of overtime already included in hou <mark>r</mark> l	у 0	0	0	0		55. 00
computation at the AHSEA (multiply line 47						
times line 52)	_	0	0		0	F/ 00
56.00 Overtime allowance (line 54 minus line 55 - i negative enter zero) (Enter in column 5 the	f 0	U .	0	U	0	56.00
sum of columns 1, 3, and 4 for respiratory						
therapy and columns 1 through 3 for all						
others.)						
• •		-				
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COS	T ADJUSTMENT				
57.00 Salary equivalency amount (from line 23)	(6 11 o	2 24 25))			545, 599	•
58.00 Travel allowance and expense - provider site 59.00 Travel allowance and expense - Offsite service					14, 816 0	•
60.00 Overtime allowance (from column 5, line 56)	es (ITOIII ITIIe	5 44, 45, 01 2	+0)		0	
61.00 Equipment cost (see instructions)					0	
52.00 Supplies (see instructions)					0	
63.00 Total allowance (sum of lines 57-62)					560, 415	
754.00 Total cost of outside supplier services (from	your records)		İ	452, 238	
65.00 Excess over limitation (line 64 minus line 63)		0	•
LINE 33 CALCULATION						1
100.00 Line 26 = line 24 for respiratory therapy or					13, 079	
100.01 Line 27 = line 7 times line 3 for respiratory	/ therapy or s	um of lines 3	and 4 for all	others	1, 737	100.01

	1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT		
57.00 Salary equivalency amount (from line 23)	545, 599	57.00
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35))	14, 816	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)	560, 415	63.00
64.00 Total cost of outside supplier services (from your records)	452, 238	
65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)	0	65.00
LINE 33 CALCULATION		
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others	13, 079	
100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others		100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27	14, 816	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		101. 00
101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		101. 01
101.02 Line 34 = sum of lines 27 and 31	1, 737	101. 02
LINE 35 CALCULATION		
102.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others		102. 00
102.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, lin	e 13 for 0	102. 01
all others		İ
102.02 Line 35 = sum of lines 31 and 32	0	102. 02

REASON SUPPLI	IABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTBrownia der CCN: 15-1316 Period: From 01/01/2020		
		Date/Time Pre 7/13/2021 4:2	
	Occupati onal Therapy	Cost	
		1. 00	
1. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions)	52	1.0
2.00	Line 1 multiplied by 15 hours per week	780	2. 0
3. 00 4. 00	Number of unduplicated days in which supervisor or therapist was on provider site (see instruction Number of unduplicated days in which therapy assistant was on provider site but neither supervisor	,	
5. 00	therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions)	0	5.0
6. 00	Number of unduplicated offsite visits - supervisors of therapists (see first detroits) Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy as	_	
7. 00	and on which supervisor and/or therapist was not present during the visit(s)) (see instructions) Standard travel expense rate	5. 75	7.0
8. 00	Optional travel expense rate per mile	0. 00	
	Supervisors Therapists Assistants Aides 1.00 2.00 3.00 4.00	Trai nees 5. 00	
9.00	Total hours worked 0.00 1,557.41 1,595.07 484.86	0.00	
10. 00 11. 00	AHSEA (see instructions) 0.00 82.29 56.78 33.84 Standard travel allowance (columns 1 and 2, 41.15 41.15 28.39	0.00	10. 0 11. 0
	one-half of column 2, line 10; column 3, one-half of column 3, line 10)		
	Number of travel hours (provider site) 0 0 0		12.0
	Number of travel hours (offsite) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		12. C
	Number of miles driven (offsite) 0 0 0		13. 0
		1.00	
14 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, line 10)	0	14. (
15.00	Therapists (column 2, line 9 times column 2, line 10)	128, 159	15. (
	Assistants (column 3, line 9 times column 3, line10) Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14–16 for all o	90,568 thers) 218,727	
18.00	Aides (column 4, line 9 times column 4, line 10)	16, 408	18. (
	Trainees (column 5, line 9 times column 5, line 10) Total allowance amount (sum of lines 17–19 for respiratory therapy or lines 17 and 18 for all othe	0 rs) 235, 135	
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and		
	and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.		
21. 00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, lin respiratory therapy or columns 1 thru 3, line 9 for all others)	e 9 for 0.00	21.0
	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	1
23.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE	235, 135	23. (
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)	8, 024	24 (
25. 00	Assistants (line 4 times column 3, line 11)	6, 104	25. (
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others) Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for a	14, 128 I 2, 358	1
28. 00	others) Total standard travel allowance and standard travel expense at the provider site (sum of lines 26)	and 27) 16 406	28. 0
	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 Optional Travel Allowance and Optional Travel Expense	and 27) 10, 480	20.0
29. 00 30. 00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) Assistants (column 3, line 10 times column 3, line 12)	0	
31. 00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.0
32. 00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of c 1-3, line 13 for all others)	olumns 0	32.0
33.00	Standard travel allowance and standard travel expense (line 28) Optional travel allowance and standard travel expense (sum of lines 27 and 31)	16, 486	•
34. 00 35. 00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	•
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE		
	Standard Travel Expense		
	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	0	
	Subtotal (sum of lines 36 and 37)	0	
J7. UU	Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense	0	1
40. 00 41. 00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10)	0	
42. 00	Subtotal (sum of lines 40 and 41)	0	42.0
43. 00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01) Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three	0	43.0
	lines 44, 45, or 46, as appropriate.		ļ , ,
44. 00 45. 00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions) Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	
	Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)		46.0

Health Financial Systems IU HEALTH F REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHEI SUPPLIERS		FURNI SHED BY (Period: From 01/01/2020 To 12/31/2020	Date/Time Prepared 7/13/2021 4:29 pm	
					Occupati onal Therapy	Cost	
		Therapi sts 1.00	Assistants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
PART V - OVERTIME	COMPUTATION	1.00	2.00	3.00	4.00	5.00	
0vertime hours wo (if column 5, lingreater than 2,08	orked during reporting perione 47, is zero or equal to complete lines tero in each column of line		0.00	0.0	0.00	0. 00	47.00
allowance) (multi	ncluding base and overtime ply line 47 times line 48)	0. 00 0. 00	0. 00 0. 00	N .			48. 00 49. 00
(di vi de the hours	mil ertime hours by category s in each column on line 47 ne worked - column 5, line 4		0. 00	0.0	0.00	0.00	50.00
51.00 Allocation of pro for one full-time percentages on li	ovider's standard work year e employee times the ne 50) (see instructions) OVERTIME ALLOWANCE	0. 00	0. 00	0. 0	0 0.00	0. 00	51.00
	salary equivalency amount (s	see 82.29	56. 78	33.8	4 0.00		52.00
instructions) Overtime cost lir 52)	nitation (line 51 times line	9 0	0		0 0		53.00
54.00 Maximum overtime line 49 or line !		0	0		0 0		54.00
computation at the times line 52) 56.00 Overtime allowand negative enter 20 sum of columns 1,	me already included in hour ne AHSEA (multiply line 47 se (line 54 minus line 55 - ero) (Enter in column 5 the 3, and 4 for respiratory nns 1 through 3 for all	if 0	0		0 0	0	55.00
						1. 00	
Part VI - COMPUTA	TION OF THERAPY LIMITATION	AND EXCESS COS	T ADJUSTMENT			1.00	
7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 9.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 0.00 Overtime allowance (from column 5, line 56) 1.00 Equipment cost (see instructions) 2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)					235, 135 16, 486 0 0 0 0 251, 621 192, 294	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	
LINE 33 CALCULATION 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					14, 128 2, 358 16, 486	100.01	
01.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others					0 2, 358	101. 00 101. 0 101. 0	
	times columns 1 and 2, line				olumns 1-3, lin		102. 00 102. 0

Health Financial Systems I	U HEALTH FRANK	FORT HOSPITAL		In Lieu	of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-1316 P	eriod: rom 01/01/2020	Worksheet B	
			Ť		Date/Time Pre	
		CAPITAL RELATED COSTS			7/13/2021 4: 2	29 pili
Ocat Ocaton Becombatton	Not Employe	DIDO a FLVT	DIDO A FLVT	EMPL OVEE		
Cost Center Description	Net Expenses for Cost	BLDG & FIXT	BLDG & FIXT - HOSPITAL	MOB	EMPLOYEE BENEFITS	
	Allocation				DEPARTMENT	
	(from Wkst A					
	col. 7) 0	1.00	1. 01	1. 02	4. 00	
GENERAL SERVICE COST CENTERS		1. 00	1.01	1. 02	1. 00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT	16, 415	16, 415	l e			1.00
1. 01 O0101 CAP REL COSTS-BLDG & FLXT - HOSPITAL 1. 02 O0102 CAP REL COSTS-BLDG & FLXT - MOB	2, 171, 059 2, 250	0	1	2, 250		1. 01 1. 02
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 504, 398	61	8, 236		1, 512, 695	
5. 00 00500 ADMINISTRATIVE & GENERAL	6, 629, 902	3, 028			119, 494	•
7. 00 00700 0PERATI ON OF PLANT 7. 01 00701 0PERATI ON OF PLANT - HOSPI TAL	563, 585	232			111, 541	7.00
7. 01 00701 0PERATI ON OF PLANT - HOSPI TAL 7. 02 00702 0PERATI ON OF PLANT - MOB	1, 102, 777 0	3, 071 0		0	0	
8. 00 00800 LAUNDRY & LINEN SERVICE	40, 677	0	· ·	Ö	0	
9. 00 00900 HOUSEKEEPI NG	343, 979	544		0	63, 761	9. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	173, 441	470 584		0	16, 945	1
13. 00 01300 NURSI NG ADMINI STRATI ON	164, 908 1, 092, 869	105		0	21, 060 215, 943	
14.00 01400 CENTRAL SERVICES & SUPPLY	569, 434	322			0	1
15. 00 01500 PHARMACY	776, 512	299		1	95, 144	
16. 00 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	16. 00
30. 00 03000 ADULTS & PEDIATRICS	1, 138, 546	1, 849	251, 588	0	224, 923	30. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 0PERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOSTI C	598, 368 938, 747	1, 563 818		0	61, 933 162, 042	•
60. 00 06000 LABORATORY	1, 815, 064	594		ő	0	1
66.00 06600 PHYSI CAL THERAPY	454, 123	465			13	•
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	192, 297	193			10 100	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	81, 819 52, 461	101 294		0	18, 100 11, 039	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44, 818	0		0	0	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	229, 287	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS 73.01 07301 ONCOLOGY DRUGS	310, 797 408, 375	0	· ·	0	0	
76. 00 03160 CARDI OPULMONARY	813, 746	440	· ·	Ö	163, 263	•
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	0 2, 557, 555	0 851	· ·		0 227, 494	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 557, 555	651	113,612	Ŭ	221, 494	92.00
OTHER REIMBURSABLE COST CENTERS						1
101. OQ 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	24, 788, 209	15, 884	2, 160, 956	O	1, 512, 695	118 00
NONREI MBURSABLE COST CENTERS	21,700,207	10,001	2, 100, 700	o o	1,012,070	1 10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190. 00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	0		191. 00 192. 00
192. 0219202 MOB	-56, 058	457		2, 250		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194. 00 07950 LEASED SPACE	0	74	10, 103	0		194.00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0	0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	24, 732, 151	16, 415	2, 171, 059	2, 250	1, 512, 695	
	•		-	· '		-

Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

Cost Center Description					Ť	o 12/31/2020	Date/Time Pre 7/13/2021 4:2	epared:
GENERAL SERVICE COST CENTERS		Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF		2 piii
CEMBERAL SERVICE COST CENTERS		· ·		& GENERAL	PLANT	PLANT -	PLANT - MOB	
CEMERAL SERVICE COST CENTERS						HOSPI TAL		
1.00			4A	5. 00	7. 00	7. 01	7. 02	
1. 01 00101 CAP REL. COSTS-BLIDG & FIXT - HOSPITAL 1. 02 00102 CAP REL. COSTS-BLIDG & FIXT - MOB 1. 02 1. 02 00102 CAP REL. COSTS-BLIDG & FIXT - MOB 1. 02 1. 02 00102 CAP REL. COST CENTERS 1. 01 1. 02 00102 CAP REL. COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 00100 CAP REL COST CENTERS 1. 01 CAP REL CO								
1. 02								
4. 00								
5.00								•
7. 00 00700								
7. 01 00701 00701								•
7. 02 00702 00702								•
8. 00 00800 LAUNDRY & LINEN SERVICE			1, 523, /18		233, 220	2, 3/6, 451		
9.00 00900 HOUSEKEEPING		· · ·	0	_	0	0	_	
10.00 01000 01000 01 01 01					0	105 100	_	
11.00 0110				· · · · · · · · · · · · · · · · · · ·	, ·		-	•
13.00 01300 01300 01300 01500 01500 01600 01600 01400 01400 01400 01400 01400 01400 01400 01400 01400 01400 01500 01400 01500 01400 01500 01400 01500 01500 01600 01500 01600 01500 01600 01500 01600 01500 0160					, ·			
14. 00 01400 CENTRAL SERVICES & SUPPLY 613, 551 249, 458 24, 442 79, 969 0 14. 00							-	
15.00 01500 PHARMACY 912, 631 371, 058 22, 702 74, 274 0 15.00							_	
16.00 16.00 16.00 16.00 16.00 16.00		· · ·		· ·	· ·		_	
INPATI ENT ROUTI NE SERVICE COST CENTERS 1,616,906 657,402 140,415 459,400 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 500.00 PAROLILLARY SERVICE COST CENTERS 50.00 50				1				•
30.00 03000 ADULTS & PEDIATRICS	16.00	UNDATIONS DOUBLING SERVICE COST CENTERS	0	0	0	0	0	16.00
ANCILLARY SERVICE COST CENTERS Service CO	30.00		1 616 906	657 402	140 415	459 400	0	30 00
50.00	00.00		1,010,700	007, 102	110, 110	107, 100		00.00
60. 00 06000 LABORATORY 1, 896, 439 771, 054 45, 085 147, 506 0 60. 00 0600 06000 PHYSI CAL THERAPY 517, 833 210, 541 35, 291 115, 462 0 66. 00 06700 0CCUPATI ONAL THERAPY 218, 758 88, 943 14, 661 47, 965 0 67. 00 06800 SPEECH PATHOLOGY 113, 813 46, 274 7, 698 25, 186 0 68. 00 06800 SPEECH PATHOLOGY 103, 745 42, 181 22, 297 72, 951 0 69. 00 06900 ELECTROCARDI OLOGY 103, 745 42, 181 22, 297 72, 951 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 244, 818 18, 222 0 0 0 0 0 0 0 0 0	50.00		874, 511	355, 559	118, 682	388, 295	0	50.00
66. 00 06600 PHYSI CAL THERAPY 517, 833 210, 541 35, 291 115, 462 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 218, 758 88, 943 14, 661 47, 965 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 113, 813 46, 274 7, 698 25, 186 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 103, 745 42, 181 22, 297 72, 951 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 44, 818 18, 222 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 229, 287 93, 224 0 0 0 0 0 0 73. 01 07301 DNCOLOGY DRUGS 408, 375 166, 037 0 0 0 0 0 0 73. 01 07301 ONCOLOGY DRUGS 408, 375 166, 037 0 0 0 0 0 0 74. 00 03160 CARDI OPULMONARY 1, 037, 365 421, 772 33, 440 109, 406 0 0 0 75. 00 09000 CLIN C 0 0 0 0 0 0 0 76. 00 09000 CLIN C 0 0 0 0 0 0 0 77. 00 09100 EMERGENCY 2, 901, 712 1, 179, 770 64, 636 211, 473 0 91. 00 78. 01 07301 ONCOLOGY DRUGS 0 0 0 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 79. 00 OBSERVATION BEDS COST CENTERS 0 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0 0 0 79. 00 OUTPATIENT SERVICE COST CENTERS 0 0 0	54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 212, 872	493, 129	62, 099	203, 171	0	54.00
67. 00 06700 0CCUPATI ONAL THERAPY 218, 758 88, 943 14, 661 47, 965 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 113, 813 46, 274 7, 698 25, 186 0 68. 00 6900 ELECTROCARDI OLOGY 113, 813 46, 274 7, 698 25, 186 0 68. 00 71. 00 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 44, 818 18, 222 0 0 0 0 72, 951 0 0 72. 00 7200 IMPL. DEV. CHARGED TO PATI ENTS 229, 287 93, 224 0 0 0 0 72. 00 73. 00 7300 DRUGS CHARGED TO PATI ENTS 310, 797 126, 364 0 0 0 0 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	1, 896, 439	771, 054	45, 085	147, 506	0	60.00
68.00 06800 SPEECH PATHOLOGY	66.00	06600 PHYSI CAL THERAPY	517, 833	210, 541	35, 291	115, 462	0	66.00
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	67.00	06700 OCCUPATI ONAL THERAPY	218, 758	88, 943	14, 661	47, 965	0	67. 00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	68.00	06800 SPEECH PATHOLOGY	113, 813	46, 274	7, 698	25, 186	0	68.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 229, 287 93, 224 0 0 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 01 07301 0XCOLOGY DRUGS 408, 375 166, 037 0 0 0 0 0 73. 01 73. 01 73. 01 07301 0XCOLOGY DRUGS 408, 375 166, 037 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	103, 745	42, 181	22, 297	72, 951	0	69. 00
73. 00	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	44, 818	18, 222	0	0	0	71.00
73. 01 07301 ONCOLOGY DRUGS	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	229, 287	93, 224	0	0	0	72. 00
76. 00 03160 CARDI OPULMONARY 1, 037, 365 421, 772 33, 440 109, 406 0 76. 00 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 90. 00 91. 00 991. 00 991. 00 992. 00 98ERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 92. 00 0716 PURPOSE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 92. 00 92. 00 0716 PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 24, 775, 325 7, 160, 249 953, 941 2, 358, 003 0 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT., FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 191. 00 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 192. 02 19202 MOB -53, 351 0 34, 727 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 LEASED SPACE 10, 177 4, 138 5, 639 18, 448 0 194. 00 07950 LEASED SPACE 10, 177 4, 138 5, 639 18, 448 0 194. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	310, 797	126, 364	0	0	0	73. 00
OUTPATI ENT SERVI CE COST CENTERS O			408, 375	166, 037	0	0	0	73. 01
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	76.00		1, 037, 365	421, 772	33, 440	109, 406	0	76. 00
91. 00 09100 EMERGENCY 2, 901, 712 1, 179, 770 64, 636 211, 473 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0					1			
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0 001 710				-	
OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 901, 712	1, 179, 770	64, 636	211,4/3	0	
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	92.00							92.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 24,775,325 7,160,249 953,941 2,358,003 0 118.00	101 0		0	0	0	0	0	101 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 24,775,325 7,160,249 953,941 2,358,003 0 118. 00	101.0					<u> </u>		1
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00	118. 0		24, 775, 325	7, 160, 249	953, 941	2, 358, 003	0	118. 00
191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192								
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 192. 02 19202 MOB -53, 351 0 34, 727 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 194. 0007950 LEASED SPACE 10, 177 4, 138 5, 639 18, 448 0 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0	190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 0219202 MOB -53, 351 0 34, 727 0 0 192. 02 193. 0019300 NONPALD WORKERS 0 0 0 0 0 193. 00 194. 0007950 LEASED SPACE 10, 177 4, 138 5, 639 18, 448 0 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0			0	0	0	0	0	191. 00
193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 194. 0007950 LEASED SPACE 10, 177 4, 138 5, 639 18, 448 0 194. 00 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>192. 00</td></t<>			0	0	0	0	0	192. 00
194. 0007950 LEASED SPACE 10, 177 4, 138 5, 639 18, 448 0 194. 00 200. 00 Cross Foot Adjustments 0			-53, 351	0	34, 727	0		
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0<			0	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			10, 177	4, 138	5, 639	18, 448	0	
		1	0					
202.00		1 1 3	0	0	0	0		
	202. 0	U	24, 732, 151	7, 164, 387	994, 307	2, 376, 451	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1316

