This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1311 Worksheet S Period: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/9/2021 Time: 10:17 am Manually prepared cost report use only]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 (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] 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. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened (5) Amended

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) for the cost reporting period beginning 01/01/2020 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. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) CARA BREIDSTER
Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)

Date

Cost Center Description			Title XVIII				
		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	867, 498	-956, 263	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	148, 383	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1, 015, 881	-956, 263	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	reporting period? In column 2, enter "Y" for yes or	"N" for no	١.					
		In-State	In-State	Out-of	Out-of	Medi cai d	Other	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		pai d days	eligible	Medi cai d	Medi cai d		days	
			unpai d	pai d days	eligible			
			days		unpai d			
		1.00	2. 00	3. 00	4. 00	5. 00	6.00	
24.00	If this provider is an IPPS hospital, enter the	0	0	0	0	C	0	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 TIPTON HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1311 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/9/2021 10:17 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N 39 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40 00 Ν Ν no in column 2, for discharges on or after October 1. (see instructions) XVIII 1.00 2. 00 3. 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.

		N HOSPITAL			u of Form CMS-2				
SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	DATA	Provi der (Period: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part I Date/Time Pre 7/9/2021 10:1	pared			
	Y/N	I ME	Direct GME	I ME	Direct GME	/ aiii			
	1.00	2. 00	3. 00	4. 00	5. 00				
.00 Did your hospital receive FTE slots under ACA	N			0.00		61. (
section 5503? Enter "Y" for yes or "N" for no in									
column 1. (see instructions) .01 Enter the average number of unweighted primary care						61.			
FTEs from the hospital's 3 most recent cost reports									
ending and submitted before March 23, 2010. (see									
instructions) .02 Enter the current year total unweighted primary care	۵					61.			
FTE count (excluding OB/GYN, general surgery FTEs,						01.			
and primary care FTEs added under section 5503 of									
ACA). (see instructions) .03 Enter the base line FTE count for primary care						61.			
and/or general surgery residents, which is used for						01.			
determining compliance with the 75% test. (see									
instructions) .04 Enter the number of unweighted primary care/or						61.			
surgery allopathic and/or osteopathic FTEs in the						01.			
current cost reporting period (see instructions).									
05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's						61.			
primary care and/or general surgery FTE counts (line	e								
61.04 minus line 61.03). (see instructions)									
.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.			
care or general surgery. (see instructions)									
	Pro	gram Name	Program Code		Unwei ghted				
				IME FTE Count	Direct GME FTE Count				
		1. 00	2.00	3. 00	4. 00				
.10 Of the FTEs in line 61.05, specify each new program				0.00	0. 00	61.			
specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in									
column 1, the program name. Enter in column 2, the									
program code. Enter in column 3, the IME FTE									
unweighted count. Enter in column 4, the direct GME FTE unweighted count.									
. 20 Of the FTEs in line 61.05, specify each expanded				0.00	0. 00	61.			
program specialty, if any, and the number of FTE									
residents for each expanded program. (see instructions) Enter in column 1, the program name.									
Enter in column 2, the program code. Enter in column	n								
3, the IME FTE unweighted count. Enter in column 4,									
the direct GME FTE unweighted count.									
					1. 00				
ACA Provisions Affecting the Health Resources and S									
.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru		lin this cos	t reporting pe	eriod for which	0. 00	62.			
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62									
during in this cost reporting period of HRSA THC program. (see instructions)									
		200				I			
Teaching Hospitals that Claim Residents in Nonprovi			cost reporting	neriod2 Enter	N	63			
Teaching Hospitals that Claim Residents in Nonprovi	setti ngs	during this			N	63.			
Teaching Hospitals that Claim Residents in Nonprovi .00 Has your facility trained residents in nonprovider	setti ngs	during this			N Ratio (col. 1/ (col. 1 +	63.			

	"Y" for yes or "N" for no in column I. If yes, complete lines 64 through 6	o/. (see instri	JCTI ONS)		
		Unwei ghted	Unwei ghted	Ratio (col.	
		FTEs	FTEs in	1/ (col. 1 +	
		Nonprovi der	Hospi tal	col. 2))	
		Si te			
ı		1. 00	2. 00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings1	Γhis base year	is your cost	reporti ng	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
(64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0.000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTEs FTEs in 3/(col. 3 +col. 4)) Nonprovi der Hospi tal 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? 70.00 70.00 N Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N"

			1.00	2.00 3	. 00
6. 00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in t recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y,	"N" for			0 7
	indicate which program year began during this cost reporting period. (see instructions)				
				1. 00	
	Long Term Care Hospital PPS				
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	peri od? l	Enter	N N	3
6. 00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		no.	N	8
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section			N	8
	1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				
		1. 00		2. 00	
	Title V and XIX Services	1.00		2.00	
0. 00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Υ	9
. 00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N	ç
. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		ŀ	N	ç
. 00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	ç
00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	ç
00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0. 00		0. 00	9
. 00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	Ġ
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 N		0. 00 Y	ç
01	Column 1 of title V, and in Column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ	ç
02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ	ç
03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	Ç
	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N	Ç
	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ	Ç
06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y	Ç
5 00	Rural Providers Does this hospital qualify as a CAH?	Y			10
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment	N			10
7. 00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or LRF unit(s)?	N			10
	Enter "Y" for yes or "N" for no in column 2. (see instructions) Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			10

131.00

date in column 1 and termination date, if applicable, in column 2.

date in column 1 and termination date, if applicable, in column 2.

131.00 If this is a Medicare certified intestinal transplant center, enter the certification

Health Financial Systems	IU HEALTH TIP					of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provi der CC	CN: 15-1311		: 1/01/2020 2/31/2020	Worksheet S- Part I Date/Time Pr	
				10 1	2/31/2020	7/9/2021 10:	
					1. 00	2. 00	_
32.00 If this is a Medicare certified in column 1 and termination date,			ication dat		1.00	2.00	132.00
33.00 Removed and reserved 34.00 If this is an organ procurement o and termination date, if applicab		the OPO number	in column 1				133. 00 134. 00
All Providers 40.00 Are there any related organization chapter 10? Enter "Y" for yes or	n or home office costs as				Υ	15H059	140. 00
are claimed, enter in column 2 th		r. (see instruc			3. 00		
If this facility is part of a cha office and enter the home office	in organization, enter on	lines 141 thro	ough 143 the	name ar		of the home	
41.00 Name: INDIANA UNIVERSITY HEALTH 42.00 Street: 340 WEST 10TH STREET	Contractor's Name: WF		Contrac	tor's Nu	ımber: 0810	1	141. 00 142. 00
43.00 City: INDIANAPOLIS	State: IN	N	Zi p Coo	le:	4620	2	143. 0
			<u> </u>				
44.00 Are provider based physicians' co	sts included in Worksheet	Α?				1. 00 Y	144.00
The provider sassa prijererane	oto moradou m nomonec	,					
45.00 f costs for renal services are c	laimed on Wkst A line 7/	1 are the cost	s for		1. 00	2. 00	145. 00
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no ir clude Medicare utilizatior	n column 1. If	column 1 is				
46.00Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub.			lf	N		146. 0
						1. 00	-
47.00 Was there a change in the statist						N	147. 0
48.00 Was there a change in the order o 49.00 Was there a change to the simplif				or no		N N	148. 00
47. 00 was there a change to the shiphin	rea cost finding method: L	Part A	Part B		itle V	Title XIX	147.0
<u> </u>		1.00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal		N	N	. (000	N N	N	155. 0
56.00 Subprovi der - IPF		N	N		N	N	156. 0
57.00 Subprovi der - IRF		N	N		N	N	157. 0
58. OO SUBPROVI DER 59. OO SNF		N	l N		N	N	158. 00 159. 00
60. OOHOME HEALTH AGENCY		N N	N N		N	N	160. 0
61. 00 CMHC			N		N	N	161. 0
						1. 00	
Multicampus 65.00 s this hospital part of a Multic	ampus hospital that has or	ne or more camp	uses in dif	ferent C	BSAs?	N	165. 00
Enter "Y" for yes or "N" for no.		<u> </u>					
	Name O	County 1.00	2. 00	i p Code 3.00	4. 00	FTE/Campus 5.00	
66.00 f line 165 is yes, for each	Ü	1.00	2.00	0.00	1.00		0 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						1. 00	
Health Information Technology (HI				nent Act			
67.00 s this provider a meaningful use 68.00 of this provider is a CAH (line 1) reasonable cost incurred for the	05 is "Y") and is a meanir	ngful user (lin		"), ente	r the	Y	167. 00 168. 00
68.01 If this provider is a CAH and is	not a meaningful user, doe	es this provide			dshi p	N	168. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful transition factor. (see instructi	user (line 167 is "Y") and				enter the	0.0	00169.00

Health Financial Systems	In Lieu of Form CMS-2552-10				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	CATION DATA	Peri od: From 01/01/2020			
			To 12/31/2020	Date/Time Pre 7/9/2021 10:1	7 am
	Begi nni ng	Endi ng			
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have section 1876 Medicare cost plans reported o "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instru-	on	17	171.00		

Heal th	Financial Systems IU HEALTH TIP	TON HOSPITAL		Inlie	u of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider Co		Peri od: From 01/01/2020 To 12/31/2020	Worksheet S-2 Part II	epared:
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter I	N for all NO re	esponses. Ent	1.00 er all dates in	2.00 the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in	e beginning of	the cost	N		1.00
	preporting period: IT yes, enter the date of the change ITI	cordiiir 2. (See	Y/N	Date	V/I	
0.00	In the state of th	2.16	1.00	2. 00	3. 00	0.00
2. 00	Has the provider terminated participation in the Medicare I yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	mn 3, "V" for	N			2.00
3. 00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providences, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)		3.00			
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date avaccolumn 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A	02/25/2021	4.00
5. 00	Are the cost report total expenses and total revenues differentiates on the filed financial statements? If yes, submit re-		N			5.00
	-			Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities				2.00	
6.00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		he provider i			6.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
10.00	Was an approved Intern and Resident GME program initiated of cost reporting period? If yes, see instructions.		the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
					Y/N 1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? In	fyes, see in	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost report		yes, see ins t A	tructions.	N t B	15. 00
		Y/N	Date	Y/N	Date	
	PS&R Data	1. 00	2. 00	3.00	4. 00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	N		N		16.00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Υ	04/02/2021	Y	04/02/2021	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions.	N		N		19.00