				To	12/31/2020	Date/Time Pre 7/13/2021 4:2	epared:
	Cost Center Description L	AUNDRY & LINEI SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	
		8. 00	9. 00	10.00	11. 00	13. 00	
	GENERAL SERVICE COST CENTERS	•	•	•			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT - MOB	1					1. 02
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL						7. 01
7. 02	00702 OPERATION OF PLANT - MOB						7. 02
8. 00	00800 LAUNDRY & LINEN SERVICE	57, 215					8.00
9. 00	00900 HOUSEKEEPI NG	0	854, 939				9.00
10.00	01000 DI ETARY	0	44, 502	555, 147			10.00
11. 00	01100 CAFETERI A	0	55, 303	0	618, 674		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	9, 959	0	74, 392	1, 979, 647	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	30, 505	0	, ,, 0,2	0	1
15. 00	01500 PHARMACY	l	28, 332	O O	31, 624	0	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	Ô	0.,02.	0	
10.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		10.00
30.00		57, 215	175, 242	555, 147	113, 785	1, 005, 861	30. 00
00.00	ANCILLARY SERVICE COST CENTERS	0.72.10	170/212	000/11/	1107700	1,7000,7001	00.00
50.00	05000 OPERATING ROOM	0	148, 117	0	31, 310	160, 293	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	77, 501	0	72, 037	0	54.00
60.00	06000 LABORATORY	0	56, 267	0	80, 355	0	60.00
66.00	06600 PHYSI CAL THERAPY	0	44, 043	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	18, 297	0	O	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	9, 607	0	6, 435	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	27, 827	0	6, 121	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73.01	07301 ONCOLOGY DRUGS	0	0	0	0	0	73. 01
76.00	03160 CARDI OPULMONARY	0	41, 733	0	77, 844	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0	0	0	0	90.00
91. 00	· · · ·	0	80, 667	0	124, 771	813, 493	
92. 00							92. 00
101 0	OTHER REIMBURSABLE COST CENTERS					-	101 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
110 0	SPECIAL PURPOSE COST CENTERS	E7 01E	847, 902	EEE 147	410 474	1 070 447	110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	57, 215	847, 902	555, 147	618, 674	1, 979, 647	118.00
100 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	o	0	0	190. 00
	19100 RESEARCH		0	0	0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES		١	0	0		192.00
	19202 MOB		١	0	0		192.02
	19300 NONPALD WORKERS			0	0		193. 00
	007950 LEASED SPACE	1	7, 037	0	0		193.00
200. 00		I	7,037	U	o I	U	200.00
200. 00	, ,	0	_	0	0	Ω	200.00
201.00		57, 215	854, 939	555, 147	618, 674	1, 979, 647	
202.00	1 1.5 (3dm 111103 110 till 0dgil 201)	07,210	001,707	000, 147	313, 074	1, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	F-52. 00

COST ALLOCATION - GENERAL SERVICE COSTS	U HEALTH FRANKE	Provi der CC		Period: From 01/01/2020 To 12/31/2020	of Form CMS-2 Worksheet B Part I Date/Time Pre 7/13/2021 4:2	
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	14. 00	15. 00	16. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS						4
1.00 00100 CAP REL COSTS-BLDG & FLXT						
I. 01 O0101 CAP REL COSTS-BLDG & FLXT - HOSPITAL						
1. 02 00102 CAP REL COSTS-BLDG & FLXT - MOB						
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL						ŀ
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT						ł
7.01 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - HOSPITAL						ŀ
7. 02 00707 OPERATION OF PLANT - MOB						
3. 00 00800 LAUNDRY & LINEN SERVICE						l
9. 00 00900 HOUSEKEEPI NG						l
10. 00 01000 DI ETARY						1
11. 00 01100 CAFETERI A						1 1
13.00 01300 NURSING ADMINISTRATION	1					1
14.00 01400 CENTRAL SERVICES & SUPPLY	997, 925					1
15. 00 01500 PHARMACY	5, 789	1, 446, 410				1
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0		0] 1
INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00 03000 ADULTS & PEDIATRICS	151, 459	8, 644		0 4, 941, 476	0	3
ANCILLARY SERVICE COST CENTERS				al a ana (a)		4_
50. 00 05000 OPERATING ROOM	0	1, 927		0 2, 078, 694	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	37, 702	971		0 2, 159, 482	0	1 .
60. 00 06000 LABORATORY 66. 00 06600 PHYSI CAL THERAPY	3, 814 28, 999	0		0 3, 000, 520	0	6
57. 00 06700 OCCUPATI ONAL THERAPY	20, 999	0		0 952, 169 0 388, 624	0	
68. 00 06800 SPEECH PATHOLOGY		0		0 209, 013	0	
69. 00 06900 ELECTROCARDI OLOGY	6, 471	33		0 281, 626	0	6
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	81, 973	0		0 145, 013	0	1 7
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	419, 369	ő		0 741, 880	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	611, 100		0 1, 048, 261	0	1 7
73. 01 07301 ONCOLOGY DRUGS	0	802, 962		0 1, 377, 374	0	7
76. 00 03160 CARDI OPULMONARY	11, 243	965		0 1, 733, 768	0	<u> </u>
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0		0	0	
91. 00 09100 EMERGENCY	251, 106	19, 808		0 5, 647, 436	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	9
OTHER REIMBURSABLE COST CENTERS	1 1	ما				4.
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0	10
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	997, 925	1, 446, 410		0 24, 705, 336		4.,
<pre>I18. 00</pre>	997, 925	1, 446, 410		0 24, 705, 336	0	111
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		ol ol	0	19
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN	0	o				19
192. 0019200 PHYSI CLANS' PRI VATE OFFI CES						19
192. 0219202 MOB	١	0		0 -18, 624		19
193. 0019300 NONPALD WORKERS	١	ol Ol		0 0		19
194. 0007950 LEASED SPACE	١	ol Ol		0 45, 439		19
200.00 Cross Foot Adjustments	l ĭ	ĭ] 10, 10,		20
201.00 Negative Cost Centers	0	ol		ol o		20
202.00 TOTAL (sum lines 118 through 201)	997, 925	1, 446, 410		0 24, 732, 151		20

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-		
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1316	Period: Worksheet B From 01/01/2020 Part I		

12/31/2020 Date/Time Prepared: 7/13/2021 4:29 pm Cost Center Description Total 26. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 1.01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 00102 CAP REL COSTS-BLDG & FLXT - MOB 1.02 1.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 7.01 00702 OPERATION OF PLANT - MOB 7. 02 7.02 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 10 00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 941, 476 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 078, 694 50.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 159, 482 54.00 60 00 06000 LABORATORY 3,000,520 60 00 66.00 06600 PHYSI CAL THERAPY 952, 169 66.00 67.00 06700 OCCUPATIONAL THERAPY 388, 624 67.00 68.00 06800 SPEECH PATHOLOGY 209, 013 68.00 06900 ELECTROCARDI OLOGY 69 00 281, 626 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 145, 013 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 741,880 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 1,048,261 73.00 73.00 73.01 07301 ONCOLOGY DRUGS 1, 377, 374 73 01 76.00 03160 CARDI OPULMONARY 1, 733, 768 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 91.00 09100 EMERGENCY 5, 647, 436 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 118.00 24, 705. 336 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 191. 00 19100 RESEARCH 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 192. 02 19202 MOB 192. 02 -18, 624 193. 00 19300 NONPALD WORKERS 193. 00 194.0007950 LEASED SPACE 194. 00 45, 439 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 24, 732, 151 202.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1316	Period: Worksheet B From 01/01/2020 Part II

					rom 01/01/2020 o 12/31/2020	Date/Time Pre	
			CAPI	TAL RELATED C	OSTS	7/13/2021 4:2	29 pm
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT - HOSPITAL	BLDG & FIXT - MOB	Subtotal	
		0	1.00	1. 01	1. 02	2A	
	GENERAL SERVICE COST CENTERS						
1. 01 (1. 02 (1.	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - MOB 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT - HOSPITAL 00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - MOB 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 0 0	61 3, 028 232 3, 071 0 0 544	31, 539 417, 870 0	0 0 0 0	8, 297 414, 991 31, 771 420, 941 0 0 74, 582	1.00 1.01 1.02 4.00 5.00 7.00 7.01 7.02 8.00 9.00
	01000 DI ETARY	0	470	.,	0	64, 361	10.00
	01100 CAFETERI A	l o	584	79, 397	1	79, 981	11. 00
13.00	01300 NURSING ADMINISTRATION	o	105	14, 298		14, 403	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	322	43, 795	0	44, 117	14.00
15.00	D1500 PHARMACY	0	299	40, 676	0	40, 975	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	0	1, 849	251, 588	0	253, 437	30. 00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM	I 0	1, 563	212, 647	l ol	214, 210	50.00
	D5400 RADI OLOGY-DI AGNOSTI C	0	818			112, 083	
	06000 LABORATORY	0	594	80, 781	0	81, 375	
	06600 PHYSI CAL THERAPY		465	63, 232	1	63, 697	
	06700 OCCUPATI ONAL THERAPY	l ő	193			26, 461	67. 00
	06800 SPEECH PATHOLOGY	l o	101	13, 793		13, 894	
69.00	06900 ELECTROCARDI OLOGY	O	294	39, 951	0	40, 245	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07301 ONCOLOGY DRUGS	0	0	0	0	0	73. 01
	03160 CARDI OPULMONARY	0	440	59, 916	0	60, 356	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS	1			1		
	09000 CLINIC	0	0			11/ //3	90.00
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART)	١	851	115, 812	U	116, 663	1
	OTHER REIMBURSABLE COST CENTERS					0	92. 00
	10100 HOME HEALTH AGENCY	O	0	0	O	0	101. 00
	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		<u> </u>		101.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	O	15, 884	2, 160, 956	0	2, 176, 840	118.00
	NONREI MBURSABLE COST CENTERS	·		_,,	,	_,,	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00	19100 RESEARCH	0	0	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19202 MOB	0	457	0	2,200		192. 02
	19300 NONPALD WORKERS	0	0	-	1 ~		193. 00
	07950 LEASED SPACE	0	74	10, 103	0	10, 177	1
200.00	Cross Foot Adjustments		0	,			200.00
201. 00 202. 00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	16, 415	-	2, 250	2, 189, 724	201.00 202.00
202.09	Trome (sum rines ito through 201)	1 9	10, 413	2, 171, 037	2, 230	2, 107, 724	F02.00

				Ť	o 12/31/2020	Date/Time Pre 7/13/2021 4:2	epared:
	Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	2 piii
	'	BENEFITS	& GENERAL	PLANT	PLANT -	PLANT - MOB	
		DEPARTMENT			HOSPI TAL		
		4. 00	5. 00	7. 00	7. 01	7. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FLXT - MOB						1. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	8, 297					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	656					5. 00
7. 00	00700 OPERATION OF PLANT	612	16, 674				7. 00
7. 01	00701 OPERATION OF PLANT - HOSPITAL	0	35, 941	11, 507	468, 389	_	7. 01
7. 02	00702 OPERATION OF PLANT - MOB	0	0	0	0	0	
8. 00	00800 LAUNDRY & LINEN SERVICE	0	959	0	0	0	0.00
9. 00	00900 HOUSEKEEPI NG	350	, -	2, 039	26, 646	0	7.00
10.00	01000 DI ETARY	93	6, 009		22, 994	0	
11.00	01100 CAFETERI A	116		2, 186	28, 575	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 185	31, 212	394	5, 146	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	14, 472	1, 206	15, 762	0	
15.00	01500 PHARMACY	522	21, 527	1, 120	14, 639	0	
16. 00		0	0	0	0	0	16. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 234	38, 140	6, 928	90, 547	0	30.00
30.00	ANCILLARY SERVICE COST CENTERS	1, 234	30, 140	0, 920	90, 347	U	30.00
50.00	05000 OPERATI NG ROOM	340	20, 628	5, 856	76, 531	0	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	889		3, 064	40, 044	0	
60.00	06000 LABORATORY	0	1	2, 224	29, 073	0	1
66.00	06600 PHYSI CAL THERAPY	0		1, 741	22, 757	0	•
67. 00	06700 OCCUPATI ONAL THERAPY	0		723	9, 454	0	1
68.00	06800 SPEECH PATHOLOGY	99		380	4, 964	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	61	2, 447	1, 100	14, 378	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 057	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 408	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	7, 331	0	0	0	73. 00
73.01	07301 ONCOLOGY DRUGS	0	9, 633	0	0	0	73. 01
76.00	03160 CARDI OPULMONARY	896	24, 469	1, 650	21, 563	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		0	0	0	
91.00	09100 EMERGENCY	1, 244	68, 448	3, 189	41, 680	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
101 00	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	101 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0		0	U	101.00
118. 00		8, 297	415, 407	47, 066	464, 753	0	118.00
110.00	NONREI MBURSABLE COST CENTERS	0, 277	413, 407	47,000	404, 733	0	1 10.00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	o o	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19202 MOB	Ō	Ō	1, 713	0		192. 02
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
	07950 LEASED SPACE	0	240	278	3, 636	0	194. 00
200.00	•						200.00
201.00	1 1	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	8, 297	415, 647	49, 057	468, 389	0	202. 00
					•		

Period: Worksheet B
From 01/01/2020 Part II
To 1/21/2020 Patt II
To 1/21/2020 Patt II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1316