IRSPITAL AND HISPITAL HEALTH CARE RETURNISHENT QUESTIONALER Provider CCN: 15-1311 Period 17/10/2002 Period 17/10/2002 Period 17/10/2002 Period 17/10/2002 Period 17/10/2002 Period 17/10/2002 Period 17/10/20110: 17 as 17/2002 Period 17/2	Heal th	Financial Systems IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CM:	S-2552-10			
20.00 If Films 16 or 17 is yes, were adjustments made to PS&R N N N 20.00	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			From 01/01/2020 To 12/31/2020	Part II Date/Time P 7/9/2021 10	repared:			
Report data for Other? Describe the other adjustments: Y/N Date										
Report data for Other? Describe the other adjustments: Y/N Date Y/N Date Da	2000	If line 16 or 17 is was were adjustments made to DS&D		Ü			20, 00			
21.00 Was the cost report prepared only using the provider's N 21.00 3.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00 2.00 4.00	20.00				IV.	IN.	20.00			
21.00 Was the cost report prepared only using the provider's N N 21.00			Y/N	Date	Y/N	Date				
records? If yes, see instructions. 1.00				2.00		4. 00				
Complete By COST RELIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related CoSt Apple Have assests been relifed for Medicare purposes? If yes, see instructions 1. 22.00 Apple Have assests been relifed for Medicare purposes? If yes, see instructions 2. 00 Apple Have assests been relifed for Medicare depreciation expense due to appraisals made during the cost 1. 22.00 Apple Have assests and or amendments to existing leases entered into during this cost reporting period? In 24.00 Apple Have releases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 1. 25.00 Apple Have releases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 1. 25.00 Apple Have releases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 1. 25.00 Apple Have releases and apple Have released	21. 00		N		N		21.00			
Complete By COST RELIMBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related CoSt Apple Have assests been relifed for Medicare purposes? If yes, see instructions 1. 22.00 Apple Have assests been relifed for Medicare purposes? If yes, see instructions 2. 00 Apple Have assests been relifed for Medicare depreciation expense due to appraisals made during the cost 1. 22.00 Apple Have assests and or amendments to existing leases entered into during this cost reporting period? In 24.00 Apple Have releases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 1. 25.00 Apple Have releases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 1. 25.00 Apple Have releases and/or amendments to existing leases entered into during this cost reporting period? If yes, see 1. 25.00 Apple Have releases and apple Have released						1 00				
Capital Related Cost Cost Capital Related Cost N 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions N 23.00 Reporting period? If yes, see instructions N 23.00 Reporting period? If yes, see instructions N 24.00 Reporting period? If yes, see instructions N 24.00 Reporting period? Reporting period? N 24.00 Reporting period? Reporting period? Reporting period? N 25.00 Reporting period? Reporting period. Reporting		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1.00				
23.00 lave changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 reporting period? If yes, see instructions N 24.00 Nor new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions N 25.00 Nor assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 25.00 Instructions N 26.00 Instruction				,						
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 N 24.0	22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22. 00			
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see Instructions N 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 Instructions. N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Instructions. N 27.00 Instructions. N 27.00 Instructions N 27.00 Instructions N 28.00 Instructi	23.00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made dur	ing the cost	N	23.00			
If yes, see instructions										
Sample S	24. 00		ed into during	this cost re	eporting period?	N	24. 00			
instructions. 20.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see	25. 00		the cost repo	rtina period?	Plf ves. see	N	25.00			
Instructions. 27.00 As the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00					,,					
27.00 what the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. Interest Expense	26.00		he cost report	ing period? I	f yes, see	N	26.00			
Copy. Interest Expense										
Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N period? If yes, see instructions. 28.00 Period? If yes, see instructions N 29.00 Treated as a funded depreciation account? If yes, see instructions N 29.00 Treated as a funded depreciation account? If yes, see instructions N 30.00 Instructions	27. 00	, , , , , , , , , , , , , , , , , , , ,	e cost reporti	ng period? If	yes, submit	N	27.00			
28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 trated as a funded depreciation account? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see Instructions. 33.00 If I ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see Instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If Jine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If Iine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If Iine 36 is yes, has a home office cost statement been prepared by the home office? Y 37.00 If Jine 36 is yes, were there new agreements or amended existing agreements with the provider-based N 37.00 If Iine 36 is yes, we will not the provider facility under an arrangement with provider-based N 35.00 If Iine 36 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If Jine 36 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If Jine 36 is yes, were there new agree										
period? If yes, see instructions. 20.00 Id the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Id as existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 If ilne 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If ilne 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. 36.00 Were home office Costs 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider preys, see instructions. 38.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes enstructions. 38.00 If line 36 is yes, did the provider render services to the home office? 39.00 If line 36 is yes, did the provider render services to the home office? If yes, see Instructions. 39.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the lengthous number and email address of the cost 317. 962.1093 37.00 If until the cost is	28. 00	<u> </u>	ntered into du	ring the cost	reporting	N	28.00			
treated as a funded depreciation account? If yes, see instructions 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Instructions. 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Instructions. 10.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 If I ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 10.00 If I ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 11.00 If I ine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 12.00 If I ine 32 is yes, were there new agreements or amended existing agreements with the provider-based physicians? If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If I ine 36 is yes, as a home office cost statement been prepared by the home office? Y 37.00 If I ine 36 is yes, as a home office cost statement been prepared by the home office? Y 37.00 If I ine 36 is yes, as a home office cost statement been prepared by the home office? Y 37.00 I ine 36 is yes, did the provider render services to other chain components? If yes, Y 37.00 I ine 36 is yes, did the provider render services to the home office? If yes, see N 40.00 I instructions. 11.00 Enter the first name, I ast name and the title/position held by the cost report p				3	, ,					
30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 32.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 34.00 Are services Turnished at the provider facility under an arrangement with provider-based physicians? Provider-Based Physicians 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Y 37.00 If yes, see instructions. 38.00 If line 36 is yes, has a home office cost statement been prepared by the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, ye instructions. 10.00 If line 36 is yes, did the provider render services to other chain components? If yes, ye instructions. 11.00 2.00 12.00 If line 36 is yes, did the provider render services to the home office. 12.00 If line 36 is yes, did the provider render services to other chain components? If yes, ye instructions. 13.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 14.00 Enter the first name, liast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 14.00 Enter the employer/company name of the cost report preparer. 15.00 Indicate the telephone number and email address of the cost and analyses of the cost analyses of the cost analyses of the line and analyses of the cost analyses of the cost analyses o	29. 00			ebt Service F	Reserve Fund)	N	29. 00			
instructions. At debt been recalled before scheduled maturity without issuance of new debt? If yes, see Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual Arrangements with suppliers of services? If yes, see instructions. 32.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 40.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 41.00 English Sec. 1 42.00 English Sec. 1 42.00 English Sec. 2 43.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. At the provider? If yes, enter in column 2 the fiscal year end of the home office. At the provider? If yes, enter in column 2 the fiscal year end of the home office. At the provider? If yes, enter in column 2 the fiscal year end of the home office. At the provider? If yes, did the provider render services to other chain components? If yes, see instructions. At the provider? If yes, did the provider render services to the home office? If yes, see Instructions. At the provider? Preparer Contact Information At the provider Preparer Contact Information At the provider Preparer Contact Information At the provider of the provider render services to the home office? If yes, see At 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. At 1.00 Enter the enter the enter the enter the provider and email address of the cost At 1.00 Enter the enter										
31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00	30. 00	i i	urity with new	debt? If yes	s, see	N	30.00			
Purchased Services Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 More home office costs claimed on the cost report? Y	31. 00	Has debt been recalled before scheduled maturity without i	s, see	N	31.00					
Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 33.00 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions. 33.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If yes, see instructions. Y/N Date										
33.00 If line 32 is yes, we're the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If no, see instructions. 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions. 35.00 If line 34 is yes, we're there new agreements or amended existing agreements with the provider-based November of the physicians during the cost reporting period? If yes, see instructions. No	32.00		rvices furnish	ed through co	ntractual	N	32.00			
Provider-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00	33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competi	tive bidding? If		33.00			
34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs										
If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00	24.00			h			24.00			
35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00	34.00		rrangement wit	n provider-ba	ised physicians?	Y	34.00			
Home Office Costs	35. 00	If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based	N	35. 00			
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the employer/company name of the cost report preparer. 42.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER®IUHEALTH. ORG		11. J			Y/N	Date				
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, you see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see North 1.00 North										
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider render services to other chain components? If yes, yes, did the provider end of the home office.										
If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 Instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 41.00 Enter the employer/company name of the cost report INDIANA UNIVERSITY HEALTH Preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG										
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see N 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, see	37. 00		repared by the	home office?	' Y		37.00			
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes e instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00	38. 00	If line 36 is yes , was the fiscal year end of the home of			- N		38. 00			
see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 40.00 Adv. 00 RHONDA UTTER 41.00 RUTTER@IUHEALTH. ORG 43.00	39. 00	, ,			s, Y		39. 00			
instructions. 1.00 2.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@I UHEALTH. ORG 43.00		see instructions.	•	,						
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	40. 00		home office?	If yes, see	N		40.00			
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00			1	00	2	00				
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 43.00										
respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH. ORG 43.00	41. 00	Enter the first name, last name and the title/position	RHONDA		UTTER		41.00			
preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@I UHEALTH. ORG 43.00	40.00	respecti vel y.	LND ANA	OLTV 11541 T.:			40.05			
43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	42.00		INDIANA UNIVER	OLLY HEALIH			42.00			
	43. 00	Enter the telephone number and email address of the cost	317. 962. 1093		RUTTER@I UHEALT	H. ORG	43.00			

Heal th	Financial Systems	HEALTH TIE	PTON HOSPITAL			In Lie	u of Form CMS-2	2552-10
HOSPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIO	Provi der	CCN: 15-		eriod: rom 01/01/2020	Worksheet S-2 Part II		
						o 12/31/2020		pared: 7 am
				3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/pos	sition	DI RECTOR OF	GOVERNME	NT			41.00
	held by the cost report preparer in columns 1, 2,	, and 3,	PROGRAMS					
	respecti vel y.							
42.00	Enter the employer/company name of the cost report	rt						42.00
	preparer.							
43.00	Enter the telephone number and email address of	the cost						43.00
	report preparer in columns 1 and 2, respectively.							