			To	12/31/2020	Date/Time Pre 7/13/2021 4:2	epared:
Cost Center Description	LAUNDRY & LINEN	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	SERVI CE 8. 00	9. 00	10. 00	11. 00	ADMI NI STRATI ON 13. 00	
GENERAL SERVICE COST CENTERS	0.00	9.00	10.00	11.00	13.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
1. 02 00102 CAP REL COSTS-BLDG & FLXT - MOB						1. 02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 00701 OPERATION OF PLANT - HOSPITAL						7. 01
7.02 00702 OPERATION OF PLANT - MOB						7. 02
8.00 00800 LAUNDRY & LINEN SERVICE	959					8. 00
9. 00 00900 HOUSEKEEPI NG	0	114, 994				9. 00
10. 00 01000 DI ETARY	O	5, 986	101, 202			10.00
11. 00 01100 CAFETERI A	O	7, 439	0	124, 570		11. 00
13.00 01300 NURSING ADMINISTRATION	0	1, 340	0	14, 979	68, 659	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	4, 103	0	0	0	14. 00
15. 00 01500 PHARMACY	0	3, 811	0	6, 368	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS		-,				
30. 00 03000 ADULTS & PEDIATRICS	959	23, 570	101, 202	22, 911	34, 886	30. 00
ANCILLARY SERVICE COST CENTERS		-,,		, <u>, , , , , , , , , , , , , , , , , , </u>	,	
50. 00 05000 OPERATING ROOM	0	19, 923	0	6, 304	5, 559	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	10, 424	0	14, 505	0	54.00
60. 00 06000 LABORATORY	0	7, 568	0	16, 180	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 924	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	2, 461	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	1, 292	0	1, 296	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 743	0	1, 232	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01 07301 ONCOLOGY DRUGS	0	0	0	0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0	5, 613	0	15, 674	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0	10, 850	0	25, 121	28, 214	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
101.0010100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	اده اد			1		
118. 00 SUBTOTALS (SUM OF LINES 1 through 117	7) 959	114, 047	101, 202	124, 570	68, 659	118. 00
NONREI MBURSABLE COST CENTERS	1 0	0	ol	ol	-	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
192. 0219202 MOB	0	0	0	0		192. 02
193. 00 19300 NONPALD WORKERS		0 4 7	O	0		193.00
194. 0007950 LEASED SPACE		947	O	O	0	194. 00
200.00 Cross Foot Adjustments					^	200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	959	114, 994	101, 202	124, 570	68, 659	201.00
202. UM TOTAL (Suil Titles To thi bugh 201)	1 959	114, 994	101, 202	124, 370	00, 039	K02.00

Health Financial Systems	11	J HEALTH FRANKF	ORT HOSPITAL		Inlie	of Form CMS-2	2552_10
ALLOCATION OF CAPITAL RELATED		S HEACHT TOWN	Provi der CC	l F	Period: From 01/01/2020	Worksheet B Part II Date/Time Pre 7/13/2021 4:2	epared:
Cost Center Descr	ipti on	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	, D
		14. 00	15. 00	16. 00	24. 00	25. 00	
GENERAL SERVICE COST CE							
1. 00 00100 CAP REL COSTS-BLD 1. 01 00101 CAP REL COSTS-BLD 1. 02 00102 CAP REL COSTS-BLD 4. 00 00400 EMPLOYEE BENEFITS 5. 00 00500 ADMI NI STRATI VE & 7. 00 00700 OPERATI ON OF PLAN 7. 01 00701 OPERATI ON OF PLAN 7. 02 00702 OPERATI ON OF PLAN 8. 00 00800 LAUNDRY & LI NEN S 9. 00 00900 HOUSEKEEPI NG 10. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STR 14. 00 01400 CENTRAL SERVI CES	G & FIXT - HOSPITAL G & FIXT - MOB G DEPARTMENT GENERAL IT IT - HOSPITAL IT - MOB GERVICE	79, 660					1.00 1.01 1.02 4.00 5.00 7.01 7.02 8.00 9.00 10.00 11.00 13.00
15. 00 01500 PHARMACY	u 001121	462	89, 424				15. 00
16.00 01600 MEDICAL RECORDS &		0	0	()		16. 00
INPATIENT ROUTINE SERVI							
30. 00 03000 ADULTS & PEDI ATRI		12, 090	534	(586, 438	0	30.00
ANCILLARY SERVICE COST 50.00 05000 OPERATING ROOM	CENTERS	0	119		349, 470	0	EO 00
50. 00 05000 OPERATI NG ROOM 54. 00 05400 RADI OLOGY-DI AGNOS	TIC	3, 010	60	-	212, 688	0	50. 00 54. 00
60. 00 06000 LABORATORY	,,,,,	304	0		181, 457	0	60.00
66. 00 06600 PHYSI CAL THERAPY		2, 315	0	(108, 649	0	66.00
67. 00 06700 OCCUPATI ONAL THER	PAPY	2, 0.10	Ö	(44, 259	0	67. 00
68.00 06800 SPEECH PATHOLOGY		Ö	Ö	(24, 610	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	,	517	2	(63, 725	0	69. 00
71.00 07100 MEDICAL SUPPLIES		6, 544	0	(7, 601	0	71. 00
72.00 07200 I MPL. DEV. CHARGE		33, 476	0	(38, 884	0	72. 00
73.00 07300 DRUGS CHARGED TO		0	37, 781	(45, 112	0	73. 00
73.01 07301 ONCOLOGY DRUGS		0	49, 643	(59, 276	0	73. 01
76.00 03160 CARDI OPULMONARY		897	60	(131, 178	0	76. 00
OUTPATIENT SERVICE COST	T CENTERS						
90. 00 09000 CLI NI C		0	0	(0	0	90.00
91.00 09100 EMERGENCY		20, 045	1, 225	(316, 679	0	91.00
92.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST							
101.00 10100 HOME HEALTH AGENC		0	0	(0	0	101. 00
SPECIAL PURPOSE COST CE							
	LINES 1 through 117)	79, 660	89, 424	(2, 170, 026	0	118. 00
NONREI MBURSABLE COST CE	ENTERS		0		al al	0	100 00
190.0019000 GLFT, FLOWER, COF 191.0019100 RESEARCH	FEE SHUP & CANTEEN	0	0	(190. 00 191. 00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VA	TE OFFICES	0	0	(191.00
192. 0019200 PHT31 CTANS PRI VA	III OITTOLO	0	0	(4, 420		192.00
193. 0019300 NONPALD WORKERS	ŀ	0	0	(7, 720		193. 00
194. 0007950 LEASED SPACE	l	0	n	(15, 278		194. 00
200.00 Cross Foot Adjust	ments	9	ĭ		10,270		200.00
201.00 Negative Cost Cen		O	n	(ol ŏ		201.00
202.00 TOTAL (sum lines		79, 660	89, 424	(2, 189, 724	0	202. 00
	-				•		•

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1316	Period: Worksheet B From 01/01/2020 Part II To 12/31/2020 Date/Time Prepared:

		To 12/31/2020 Date/Time Pr 7/13/2021 4:	
Cost Center Description	Total	1771372021 4.	Z / piii
	26. 00		
GENERAL SERVICE COST CENTERS			
1.00 O0100 CAP REL COSTS-BLDG & FLXT			1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL			1.01
1. 02 00102 CAP REL COSTS-BLDG & FIXT - MOB			1.02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL			5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - HOSPITAL			7. 00 7. 01
7.01 00701 OPERATION OF PLANT - HOSPITAL 7.02 00702 OPERATION OF PLANT - MOB			7.01
8. 00 00800 LAUNDRY & LINEN SERVICE			8.00
9. 00 00900 HOUSEKEEPING			9.00
10. 00 01000 DI ETARY			10.00
11. 00 01100 CAFETERI A			11.00
13.00 01300 NURSING ADMINISTRATION			13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY			14. 00
15. 00 01500 PHARMACY			15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY			16. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 .0.00
30. 00 03000 ADULTS & PEDIATRICS	586, 438		30.00
ANCILLARY SERVICE COST CENTERS			
50. 00 05000 OPERATING ROOM	349, 470		50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	212, 688		54.00
60. 00 06000 LABORATORY	181, 457		60.00
66.00 06600 PHYSI CAL THERAPY	108, 649		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	44, 259		67. 00
68.00 O6800 SPEECH PATHOLOGY	24, 610		68. 00
69. 00 06900 ELECTROCARDI OLOGY	63, 725		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 601		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	38, 884		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	45, 112		73. 00
73. 01 07301 0NCOLOGY DRUGS	59, 276		73. 01
76. 00 03160 CARDI OPULMONARY	131, 178		76. 00
OUTPATIENT SERVICE COST CENTERS	0		- 00 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0 316, 679		90. 00 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	310, 079		91.00
OTHER REIMBURSABLE COST CENTERS			92.00
101. 00 10100 HOME HEALTH AGENCY	0		101.00
SPECIAL PURPOSE COST CENTERS	0		101.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 170, 026		118. 00
NONREI MBURSABLE COST CENTERS	2, 170, 020		110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
191. 0019100 RESEARCH	Ö		191. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0		192. 00
192. 02 19202 MOB	4, 420		192. 02
193. 00 19300 NONPALD WORKERS	0		193. 00
194. 0007950 LEASED SPACE	15, 278		194. 00
200.00 Cross Foot Adjustments	0		200. 00
201.00 Negative Cost Centers	0		201.00
202.00 TOTAL (sum lines 118 through 201)	2, 189, 724		202. 00

	Financial Systems I	U HEALTH FRANK	FORT HOSPITAL Provider C	CN. 1E 1214 D		of Form CMS-2 Worksheet B-1	
CUST A	LLUCATION - STATISTICAL BASIS		Provider C	Fr	eriod: com 01/01/2020		
				To	12/31/2020	Date/Time Pre 7/13/2021 4:2	epared: 29 pm
		CAPI	TAL RELATED C	OSTS			
	Cost Center Description	BLDG & FIXT	BLDG & FIXT -	BLDG & FIXT -	EMPLOYEE	Reconciliation	
		(SQUARE FEET)		MOB (SQUARE FEET)	BENEFITS DEPARTMENT		
			(SQUARE FEET)	(SQUARE FEET)	(GROSS		
					SALARI ES)		
	GENERAL SERVICE COST CENTERS	1. 00	1. 01	1. 02	4. 00	5A	
	00100 CAP REL COSTS-BLDG & FIXT	101, 683					1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 00102 CAP REL COSTS-BLDG & FIXT - MOB	0	,				1.01
	00400 EMPLOYEE BENEFITS DEPARTMENT	375	0 375	_,	6, 364, 574		1. 02 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	18, 757	18, 757	0	502, 764	-7, 164, 387	5. 00
	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - HOSPITAL	1, 436 19, 026			469, 301 0	0	7. 00 7. 01
	00701 OPERATION OF PLANT - HOSPITAL 00702 OPERATION OF PLANT - MOB	19,020	19, 020		0	0	
	00800 LAUNDRY & LINEN SERVICE	0	0	- 1	O	0	
	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 371 2, 909	3, 371 2, 909		268, 269 71, 297	0	9. 00 10. 00
	01100 CAFETERI A	3, 615			88, 610	0	11.00
	01300 NURSING ADMINISTRATION	651	651		908, 569	0	13. 00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 994 1, 852			0 400, 313	0	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	1, 032	,		400, 313	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	11 455	11 455		04/ 252	0	20.00
30. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	11, 455	11, 455	0	946, 352	0	30.00
50.00	05000 OPERATING ROOM	9, 682		-	260, 578	0	50. 00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	5, 066 3, 678			681, 784	0	54. 00 60. 00
	06600 PHYSI CAL THERAPY	2, 879			55	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 196	1, 196	О	0	0	67. 00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	628 1, 819			76, 156	0	68. 00 69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,619	1, 819 0	0	46, 447 O	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY DRUGS	0	0	0	0	0	73. 00 73. 01
	03160 CARDI OPULMONARY	2, 728	2, 728	Ö	686, 918	0	
	OUTPATIENT SERVICE COST CENTERS	^		l al			00.00
	09000 CLINIC 09100 EMERGENCY	0 5, 273	_		0 957, 161	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,270	0,2,0	J	7077 101		92. 00
	OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0	0	l ol	ol	0	101. 00
	SPECIAL PURPOSE COST CENTERS	U		<u> </u>	U	U	101.00
118. 00		98, 390	98, 390	0	6, 364, 574	-7, 164, 387	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	l ol	O	0	190. 00
191. 00	19100 RESEARCH	Ö	Ö	ő	Ö		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0		192.00
	19202 MOB 19300 NONPALD WORKERS	2, 833 0	0	,	0	53, 351 0	192. 02 193. 00
	07950 LEASED SPACE	460		-	Ö		194. 00
200.00	Cross Foot Adjustments						200.00
201. 00 202. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Par	t 16, 415	2, 171, 059	2, 250	1, 512, 695		201. 00 202. 00
	1)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 161433	21. 963166	0. 794211	0. 237674		203.00
204. 00	Cost to be allocated (per Wkst. B, Par	l l			8, 297		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II				0. 001304		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D,				ŀ		207. 00
	Parts III and IV)			ı l	l		

<u>Health Financial Systems</u>	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-1316	Peri od: Worksheet B-1

From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/13/2021 4:29 pm Cost Center Description ADMINISTRATIVE OPERATION OF OPERATION OF OPERATION OF LAUNDRY & & GENERAL **PLANT** PLANT -PLANT - MOB LINEN SERVICE HOSPI TAL (ACCUM. COST) (SQUARE FEET) (SQUARE FEET) (PATIENT DAYS) (SQUARE FEET) 5.00 7.00 7. 01 7. 02 8.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.01 1.01 00102 CAP REL COSTS-BLDG & FIXT - MOB 1.02 1.02 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 17, 621, 115 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 706, 897 81, 115 7.00 00701 OPERATION OF PLANT - HOSPITAL 7.01 1, 523, 718 19,026 59, 256 7.01 7 02 00702 OPERATION OF PLANT - MOB 2.833 7 02 00800 LAUNDRY & LINEN SERVICE 1, 437 8.00 40,677 8.00 00900 HOUSEKEEPI NG 482, 322 3, 371 3, 371 0 9.00 9.00 10.00 01000 DI ETARY 254, 747 2,909 2,909 0 10.00 01100 CAFETERI A 265, 949 11.00 3, 615 3, 615 0 11.00 13.00 01300 NURSING ADMINISTRATION 1, 323, 215 651 651 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 613, 551 1, 994 1, 994 0 14.00 15 00 01500 PHARMACY 1, 852 15 00 912, 631 1.852 0 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 1, 437 30.00 1, 616, 906 11, 455 11, 455 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 874, 511 9, 682 9, 682 0 0 50.00 05400 RADI OLOGY-DI AGNOSTI C 1, 212, 872 0 54.00 5,066 5,066 54.00 60.00 06000 LABORATORY 1, 896, 439 3, 678 3,678 0 60.00 0 66 00 06600 PHYSI CAL THERAPY 517, 833 2.879 2.879 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 218, 758 1, 196 1, 196 0 67.00 06800 SPEECH PATHOLOGY 113, 813 68.00 628 628 68.00 06900 ELECTROCARDI OLOGY 103, 745 69.00 69.00 1,819 1,819 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 44, 818 C 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 229, 287 0 72.00 73 00 07300 DRUGS CHARGED TO PATIENTS 310, 797 73.00 07301 ONCOLOGY DRUGS 73.01 408, 375 0 73.01 03160 CARDI OPULMONARY 2, 728 76.00 1, 037, 365 2,728 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 90.00 09100 EMERGENCY 2, 901, 712 91.00 91.00 5.273 5, 273 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101. 00 10100 HOME HEALTH AGENCY 0101.00 0 0 0 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 17, 610, 938 77, 822 58, 796 0 1, 437 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 191. 00 19100 RESEARCH 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 192. 02 19202 MOB 2, 833 2,833 0 192. 02 193. 00 19300 NONPALD WORKERS 0 193, 00 194. 00 07950 LEASED SPACE 10, 177 460 460 0 194.00 200.00 Cross Foot Adjustments 200. 00 201. 00 201 00 Negative Cost Centers Cost to be allocated (per Wkst. B, Part 57, 215 202. 00 202.00 7, 164, 387 994, 307 2, 376, 451 203.00 Unit cost multiplier (Wkst. B, Part I 0.406580 12. 257992 40. 104816 0.000000 39. 815588 203. 00 959 204. 00 Cost to be allocated (per Wkst. B, Part 49, 057 204.00 415, 647 468, 389 II) 205.00 Unit cost multiplier (Wkst. B, Part II) 0.023588 0.604783 7. 904499 0.000000 0. 667363 205. 00 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207. 00 Parts III and IV)