 Health Financial
 Systems
 IU HEALT

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | Date/Time Prepared: | Provi der CCN: 15-1311

						o 12/31/2020	Date/Time Pre 7/9/2021 10:1	
							I/P Days /	, dili
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 150	46, 512. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2.00
2.00	HMO and other (see instructions)							2.00 3.00
3. 00 4. 00	HMO IPF Subprovider							4.00
5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF						0	6.00
7. 00	Total Adults and Peds. (exclude observation			25	9, 150	46, 512. 00		7.00
7.00	beds) (see instructions)			25	7, 150	40, 512.00	U	7.00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY							13.00
14.00	Total (see instructions)		İ	25	9, 150	46, 512. 00	0	14.00
15.00	CAH visits		İ		1		0	15.00
16.00	SUBPROVIDER - IPF							16. 00
17.00	SUBPROVI DER - I RF							17.00
18.00	SUBPROVI DER							18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGI CAL 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
26. 00	RURAL HEALTH CLINIC						_	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25			0	27. 00
28. 00	Observation Bed Days						0	28. 00
29.00	Ambul ance Trips							29. 00 30. 00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - LRF							30.00
31.00	Labor & delivery days (see instructions)			0				31.00
32. 00	Total ancillary labor & delivery room			U				32.00
JZ. U1	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33. 01
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	ı	1		1	1		

Provider CCN: 15-1311

Period: Worksheet S-3
From 01/01/2020 Part I
To 12/31/2020 Date/Time Prepared:
7/0/2021 10: 17 am

						7/9/2021 10: 1	7 am
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
				•		·	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 146	4	1, 938	3		1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	458	115				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	224	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	36			6.00
7. 00	Total Adults and Peds. (exclude observation	1, 370	4	2, 198	3		7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14.00	Total (see instructions)	1, 370	4	2, 198	0. 00	170. 17	
15. 00	CAH visits	0	0	()		15.00
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			C	,		24. 10
25. 00 26. 00	CMHC						25. 00 26. 00
		0	0	(0.00	0.00	
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	۷	U		0.00		
28. 00	1 '		0	390		170.17	28.00
29. 00	Observation Bed Days Ambulance Trips	0	U	390	,		29.00
30.00	Employee discount days (see instruction)	٥		(,		30.00
31.00	Employee discount days (see Histruction)						31.00
32.00	Labor & delivery days (see instructions)	0	0	· ·			32.00
32. 00	Total ancillary labor & delivery room	١	U				32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	l o					33. 01
55.51	1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 = 1 =	۱ ۲		ı	1	I	1 30.01

| Period: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:
 Health Financial
 Systems
 IU HEALT

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1311

				To	12/31/2020	Date/Time Prep 7/9/2021 10:1	
		Full Time		Di sch	arges	77 77 2021 1011	, (111
		Equi val ents		1			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	322	2	545	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			110	20		2 00
2.00	HMO and other (see instructions)			110	28 0		2.00
3.00	HMO IPF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				U		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						8. 00
8. 00 9. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	0	322	2	545	14. 00
15. 00	CAH visits	0.00	Ü	322	2	343	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	·					24. 10
25. 00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0		l	33. 01

	AL UNCOMPENSATED AND INDIGENT CARE DATA Provi	der CCN: 1		Peri od:	Worksheet S-1	2552 0
				From 01/01/2020		
				To 12/31/2020	Date/Time Pre 7/9/2021 10:1	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	d by line	202 colum	า 8)	0. 319824] 1.
	Medicaid (see instructions for each line)					
00	Net revenue from Medicaid				2, 779, 344	
00	Did you receive DSH or supplemental payments from Medicaid?		M!! -	-: -10	N N	3
00 00	If line 3 is yes, does line 2 include all DSH and/or supplemental particle of the line 4 is no, then enter DSH and/or supplemental payments from N		rom wearc	ai a ?	0	5
00	Medicaid charges	near car a			18, 345, 822	
00	Medicaid cost (line 1 times line 6)				5, 867, 434	
00	Difference between net revenue and costs for Medicaid program (line	e 7 minus	sum of li	nes 2 and 5; if	3, 088, 090	
	< zero then enter zero)					
20	Children's Health Insurance Program (CHIP) (see instructions for ea	nch line)			1 0	_
00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0 0	
00	Stand-alone CHIP cost (line 1 times line 10)				0	
00	Difference between net revenue and costs for stand-alone CHIP (line	e 11 minus	line 9:	f < zero then	Ö	1
	enter zero)					
	Other state or local government indigent care program (see instruct					
00	Net revenue from state or local indigent care program (Not included				830	
00	Charges for patients covered under state or local indigent care pro	ogram (Not	i nci uded	in lines 6 or	4, 442	14
00	State or local indigent care program cost (line 1 times line 14)				1, 421	15
00	Difference between net revenue and costs for state or local indigen	nt care pr	ogram (li	ne 15 minus line		
	13; if < zero then enter zero)	<u>'</u>				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP an		!:	ant care progre		
	instructions for each line)	na state/i	ocai indi	gent care progra	ams (see	
	instructions for each line) Private grants, donations, or endowment income restricted to fundin	ng charity	care	gent care progra	0	
. 00	instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi	ng charity tal opera	care iti ons	· · ·	0 0	18
. 00 . 00 . 00	instructions for each line) Private grants, donations, or endowment income restricted to fundin	ng charity tal opera	care iti ons	· · ·	0	18
00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local inc</pre>	ng charity tal opera digent car	care itions e program	s (sum of lines	0 0 3, 088, 681 Total (col. 1	18
00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local inc</pre>	ng charity tal opera digent car	care itions re program: ininsured patients	s (sum of lines	0 0 3,088,681 Total (col. 1 + col. 2)	18
00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fundin Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local inc</pre>	ng charity tal opera digent car	care itions e program	s (sum of lines	0 0 3, 088, 681 Total (col. 1	18
00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local income, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility	ng charity tal opera digent car	care itions re program: ininsured patients	s (sum of lines Insured patients 2.00	0 0 3,088,681 Total (col. 1 + col. 2) 3.00	18 19
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions)	ng charity tal opera digent car U	r care itions e program ininsured catients 1.00	s (sum of lines Insured patients 2.00 58,533	0 0 3, 088, 681 Total (col. 1 + col. 2) 3. 00	18 19
00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts	ng charity tal opera digent car U	care itions re program ininsured patients 1.00	s (sum of lines Insured patients 2.00 58,533	0 0 3, 088, 681 Total (col. 1 + col. 2) 3. 00	18 19
. 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosping Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions)	ng charity tal opera digent car U ty (see	r care iti ons re program: ini nsured cati ents 1.00 876, 15	Insured patients 2.00 58,533 4 58,533	0 0 3,088,681 Total (col. 1 + col. 2) 3.00 934,683 338,747	18 19 20 21
00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts	ng charity tal opera digent car U ty (see	r care iti ons re program: ini nsured pati ents 1.00 876, 15	s (sum of lines Insured patients 2.00 58,533	0 0 3,088,681 Total (col. 1 + col. 2) 3.00 934,683 338,747	18 19 20 21
00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosping Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off	ng charity tal opera digent car U ty (see	r care iti ons re program: ini nsured pati ents 1.00 876, 15	Insured patients 2.00 58,533 4 58,533 0 0	0 0 3,088,681 Total (col. 1 + col. 2) 3.00 934,683 338,747	20 21 22
00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ng charity tal opera digent car U ty (see	ni nsured patients 1.00 876, 15	Insured patients 2.00 58,533 4 58,533 0 0	0 0 3,088,681 Total (col. 1 + col. 2) 3.00 934,683 338,747 0	20 21 22
00 00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosping total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22)	ng charity tal opera digent car U I I I I I I I I I I I I I I I I I I	r care iti ons re program in insured pati ents 1.00 876, 15 280, 21	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747	20 21 22 23
00 00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospi Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care	ng charity tal operadigent can be seen to be	r care iti ons re program in insured pati ents 1.00 876, 15 280, 21	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533	0 0 3,088,681 Total (col. 1 + col. 2) 3.00 934,683 338,747 0	200 211 222 23
00 00 00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosping Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care proglif line 24 is yes, enter the charges for patient days beyond the incomes.	ng charity tal opera digent car U see as ays beyond gram?	ni nsured pati ents 1.00 876, 15 280, 21	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533 of stay limit	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747	20 21 22 23
00 00 00 00 00 00 00	instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hosping Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care programments.	ty (see as ays beyond gram?	ni nsured pati ents 1.00 876, 15 280, 21	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533 of stay limit	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747	20 21 22 23 24 25
00 00 00 00 00 00 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient dai imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit	ng charity tal opera digent car U I I I I I I I I I I I I I I I I I I	r care ations are programmer programmer programmer at length at length are programmer programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length are programmer at length at length are programmer at length are programmer.	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533 of stay limit	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747	20 21 22 23 24 25 26
00 00 00 00 00 00 00 00 00 01	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see instructions)	g charity tal opera digent car U I I I I I I I I I I I I I I I I I I	r care iti ons re program ni nsured pati ents 1.00 876, 15 280, 21 I a Length are program etti ons)	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533 of stay limit	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747 1.00 N 0 1, 481, 510 171, 520 263, 877	20 21 22 23 24 25 26 27 27
00 00 00 00 00 00 00 00 00 00 00 00 00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care proglif line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see instructions)	ays beyond gram? ndigent can	care itions re programs	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533 of stay limit m's length of	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747 1.00 N 0 1, 481, 510 171, 520 263, 877 1, 217, 633	200 211 222 233 244 25 26 27 27 28
.00	Instructions for each line) Private grants, donations, or endowment income restricted to funding Government grants, appropriations or transfers for support of hospit Total unreimbursed cost for Medicaid, CHIP and state and local incomes, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facilit (see instructions) Cost of patients approved for charity care and uninsured discounts instructions) Payments received from patients for amounts previously written off charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the instay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see instructions)	ays beyond gram? ndigent can	care itions re programs	Insured patients 2.00 58,533 4 58,533 0 0 4 58,533 of stay limit m's length of	0 0 3, 088, 681 Total (col. 1 + col. 2) 3.00 934, 683 338, 747 0 338, 747 1.00 N 0 1, 481, 510 171, 520 263, 877	20 21 22 23 24 25 26 27 27 28 29