Health Fina	uncial Systems I	U HEALTH FRANK	KFORT HOSPITAL		In Lieu	of Form CMS-2	<u> 2552-10</u>
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der C	CN: 15-1316 P	eriod: rom 01/01/2020	Worksheet B-1	
					o 12/31/2020	Date/Time Pro 7/13/2021 4:2	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	7 DIII
		(SQUARE FEET)	(PATIENT DAYS)	(FTE'S)	ADMI NI STRATI ON	SERVICES &	
					(DI RECT	SUPPLY	
					NURSING HOURS)	(COSTED	
		9. 00	10. 00	11. 00	13. 00	REQUIS.) 14.00	
GENE	RAL SERVICE COST CENTERS	7.00	10.00	11.00	13.00	14.00	
	CAP REL COSTS-BLDG & FLXT						1.00
	1 CAP REL COSTS-BLDG & FIXT - HOSPITAL						1. 01
	2 CAP REL COSTS-BLDG & FLXT - MOB						1. 02
	DEMPLOYEE BENEFITS DEPARTMENT						4.00
	O ADMINISTRATIVE & GENERAL O OPERATION OF PLANT						5. 00 7. 00
	1 OPERATION OF PLANT - HOSPITAL						7. 01
	2 OPERATION OF PLANT - MOB		1		1		7. 02
	D LAUNDRY & LINEN SERVICE						8. 00
	O HOUSEKEEPI NG	55, 885	•				9. 00
	D DI ETARY	2, 909					10.00
	O CAFETERIA O NURSING ADMINISTRATION	3, 615	0	,	1		11. 00 13. 00
•	O CENTRAL SERVICES & SUPPLY	651 1, 994		948	1	545, 607	14. 00
	O PHARMACY	1, 852		403	1	3, 165	1
	MEDICAL RECORDS & LIBRARY	0		0	1	0	1
	TIENT ROUTINE SERVICE COST CENTERS						
	DADULTS & PEDIATRICS LLARY SERVICE COST CENTERS	11, 455	1, 437	1, 450	25, 339	82, 809	30.00
	O OPERATING ROOM	9, 682	I 0	399	4, 038	0	50.00
	O RADI OLOGY-DI AGNOSTI C	5, 066				20, 613	
	LABORATORY	3, 678		1, 024		2, 085	•
•	PHYSI CAL THERAPY	2, 879	0	0	0	15, 855	66. 00
	O OCCUPATI ONAL THERAPY	1, 196		0	0	0	67. 00
	O SPEECH PATHOLOGY	628		82	0	0	
	DELECTROCARDIOLOGY DIMEDICAL SUPPLIES CHARGED TO PATIENTS	1, 819	0	78	0	3, 538 44, 818	•
	OIMPL. DEV. CHARGED TO PATIENTS		0		0	229, 287	
	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
	1 ONCOLOGY DRUGS	0	0		0	0	
	O CARDI OPULMONARY	2, 728	0	992	0	6, 147	76. 00
90. 00 0900	ATIENT SERVICE COST CENTERS CLINIC	0	0	1		0	90.00
	DEMERGENCY	5, 273			1 ~	137, 290	•
	OBSERVATION BEDS (NON-DISTINCT PART)			,	,		92. 00
	R REIMBURSABLE COST CENTERS						
	O HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	55, 425	1, 437	7, 884	49, 870	545, 607	118 00
	EI MBURSABLE COST CENTERS	00, 120	1, 10,	7,001	17,070	010,007	1 10.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 1910		0	0	0	0		191. 00
	O PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
192. 02 1920:	ZIMOB DINONPALD WORKERS		0		0		192. 02 193. 00
	D LEASED SPACE	460	0		0		193.00
200. 00	Cross Foot Adjustments				Ŭ	· ·	200.00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Par	t 854, 939	555, 147	618, 674	1, 979, 647	997, 925	202. 00
202 20	(West B Boot I)	15 000104	20/ 202504	70 470005	20 (0(150	1 000010	000 00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Par					1. 829018 79. 660	203. 00 204. 00
204.00	Cost to be allocated (per wkst. B, Par	114, 994	101, 202	124, 370	00,039	19,000	204.00
205. 00	Unit cost multiplier (Wkst. B, Part II) 2. 057690	70. 425887	15. 800355	1. 376760	0. 146003	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
l	Parts III and IV)	I	I	I	ı l		I

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316 Period: From 01/01/2020

COST ALLOCATION - STATISTICAL BASIS		Provider CC	N: 15-1316	From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Prep	oared:
Cost Center Description	PHARMACY	MEDI CAL			7/13/2021 4: 29	
cost center bescription	(COSTED	RECORDS &				
	REQUI S.)	LI BRARY				
	15. 00	(TIME SPENT) 16.00				
GENERAL SERVICE COST CENTERS	10.00	10.00				
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FIXT - HOSPITAL 1.02 O0102 CAP REL COSTS-BLDG & FIXT - MOB						1. 01 1. 02
4.00 O0400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 00700 OPERATI ON OF PLANT 7. 01 00701 OPERATI ON OF PLANT - HOSPI TAL						7. 00 7. 01
7. 02 00701 OPERATION OF PLANT - HOSPITAL 7. 02 00702 OPERATION OF PLANT - MOB						7. 01
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A						10. 00 11. 00
13.00 01300 NURSING ADMINISTRATION					•	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	/-/				•	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	735, 624 0	0			•	15. 00 16. 00
INPATIENT ROUTINE SERVICE COST CENTERS	- υ <u></u>	<u> </u>				10.00
30. 00 03000 ADULTS & PEDIATRICS	4, 396	0				30.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	980	O				50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	494	0			•	54. 00
60. 00 06000 LABORATORY	0	Ō			•	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0			•	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0			•	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	17	Ö				69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0			•	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0 310, 797	0			•	72. 00 73. 00
73. 01 07301 0NCOLOGY DRUGS	408, 375	Ö			•	73. 00
76. 00 03160 CARDI OPULMONARY	491	0				76. 00
OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	ol	ol				90. 00
91. 00 09100 EMERGENCY	10, 074	Ö				91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS	ol	ol			1	101 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	<u>U</u>	<u> </u>			'	101. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	735, 624	0			1	18. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	٥			1	
191. 0019100 RESEARCH	0	0			•	190. 00 191. 00
192.0019200 PHYSICIANS' PRIVATE OFFICES	Ō	O			•	92. 00
192. 0219202 MOB	0	0				92. 02
193. 0019300 NONPALD WORKERS 194. 0007950 LEASED SPACE	0	0				93. 00 194. 00
200.00 Cross Foot Adjustments	J				•	200.00
201.00 Negative Cost Centers					•	201.00
202.00 Cost to be allocated (per Wkst. B, Par	t 1, 446, 410	0			2	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	1. 966235	0. 000000			2	203. 00
204.00 Cost to be allocated (per Wkst. B, Par		0			•	204.00
205.00 Unit cost multiplier (Wkst. B. Part II) 0 121542	0. 000000			ļ	205. 00
205.00 Unit cost multiplier (Wkst. B, Part II 206.00 NAHE adjustment amount to be allocated		0.000000				205.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,					2	207. 00
Parts III and IV)	I	l			I	

Health Finar	ncial Systems I	U HEALTH FRANK	FORT HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
COMPUTATION	OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2020 To 12/31/2020		epared: 29 pm
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
I NPAT	TIENT ROUTINE SERVICE COST CENTERS		•		•		
30.00 03000	ADULTS & PEDIATRICS	4, 941, 476		4, 941, 47	6 0	0	30. 00
ANCI L	LARY SERVICE COST CENTERS		•				
50.00 05000	OPERATING ROOM	2, 078, 694		2, 078, 69	4 0	0	50.00
54.00 05400	RADI OLOGY-DI AGNOSTI C	2, 159, 482	1	2, 159, 48	2 0	0	54.00
60.00 06000	LABORATORY	3, 000, 520	1	3, 000, 52	o o	0	60.00
66.00 06600	PHYSI CAL THERAPY	952, 169	0	952, 16	9 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	388, 624	0	388, 62	4 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	209, 013	0	209, 01	3 0	0	68. 00
69.00 06900	ELECTROCARDI OLOGY	281, 626		281, 62	6 0	0	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	145, 013	1	145, 01	3 0	0	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	741, 880	1	741, 88	o o	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	1, 048, 261		1, 048, 26		0	73. 00
73. 01 07301	ONCOLOGY DRUGS	1, 377, 374	1	1, 377, 37	4 0	0	73. 01
76.00 03160	CARDI OPULMONARY	1, 733, 768	1	1, 733, 76	8 0	0	76. 00
OUTPA	TIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0			0 0	0	90.00
91.00 09100	EMERGENCY	5, 647, 436		5, 647, 43	6 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	1, 267, 892		1, 267, 89	2	0	92.00
OTHER	REIMBURSABLE COST CENTERS						
101. 00 10100	HOME HEALTH AGENCY	0			0	0	101. 00
200. 00	Subtotal (see instructions)	25, 973, 228	0	25, 973, 22	8 0		200. 00
201. 00	Less Observation Beds	1, 267, 892		1, 267, 89			201. 00
202. 00	Total (see instructions)	24, 705, 336	0	24, 705, 33	6 0	0	202. 00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2020	Worksheet C Part I	
				To 12/31/2020	Date/Time Pre 7/13/2021 4:2	epared: 29 pm
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		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				.1		
30. 00 03000 ADULTS & PEDI ATRI CS	2, 403, 666		2, 403, 66	6		30. 00
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM	FO 101	4 002 050	4 0/1 05	0 51100/	0.000000	FO 00
	59, 191	4, 002, 059				
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	304, 849 525, 669	6, 176, 040 3, 102, 014			0. 000000 0. 000000	
66. 00 06600 PHYSI CAL THERAPY	379, 104	1, 514, 438			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	212, 028	696, 980				
68. 00 1068001 SPEECH PATHOLOGY	90, 751	222, 114			0.00000	
69. 00 06900 ELECTROCARDI OLOGY	90, 731	811, 742			0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	396	249, 374				
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	10, 653	801, 081		•		•
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 226, 427	1, 542, 205			0. 000000	
73. 01 07300 DROGS GIVINGED TO TATTENTS	344, 140	3, 606, 153				
76. 00 03160 CARDI OPULMONARY	413, 821	2, 325, 434				
OUTPATIENT SERVICE COST CENTERS	110,021	2,020,101	2,707,20	0.002701	0.00000	70.00
90. 00 09000 CLINIC	0	0		0. 000000	0.000000	90.00
91. 00 09100 EMERGENCY	335, 216	16, 636, 866	16, 972, 08	2 0. 332749	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 650	1, 785, 754		4 0. 708160	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
101.00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
200.00 Subtotal (see instructions)	6, 310, 561	43, 472, 254	49, 782, 81	5		200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	6, 310, 561	43, 472, 254	49, 782, 81	5		202. 00

Health Financial Systems I	U HEALTH FRANKFO	ORT HOSPITAL	In Lieu	of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1316	Peri od:	Worksheet C	
			From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	enared:
			10 12/31/2020	7/13/2021 4:	29 pm
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
LANGUE DOLLEGE DESIGNATION OF THE PROPERTY OF	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				
	0.000000				50. 00 54. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 000000 0. 000000				60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 066700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
73. 01 07301 0NCOLOGY DRUGS	0. 000000				73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000				76. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000				90. 00
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
101.00 10100 HOME HEALTH AGENCY					101. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)	I I				202. 00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	<u> </u>	Period: From 01/01/2020 Fo 12/31/2020	Worksheet C Part I Date/Time Pre 7/13/2021 4:2	epared: 29 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						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 941, 476		4, 941, 470	6 0	4, 941, 476	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 078, 694		2, 078, 694	1 0	2, 078, 694	50. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 159, 482		2, 159, 482	2 0	2, 159, 482	54.00
60. 00 06000 LABORATORY	3, 000, 520		3, 000, 520		3, 000, 520	60.00
66. 00 06600 PHYSI CAL THERAPY	952, 169		952, 169		952, 169	
67. 00 06700 OCCUPATI ONAL THERAPY	388, 624		388, 624		388, 624	
68.00 06800 SPEECH PATHOLOGY	209, 013	0	209, 013	0	209, 013	
69. 00 06900 ELECTROCARDI OLOGY	281, 626	1	281, 626		281, 626	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	145, 013		145, 013		145, 013	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	741, 880		741, 880	0	741, 880	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 048, 261		1, 048, 26°	0	1, 048, 261	73. 00
73. 01 07301 ONCOLOGY DRUGS	1, 377, 374		1, 377, 374		1, 377, 374	
76.00 03160 CARDI OPULMONARY	1, 733, 768		1, 733, 768	0	1, 733, 768	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0		(0	0	, , , , , ,
91. 00 09100 EMERGENCY	5, 647, 436		5, 647, 436		5, 647, 436	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 267, 892		1, 267, 892	2	1, 267, 892	92. 00
OTHER REIMBURSABLE COST CENTERS		1	T .	.1		
101.0010100 HOME HEALTH AGENCY	0		05 070 000			101.00
200.00 Subtotal (see instructions)	25, 973, 228		25, 973, 228		25, 973, 228	
201.00 Less Observation Beds	1, 267, 892		1, 267, 892		1, 267, 892	
202.00 Total (see instructions)	24, 705, 336	0	24, 705, 336	이 이	24, 705, 336	P02.00

Heal th Fi nanci	ial Systems I	U HEALTH FRANK	FORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION O	F RATIO OF COSTS TO CHARGES		Provi der C		Peri od:	Worksheet C	
					From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narod.
					10 12/31/2020	7/13/2021 4: 2	
				e XIX	Hospi tal	Cost	
			Charges				
C	ost Center Description	I npati ent	Outpati ent		6 Cost or Other		
				+ col . 7)	Ratio	Inpati ent	
		6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
ΙΝΡΔΤΙΕ	ENT ROUTINE SERVICE COST CENTERS	0.00	7.00	6.00	9.00	10.00	
	DULTS & PEDIATRICS	2, 403, 666		2, 403, 66	6		30.00
	ARY SERVICE COST CENTERS				-,		1
50.00 05000 0	PERATING ROOM	59, 191	4, 002, 059	4, 061, 25	0. 511836	0. 000000	50. 00
	ADI OLOGY-DI AGNOSTI C	304, 849	6, 176, 040	6, 480, 88			
	ABORATORY	525, 669	3, 102, 014				
	HYSI CAL THERAPY	379, 104	1, 514, 438				
	CCUPATI ONAL THERAPY	212, 028	696, 980				
	PEECH PATHOLOGY	90, 751	222, 114				
	LECTROCARDIOLOGY EDICAL SUPPLIES CHARGED TO PATIENTS	396	811, 742 249, 374				
	MPL. DEV. CHARGED TO PATIENTS	10, 653	801, 081				
	RUGS CHARGED TO PATTENTS	1, 226, 427	1, 542, 205				
	NCOLOGY DRUGS	344, 140	3, 606, 153				
	ARDI OPULMONARY	413, 821	2, 325, 434				
	ENT SERVICE COST CENTERS		_,,	_, _, _,			
90.00 09000 C	LINIC	0	0		0. 000000	0. 000000	90.00
91.00 09100 E		335, 216	16, 636, 866				
	BSERVATION BEDS (NON-DISTINCT PART)	4, 650	1, 785, 754	1, 790, 40	0. 708160	0. 000000	92. 00
	REIMBURSABLE COST CENTERS				al		
	OME HEALTH AGENCY	0	0	40 700 04	0		101.00
	ubtotal (see instructions) ess Observation Beds	6, 310, 561	43, 472, 254	49, 782, 81	5		200.00
	otal (see instructions)	6, 310, 561	43, 472, 254	49, 782, 81	5		201. 00 202. 00
202.04	otal (See Histiactions)	0,310,301	43, 472, 234	47, /02, 01	ગ	i	K02.00

Health Financial Systems I	U HEALTH FRANKFO	RT HOSPITAL	In Lieu	of Form CMS-2552	-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1316	Peri od:	Worksheet C	
				Part I Date/Time Prepare	od:
			10 12/31/2020	7/13/2021 4: 29 pr	eu: m
		Title XIX	Hospi tal	Cost	_
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30.	. 00
ANCI LLARY SERVI CE COST CENTERS	0.000000				00
50. 00 05000 OPERATING ROOM	0. 000000			50.	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 000000 0. 000000			54. 60.	
66. 00 06600 PHYSI CAL THERAPY	0. 000000			60.	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.	
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.	
69. 00 106900 ELECTROCARDI OLOGY	0. 000000			69.	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 000000			71.	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	
73. 01 07301 ONCOLOGY DRUGS	0. 000000			73.	
76. 00 03160 CARDI OPULMONARY	0. 000000			76.	
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0. 000000			90.	. 00
91. 00 09100 EMERGENCY	0. 000000			91.	. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.	. 00
OTHER REIMBURSABLE COST CENTERS					
101.0010100 HOME HEALTH AGENCY				101.	
200.00 Subtotal (see instructions)				200.	
201.00 Less Observation Beds				201.	
202.00 Total (see instructions)				202.	. 00

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10							
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS	Provi der C	CN: 15-1316	Peri od:	Worksheet D		
				From 01/01/2020 To 12/31/2020		naradi	
				10 12/31/2020	7/13/2021 4: 2	epareu: 19 nm	
		Title	XVIII	Hospi tal	Cost	, p	
Cost Center Description	Capital Related	Total Charges	Ratio of Cos		Capital Costs		
· ·		(from Wkst. C,		Program	(column 3 x		
	Wkst. B, Part	Part I, col.	(col. 1 ÷ col	. Charges	column 4)		
	II, col. 26)	8)	2)				
	1. 00	2. 00	3. 00	4. 00	5. 00		
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	349, 470						
54. 00 05400 RADI OLOGY-DI AGNOSTI C	212, 688	6, 480, 889				54.00	
60. 00 06000 LABORATORY	181, 457					60.00	
66. 00 06600 PHYSI CAL THERAPY	108, 649				3, 925	66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	44, 259					67.00	
68.00 06800 SPEECH PATHOLOGY	24, 610	312, 865			1, 875	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	63, 725				0	69. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	7, 601				0	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	38, 884						
73.00 07300 DRUGS CHARGED TO PATIENTS	45, 112				· ·	73. 00	
73. 01 07301 ONCOLOGY DRUGS	59, 276	3, 950, 293			1, 225	73. 01	
76. 00 03160 CARDI OPULMONARY	131, 178	2, 739, 255	0. 04788	8 170, 421	8, 161	76. 00	
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC	0	0			0	90.00	
91. 00 09100 EMERGENCY	316, 679					91. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	150, 470					92.00	
200.00 Total (lines 50 through 199)	1, 734, 058	47, 379, 149		1, 217, 766	40, 632	200. 00	

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER P.	ASS Provider C	CN: 15-1316 P	eri od:	Worksheet D	
THROUGH COSTS				rom 01/01/2020 o 12/31/2020	Part IV Date/Time Pre	nared.
				0 12/31/2020	7/13/2021 4: 2	
		Title	: XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health		
		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
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	,
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	,
73. 01 07301 ONCOLOGY DRUGS	0	0	O.	0	0	
76. 00 03160 CARDI OPULMONARY	0	0		0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	1 0		1 0	J ol		00 00
90. 00 09000 CLINIC	0	0		0	0	70.00
91. 00 09100 EMERGENCY	0	U		y o	0	71.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		_			0	
200.00 Total (lines 50 through 199)	1 0	ı	ı	۱۲ ۱۲	, 0	200. 00

	U HEALTH FRANK				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER P.	ASS Provi der C		Period: From 01/01/2020	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2020	Date/Time Pre	epared:
					7/13/2021 4: 2	9 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.		(from Wkst. C,		
	Education Cost			Part I, col.		
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	0	0	9	4, 061, 250		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	9	6, 480, 889		
60. 00 06000 LABORATORY	0	0	9	3, 627, 683		
66. 00 06600 PHYSI CAL THERAPY	0	0	9	1, 893, 542		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	9	909, 008		
68. 00 06800 SPEECH PATHOLOGY	0	0	9	312, 865		
69. 00 06900 ELECTROCARDI OLOGY	0	0	9	811, 742		
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	(249, 770		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(811, 734		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(2, 768, 632		
73. 01 07301 ONCOLOGY DRUGS	0	0	(3, 950, 293		
76. 00 03160 CARDI OPULMONARY	0	0		2, 739, 255	0. 000000	76. 00
OUTPATIENT SERVICE COST CENTERS		_	i			
90. 00 09000 CLI NI C	0	0	(0	0. 000000	
91. 00 09100 EMERGENCY	0	0	(16, 972, 082		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(1, 790, 404		
200.00 Total (lines 50 through 199)	0	0	l (47, 379, 149		200. 00

Health Financial Systems I APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	U HEALTH FRANKE		CN. 15 1214	In Lieu Period:	of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	ERVICE UIHER PA	33 Provider C	CN: 15-1316	From 01/01/2020	Part IV	
THROUGH GOOTS				To 12/31/2020	Date/Time Pre	
		Title	XVIII	Hospi tal	7/13/2021 4: 2 Cost	29 piii
Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
μ	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	3	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	27, 776		0 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	88, 893		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	203, 952		0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	68, 397		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	14, 419		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	23, 831		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	10, 653		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATLENTS	0. 000000	511, 860		0	0	73. 00
73. 01 07301 0NCOLOGY DRUGS	0. 000000	81, 631		0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000	170, 421		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						_
90. 00 09000 CLI NI C	0. 000000	0		0	0	
91. 00 09100 EMERGENCY	0. 000000	14, 583		0	0	,
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 350		0	0	, 2. 00
200.00 Total (lines 50 through 199)	1 1	1, 217, 766	l	0 0	0	200. 00

Health Financial Systems I	U HEALTH FRANK	FORT HOSPITAL		In lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF MEDI CAL, OTHER HEALTH SERVI CES AI		T Provi der C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet D Part V	epared:
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 511836	0	1, 109, 781	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 333208	0	1, 317, 101	0	0	54.00
60. 00 06000 LABORATORY	0. 827117	0	685, 713	0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 502851	0	413, 610	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 427525	0	214, 744	. 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 668061	0	22, 172	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 346940	0	181, 784	. 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 580586	0	82, 874	. 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 913945	0	390, 892		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 378621	0	281, 886	193	0	73. 00
73. 01 07301 ONCOLOGY DRUGS	0. 348676	0	1, 654, 983	0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 632934	0	716, 158		0	76. 00
OUTPATIENT SERVICE COST CENTERS		•				ĺ
90. 00 09000 CLI NI C	0. 000000	0	C	0	0	90. 00
91. 00 09100 EMERGENCY	0. 332749	0	3, 404, 449	356	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 708160	0	570, 295	0	0	92.00
200.00 Subtotal (see instructions)		0	11, 046, 442	549	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			C	0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	11, 046, 442	549	0	202. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL			In Lieu	of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AT	ND VACCINE COST	Provi der CO	CN: 15-1316	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part V	epared:
		Title	XVIII	Hospi tal	Cost	
·	Cost ost Reimbursed Services Jubject To Ded S	Cost Reimbursed				
		Subject To				
	,	ed. & Coins.				
		(see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	568, 026	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	438, 869	0				54.00
60. 00 06000 LABORATORY	567, 165	0				60.00
66. 00 06600 PHYSI CAL THERAPY	207, 984	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	91, 808	0				67. 00
68.00 06800 SPEECH PATHOLOGY	14, 812	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	63, 068	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	48, 115	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	357, 254	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	106, 728	73				73. 00
73. 01 07301 ONCOLOGY DRUGS	577, 053	0				73. 01
76. 00 03160 CARDI OPULMONARY	453, 281	0				76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	1, 132, 827	118				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	403, 860	0				92.00
200.00 Subtotal (see instructions)	5, 030, 850	191				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges	5 000 050	101				000 00
202.00 Net Charges (line 200 - line 201)	5, 030, 850	191				202. 00

Health Financial Systems	II IIFALTII FDANK	YEART HASRITAL		In II o	of Form CMC	DEED 10
Health Financial Systems I APPORTIONMENT OF MEDICAL. OTHER HEALTH SERVICES AI	U HEALTH FRANK ND VACCINE COS		CN: 15-1316 P	eri od:	u of Form CMS-2 Worksheet D	2552-10
THE TOTAL STATE OF THE STATE OF	ID WHOOTHE GOO		F	rom 01/01/2020		
		Title	XVIII Sv	ving Beds - SNF	F Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Services (see	Rei mbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9)	Subject To	Subj ect To		
			Ded. & Coins.	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. 511836	0	C	0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 333208	0	C	0	0	54.00
60. 00 06000 LABORATORY	0. 827117	0	C	0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 502851	0	C	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 427525	0	C	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 668061	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 346940	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 580586	0	C	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 913945	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 378621	0	C	0	0	73. 00
73. 01 07301 ONCOLOGY DRUGS	0. 348676	0	C	0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 632934			0	Ó	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	C	0	0	90. 00
91. 00 09100 EMERGENCY	0. 332749	0	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 708160	0		o	0	92.00
200.00 Subtotal (see instructions)		0		o	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				o	_	201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	[0	0	202. 00

Health Financial Systems	U HEALTH FRANKF	ORT HOSPITAL		In Lieu	of Form CMS-25	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A			CN: 15-1316	Peri od:	Worksheet D	
		Component	CCN: 15-Z316	From 01/01/2020 To 12/31/2020		narod:
		Component	CCN. 13-2310	10 12/31/2020	7/13/2021 4: 29	
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos					
Cost Center Description	ost Reimbursed	Cost				
	Servi ces	Rei mbursed				
	ubject To Ded. & Coins. (see	Subject To				
		Ded. & Coins.				
	11131.)	(see inst.)				
	6, 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0	0				50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
66.00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			· · · · · · · · · · · · · · · · · · ·	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				72. 00 73. 00
73. 01 07301 0NCOLOGY DRUGS	0	0				73. 00
76. 00 03160 CARDI OPULMONARY		0				76. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>				70.00
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0			İ	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0				2	201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	i ol	O			12	202. 00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COS	T Provider C		Period: From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not		
	Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.		
			(see inst.)	(see inst.)		
Table 1 and	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		_	1	ءا ء	_	
50. 00 05000 OPERATING ROOM	0. 511836			0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 333208			0	0	0 00
60. 00 06000 LABORATORY	0. 827117	0		0	0	00.00
66. 00 06600 PHYSI CAL THERAPY	0. 502851	0		0	0	66. 00
67.00 06700 OCCUPATI ONAL THERAPY	0. 427525	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 668061	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 346940			0	0	07.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 580586			0	0	,
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 913945	0		0	0	, ,
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 378621	0		0	0	
73. 01 07301 ONCOLOGY DRUGS	0. 348676			0	0	
76. 00 03160 CARDI OPULMONARY	0. 632934	0		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS			1	ءا ء	_	
90. 00 09000 CLINIC	0. 000000			0	0	
91. 00 09100 EMERGENCY	0. 332749			0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 708160	0		0	0	, ,
200.00 Subtotal (see instructions)		0		0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program						201. 00
Only Charges		_			_	000 00
202.00 Net Charges (line 200 - line 201)		0	l	0 0	j O	202. 00

Health Financial Systems I	IU HEALTH FRANKFORT HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ND VACCINE COST	Provi der CC	CN: 15-1316	Peri od: From 01/01/2020 To 12/31/2020		epared: 29 pm	
		Title	e XIX	Hospi tal	Cost		
·	ubject To Ded. Se & Coins. (see	Cost Reimbursed					
		see inst.)					
	6. 00	7. 00					
ANCI LLARY SERVI CE COST CENTERS 50.00 O5000 OPERATI NG ROOM 54.00 O5400 RADI OLOGY - DI AGNOSTI C 60.00 O6000 LABORATORY 66.00 O6600 PHYSI CAL THERAPY 67.00 O6700 OCCUPATI ONAL THERAPY 68.00 O6800 SPEECH PATHOLOGY 69.00 O6900 ELECTROCARDI OLOGY 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 73.01 O7301 ONCOLOGY DRUGS 76.00 O3160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0				50. 00 54. 00 60. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 73. 01 76. 00	
90.00 09000 CLINIC 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program Only Charges 202.00 Net Charges (line 200 - line 201)	0 0 0 0 0	0 0 0 0				90. 00 91. 00 92. 00 200. 00 201. 00	

Heal th	Financial Systems IU HEALTH FRANKFO	RT HOSPITAL	In Lieu	ı of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1316	Period: From 01/01/2020 To 12/31/2020		
		Title XVIII	Hospi tal	7/13/2021 4:2 Cost	29 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed d	avs. excluding newborn)		1, 886	1.00
2.00	Inpatient days (including private room days, excluding swin	g-bed and newborn days)	1, 533	2.00
3. 00	Private room days (excluding swing-bed and observation bed not complete this line.	days). If you have only	private room da	ys, do 0	3. 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private reporting period		mber 31 of the c	1,082 pst 214	
6. 00	Total swing-bed SNF type inpatient days (including private	room days) after Decemb	er 31 of the cos	t 0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private r	oom days) through Decem	ber 31 of the co	st 139	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private r	oom days) after Decembe	r 21 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	<i>3</i> ,			
9. 00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (exclud	ing swing-bed an	d 545	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	e room days) thr	ough 214	10. 00
11.00	December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII		e room days) aft	er 0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or		vate room days)	through 0	12. 00
13 00	December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or	3 1 0 1		Ü	13. 00
	December 31 of the cost reporting period (if calendar year,	enter 0 on this line)			
	Medically necessary private room days applicable to the Pro Total nursery days (title V or XIX only)	gram (excluding swing-b	ed days)	0	
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17.00	Medicare rate for swing-bed SNF services applicable to serv	ices through December 3	1 of the cost re	porti ng	17. 00
18. 00	period Medicare rate for swing-bed SNF services applicable to serv period	ices after December 31	of the cost repo	rti ng	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to servi	ces through December 31	of the cost rep	orting 216.95	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to serviperiod	ces after December 31 o	f the cost repor	ting 0.00	20. 00
21.00	Total general inpatient routine service cost (see instructi Swing-bed cost applicable to SNF type services through Dece		orting period (I	4, 941, 476 ine 5 x 0	1
	line 17)	·			
23.00	Swing-bed cost applicable to SNF type services after Decemb line 18)	er 31 of the cost repor	ting period (lin	e 6 x 0	23. 00
24.00	Swing-bed cost applicable to NF type services through Decem line 19)	ber 31 of the cost repo	rting period (li	ne 7 x 30,156	24. 00
25. 00	Swing-bed cost applicable to NF type services after Decembe line 20)	r 31 of the cost report	ing period (line	8 x 0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos	t (line 21 minus line 2	6)	631, 772 4, 309, 704	•
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	•			1
28. 00 29. 00	General inpatient routine service charges (excluding swing- Private room charges (excluding swing-bed charges)	bed and observation bed	cnarges)	0	•
30.00	Semi-private room charges (excluding swing-bed charges)	7 11 20)		0	
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 2 Average private room per diem charge (line 29 ÷ line 3)	7 ÷ 11ne 28)		0. 000000 0. 00	31.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4			0. 00	33. 00
	Average per diem private room charge differential (line 32		ructi ons)	0.00	34. 00 35. 00
36.00	Average per diem private room cost differential (line 34 x Private room cost differential adjustment (line 3 x line 35			0. 00 0	36.00
	General inpatient routine service cost net of swing-bed cosminus line 36)		differential (I	ne 24, 309, 704	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST A			2 011 20	20 00
	Adjusted general inpatient routine service cost per diem (s Program general inpatient routine service cost (line 9 x li			2, 811. 29 1, 532, 153	•
40.00	Medically necessary private room cost applicable to the Pro	gram (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line	39 + line 40)		1, 532, 153	41.00