Heal th	n Financial Systems	IU HEALTH TIPTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provi der Co		Peri od:	Worksheet A	
					From 01/01/2020		
					To 12/31/2020		
	Cost Center Description	Sal ari es	Other	Total (col 1	Reclassi fi cat	7/9/2021 10: 1 Recl assi fi ed	/ am
	cost center bescription	Sal al Les	other	+ col . 2)	i ons (See	Trial Balance	
				+ (01. 2)	A-6)	(col. 3 +-	
					h-0)	col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		0		0 766, 963	766, 963	1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES		0		0 658, 849	658, 849	1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 935, 043	935, 043	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	241, 702	19, 759	261, 46	1 2, 076, 372	2, 337, 833	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	951, 818	10, 318, 279			8, 796, 599	5.00
7.00	00700 OPERATION OF PLANT	891, 983	3, 516, 184	4, 408, 16	7 -24, 375	4, 383, 792	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	O	0		0 50, 172	50, 172	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	59, 571	85, 157	144, 72	8 -26, 972	117, 756	8.00
9.00	00900 HOUSEKEEPI NG	351, 341	263, 886	615, 22	7 -151, 369	463, 858	9.00
10.00	01000 DI ETARY	385, 073	545, 002	930, 07	5 -709, 394	220, 681	10.00
11. 00	01100 CAFETERI A	O	0		0 597, 274	597, 274	11.00
13.00	01300 NURSING ADMINISTRATION	623, 639	181, 108	804, 74	7 82, 190	886, 937	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	O	1, 792	1, 79	2 705, 782	707, 574	14.00
15.00		711, 978	5, 667, 792	6, 379, 77	0 -5, 209, 088	1, 170, 682	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 882, 063	1, 270, 715	3, 152, 77	8 -501, 571	2, 651, 207	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 010, 847	2, 671, 077	3, 681, 92	4 -2, 198, 940	1, 482, 984	50.00
53.00	05300 ANESTHESI OLOGY	179, 716	334, 239	513, 95	5 -23, 084	490, 871	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 072, 407	549, 203	1, 621, 61	0 -268, 188	1, 353, 422	54.00
60.00	06000 LABORATORY	0	1, 411, 862	1, 411, 86	2 0	1, 411, 862	60.00
65.00	06500 RESPI RATORY THERAPY	533, 410	200, 525	733, 93	5 -155, 666	578, 269	65.00
66.00		743, 285	417, 466	1, 160, 75	1 -391, 877	768, 874	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	183, 853	47, 940			251, 866	67.00
68. 00		22, 851	3, 701	26, 55	2 1, 089	27, 641	68. 00
69. 00		504, 218	231, 500	735, 71	8 -77, 462	658, 256	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 409, 034	409, 034	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 200, 134	1, 200, 134	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 996, 998	3, 996, 998	73.00
73. 01	03480 ONCOLOGY	216, 393	87, 461	303, 85	4 -50, 469	253, 385	73. 01
73. 02		0	0		0 1, 197, 921	1, 197, 921	73. 02
76.00		0	0		0 0	0	76. 00
76. 97		79, 584	21, 505	101, 08	9 -16, 718	84, 371	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 063, 963	1, 999, 794	3, 063, 75	7 -312, 414	2, 751, 343	91.00
92.00							92.00
	SPECIAL PURPOSE COST CENTERS						
118.0	, , ,	11, 709, 695	29, 845, 947	41, 555, 64	2 106, 809	41, 662, 451	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19200 PHYSICIANS' PRIVATE OFFICES	104, 443	93, 554			117, 009	
	1 19201 OCCUPATI ONAL MEDI CI NE	53, 385	83, 755	137, 14		111, 319	
	2 19202 VACANT SPACE	0	0		0 0		192. 02
200. 0	0 TOTAL (SUM OF LINES 118 through 199)	11, 867, 523	30, 023, 256	41, 890, 77	9 0	41, 890, 779	200. 00

Health FinancialSystemsIU HEALTH TO THE ALTH Provi der CCN: 15-1311

				7/9/2021 10: 1	
	Cost Center Description	Adjustments	Net Expenses	1 = = =	
	·	(See A-8)	For		
		,	Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	792, 494	1, 559, 457		1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	-550, 676	108, 173		1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	279, 710	1, 214, 753		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	228, 856	2, 566, 689	1	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-728, 141	8, 068, 458		5. 00
7.00	00700 OPERATION OF PLANT	-21, 881	4, 361, 911		7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	-50, 172	0		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	117, 756	,	8. 00
9.00	00900 HOUSEKEEPI NG	-61, 338	402, 520		9. 00
10.00	01000 DI ETARY	130	220, 811		10.00
11.00	01100 CAFETERI A	-136, 636	460, 638		11.00
13.00	01300 NURSING ADMINISTRATION	19, 500	906, 437		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	707, 574		14.00
15.00	01500 PHARMACY	-336, 443	834, 239	,	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·			1
30.00	03000 ADULTS & PEDIATRICS	-595, 089	2, 056, 118		30.00
	ANCILLARY SERVICE COST CENTERS				1
50.00	05000 OPERATING ROOM	-265, 956	1, 217, 028		50.00
53.00	05300 ANESTHESI OLOGY	-431, 452			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-133, 820			54.00
60.00	06000 LABORATORY	0	1, 411, 862		60.00
65.00	06500 RESPIRATORY THERAPY	0	578, 269		65.00
66.00	06600 PHYSI CAL THERAPY	0	768, 874		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	251, 866		67.00
68.00	06800 SPEECH PATHOLOGY	0	27, 641		68.00
69.00	06900 ELECTROCARDI OLOGY	-121, 406			69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	409, 034		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 200, 134		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	3, 996, 998		73.00
73. 01	03480 ONCOLOGY	0	253, 385		73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	1, 197, 921		73. 02
76.00	03160 CARDI OPULMONARY	0	0		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	84, 371		76. 97
	OUTPATIENT SERVICE COST CENTERS				
91.00	09100 EMERGENCY	-1, 055, 642	1, 695, 701		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-3, 167, 962	38, 494, 489	1	118.00
	NONREI MBURSABLE COST CENTERS				1
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	117, 009	,	192. 00
	19201 OCCUPATIONAL MEDICINE	0	111, 319	l control of the cont	192. 01
	19202 VACANT SPACE	0	0	l control of the cont	192.02
200.00		-3, 167, 962			200.00
	1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3			1	

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2020 Date/Time Prepared: 7/0/2021 10:17 am Provider CCN: 15-1311

					To 12/31/2020 Date/Time Pro 7/9/2021 10:	epared: 17 am
	Cost Contor	Increases	Coloru	Othor		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - DEPRECIATION					
1. 00 2. 00	CAP REL COSTS MANDE FOULD	1.00	0	553, 461 933, 043		1. 00 2. 00
2.00	CAP REL COSTS-MVBLE EQUIP		0	1, 486, 504		2.00
	B - INTEREST					1
1. 00	CAP REL COSTS-BLDG & FIXT -	1. 01	0	658, 849		1.00
2. 00	INTERES	0. 00	О	О		2.00
	0		0	658, 849		
1. 00	C - OTHER CAPITAL ADMINISTRATIVE & GENERAL	5. 00	0	5, 032		1.00
1.00	0			5, 032		1.00
1 00	D - EMPLOYEE BENEFITS	4 00		2.07/.040		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	2, 076, 349 0		1.00 2.00
3. 00		0. 00	Ö	Ö		3.00
4. 00		0. 00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0. 00	Ö	Ö		7. 00
8. 00		0. 00	o	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	0	0		11.00
12.00		0. 00	Ō	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0. 00	Ö	Ö		16.00
17. 00		0. 00	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20. 00		0.00	0	o		20.00
21. 00		0.00	0	0		21.00
	O E - CAFETERIA		0	2, 076, 349		-
1. 00	CAFETERI A	11. 00	281, 182	316, 092		1.00
	0		281, 182	316, 092		
1. 00	F - MEDICAL SUPPLIES EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	23		1.00
2. 00	OPERATION OF PLANT	7. 00	Ö	31, 227		2.00
3.00	NURSING ADMINISTRATION	13. 00	0	2, 924		3.00
4. 00 5. 00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO	14. 00 71. 00	0	705, 782 409, 034		4. 00 5. 00
3.00	PATI ENT	71.00		407, 034		3.00
6. 00	IMPL. DEV. CHARGED TO	72. 00	0	1, 200, 134		6. 00
7. 00	PATI ENTS	0. 00	o	0		7. 00
8. 00		0.00	Ö	Ö		8.00
9. 00		0. 00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10.00 11.00
12. 00		0. 00	o	Ö		12.00
13.00		0. 00	o	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	0	0		16.00
17.00		0.00	0	0		17. 00
	O G - DRUGS		0	2, 349, 124		
1. 00	PHARMACY	15. 00	0	45, 967		1.00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	0	5, 194, 919		2.00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6.00		0. 00	o	0		6.00
7.00		0.00	0	0		7.00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	o		10.00
11.00		0.00	o	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
13.00			0	5, 240, 886		13.00
		I	-1	. ,		•

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-1311	Period: Worksheet A-6 From 01/01/2020