Health Financial Systems	s IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2							
COMPUTATION OF INPATIENT OPERATING COST		Provi der C	CCN: 15-1316	Period: From 01/01/2020	Worksheet D-1			
				To 12/31/2020	Date/Time Pre			
		Title	e XVIII	Hospi tal	7/13/2021 4:2 Cost	29 piii		
Cost Center Description	Total Inpatien		Average Per		Program Cost			
	Cost	Inpatient Days	col. 2)	÷	(col. 3 x col. 4)			
42 00 NUDCERV (+i+l a V a VIV and a)	1.00	2. 00	3. 00	4. 00	5. 00	42.00		
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Ur	l ni ts					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			ļ			46. 00		
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00		
	(What D 2 and	2 11 - 200)			1.00	40.00		
48.00 Program inpatient ancillary service cost 49.00 Total Program inpatient costs (sum of lin			tions)		614, 680 2, 146, 833	•		
PASS THROUGH COST ADJUSTMENTS						1		
50.00 Pass through costs applicable to Program 51.00 Pass through costs applicable to Program					and III)			
[1V]	•	a. y 20. 1. 200	(5, 5 a 51 . a. ts				
52.00 Total Program excludable cost (sum of line 53.00 Total Program inpatient operating cost ex		related non-	nhysician ane	esthetist and m	0 edical 0	52. 00 53. 00		
education costs (line 49 minus line 52)	ter during outpritur	Toratea, Horr		sserioti st, una iii	our car	00.00		
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	54. 00		
55.00 Target amount per discharge					0. 00	55. 00		
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient ope	erating cost and	target amount	(line 56 mir	nus line 53)	0			
58.00 Bonus payment (see instructions)	0	Ü	•	•	0	58. 00		
59.00 Lesser of lines 53/54 or 55 from the cost	t reporting perio	nd ending 1996	, updated and	d compounded by	the 0.00	59. 00		
60.00 Lesser of lines 53/54 or 55 from prior ye						60.00		
61.00 If line 53/54 is less than the lower of loperating costs (line 53) are less than						61. 00		
56), otherwise enter zero (see instructions)								
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive p	navment (see inst	ructions)			0	62. 00 63. 00		
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs through De	ecember 31 of	the cost repo	orting period (S	ee 601, 616	64.00		
65.00 Medicare swing-bed SNF inpatient routine	costs after Dece	ember 31 of the	e cost report	ting period (See	0	65. 00		
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient ro	outine costs (lin	ne 64 plus lin	e 65)(title)	(VIII only). For	CAH 601,616	66. 00		
(see instructions)	·	•	, ,	3,				
67.00 Title V or XIX swing-bed NF inpatient rount 12 x line 19)	itine costs throu	igh December 3	1 of the cost	t reporting peri	bd (line 0	67. 00		
68.00 Title V or XIX swing-bed NF inpatient rou	utine costs after	December 31	of the cost r	reporting period	(line 0	68. 00		
13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatie	ent routine costs	s (line 67 + l	ine 68)		0	69. 00		
PART III - SKILLED NURSING FACILITY, OTHE				27)		70.00		
70.00 Skilled nursing facility/other nursing				37)		70. 00 71. 00		
72.00 Program routine service cost (line 9 x li	,					72.00		
73.00 Medically necessary private room cost app 74.00 Total Program general inpatient routine s						73. 00 74. 00		
75.00 Capital-related cost allocated to inpatie	ent routine servi	ce costs (fro	m Worksheet E	3, Part II, colu	mn 26,	75. 00		
line 45) 76.00 Per diem capital-related costs (line 75 -	: line 2)					76. 00		
77.00 Program capital -related costs (line 9 x l						77.00		
78.00 Inpatient routine service cost (line 74 r 79.00 Aggregate charges to beneficiaries for ex	,	n provider rec	ords)			78. 00 79. 00		
80.00 Total Program routine service costs for a	•	cost limitat	ion (line 78	minus line 79)		80. 00 81. 00		
81.00 Inpatient routine service cost per diem I 82.00 Inpatient routine service cost limitation		81)				82.00		
83.00 Reasonable inpatient routine service cost	33.00 Reasonable inpatient routine service costs (see instructions)							
84.00 Program inpatient ancillary services (see 85.00 Utilization review - physician compensati		i ons)				84. 00 85. 00		
86.00 Total Program inpatient operating costs	(sum of lines 83	through 85)				86. 00		
PART IV - COMPUTATION OF OBSERVATION BED 87.00 Total observation bed days (see instructi		1			451	87. 00		
88.00 Adjusted general inpatient routine cost p	oer diem (line 27				2, 811. 29			
89.00 Observation bed cost (line 87 x line 88)	(see This truction	13)			1, 267, 892	I 07. UU		

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lieu of Form CMS-2552-			
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1		
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/13/2021 4:2		
		Title	XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	586, 438	4, 941, 476	0. 11867	7 1, 267, 892	150, 470	90.00	
91.00 Nursing School cost	0	4, 941, 476	0. 00000	0 1, 267, 892	0	91.00	
92.00 Allied health cost	0	4, 941, 476	0.00000	0 1, 267, 892	0	92.00	
93.00 All other Medical Education	0	4, 941, 476	0. 00000	0 1, 267, 892	0	93. 00	

	ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1316	Peri od:	Worksheet	D-1	
			From 01/01/2020 To 12/31/2020	Date/Time	Pre	pared
		Title XIX	Hospi tal	7/13/2021 Co	4:2 st	29 pm
	Cost Center Description			1. 00		
	PART I - ALL PROVIDER COMPONENTS			1.00		
00	INPATIENT DAYS	dava avalvedi na navdana		1	007	1 ,
	Inpatient days (including private room days and swing-bed Inpatient days (including private room days, excluding swi				886 533	
	Private room days (excluding swing-bed and observation bed				0	•
	not complete this line.					١
	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private		ombor 21 of the c		082 214	4. 0 5. 0
. 00	reporting period	e room days) through bece	siliber 31 of the c	551	214] 5. 0
b. 00	Total swing-bed SNF type inpatient days (including private	e room days) after Decemb	er 31 of the cos	t	0	6.0
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private	room days) through Docom	phor 21 of the co	o+	139	7.0
. 00	reporting period	100m days) till odgir becen	iber 31 of the co	51	137	′. 0
3. 00	Total swing-bed NF type inpatient days (including private	room days) after December	er 31 of the cost		0	8. 0
	reporting period (if calendar year, enter 0 on this line)	o to the December (ling owing to d	4	4.4	
9. 00	Total inpatient days including private room days applicable newborn days) (see instructions)	e to the Program (exclud	ning swing-bed an	u	11	9.0
0.00	Swing-bed SNF type inpatient days applicable to title XVII	I only (including privat	e room days) thr	ough	0	10. 0
1 00	December 31 of the cost reporting period (see instructions					
1. 00	Swing-bed SNF type inpatient days applicable to title XVII December 31 of the cost reporting period (if calendar year		e room days) aft	er	0	11.0
2. 00	Swing-bed NF type inpatient days applicable to titles V or	· XIX only (including pri	vate room days)	through	0	12.0
	December 31 of the cost reporting period					
3. 00	Swing-bed NF type inpatient days applicable to titles V or December 31 of the cost reporting period (if calendar year		vate room days)	after	0	13. 0
4. 00	Medically necessary private room days applicable to the Pr		ed davs)		0	14.0
5.00	Total nursery days (title V or XIX only)				0	15. 0
6. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16. 0
	Medicare rate for swing-bed SNF services applicable to ser	rvices through December 3	31 of the cost re	porting		17. 0
0.00	peri od					100
8. 00	Medicare rate for swing-bed SNF services applicable to ser period	rvices after December 31	of the cost repo	rting		18. 0
9. 00	Medicaid rate for swing-bed NF services applicable to serv	vices through December 31	of the cost rep	orting 216	5. 95	19. 0
20.00	period Medicaid rate for swing-bed NF services applicable to serv	vices after December 31 c	of the cost repor	ting (0. 00	20. 0
	peri od			4 044	47.	
	Total general inpatient routine service cost (see instruct Swing-bed cost applicable to SNF type services through Dec		orting period (4,941,	4/6	•
2.00	line 17)	sember of the dest rep	or tring period (i	THE U X	Ŭ	22.0
	Swing-bed cost applicable to SNF type services after December 10	mber 31 of the cost repor	ting period (lin	e 6 x	0	23. 0
	line 18) Swing-bed cost applicable to NF type services through Dece	ember 31 of the cost repo	rting period (li	ne 7 x 30,	156	24. 0
	line 19)					
:5. 00	Swing-bed cost applicable to NF type services after Decembline 20)	per 31 of the cost report	ing period (line	8 x	0	25. 00
26. 00	Total swing-bed cost (see instructions)			631.	772	26. 0
	General inpatient routine service cost net of swing-bed co	ost (line 21 minus line 2	26)	4, 309,		
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing	a had and observation had	L charges)		0	28. 0
	Private room charges (excluding swing-bed charges)	g-bed and observation bed	r charges)		0	•
0.00	Semi -pri vate room charges (excluding swing-bed charges)				0	30.0
	General inpatient routine service cost/charge ratio (line	27 ÷ line 28)				31. C
	Average private room per diem charge (line 29 ÷ line 3)	4)			0. 00	•
	Average semi-private room per diem charge (line 30 ÷ line	,	ructions)		0.00	•
	Average per diem private room charge differential (line 32 Average per diem private room cost differential (line 34 x	, ,	i uctions)). 00). 00	34. C
	Private room cost differential adjustment (line 3 x line 3). UU 0	36.0
	General inpatient routine service cost net of swing-bed co		: differential (I	ne 2 4 , 309.	-	
	minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST	AD HISTMENTS				
, i	TROOMS INTATIENT OF ERATING COST DETORE PASS THROUGH COST				1 20	38 0
	Adjusted general inpatient routine service cost per diem ((see instructions)		2, 811	I. 291	50. 0
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (Program general inpatient routine service cost (line 9 x I Medically necessary private room cost applicable to the Pr	ine 38)				39.0

	IU HEALTH	I FRANK	FORT HOSPITAL		In Lieu	ı of Form	CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der	CCN: 15-1316	Peri od: From 01/01/2020	Workshee	et D-1	
					To 12/31/2020			
			_	le XIX	Hospi tal	(Cost	7 piii
Cost Center Description	Total In			Average Per sDiem (col. 1		Program (col. 3 x		
			impatrent bay	col . 2)	7	4)		
42.00 NURSERY (title V & XIX only)	1.0	00	2.00	3.00	4. 00	5. 00)	42. 00
Intensive Care Type Inpatient Hospital Uni	ts							42.00
43.00 INTENSIVE CARE UNIT 44.00 CORONARY CARE UNIT								43. 00 44. 00
45.00 BURN INTENSIVE CARE UNIT								45. 00
46.00 SURGICAL INTENSIVE CARE UNIT								46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description								47. 00
48.00 Program inpatient ancillary service cost (Wkct D 3	2 col	2 Line 200)			1.00) 4, 229	48. 00
49.00 Total Program inpatient costs (sum of line							5, 153	
PASS THROUGH COST ADJUSTMENTS				See and William D	- C Davita I			F0. 00
50.00 Pass through costs applicable to Program i 51.00 Pass through costs applicable to Program i						and III) II and	0	50. 00 51. 00
IV)	. 50 and	F1)	•				0	F2 00
52.00 Total Program excludable cost (sum of line 53.00 Total Program inpatient operating cost exc			related, non-	physician ane	! sthetist, and m!	edi cal	0	52. 00 53. 00
education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION		•						
54.00 Program discharges							0	54.00
55.00 Target amount per discharge								55. 00
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient oper	ating cos	st and	target amount	(line 56 mir	us line 53)		0	56. 00 57. 00
58.00 Bonus payment (see instructions)	J		· ·	•	, i		0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost market basket	reporti no	g perio	d ending 1996	b, updated and	compounded by	the	0. 00	59. 00
60.00 Lesser of lines 53/54 or 55 from prior yea								60.00
61.00 If line 53/54 is less than the lower of li operating costs (line 53) are less than ex							0	61. 00
56), otherwise enter zero (see instructions)								
								62. 00 63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST			,					(4.00
64.00 Medicare swing-bed SNF inpatient routine c instructions) (title XVIII only)	osts thro	ougn De	cember 31 or	the cost repo	erting period (S	ee	U	64. 00
65.00 Medicare swing-bed SNF inpatient routine c	osts afte	er Dece	mber 31 of th	ne cost report	ing period (See		0	65. 00
instructions)(title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient rou	tine cost	ts (lin	e 64 plus lir	ne 65)(title X	VIII only). For	CAH	0	66. 00
(see instructions) 67.00 Title V or XIX swing-bed NF inpatient rout			· Danamban S	11 -6 +6+		a al (1) a a	0	(7.00
67.00 Title V or XIX swing-bed NF inpatient rout 12 x line 19)	THE COSTS	s till ou	ign beceiliber 3	or the cost	reporting perio	ba (TTTTe	U	67. 00
68.00 Title V or XIX swing-bed NF inpatient rout 13 x line 20)	ine costs	s after	December 31	of the cost r	eporting period	(Line	0	68. 00
69.00 Total title V or XIX swing-bed NF inpatien							0	69. 00
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing fac					37)			70. 00
71.00 Adjusted general inpatient routine service	cost per				0.7)			71. 00
72.00 Program routine service cost (line 9 x lin 73.00 Medically necessary private room cost appl		Progr	am (line 14 v	(line 35)				72. 00 73. 00
74.00 Total Program general inpatient routine se								74.00
75.00 Capital-related cost allocated to inpatien	t routine	e servi	ce costs (fro	om Worksheet B	, Part II, colu	mn 26,		75. 00
76.00 Per diem capital-related costs (line 75 ÷	line 2)							76. 00
77.00 Program capital-related costs (line 9 x li 78.00 Inpatient routine service cost (line 74 mi		77)						77. 00 78. 00
79.00 Aggregate charges to beneficiaries for exc			provider red	cords)				79. 00
80.00 Total Program routine service costs for co	•	to the	cost limitat	tion (line 78	minus line 79)			80.00
81.00 Inpatient routine service cost per diem li 82.00 Inpatient routine service cost limitation		<pre>< line</pre>	81)					81. 00 82. 00
83.00 Reasonable inpatient routine service costs	(see ins	structi						83. 00
84.00 Program inpatient ancillary services (see			i one)					84.00
								85. 00 86. 00
PART IV - COMPUTATION OF OBSERVATION BED P	ASS THROU						454	
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost pe	,	ine 27	÷ line 2)			2, 8		87. 00 88. 00
89.00 Observation bed cost (line 87 x line 88) (İ			89. 00

Health Financial Systems I	U HEALTH FRANK	FORT HOSPITAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1		
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/13/2021 4:2		
		Ti tl	e XIX	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3. 00	4. 00	5. 00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capi tal -related cost	586, 438	4, 941, 476	0. 11867	7 1, 267, 892	150, 470	90.00	
91.00 Nursing School cost	0	4, 941, 476	0. 00000	0 1, 267, 892	0	91.00	
92.00 Allied health cost	0	4, 941, 476	0. 00000	0 1, 267, 892	0	92.00	
93.00 All other Medical Education	0	4, 941, 476	0. 00000	0 1, 267, 892	0	93.00	

Heal th Finar	ncial Systems IU HE	EALTH FRANKFORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
INPATIENT A	NCILLARY SERVICE COST APPORTIONMENT	Provi der (CCN: 15-1316	Peri od:	Worksheet D-3	3
				From 01/01/2020 To 12/31/2020		nared.
					7/13/2021 4: 2	19 pm
		Ti tl e	e XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
LAIDAT	LENT DOUTINE CERVILOE COCT CENTERS		1.00	2. 00	3. 00	
	I ENT ROUTI NE SERVI CE COST CENTERS		1	1 005 11/	l	20.00
	ADULTS & PEDIATRICS LARY SERVICE COST CENTERS			1, 035, 116		30. 00
	OPERATING ROOM		0. 51183	6 27,776	14, 217	50. 00
	RADI OLOGY-DI AGNOSTI C		0. 33320			
	LABORATORY		0. 82711			
	PHYSI CAL THERAPY		0. 50285			
	OCCUPATI ONAL THERAPY		0. 42752			
	SPEECH PATHOLOGY		0. 66806	1 23, 831	15, 921	68. 00
69.00 06900	ELECTROCARDI OLOGY		0. 34694	0	0	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 58058	6 0	0	71. 00
	IMPL. DEV. CHARGED TO PATIENTS		0. 91394	5 10, 653	9, 736	72. 00
	DRUGS CHARGED TO PATIENTS		0. 37862	1 511, 860	193, 801	73. 00
	ONCOLOGY DRUGS		0. 34867		· ·	
	CARDI OPULMONARY		0. 63293	4 170, 421	107, 865	76. 00
	TIENT SERVICE COST CENTERS		,	1	1	
	CLINIC		0. 00000		0	90.00
91.00 09100			0. 33274			
	OBSERVATION BEDS (NON-DISTINCT PART)	the county (OO)	0. 70816			92.00
200. 00	Total (sum of lines 50 through 94 and 96		.l	1, 217, 766		
201. 00	Less PBP Clinic Laboratory Services-Progra	am only cnarges (line 61	P	1 217 7//		201. 00
202. 00	Net charges (line 200 minus line 201)			1, 217, 766		202. 00