					To 12/31/2020 Date/Time Pro 7/9/2021 10:	
		Increases		·		
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	H - ORTHOPEDIC CLERICAL STAFF					
1.00	OCCUPATI ONAL THERAPY	67. 00	53, 465	0		1.00
2.00	SPEECH PATHOLOGY	6800	2, 027	0		2.00
	0		55, 492	0		
	I - VP OF NURSING					
1.00	NURSING ADMINISTRATION	13. 00	17 <u>8, 6</u> 06	0		1.00
	0		178, 606	0		
	J - MAINTENANCE & LEASE EXPEN	ISE				
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	166, 567		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 348		2. 00
3.00	OPERATION OF PLANT	7. 00	0	6, 199		3.00
4.00	OPERATION OF PLANT - OFFSITE	7. 01	0	5 <u>0, 1</u> 72		4.00
	0		0	224, 286		
	L - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	51, 967		1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0			2. 00
	0		0	53, 967		
	M - INFUSION DRUGS					
1.00	BLOOD DI SORDER DRUGS	73. 02	0	1, 197, 921		1.00
	TOTALS		0	1, 197, 921		
500.00	Grand Total: Increases		515, 280	13, 609, 010		500.00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-1311

Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am

		Decreases				1/9/2021 10:	17 am
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8. 00	9. 00	10.00		
	A - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 477, 569	9		1.00
2.00	OPERATION OF PLANT	7.00	0	<u>8, 9</u> 35	9		2.00
	0		0	1, 486, 504]
	B - INTEREST						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	657, 308			1.00
2. 00	OPERATION OF PLANT	7.00	0	1, 541			2.00
	0		0	658, 849)		_
1 00	C - OTHER CAPITAL	1 00	ما	F 022	1.0		1 00
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,032			1.00
	D - EMPLOYEE BENEFITS		U	5, 032			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	102, 021	0		1.00
2. 00	OPERATION OF PLANT	7. 00	0	51, 325			2.00
3. 00	LAUNDRY & LINEN SERVICE	8.00	o	26, 972			3.00
4. 00	HOUSEKEEPI NG	9. 00	Ö	133, 088			4.00
	DI ETARY	10.00	o	112, 097			5.00
	NURSING ADMINISTRATION	13. 00	Ö	99, 340			6.00
7. 00	PHARMACY	15. 00	0	104, 435			7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	388, 689	0		8.00
9. 00	OPERATING ROOM	50.00	0	198, 032	0		9.00
10.00	ANESTHESI OLOGY	53.00	0	7, 591	0		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	204, 276	0		11.00
	RESPI RATORY THERAPY	65. 00	0	119, 504			12.00
	PHYSI CAL THERAPY	66. 00	0	143, 311			13. 00
	OCCUPATI ONAL THERAPY	67. 00	0	32, 779			14. 00
	SPEECH PATHOLOGY	68. 00	0	915			15.00
	ELECTROCARDI OLOGY	69.00	0	54, 804			16.00
	ONCOLOGY	73. 01	0	34, 377			17.00
	CARDI AC REHABI LI TATI ON	76. 97	0	15, 879	1		18.00
	EMERGENCY PHYSICIANS' PRIVATE OFFICES	91.00	0	203, 019			19. 00 20. 00
	OCCUPATIONAL MEDICINE	192. 00 192. 01	0	29, 515 14, 380			21.00
21.00	OCCOPATIONAL MEDICINE	192.01		2, 076, 349			21.00
	E - CAFETERIA		<u> </u>	2,070,017			
1.00	DI ETARY	10.00	281, 182	316, 092	2 0		1.00
	0 — — — — — —		281, 182	316, 092			
	F - MEDICAL SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	10, 330			1.00
2.00	HOUSEKEEPI NG	9. 00	0	18, 281			2. 00
	DI ETARY	10. 00	0	23			3. 00
	PHARMACY	15. 00	0	33, 536			4.00
5. 00	ADULTS & PEDIATRICS	30.00	0	105, 864			5.00
6. 00	OPERATING ROOM	50.00	0	1, 989, 782			6.00
7. 00 8. 00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54.00	0	17, 929			7.00
9. 00	PHYSI CAL THERAPY	65. 00	0	35, 927			9.00
	OCCUPATIONAL THERAPY	66. 00 67. 00	0	19, 163 613			10.00
	SPEECH PATHOLOGY	68.00	0	23			11.00
	ELECTROCARDI OLOGY	69. 00	Ö	8, 663			12.00
	ONCOLOGY	73. 01	0	13, 279			13.00
	CARDI AC REHABI LI TATI ON	76. 97	Ö	830			14.00
	EMERGENCY	91.00	0	92, 305			15.00
	PHYSICIANS' PRIVATE OFFICES	192. 00	0	848			16.00
17.00	OCCUPATIONAL MEDICINE	192. 01	0	1, 728	0		17.00
	0		0	2, 349, 124			
	G - DRUGS						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	77	1		1.00
	PHARMACY	15. 00	0	5, 117, 084			2.00
3. 00	ADULTS & PEDIATRICS	30.00	0	7, 018			3.00
4. 00	OPERATING ROOM	50.00	0	11, 126			4.00
5.00	ANESTHESI OLOGY	53.00	0	15, 493			5.00
6. 00 7. 00	RADI OLOGY-DI AGNOSTI C	54. 00 65. 00		45, 983			6.00
7. 00 8. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	66. 00	0	235 250			7. 00 8. 00
	ELECTROCARDI OLOGY	69.00	0	13, 995			9.00
	ONCOLOGY	73. 01	0	2, 813			10.00
	CARDI AC REHABI LI TATI ON	76. 97	o	2,013			11.00
	EMERGENCY	91.00	Ö	17, 090			12.00
	OCCUPATIONAL MEDICINE	192. 01	o	9, 713			13.00
	<u> </u>		₀	5, 240, 886			
		·	•		·		

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-1311	Period: Worksheet A-6 From 01/01/2020
		To 12/31/2020 Date/Time Prepared:

						To 12/31/2020 Date/Time Pr 7/9/2021 10:	repared: :17 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSI CAL THERAPY	66. 00	55, 492	0	0		1.00
2.00		000	0	0	0		2. 00
	0		55, 492	0			
	I - VP OF NURSING						
1.00	ADMI NI STRATI VE & GENERAL	5. 00	17 <u>8, 6</u> 06	0	0		1.00
	0		178, 606	0			
	J - MAINTENANCE & LEASE EXPEN						
1. 00	PHYSI CAL THERAPY	66. 00	0	173, 661			1. 00
2. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	50, 625	0		2. 00
3.00		0. 00	0	0	0		3. 00
4. 00				0	0		4. 00
	0		0	224, 286			
	L - PROPERTY INSURANCE						
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	53, 967	12		1.00
2. 00				0	12		2. 00
	0		0	53, 967			
	M - INFUSION DRUGS						
1. 00	DRUGS CHARGED TO PATIENTS	7300		<u>1, 197, 9</u> 21			1. 00
	TOTALS		0	1, 197, 921			
500.00	Grand Total: Decreases		515, 280	13, 609, 010			500.00

Provider CCN: 15-1311

				To	12/31/2020		
				A = = :		7/9/2021 10: 1	/ am
		D	D	Acqui si ti ons	Title	D	
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances	0.00	0.00	4.00	Retirements	
	DART	1.00	2. 00	3. 00	4. 00	5. 00	
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	I BALANCES					
1.00	Land	0	0	0	0	0	1
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	2, 872, 457	0	0	0	0	4. 00
5. 00	Fixed Equipment	0	0	0	0	0	5. 00
6. 00	Movable Equipment	12, 249, 840	719, 748	0	719, 748	1, 629, 180	6. 00
7.00	HIT designated Assets	964, 363	-123, 712	0	-123, 712	0	7. 00
8.00	Subtotal (sum of lines 1-7)	16, 086, 660	596, 036	0	596, 036	1, 629, 180	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	16, 086, 660	596, 036	0	596, 036	1, 629, 180	10.00
		Endi ng	Ful I y				
		Bal ance	Depreciated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0				1.00
2.00	Land Improvements	O	0				2.00
3.00	Buildings and Fixtures	O	0				3.00
4.00	Building Improvements	2, 872, 457	372, 370				4. 00
5.00	Fi xed Equi pment	0	0				5.00
6.00	Movable Equipment	11, 340, 408	7, 154, 001				6.00
7.00	HIT designated Assets	840, 651	0				7.00
8. 00	Subtotal (sum of lines 1-7)	15, 053, 516	7, 526, 371				8. 00
9. 00	Reconciling Items	0	0				9.00
10. 00	Total (line 8 minus line 9)	15, 053, 516	7, 526, 371				10.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C	CN: 15-1311	Peri od: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part II Date/Time Pre 7/9/2021 10:1	pared:
	SUMMARY OF CAPITAL					
Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
				(see instructions)	instructions)	
	9. 00	10. 00	11.00	12. 00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00
1.01 CAP REL COSTS-BLDG & FIXT - INTERES	0	0		0	0	1. 01
2.00 CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2.00
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at					
	ed Costs (see	9 through 14)				
	instructions)					
	14. 00	15. 00				

		14.00	15.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLU	MN 2, LINES 1	and 2	
1.00	CAP REL COSTS-BLDG & FIXT	C)		1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	C) (1.01
2.00	CAP REL COSTS-MVBLE EQUIP	C) (2.00
3.00	Total (sum of lines 1-2)	C) (3.00
		•			

llool +h	Financial Cyatama	III UEALTH TID	TON HOODITAL		ملاها	u of Form CMS-2	NEEO 10
Health Financial Systems RECONCILIATION OF CAPITAL COSTS CENTERS				F	Period: From 01/01/2020 To 12/31/2020	Worksheet A-7 Part III Date/Time Pre 7/9/2021 10:1	pared:
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	3, 713, 108	0	3, 713, 108		0	1.00
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	(0. 000000		1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	11, 340, 407	0	11, 340, 407			2.00
3. 00	Total (sum of lines 1-2)	15, 053, 515		15, 053, 515			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	(1, 376, 531	135, 991	1.00
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	0	0	(364, 711	0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(1, 212, 753		2.00
3.00	Total (sum of lines 1-2)	0	0	(2, 953, 995	135, 991	3.00
			SL	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
	'		(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)	,	
		11. 00	12. 00	13. 00	14.00	15. 00	
	DADT III DECONCILIATION OF CADITAL COSTS C	ENTERC					

0 -256, 538

-256, 538

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-BLDG & FIXT - INTERES

CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)

51, 967

2, 000 53, 967

-5, 032

0 0 0 -5, 032

0 0 0

1, 559, 457 108, 173 1, 214, 753 2, 882, 383

1.01

2.00

1.00

1.01

2. 00

3.00

Provi der CCN: 15-1311 ADJUSTMENTS TO EXPENSES Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 1.00 COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL 1.01 В -915, 387 CAP REL COSTS-BLDG & FIXT -1.01 11 1.01 COSTS-BLDG & FIXT - INTERES I NTERES (chapter 2) Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) Investment income - other 3.00 0.00 3.00 (chapter 2) Trade, quantity, and time 4.00 0.00 4.00 discounts (chapter 8) Refunds and rebates of 5.00 0.00 5.00 expenses (chapter 8) Rental of provider space by 0.00 6.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay 0.00 7.00 stations excluded) (chapter 21) Tel evision and radio service 8.00 8.00 0.00 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 Provi der-based physici an 10.00 A-8-2 -2, 455, 450 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 11.00 0.00 (chapter 23) 12.00 Related organization A-8-1 3, 618, 214 12.00 transactions (chapter 10) Laundry and linen service 13.00 0.00 13.00 -136, 636 CAFETERI A 14.00 14.00 Cafeteria-employees and guests В 11.00 0 15.00 Rental of quarters to employee 0.00 15.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents -336, 439 PHARMACY 17.00 Sale of drugs to other than В 15.00 17.00 pati ents 18.00 Sale of medical records and 0.00 18.00 0 abstracts 19.00 Nursing and allied health 0 0.00 19.00 education (tuition, fees, books, etc.) Vending machines 20.00 0.00 20.00 Income from imposition of 21 00 0 00 21 00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 22.00 overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory ORESPIRATORY THERAPY 23.00 23.00 A-8-3 65.00 therapy costs in excess of limitation (chapter 14) Adjustment for physical OPHYSICAL THERAPY 24.00 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 Utilization review 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL 781, 648 CAP REL COSTS-BLDG & FIXT 1.00 26.00 Α COSTS-BLDG & FIXT Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT -1.01 26.01 26.01

I NTERES

35, 545 CAP REL COSTS-MVBLE EQUIP

0 *** Cost Center Deleted ***

27.00

28 00

0 29.00

2.00

19 00

0.00

27.00

COSTS-BLDG & FIXT - INTERES

Depreciation - CAP REL

COSTS-MVBLE EQUIP 28. 00 Non-physi ci an Anestheti st 29. 00 Physi ci ans' assi stant From 01/01/2020 To 12/31/2020 Date/Time Prepared:

				To	12/31/2020	Date/Time Pre 7/9/2021 10:1	pared:
				Expense Classification on	Workshoot A	1/9/2021 10: 1	/ alli
				To/From Which the Amount is			
				TOTT OIL WITCH THE AMOUNT 13	to be Aujusteu		
	Coot Conton Decement on	Basis/Code	Amount	Cost Center	line #	Wkst. A-7	
	Cost Center Description		Amount	Cost Center	Li ne #		
		(2) 1. 00	2.00	3.00	4. 00	Ref.	
20.00	Adiustment for accumational	A-8-3	2. 00	3.00 OCCUPATI ONAL THERAPY		5. 00	30.00
30.00	Adjustment for occupational	A-8-3	Ü	OCCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14)		0	ADULTS & DEDLATRICS	20.00		30. 99
30. 99	Hospice (non-distinct) (see		Ü	ADULTS & PEDIATRICS	30. 00		30.99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
31.00	pathology costs in excess of	A-8-3	Ü	SPEECH PATHULUGY	68.00		31.00
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for	A	0	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00
32.00	Depreciation and Interest	_ ^	U	CAF REL COSTS-WINDEL EQUIP	2.00	7	32.00
33. 00	MISCELLANEOUS INCOME	В	45 472	ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 00	INVESTMENT FEES	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 01	MISCELLANEOUS INCOME	В		HOUSEKEEPI NG	9. 00	0	•
33. 02	MISCELLANEOUS INCOME	В		DI ETARY	10. 00	0	
33. 04	MISCELLANEOUS INCOME	В		ELECTROCARDI OLOGY	69. 00	0	1
33. 04	MISCELLANEOUS INCOME	В	·	PHARMACY	15. 00	0	
33. 06	MEDICALD HOSPITAL ASSESSMENT	В		ADMINISTRATIVE & GENERAL	5. 00	0	ı
33.00	FEE	ь .	-1, 101, 047	ADMINISTRATIVE & GENERAL	5.00	U	33.00
33. 07	ASSISTED LIVING DEPRECIATION -	Α	125 700	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 07
33.07	BLDG	^	-125, 700	CAI REE COSTS-BEDG & TTAT	1.00	,	33.07
33. 08	ASSISTED LIVING DEPRECIATION -	Α	0	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 08
00.00	MVBLE		O	ON REE GOOTS MIVBEE EQUIT	2.00	,	00.00
33. 09	CRNA SALARY EXPENSE	A	-179 716	ANESTHESI OLOGY	53. 00	0	33. 09
33. 10	CRNA BENEFITS EXPENSE	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 11	PATIENT PHONES - SALARY	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 12	PATIENT PHONES - BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	1
33. 13	EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	
33. 14	CABLE	A		OPERATION OF PLANT	7. 00	0	1
33. 15		В		CAP REL COSTS-BLDG & FIXT	1. 00	10	
33. 16	ACCRUED PTO	Ä	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	ı
33. 17	LEASE DEPRECIATION - CARRY	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	
	FORWARD A					•	
33. 18	EQUIPMENT DEPRECIATION - CARRY	A	22, 433	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 18
	FORWA		,			•	
33. 19	RECRUTI NG	A	-18, 571	ADULTS & PEDIATRICS	30. 00	0	33. 19
33. 20	MARKETING	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	
33. 21	MARKETI NG	A		PHYSI CAL THERAPY	66. 00	0	
33. 22	MARKETI NG	A		EMERGENCY	91. 00	0	
50. 00	TOTAL (sum of lines 1 thru 49)		-3, 167, 962	1			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(4) 5				010 0 1 45 4			

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Peri od: From 01/01/2020 Worksheet A-8-1

OTTICL	00313			To 12/31/2020	Date/Time Pre 7/9/2021 10:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	/ dill
				Allowable Cost	7 7 7	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	289, 059	122, 141	1.00
2.00	1. 01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	1, 022, 019	657, 308	2.00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	221, 732	0	3.00
4.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	2, 350, 752	4, 368	4.00
4. 01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6, 674, 728	6, 120, 212	4.01
4.02	7. 00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	685, 782	707, 337	4.02
4.03	7. 01	OPERATION OF PLANT - OFFSITE	HOME OFFICE ALLOCATION	0	50, 172	4.03
4.04	0.00			0	0	4.04
4. 05	0.00			0	0	4.05
4.06	13.00	NURSING ADMINISTRATION	RELATED PARTY EXPENSE	56, 076	36, 576	4.06
4.07			RELATED PARTY EXPENSE	584, 586	584, 586	4.07
4. 08			RELATED PARTY EXPENSE	31, 100	31, 100	4.08
4. 09			RELATED PARTY EXPENSE	175, 473	159, 293	4.09
4. 10			RELATED PARTY EXPENSE	1, 387, 823	1, 387, 823	4. 10
4. 11	1		RELATED PARTY EXPENSE	293, 939	293, 939	4. 11
4. 12			RELATED PARTY EXPENSE	5, 826	5, 826	4. 12
4. 13			RELATED PARTY EXPENSE	1, 616, 232	1, 616, 232	4. 13
4. 14	192. 01	OCCUPATIONAL MEDICINE	RELATED PARTY EXPENSE	32, 844	32, 844	4. 14
5. 00	TOTALS (sum of lines 1-4).			15, 427, 971	11, 809, 757	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			Related Organization(s) and/	or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of		
•		Ownershi p		Ownershi p		
1. 00	2. 00	3. 00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6. 00	В	0. 00 I U HEALTH 100. 00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

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

4.13

4.14

5.00

Related Organization(s)		
and/or Home Office		
Type of Business		
3.		
6. 00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HEALTHCARE		6.00
7. 00 8. 00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
9. 00 10. 00 100. 00		10	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.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

4. 13

4.14

5.00

0

Ω

3, 618, 214

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Peri od: Worksheet A-8-2
From 01/01/2020
To 12/31/2020 Date/Time Prepar Provider CCN: 15-1311

						To 12/31/2020	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6.00	7. 00	
1.00		ADMINISTRATIVE & GENERAL	53, 734	53, 734	1 C	1	0	1.00
2.00	•	ADULTS & PEDIATRICS	576, 518			1		2. 00
3.00	50.00	OPERATING ROOM	265, 956	265, 956	i C	0	0	3.00
4.00	53. 00	ANESTHESI OLOGY	251, 736	251, 736	S C	0	0	4.00
5.00	54. 00	RADI OLOGY-DI AGNOSTI C	150, 000	150, 000) c	0	0	5.00
6.00	69. 00	ELECTROCARDI OLOGY	101, 864		1 C	0	0	6. 00
7.00		EMERGENCY	1, 595, 233	1, 055, 642	539, 591	0	0	7. 00
8.00	0.00		0	() C	0	0	8. 00
9. 00	0.00		0	() C	0	0	9. 00
10.00			0	() C	0	0	10.00
200.0			2, 995, 041				0	200. 00
	Wkst. A Line #	,	Unadj usted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Li mi t		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
1.00	1.00	2.00	8. 00	9. 00	12.00	13. 00	14. 00	1.00
1.00		ADMINISTRATIVE & GENERAL	0	(1	1		
2.00		ADULTS & PEDIATRICS	0	(1	ή		2.00
3.00		OPERATING ROOM	0	(1	0	3.00
4.00		ANESTHESI OLOGY	0	(0	0	4.00
5.00		RADI OLOGY-DI AGNOSTI C	0	(0	0	5. 00
6.00		ELECTROCARDI OLOGY	0	(0	0	6. 00
7.00		EMERGENCY	0	(0	0	7.00
8.00	0.00		0	(0	0	8. 00
9.00	0.00	1	0	(0	0	9.00
10.00			0	(0	0	10.00
200.0		Cook Cooker (Dhire) of or	D:==:::::=!=:=	A-1:+ DCE	RCE	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provi der	Adjusted RCE	Di sal I owance	Adjustment		
		i denti i i ei	Component Share of col.	Limit	DI Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	10.00					1. 00
2. 00		ADULTS & PEDIATRICS	0		1	1,		2.00
3. 00		OPERATING ROOM	0					3. 00
4. 00		ANESTHESI OLOGY	0					4. 00
5. 00	•	RADI OLOGY-DI AGNOSTI C	0			150,000		5. 00
6. 00		ELECTROCARDI OLOGY	0			1		6. 00
7. 00		EMERGENCY	0			1, 055, 642		7. 00
8. 00	0.00	1	1 0			0		8. 00
9. 00	0.00		0	d		o o		9. 00
10.00				1		ol o		10.00
200.0		1	1			2, 455, 450		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2020 Part I Provider CCN: 15-1311