Health Financial Systems IU HEALTH FRANKFO			In Lieu	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1316	Peri od:	Worksheet D-3	3
	Component		From 01/01/2020 To 12/31/2020	Date/Time Pre	enared.
	Component			7/13/2021 4: 2	
			Swing Beds - SNF		
Cost Center Description		Ratio of Cos	The state of the s	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS		ĺ	T 0		30.00
ANCI LLARY SERVI CE COST CENTERS					30.00
50, 00 05000 OPERATING ROOM		0. 51183	6 0	0	50.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 33320		6, 232	
60. 00 06000 LABORATORY		0. 82711	7 19, 461	16, 097	60.00
66. 00 06600 PHYSI CAL THERAPY		0. 50285	1 161, 944	81, 434	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 42752	5 115, 894		
68. 00 06800 SPEECH PATHOLOGY		0. 66806		33, 672	
69. 00 06900 ELECTROCARDI OLOGY		0. 34694		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 58058		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 91394		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 37862			
73. 01 07301 0NCOLOGY DRUGS		0. 34867			73. 01
76. 00 03160 CARDI OPULMONARY		0. 63293	4 25, 864	16, 370	76.00
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC		0.00000		0	90.00
91. 00 1091001 EMERGENCY		0. 00000 0. 33274		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33274		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.70010	475, 880	·	
201.00 Less PBP Clinic Laboratory Services-Program only char	nes (line 61)	,	473,000		200.00
202.00 Net charges (line 200 minus line 201)	ges (into or	ľ	475, 880		202.00
		ı	, 000	ı	F

Heal th Finar	ncial Systems IU HEALTH F	RANKFORT HOSPITAL		In Lieu	u of Form CMS-2	2552-10
INPATIENT AF	NCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1316	Peri od:	Worksheet D-3	3
				From 01/01/2020 To 12/31/2020		narod.
				10 12/31/2020	7/13/2021 4: 2	29 pm
		Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
li vin vin			1. 00	2. 00	3. 00	
	IENT ROUTINE SERVICE COST CENTERS		1	1		
	ADULTS & PEDIATRICS			14, 904		30. 00
	LARY SERVICE COST CENTERS OPERATING ROOM		0 51100	/1 0	0	FO 00
	RADI OLOGY-DI AGNOSTI C		0. 51183 0. 33320		0 736	
	LABORATORY		0. 33320			
	PHYSI CAL THERAPY		0. 82711		,	66.00
	OCCUPATI ONAL THERAPY		0. 30263		221	67.00
	SPEECH PATHOLOGY		0. 66806		0	68.00
	ELECTROCARDI OLOGY		0. 34694		0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 58058		0	
	IMPL. DEV. CHARGED TO PATIENTS		0. 91394	1	0	72.00
	DRUGS CHARGED TO PATIENTS		0. 37862		3 783	73.00
	ONCOLOGY DRUGS		0. 34867		0,700	1
	CARDI OPULMONARY		0. 63293		-	
	TIENT SERVICE COST CENTERS			<u>-, </u>	., ., .==	
	CLINIC		0. 00000	0 0	0	90.00
91.00 09100	EMERGENCY		0. 33274	9 15, 775	5, 249	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)		0. 70816	0	0	92.00
200. 00	Total (sum of lines 50 through 94 and 96 through	າ 98)		34, 069	14, 229	200. 00
201. 00	Less PBP Clinic Laboratory Services-Program only	y charges (line 61)	b	0		201. 00
	Net charges (line 200 minus line 201)	-		34, 069		202. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1316	Peri od: From 01/01/2020	Worksheet E	
	Title XVIII	Hospi tal	Cost	
			1. 00	
PART B - MEDICAL AND OTHER HEALTH SERVICE	ES			

PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 5,031,041 1.
PART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions) 5.031,041 5.00 Utlier reconciliation amount (see instructions) 6.00 Utlier reconciliation amount (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 12.00 Ancillary service charges Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis of the such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 Total customary charges (see instructions) 18.00 Total customary charges (see instructions) 19.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 10.00 Total customary charges (see instructions) 10.00 Conductions of line 15 to line 16 (not to exceed 1.000000) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions)
1.00 Medical and other services (see instructions) 2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.02 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 7.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.00 Organ acquisitions 11.00 Organ acquisitions 12.00 Ancillary service charges Reasonable charges 12.00 Ancillary service charges 12.00 Ancillary service charges 12.00 Ancillary service charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Organ acquisition charges (sum of lines 12 and 13) 14.00 Organ acquisition charges (sum of lines 12 and 13) 15.00 Amounts that would have been realized from patients liable for payment for services on a charge basis of the such payment been made in accordance with 42 CFR §413. 13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 Total customary charges (see instructions) 18.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions)
2.00 Medical and other services reimbursed under OPPS (see instructions) 3.00 OPPS payments 0.01 Utilier payment (see instructions) 0.02 Utilier payment (see instructions) 0.03 Utilier reconciliation amount (see instructions) 0.00 Utilier reconciliation amount (see instructions) 0.00 Enter the hospital specific payment to cost ratio (see instructions) 0.00 Utilier 2 times line 5 0.00 Enter the hospital specific payment to cost ratio (see instructions) 0.00 Utilier 2 times line 5 0.00 Utilier 2 times line 10 0.00 Utilier 2 times line 5 0.00 Utilier 2 times
3.00 OPPS payments 4.00 Outlier payment (see instructions) 5.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 7.00 Organ acquisitions 7.00 Organ acquisition charges 7.00 Organ acquisition charges 7.00 Organ acquisition charges 8.00 Organ acquisition charges 8.00 Organ acquisition charges 8.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 7.00 Organ acquisition charges 7.00 Organ acquisition charges (sum of lines 12 and 13) 7.00 Organ acquisition charges (sum of lines 12 and 13) 7.00 Organ acquisition charges (sum of lines 12 and 13) 7.00 Organ acquisition charges (sum of lines 12 and 13) 7.00 Organ acquisition charges (sum of lines 12 and 13) 8.00 Organ acquisition charges (sum of lines 12 and 13) 8.00 Organ acquisition charges (sum of lines 12 and 13) 8.00 Organ acquisition charges (sum of lines 12 and 13) 8.00 Organ acquisition charges (sum of lines 12 and 13) 8.00 Organ acquisition charges (sum of lines 12 and 13) 9.00 Organ acquisition charges (sum of lines 1 and 10) (see instructions) 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Organ acquisitions 9.00 Org
4.00 Outlier payment (see instructions) 4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.00 Organ acquisitions 11.00 Organ acquisitions 10.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 12.00 Ancillary service charges 12.00 Ancillary service charges 12.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Organ acquisition charges (sum of lines 12 and 13) 15.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebas s had 16.00 Total customary charges (see instructions) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 18.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions) 19.00 Total customary charges (see instructions)
4.01 Outlier reconciliation amount (see instructions) 5.00 Enter the hospital specific payment to cost ratio (see instructions) 6.00 Line 2 times line 5 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9.00 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 12.00 Ancillary service charges Reasonable charges Reasonable charges 12.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 0.00000 17.10 Total customary charges (see instructions) 0.000000 18.00 Total customary charges (see instructions) 0.000000 17.10 Total customary charges (see instructions) 0.000000 18.00 Total customary charges (see instructions) 0.000000 18.00 Total customary charges (see instructions) 0.000000
Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis of 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis shad of 16. Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) O 0.000000
Sum of lines 3, 4, and 4.01, divided by line 6 8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0 organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 12.00 Total reasonable charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis of the such payment been made in accordance with 42 CFR §413. 13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) 0 0.000000 17. 18.00 Total customary charges (see instructions) 0 0.000000 17. 18.00 Total customary charges (see instructions)
8.00 Transitional corridor payment (see instructions) 9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0 Organ acquisitions 11.00 Total cost (sum of lines 1 and 10) (see instructions) 0 10. COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 14.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 15.00 Total reasonable charges (sum of lines 12 and 13) 16.00 Amounts that would have been realized from patients liable for payment for services on a charge basis such payment been made in accordance with 42 CFR §413. 13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 0 8.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0 9. 10. 11.00 ComPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 0 12. 0 12. 0 12. 0 12. 0 13. 0 14. 0 15. 0 15. 0 16. 0 16. 0 17. 0 17. 0 18. 0 17. 0 18. 0 18.
9.00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 0 9. 10.00 Organ acquisitions 0 10. 11.00 Total cost (sum of lines 1 and 10) (see instructions) 5,031,041 11. COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 0 12. 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13. 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14. Customary charges 15.00 Amounts that would have been realized from patients liable for payment for services on a charge basi s 0 15. 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasi s had 0 16. 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17. 18.00 Total customary charges (see instructions) 0 18.
10.00 Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions) Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had 16.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions)
11.00 Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 5,031,041 11.00 5,031,041 12.01 12.01 13.02 14.05 15.03 16.05 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 Total customary charges (see instructions)
Reasonable charges 12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions)
12.00 Ancillary service charges 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions)
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15. 00 Amounts that would have been realized from patients liable for payment for services on a chargebasis s had 0 16. 00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions)
14.00 Total reasonable charges (sum of lines 12 and 13) Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15. Amounts that would have been realized from patients liable for payment for services on a chargebasis had 0 16. Such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 0 14.
Customary charges 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15. 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had 0 16. 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17. 18.00 Total customary charges (see instructions) 0 18.
Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15. Amounts that would have been realized from patients liable for payment for services on a chargebasis had 0 16. Such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions) 18.00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebas s had 0 16. such payment been made in accordance with 42 CFR §413.13(e) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 0 16.00 16.00 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions)
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 18.00 Total customary charges (see instructions) 0.000000 17.000000 17.000000 18.00000000000000000000000000000
18.00 Total customary charges (see instructions) 0 18.
19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.
instructions)
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see
instructions)
21.00 Lesser of cost or charges (see instructions) 5,081,351 21.
22.00 Interns and residents (see instructions) 0 22.
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.
24.00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 0 24. COMPUTATION OF REIMBURSEMENT SETTLEMENT
25. 00 Deductibles and coinsurance amounts (for CAH, see instructions) 19, 043 25.
26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 2,011,003 26.
27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 3,051,305 27.
instructions)
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 30.00 Subtotal (sum of lines 27 through 29) 3,051,305 30.
31. 00 Pri mary payer payments 2,585 31.
32.00 Subtotal (line 30 minus line 31) 3,048,720 32.
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)
33.00 Composite rate ESRD (from Wkst. I-5, line 11)
34.00 Allowable bad debts (see instructions) 485,550 34.
35.00 Adjusted reimbursable bad debts (see instructions) 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 315,608 35. 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 342,749 36.
37. 00 Subtotal (see instructions) 3,364,328 37.
38.00 MSP-LCC reconciliation amount from PS&R 0 38.
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.
39.50 Pioneer ACO demonstration payment adjustment (see instructions)
39.97 Demonstration payment adjustment amount before sequestration 0 39.
39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.
40. 00 Subtotal (see instructions) 3, 364, 328 40.
40.01 Sequestration adjustment (see instructions) 22,205 40.
40.02 Demonstration payment adjustment amount after sequestration 0 40.
40.03 Sequestration adjustment-PARHM pass-throughs
41.00 Interim payments 2,953,838 41.
41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only) 41.01 Interim payments-PARHM 42.00 Tentative settlement (for contractors use only)
42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 42. 02 Tentative settlement PARHM (for contractor use only)
43. 00 Balance due provider/program (see instructions) 388, 285 43.
43.01 Balance due provider/program-PARHM (see instructions) 43.
44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §1 5.2 500,529 44.
TO BE COMPLETED BY CONTRACTOR
90.00 Original outlier amount (see instructions) 0 90.
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 92.
93.00 Time Value of Money (see instructions)
94.00 Total (sum of lines 91 and 93)

Heal th	Financial Systems IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der (F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet E-1 Part I Date/Time Pre 7/13/2021 4:2	pared:
		Ti tl e	e XVIII	Hospi tal	Cost	
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		1, 579, 112 0		2, 758, 438 0	1. 00 2. 00
	submitted or to be submitted to the contractor for service rendered in the cost reporting period. If none, write "N					
3. 00	or enter a zero List separately each retroactive lump sum adjustment amou based on subsequent revision of the interim rate for the					3. 00
	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	08/31/2020	39, 200	08/31/2020	195, 400	3. 01
3. 02			C		0	3. 02
3. 03			C		0	3. 03
3. 04					0	3. 04
3. 05	Provider to Program				0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	ADSOSTMENTS TO TROUTING				0	3. 51
3. 52				i	Ö	3. 52
3. 53			C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		39, 200		195, 400	3. 99
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		1, 618, 312		2, 953, 838	4. 00
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after d review. Also show date of each payment. If none, write "N					5. 00
	for enter a zero. (1)	OIVE				
	Program to Provider		<u> </u>			
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5 02	<u> </u>			I	1	5 02

5.02

5.03

5. 50

5. 51 5. 52 5. 99

6.00

6.01

6.02

7.00

8. 00

0

0

0

0

0

388, 285

3,342,123 NPR Date

(Mo/Day/Yr)

2.00

390, 952

Contractor

Number 1.00

2,009,264

5.02

5.03

5.50

5.51

5. 52

5. 99

6.00

6.01

6.02

7.00

Provider to Program

TENTATI VE TO PROGRAM

cost report. (1)
SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on the

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	F	eriod: rom 01/01/2020 o 12/31/2020	Worksheet E-1 Part I Date/Time Pre 7/13/2021 4:2	epared:
		Title		ving Beds - SNF		
		I npati ent	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for service rendered in the cost reporting period. If none, write "!	ces	682, 309 0		0	
3. 00	or enter a zero List separately each retroactive lump sum adjustment amou based on subsequent revision of the interim rate for the reporting period. Also show date of each payment. If none write "NONE" or enter a zero. (1)	cost				3. 00
2 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER	}	0		0	
3. 02		}	0		0	
3. 03 3. 04		1	0		0	0.00
3. 05			0		0	
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	
3. 53			0		0	
3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	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)		682, 309		0	4. 00
	TO BE COMPLETED BY CONTRACTOR	1				
5. 00	List separately each tentative settlement payment after or review. Also show date of each payment. If none, write "I or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5. 02			0		0	
5. 03	Drovi don to Drogram		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM	1	0		0	5. 50
5. 50 5. 51	ILIVIALIVE TO FROGRAM	1	0		0	0.00
5. 52			0	1	0	•
	I and the second	1	U	1	U	0.02

5. 99

6.00

6. 01

6.02

7.00

8. 00

0

NPR Date

(Mo/Day/Yr)

155, 502

837, 811

Contractor

Number 1.00

5. 99

6.00

6.01

6. 02 7. 00 5. 50-5. 98)

8.00 Name of Contractor

cost report. (1)
SETTLEMENT TO PROVIDER

SETTLEMENT TO PROGRAM

Subtotal (sum of lines 5.01-5.49 minus sum of lines

Total Medicare program liability (see instructions)

Determined net settlement amount (balance due) based on the

Heal th	Financial Systems IU HEALTH FRANKFO	RT HOSPITAL	In Lieu	of Form CMS-	2552-10
From 01/01/2020			Worksheet E- Part II Date/Time Pr		
			12,01,2020	7/13/2021 4:	
		Title XVIII	Hospi tal	Cost	
	TO DE COMPLETED DV CONTRACTOR FOR HONOTANDARD COST REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	ONI			-
1. 00			ino 14		1.00
	3				
3.00					
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			3. 00 4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20			6. 00
7.00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technolog	gy Wkst. S-2, Pt	l line	7. 00
	168				
	Calculation of the HIT incentive payment (see instructions)				8. 00
	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	n (see Instructions)			10. 00
20.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions)				
	Other Adjustment (specify)				30. 00 31. 00
	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruct	ions)		32.00
02.00	per ance and provides (e o (er fille fo) military fille of and	3., (300 111311 401	,		1 02.00

Heal th	Financial Systems IU HEALTH FRANKFO	RT HOSPITAL	In lieu	ı of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provi der CCN: 15-1316	Peri od:	Worksheet E-2	
		Component CCN: 15-Z316	From 01/01/2020	Date/Time Pre	epared:
		Title XVIII	Swing Beds – SNF	7/13/2021 4:2 Cost	29 pm
		I II II E XVIII	Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instruction	ns)	607, 632	0	
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 FV, cols. 6 and 7, line 202, for Part B) (For CAH and swing-instructions)		D, Part 237, 153	0	3.00
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved tea	nching program (see inst	ructions)	0.00	•
5.00	Program days		214	0	5. 00
6.00	Interns and residents not in approved teaching program (see			0	
7. 00	Utilization review - physician compensation - SNF optional	method only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		844, 785	0	
9.00	Primary payer payments (see instructions)		044 705	0	
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts app	licable to physician	844, 785	0	
11.00	professional services)	or cable to physician	٩	U	11.00
12. 00	Subtotal (line 10 minus line 11)		844, 785	0	12.00
	Coinsurance billed to program patients (from provider recor	ds) (exclude coinsurance		0	
	physician professional services)		,		
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (see instructions)		843, 377	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
	Pioneer ACO demonstration payment adjustment (see instructi				16. 50
16. 55	Rural community hospital demonstration project (§410A Demor (see instructions)	istration) payment adjus	tment 0		16. 55
16. 99	Demonstration payment adjustment amount before sequestration	on	0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17. 00
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)	0	0	
	Total (see instructions)		843, 377	0	
	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration	.,	5, 566	0	
19.02	Sequestration adjustment-PARHM pass-throughs	1)	ď	O	19. 02
	Interim payments		682, 309	0	•
	Interim payments-PARHM		, , , , , , , , , , , , , , , , , , , ,		20. 01
	Tentative settlement (for contractor use only)		0	0	21. 00
	Tentative settlement-PARHM (for contractor use only)				21. 01
	Balance due provider/program (line 19 minus lines 19.01, 20), and 21)	155, 502	0	00
	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accor	dance with CMS Pub. 15-2	2, 83, 534	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demon</pre>	etration) Adjustment			ł
200 00	Is this the first year of the current 5-year demonstration		entury		200.00
200.00	Cures Act? Enter "Y" for yes or "N" for no.	ps od dilder tile 2131 0			_ 55. 55
	Cost Reimbursement				1
201.00	Medicare swing-bed SNF inpatient routine service costs (fro	om Wkst. D-1, Pt. II, li	ne 66		201.00
	(title XVIII hospital))	•			[
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (f	from Wkst. D-3, col. 3,	ine 200		202. 00
	(title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202) Medicare swing-bed SNE discharges (see instructions)				203. 00 204. 00

	(see instructions)			1
16. 99	Demonstration payment adjustment amount before sequestration	0	0	16. 99
17.00	Allowable bad debts (see instructions)	0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)	0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	18. 00
19.00	Total (see instructions)	843, 377	0	19. 00
19. 01	Sequestration adjustment (see instructions)	5, 566	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)	0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs			19. 03
20.00	Interim payments	682, 309	0	20.00
20. 01	Interim payments-PARHM			20. 01
21.00	Tentative settlement (for contractor use only)	0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)			21. 01
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	155, 502	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)			22. 01
23.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	83, 534	0	23. 00
	chapter 1, §115.2			
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Cen	tury		200.00
	Cures Act? Enter "Y" for yes or "N" for no.			
	Cost Reimbursement			[
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line	66		201. 00
	(title XVIII hospital))			
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, li	ne 200		202. 00
	(title XVIII swing-bed SNF))			
	Total (sum of lines 201 and 202)			203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)			204. 00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the curr	ent 5-year		
	demonstration period)			
	Medicare swing-bed SNF target amount			205.00
206. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)			206. 00
007.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement	ı		007 00
	Program reimbursement under the §410A Demonstration (see instructions)	4		207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines	1 and		208. 00
200 00	3)			000 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.00
210.00	Reserved for future use Comparision of PPS versus Cost Reimbursement			210. 00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see	ı		215. 00
215.00	instructions)			215.00
	(That detrois)	l		l

Hoal th	Financial Systems IU HEALTH FRANKFO	DT HOSDITAI	In lieu	ı of Form CMS-2	0552_10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1316	Peri od:	Worksheet E-3	
CALCUL	ATTON OF RETWIDORSEMENT SETTEEMENT	Frovider CCN. 15-1310	From 01/01/2020	Part V	•
			To 12/31/2020	Date/Time Pre	epared:
				7/13/2021 4:2	9 pm
		Title XVIII	Hospi tal	Cost	
	DART V. CALCULATION OF REINDURCHUENT CETTLEMENT FOR MEDICA	DE DADT A CEDVILOEC C	OCT DELMBURGEMEN	1. 00	
1 00	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	RE PART A SERVICES - C	OST KETMBURSEMEN		1 00
1.00	Inpatient services	+!>		2, 146, 833	
2.00	Nursing and Allied Health Managed Care payment (see instruc	iti ons)		0	
3. 00 4. 00	Organ acquisition Subtotal (sum of lines 1 through 3)			2, 146, 833	3. 00 4. 00
5. 00	Primary payer payments			2, 140, 833 0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 168, 301	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 100, 301	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	
9. 00	Organ acquisition charges, net of revenue			0	
	Total reasonable charges			0	
10.00	Customary charges			0	10.00
11 00	Aggregate amount actually collected from patients liable fo	r navment for services	on a charge basi	s 0	11. 00
	Amounts that would have been realized from patients liable				
12.00	such payment been made in accordance with 42 CFR 413.13(e)	Tor payment for service	on a charge ba	or or ridd	12.00
13 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13 00
	Total customary charges (see instructions)	0	1		
	Excess of customary charges over reasonable cost (complete	0			
	instructions)				
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds	line 14) (see	0	16. 00
	instructions)				
17.00	17.00 Cost of physicians' services in a teaching hospital (see instructions)				
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	·			
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 168, 301	19. 00
	Deductibles (exclude professional component)			164, 736	
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			2, 003, 565	
	Coi nsurance			0	23. 00
	Subtotal (line 22 minus line 23)			2, 003, 565	
	Allowable bad debts (exclude bad debts for professional ser	vices) (see instruction	is)	29, 304	
	Adjusted reimbursable bad debts (see instructions)			19, 048	
	Allowable bad debts for dual eligible beneficiaries (see in	structions)		· ·	27. 00
	Subtotal (sum of lines 24 and 25, or line 26)			2, 022, 613	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructi			0	
	Demonstration payment adjustment amount before sequestration	n		0	
	Subtotal (see instructions)			2, 022, 613	
	Sequestration adjustment (see instructions)			13, 349	
	Demonstration payment adjustment amount after sequestration	l		0	
	Sequestration adjustment-PARHM			1 (10 212	30. 03
	Interim payments			1, 618, 312	
	Interim payments-PARHM Tentative settlement (for contractor use only)			0	31. 01 32. 00
	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)			U	32.00
	Balance due provider/program (line 30 minus lines 30.01, 30	(02 31 and 32)		390, 952	
	Balance due provider/program-PARHM (Lines 2, 3, 18, and 26,		01 and 32 01)	370, 932	33. 00
	Protested amounts (nonallowable cost report items) in accor			15. 2 214, 417	
5 1. 00	1	aaso wi tii ows i ub. 13-	-, onaptor 1, 31		1 3 1. 00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-typevider CCN: 15-1316 accounting records, complete the General Fund column only)

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Ti me Prepared:

			['	0 12/31/2020	7/13/2021 4: 2	29 pm
		General Fund		Endowment Fund		
		1 00	Purpose Fund	2.22	4 00	
	CURRENT ASSETS	1. 00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	-277, 894	0	0	0	1.00
2. 00	Temporary investments	0	Ö	Ö	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	2, 923, 751		0	0	
5.00	Other receivable	3, 378, 761	0	0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	e 0 250, 660	0	0	0	6. 00 7. 00
8. 00	Prepai d expenses	96, 985		0	0	8.00
9. 00	Other current assets	0	0	Ō	0	9. 00
10.00	Due from other funds	0	0	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	6, 372, 263	0	0	0	11. 00
12 00	FIXED ASSETS	951, 048	0	ol	0	12 00
12. 00 13. 00	Land Land improvements	951, 048 16, 117		0	0	•
	Accumul ated depreciation	-2, 955		0	0	14. 00
	Bui I di ngs	35, 315		Ō	0	15. 00
	Accumulated depreciation	-7, 109		0	0	16. 00
	Leasehold improvements	496, 826		0	0	17. 00
	Accumulated depreciation Fixed equipment	-369, 637	0	0	0	
	Accumulated depreciation	0	1	0	0	20.00
	Automobiles and trucks	0	ĺ	Ö	0	21.00
	Accumul ated depreciation	0	0	Ö	0	22. 00
	Maj or movabl e equi pment	32, 725, 395		0	0	23. 00
	Accumulated depreciation	-4, 555, 117	0	0	0	24.00
	Minor equipment depreciable Accumulated depreciation	0	0	0	0	25. 00 26. 00
	HIT desi gnated Assets	0		0	0	
	Accumulated depreciation	0	Ö	ő	0	28. 00
	Mi nor equi pment-nondepreci abl e	0	0	Ö	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	29, 289, 883	0	0	0	30. 00
21 00	OTHER ASSETS			٥		21 00
	Investments Deposits on Leases	0	0	0	0	31. 00 32. 00
	Due from owners/officers	0	Ö	Ö	0	
34.00	Other assets	2, 562, 454	0	0	0	34. 00
	Total other assets (sum of lines 31-34)	2, 562, 454		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	38, 224, 600	0	0	0	36. 00
37 00	CURRENT LIABILITIES Accounts payable	19, 857, 004	0	0	0	37. 00
	Sal ari es, wages, and fees payable	803, 476		Ö	0	38. 00
	Payroll taxes payable	41, 888	0	0	0	39. 00
	Notes and Loans payable (short term)	0	0	0	0	40.00
	Deferred income	0 5, 684, 502	0	0	0	41. 00 42. 00
	Accelerated payments Due to other funds	4, 508, 696		0	0	43. 00
	Other current liabilities	195, 764		o		44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	31, 091, 330	0	0	0	45. 00
	LONG TERM LIABILITIES		1			
	Mortgage payable	0 20, 973, 417	0	0	0	
	Notes payable Unsecured Loans	20, 973, 417 O		0	0	
	Other long term liabilities	0	0	0	0	
	Total long term liabilities (sum of lines 46 thru 49)	20, 973, 417	0	Ö	0	
51.00	Total liabilities (sum of lines 45 and 50)	52, 064, 747	0	0	0	51. 00
F0 00	CAPI TAL ACCOUNTS	10 040 147	1	1		F0.00
	General fund balance Specific purpose fund	-13, 840, 147	0			52. 00 53. 00
	Donor created - endowment fund balance - restricted		0	0		54. 00
	Donor created - endowment fund balance - unrestricted			Ö		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
50 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	-13, 840, 147	_	^	0	59. 00
	Total liabilities and fund balances (sum of lines 51 and			0		60.00
	, com or tribe of did	,, == ., 000	'	. Y	Ü	

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-1316 Period: From 01/01/2020 Worksheet G-1

					From 01/01/202 Fo 12/31/202	O Date/Time Pre	
		General	Fund	Special D	urpose Fund	7/13/2021 4:2 Endowment Fund	
		Geriei ai	Turiu	Special Fi	ai pose i una	Lildowillett Turid	
	I a	1. 00	2.00	3. 00	4. 00	5. 00	1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		-9, 671, 749 -4, 168, 398		1	0	1. 00 2. 00
3. 00	Total (sum of line 1 and line 2)		-4, 168, 398 -13, 840, 147		1		3.00
4. 00	Additions (credit adjustments) (specify)	0	13, 040, 147)	0	
5.00		0				0	
6.00		0		(0	6. 00
7. 00		0		(0	
8. 00		0		(0	
9.00	Total additions (sum of line 4-9)	Ü	0	()	0	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		-13, 840, 147		1		11.00
12.00	Deductions (debit adjustments) (specify)	0	-13, 040, 147		ol '	0	
13.00		0				0	
14.00		0		(0	14.00
15.00		0		(0	
16.00		0		(0	
17.00	Total deductions (sum of lines 12-17)	0	0	()	0	17. 00 18. 00
19. 00	Fund balance at end of period per balance		-13, 840, 147		1		19.00
17.00	sheet (line 11 minus line 18)		13, 040, 147				17.00
		Endowment Fund	PI ant	Fund		•	
					_		
1. 00	Fund balances at beginning of period	6. 00	7. 00	8. 00			1.00
2. 00	Net income (loss) (from Wkst. G-3, line 29)	·			1		2.00
3. 00	Total (sum of line 1 and line 2)	0			ol		3. 00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5. 00
6. 00			0				6. 00
7. 00 8. 00			0				7. 00 8. 00
9. 00			0		1		9.00
10.00	Total additions (sum of line 4-9)	0	O				10.00
11. 00	Subtotal (line 3 plus line 10)	0					11. 00
12.00	Deductions (debit adjustments) (specify)		0				12. 00
13.00			0		l		13. 00
14.00			0				14.00
15. 00 16. 00			0				15. 00 16. 00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	0				18.00
	Fund balance at end of period per balance	Ö			ol		19. 00
	sheet (line 11 minus line 18)						[

Health Financial Systems	IU HEALTH FRANKFO	In Lieu of Form CMS-2552-10		
STATEMENT OF PATIENT REVENUES AND	OPERATING EXPENSES	Provi der CCN: 15-1316	Peri od:	Worksheet G-2

12/31/2020 Date/Time Prepared: 7/13/2021 4:29 pm Cost Center Description I npati ent Outpati ent Total 1.00 2.00 3.00 PART I - PATIENT REVENUES <u>General Inpatient Routine Services</u> 1.00 Hospi tal 2, 113, 646 2, 113, 646 SUBPROVIDER - IPF 2.00 2.00 SUBPROVIDER - IRF 3.00 3.00 4.00 SUBPROVI DER 4.00 5.00 290, 020 290, 020 5.00 Swing bed - SNF Swing bed - NF 6.00 6.00 7.00 SKILLED NURSING FACILITY 7.00 8.00 NURSING FACILITY 8.00 9.00 OTHER LONG TERM CARE 9.00 2, 40<u>3, 666</u> 10.00 Total general inpatient care services (sum of lines 1-9) 2, 403, 666 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 11.00 12.00 CORONARY CARE UNIT 12.00 BURN INTENSIVE CARE UNIT 13.00 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 14.00 15.00 OTHER SPECIAL CARE (SPECIFY) 15.00 Total intensive care type inpatient hospital services (sum of lines 11-15) 16 00 0 16 00 2, 403, 666 2, 403, 666 17.00 Total inpatient routine care services (sum of lines 10 and 16) 17.00 18.00 Ancillary services 3, 567, 029 25, 049, 634 28, 616, 663 18.00 18, 762, 486 19.00 Outpatient services 339, 866 18, 422, 620 19.00 20.00 RURAL HEALTH CLINIC 20 00 0 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 21.00 22.00 HOME HEALTH AGENCY 0 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 OTHER (SPECIFY) 27.00 27.00 49, 782, 815 28.00 Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, 6, 310, 561 43, 472, 254 28.00 PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 26, 059, 835 29.00 30.00 ADD (SPECIFY) 30.00 31.00 31.00 32.00 32.00 33.00 33.00 34.00 34.00 35.00 35.00 Total additions (sum of lines 30-35) 36, 00 36,00 37.00 DEDUCT (SPECIFY) 37.00 38.00 38.00 39.00 39.00 40.00 40.00 41.00 41.00 Total deductions (sum of lines 37-41) 42.00 42.00 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to 26, 059, 835 43.00 Wkst. G-3, line 4)

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL		In lieu	of Form CMS-2	552-10
	CCN: 15-1316	Peri od:	Worksheet G-3	
		From 01/01/2020		
		To 12/31/2020	Date/Time Pre 7/13/2021 4:2	
			77 137 2021 4.2	7 DIII
		1	1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			49, 782, 815	1. 00
2.00 Less contractual allowances and discounts on patients' accounts			27, 913, 982	2.00
3.00 Net patient revenues (line 1 minus line 2)				3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)			26, 059, 835	4.00
5.00 Net income from service to patients (line 3 minus line 4)			-4, 191, 002	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 communication services	;		0	8.00
9.00 Revenue from television and radio service			0	9. 00
10.00 Purchase discounts			0	10.00
11.00 Rebates and refunds of expenses			0	
12.00 Parking lot receipts				12.00
13.00 Revenue from Laundry and Linen service				13.00
14.00 Revenue from meals sold to employees and guests				14.00
15.00 Revenue from rental of living quarters				15. 00
16.00 Revenue from sale of medical and surgical supplies to other than patie	ents			16. 00
17.00 Revenue from sale of drugs to other than patients				17. 00
18.00 Revenue from sale of medical records and abstracts				18. 00
9.00 Tuition (fees, sale of textbooks, uniforms, etc.)			-	19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen			0	
21.00 Rental of vending machines			0	21. 00
22.00 Rental of hospital space			0	
23.00 Governmental appropriations			0	
24. 00 MI SCELLANEOUS I NCOME			0	
24. 50 COVI D-19 PHE Fundi ng			148, 857	
25.00 Total other income (sum of lines 6-24)			148, 857	
26.00 Total (line 5 plus line 25)			-4, 042, 145	
27. 00 MI SCELLANEOUS I NCOME			126, 253 126, 253	
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)			-4, 168, 398	
27. 00 pivet theome (of 1055) for the period (title 20 illinus title 28)			-4, 100, 398	29.00