				To	o 12/31/2020	Date/Time Pre 7/9/2021 10:1	
			CAP	TAL RELATED CO	STS	17 77 2021 10. 1	, diii
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1. 00	1. 01	2. 00	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 559, 457	1, 559, 457				1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	108, 173	0	108, 173			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 214, 753			1, 214, 753		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 566, 689	6, 910	547	5, 256	2, 579, 402	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	8, 068, 458	98, 019	7, 760	74, 553	173, 673	5. 00
7.00	00700 OPERATION OF PLANT	4, 361, 911	375, 273	26, 067	285, 429	201, 057	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	117, 756	25, 490	2, 018	19, 388	13, 428	8. 00
9.00	00900 HOUSEKEEPI NG	402, 520	15, 209	1, 204	11, 568	79, 194	9. 00
10.00	01000 DI ETARY	220, 811	17, 985	1, 424	13, 680	23, 418	10.00
11.00	01100 CAFETERI A	460, 638	48, 672	3, 853	37, 020	63, 380	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	906, 437	34, 804	2, 755	26, 472	180, 830	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	707, 574	32, 988	2, 612	25, 090	0	14. 00
15.00	01500 PHARMACY	834, 239	18, 112	1, 434	13, 776	160, 483	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 056, 118	151, 293	11, 977	143, 711	424, 231	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 217, 028	192, 365	15, 229	146, 312	227, 850	50.00
53.00	05300 ANESTHESI OLOGY	59, 419	3, 626	287	2, 758	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 219, 602	100, 613	7, 965	76, 526	241, 726	54.00
60.00	06000 LABORATORY	1, 411, 862	39, 311	3, 112	29, 900	0	60.00
65.00	06500 RESPI RATORY THERAPY	578, 269	2, 380	188	1, 810	120, 233	65.00
66.00	06600 PHYSI CAL THERAPY	768, 874	55, 527	1, 580	42, 233	155, 032	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	251, 866	18, 390	523	13, 987	53, 493	67.00
68.00	06800 SPEECH PATHOLOGY	27, 641	698	20	531	5, 608	68. 00
69.00	06900 ELECTROCARDI OLOGY	536, 850	26, 157	2, 071	19, 895	113, 653	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	409, 034	0	0	0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 200, 134	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 996, 998	0	0	0	0	73.00
73. 01	03480 ONCOLOGY	253, 385	15, 764	1, 248	11, 990	48, 776	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	1, 197, 921	0	0	0	0	73. 02
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	84, 371	17, 160	1, 359	13, 052	17, 939	76. 97
	OUTPATIENT SERVICE COST CENTERS	,					
91.00	09100 EMERGENCY	1, 695, 701	111, 379	8, 818	84, 714	239, 823	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		38, 494, 489	1, 408, 125	104, 051	1, 099, 651	2, 543, 827	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSICIANS' PRIVATE OFFICES	117, 009	136, 917		104, 138	23, 542	
	19201 OCCUPATI ONAL MEDI CI NE	111, 319	14, 415		10, 964	12, 033	
	19202 VACANT SPACE	0	0	0	0	0	192. 02
200.00	1 1						200. 00
201.00	1 1 3		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	38, 722, 817	1, 559, 457	108, 173	1, 214, 753	2, 579, 402	202. 00

Provider CCN: 15-1311

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

Cost Center Description					'	0 12/31/2020	7/9/2021 10: 1	
CEMBRAL SERVICE COST CENTERS		Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	OPERATION OF		
CEMBERAL SERVICE COST CENTERS		'		E & GENERAL	PLANT	PLANT -	LINEN SERVICE	
CEMERAL SERVICE COST CENTERS						OFFSI TE		
1.00			4A	5. 00	7. 00	7. 01	8. 00	
1, 01 00101 CAP REL COSTS-BULD & FIXT - INTERES			1					
2.00								
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT								
5.00 00500 ADMINISTRATIVE & GENERAL 8, 422, 463 8, 422, 463 8, 422, 463 7, 00 0.70								
7. 00								4.00
1.00	5.00		8, 422, 463	8, 422, 463				5.00
8. 00 00800 LAUINDRY & LINEN SERVICE 178,080 49,500 174,076 0 401,656 8. 00 0. 00	7.00	00700 OPERATION OF PLANT	5, 249, 737	1, 459, 243	6, 708, 980			7. 00
9,00 00900 HOUSEKEEPING 509,695 114,678 103,860 0 0 0,00 0 0 0 0 0 0		00701 OPERATION OF PLANT - OFFSITE	0	0	0	0		7. 01
10.0 01000 0154RY		00800 LAUNDRY & LINEN SERVICE	178, 080	49, 500	174, 076	0	401, 656	8. 00
11.00	9.00	00900 HOUSEKEEPI NG	509, 695	141, 678	103, 860	0	0	9. 00
13.00 01300 NURSI NG ADMI NI STRATI ON 1.151, 298 320, 022 237, 681 0 0 13.00 01400 CENTRAL SERVI CES & SUPPLY 768, 264 213, 551 225, 274 0 0 14.00 15.00 01500 PHARIMACY 1, 028, 044 285, 761 123, 690 0 0 15.00 15.00 10500 PHARIMACY 1, 028, 044 285, 761 123, 690 0 0 0 15.00 15.00 10500 PHARIMACY 1, 028, 044 285, 761 123, 690 0 0 0 401,656 30.00 10.00 30.00 ANCI LLARY SERVI CE COST CENTERS	10.00	01000 DI ETARY	277, 318	77, 085	122, 823	0	0	10.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 768, 264 213, 551 225, 274 0 0 14. 00 15. 00 15. 00 16. 0	11.00	01100 CAFETERI A	613, 563	170, 550	332, 385	0	0	11.00
15.00	13.00	01300 NURSING ADMINISTRATION	1, 151, 298	320, 022	237, 681	0	0	13.00
15.00	14.00	01400 CENTRAL SERVICES & SUPPLY	768, 264	213, 551	225, 274	0	0	14.00
INPATI ENT ROUTI NE SERVICE COST CENTERS	15.00						0	15.00
30.00			,					
ANCI LLARY SERVICE COST CENTERS	30.00		2, 787, 330	774, 783	1, 033, 184	0	401, 656	30.00
50.00				,	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,	
53. 00 05300 ANESTHESI OLOGY 66, 090 18, 371 24, 760 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 646, 432 457, 652 687, 092 0 0 54. 00 60. 00 06000 LABORATORY 1, 484, 185 412, 553 268, 455 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 702, 880 195, 377 16, 254 0 0 65. 00 66. 00 06600 OHYSI CAL THERAPY 1, 023, 246 284, 428 136, 259 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 338, 259 94, 025 45, 131 0 0 67. 00 68. 00 06800 SPECCH PATHOLOGY 34, 498 9, 589 1, 734 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 698, 626 194, 194 178, 627 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 409, 034 113, 698 0 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 1, 200, 134 333, 596 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 996, 998 1, 111, 030 0 0 0 0 73. 01 03480 ONCOLOGY 331, 163 92, 052 107, 653 0 0 73. 00 73. 01 03480 ONCOLOGY 331, 163 92, 052 107, 653 0 0 73. 00 76. 00 03160 CARD IOPULMONARY 0 0 0 0 0 0 76. 00 03160 CARD IOPULMONARY 0 0 0 0 0 76. 00 03160 CARD IOPULMONARY 0 0 0 0 0 76. 97 O7697 CARDI AC REHABILITATI ON 133, 881 37, 214 117, 188 0 0 0 76. 97 O7100 MEDITALS (SUM OF LINES 1 through 117) 38, 188, 358 8, 273, 902 6, 010, 403 0 401, 656 778 ONDRE IMBURSABLE COST CENTERS 149, 872 41, 659 98, 442 0 0 192, 00 780 O1920 OLOPATI ENT SERVICE OST CENTERS 149, 872 41, 659 98, 442 0 0 192, 01 780 O1920 O1920 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0 0 192, 01 780 O1920 O1920 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0 0 192, 01 780 O1920 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0 0 192, 01 780 O1920 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0	50.00		1, 798, 784	500, 001	1, 313, 665	0	0	50.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 1, 646, 432 457, 652 687, 092 0 0 54. 00 60. 00 06000 LABORATORY 1, 484, 185 412, 553 268, 455 0 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 702, 880 195, 377 16, 254 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 023, 246 284, 428 136, 259 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 338, 259 94, 025 45, 131 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 34, 498 9, 589 1, 734 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 698, 626 194, 194 178, 627 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 409, 034 113, 698 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 200, 134 333, 596 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 996, 998 1, 111, 030 0 0 0 0 73. 01 03480 0NCOLOGY 331, 163 92, 052 107, 653 0 0 73. 01 73. 02 07301 BLODD DI SORDER DRUGS 1, 197, 921 332, 981 0 0 0 0 0 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 76. 07 07697 CARDI AC REHABI LI TATI ON 133, 881 37, 214 117, 188 0 0 76, 97 79. 00 09200 DISER DRUGS 0 0 0 0 0 70. 00 09200 DISER DRUGS 0 0 0 70. 00 09200 DISER DRUGS 0 0 0 70. 00 09200 DISER DRUGS 0 0 0 70. 00 09100 EMERGENCY 0 0 0 70. 00 09100 EMERGENCY 0 0 0 70. 00 09100 EMERGENCY 0 0 0 70. 00 09100 DISER DRUGS 0 0 0 70. 00 09100 0 0 0 0 70. 00 0 0 0 0 70. 00 0 0 0 0 70. 00				· ·				
60.00 06000 LABORATORY 1,484,185 412,553 268,455 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 702,880 195,377 16,254 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 1,23,246 284,428 136,259 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 338,259 94,025 45,131 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 34,498 9,589 1,734 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 698,626 194,194 178,627 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 409,034 113,698 0 0 0 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1,200,134 333,596 0 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,200,134 333,596 0 0 0 0 73.00 73.01 03480 ONCOLOGY 331,163 92,052 107,653 0 0 73.01 73.02 07301 BLOOD DI SORDER DRUGS 1,197,921 332,981 0 0 0 0 76.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 133,881 37,214 117,188 0 0 0 76.97 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92.00 192.01 19200 PHYSICI ANS* PRIVATE OFFI CES 384,587 106,902 60,01,35 0 0 192.01 192.01 19200 PHYSICIA MEDI CINES 149,872 41,659 98,442 0 0 192.01 192.02 19202 VACANT SPACE 0 0 0 0 0 0 0 201.00 Negati ve Cost Centers 0 0 0 0 0 0 201.00 Negati ve Cost Centers 0 0 0 0 0 201.00 Negati ve Cost Centers 0 0 0 0 0 0 201.00 000 000 000 000 000 000 000 000 000 000 201.00 000 000 000 000 000 000 000 000 000 201.00 000 000 000 000 000 000 000 000 000 000 000 201.00 000 000 000 000 000 000 000 000 000 000 000 000 000 000 201.00 000			· ·	· ·			0	
65. 00 06500 RESPI RATORY THERAPY 702, 880 195, 377 16, 254 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 023, 246 284, 428 136, 259 0 0 66. 00 067. 00 000 067. 00 000 067. 00 000 068. 00 06800 SPEECH PATHOLOGY 334, 498 9, 589 1, 734 0 0 68. 00 06900 ELECTROCARDI OLOGY 698, 626 194, 194 178, 627 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 409, 034 113, 698 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 200, 134 333, 596 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 996, 998 1, 111, 030 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 3, 996, 998 1, 111, 030 0 0 0 0 0 0 0 0 0								
66. 00 06600 PHYSI CAL THERAPY 1, 023, 246 284, 428 136, 259 0 0 66. 00 67. 00 67. 00 660. 00 60700 0CCUPATI ONAL THERAPY 338, 259 94, 025 45, 131 0 0 67. 00 68. 00 06800 SPECCH PATHOLOGY 34, 498 9, 589 1, 734 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 698, 626 194, 194 178, 627 0 0 69. 00 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 409, 034 113, 698 0 0 0 0 0 71. 00 072. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 200, 134 333, 596 0 0 0 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 200, 134 333, 596 0 0 0 0 0 0 0 0 0							_	
67. 00		1 1					_	
68.00 06800 SPEECH PATHOLOGY 34,498 9,589 1,734 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 698,626 194, 194 178,627 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 409,034 113,698 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,200,134 333,596 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3,996,998 1,111,030 0 0 0 0 73.00 73.01 03480 ONCOLOGY 331,163 92,052 107,653 0 0 73.01 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 133,881 37,214 117,188 0 0 0 76.97 09100 EMERGENCY 2,140,435 594,968 760,612 0 91.00 792.00 09200 OSSERVATI ON BEDS (NON-DI STI NCT PART 0 92.00 792.00 19200 PHYSI CI ANS* PRI VATE OFFI CES 384,587 106,902 6,010,403 0 401,656 792.01 19201 OCCUPATI ONAL MEDI CI NE 149,872 41,659 98,442 0 0 192.01 792.02 19202 VACANT SPACE 0 0 0 0 0 700 00 00 0		1 1				0	_	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENT 409. 034 113, 698 0 0 0 0 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 200, 134 333, 596 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 3, 996, 998 1, 111, 030 0 0 0 0 73. 00 73. 01 03480 ONCOLOGY 331, 163 92, 052 107, 653 0 0 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 1, 197, 921 332, 981 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LITATI ON 133, 881 37, 214 117, 188 0 0 0 76. 97 0UTPATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 9, 2, 140, 435 594, 968 760, 612 0 0 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 SUBTOTALS (SUM OF LINES 1 through 117) 38, 188, 358 8, 273, 902 6, 010, 403 0 401, 656 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 384, 587 106, 902 600, 135 0 0 192. 00 192. 01 19201 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0 0 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				· ·	•	0	_	
71. 00								
72. 00							Ĭ	
73. 00							_	
73. 01				· ·	•	0	_	
73. 02 07301 BLOOD DI SORDER DRUGS						0		
76. 00			· ·				_	
76. 97 O7697 CARDI AC REHABI LI TATI ON 133, 881 37, 214 117, 188 0 0 76. 97 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 2, 140, 435 594, 968 760, 612 0 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 92. 00 SPECI AL PURPOSE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 384, 587 106, 902 600, 135 0 0 192. 00 192. 01 19200 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0 0 192. 01 192. 01 19200 VACANT SPACE 0 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 0 Negati ve Cost Centers 0 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 201. 00		1 1				_		
OUTPATIENT SERVICE COST CENTERS 2, 140, 435 594, 968 760, 612 0 0 0 91. 00		1 1	_	_				
91. 00	70. 97		133,001	37, 214	117,100	U	U	70.97
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 38, 188, 358 8, 273, 902 6, 010, 403 0 401, 656 118. 00 NONREI MBURSABLE COST CENTERS	01 00		2 140 425	E04 040	740 412	0	0	01 00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 38,188,358 8,273,902 6,010,403 0 401,656 118.00 NONREI MBURSABLE COST CENTERS 192.00 PHYSI CI ANS' PRI VATE OFFI CES 384,587 106,902 600,135 0 0 192.00 192.01 19201 OCCUPATI ONAL MEDI CI NE 149,872 41,659 98,442 0 0 192.02 192.02 19202 VACANT SPACE 0 0 0 0 0 0 192.02 200.00 Cross Foot Adjustments 0 0 Negati ve Cost Centers 0 0 0 0 0 0 201.00		1 1			760, 612	U	U	
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 38, 188, 358 8, 273, 902 6, 010, 403 0 401, 656 118.00	92.00		0					92.00
NONREI MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 384, 587 106, 902 600, 135 0 0 192.00	110 00		20 100 250	0 070 000	/ 010 402		401 (5)	110 00
192. 00	118.00		38, 188, 358	8, 273, 902	6,010,403	U	401,656	118.00
192. 01 19201 OCCUPATI ONAL MEDI CI NE 149, 872 41, 659 98, 442 0 0 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 192. 02 200. 00 0 0 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 201. 00	400.00		204 507	10/ 000	/ / / / / / / / / / / / / / / / / / / /			
192. 02 19202 VACANT SPACE 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 201. 00				· ·				
200.00 Cross Foot Adjustments 0 201.00 Negative Cost Centers 0 0 0 0 0 0 0			149, 8/2	41, 659				
201.00 Negative Cost Centers 0 0 0 0 201.00		1 1	0	0	0	0	0	
		1 1	0	_			_	
202.00			0	0	0	_		
	202.00		38, 722, 817	8, 422, 463	j 6, 708, 980	J 0	401, 656	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I | Date/Time Prepared: | Provider CCN: 15-1311

				T	o 12/31/2020	Date/Time Pre 7/9/2021 10:1	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	/ aiii
	oust defice beson per on	HOUSEREELTHO	DI EITAKI	ON ETENTA	ADMI NI STRATI O	SERVICES &	
					N	SUPPLY	
		9. 00	10. 00	11. 00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG	755, 233					9. 00
10.00	01000 DI ETARY	13, 079	490, 305				10.00
11.00	01100 CAFETERI A	35, 394	0	1, 151, 892			11.00
13.00	01300 NURSING ADMINISTRATION	25, 310	0	68, 098	1, 802, 409		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	23, 988	0	0	0	1, 231, 077	14.00
15. 00	01500 PHARMACY	13, 171	0	69, 374	0	17, 800	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	110, 019	490, 305	267, 378	786, 586	43, 780	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	139, 887	0	123, 529	383, 534	237, 642	50.00
	05300 ANESTHESI OLOGY	2, 637	0	8, 502	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	73, 165	0	128, 630	0	9, 548	
	06000 LABORATORY	28, 587	0	83, 401	0	12, 349	
	06500 RESPI RATORY THERAPY	1, 731	0	56, 196	l .	18, 584	
	06600 PHYSI CAL THERAPY	40, 379	0	73, 710		6, 803	
	06700 OCCUPATI ONAL THERAPY	13, 373	0	27, 715	l .	319	
	06800 SPEECH PATHOLOGY	508	0	2, 465		12	1
	06900 ELECTROCARDI OLOGY	19, 021	0	50, 500	l ' '	4, 777	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	- I	210, 198	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	616, 737	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	1
	03480 ONCOLOGY	11, 463	0	25, 165	· · ·	6, 853	
	07301 BLOOD DI SORDER DRUGS	0	0	0	١	0	73. 02
	03160 CARDI OPULMONARY	0	0	0	- 1	0	76.00
	07697 CARDI AC REHABI LI TATI ON	12, 479	0	8, 757	39, 763	509	76. 97
	OUTPATIENT SERVICE COST CENTERS	00.004	0	405.040	2/2 424	40.005	04.00
	09100 EMERGENCY	80, 994	0	135, 262	362, 101	43, 985	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	645, 185	490, 305	1, 128, 682	1, 758, 820	1, 229, 896	110 00
	VONREI MBURSABLE COST CENTERS	045, 165	470, 303	1, 120, 002	1, 756, 620	1, 227, 070	1110.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	99, 565	0	13, 603	O	250	192.00
	19201 OCCUPATIONAL MEDICINE	10, 483	0	9, 607	43, 589		192.00
	19202 VACANT SPACE	10, 403	0	σ, 507 Λ	43, 309 N		192.01
200.00	Cross Foot Adjustments			0	١	0	200.00
201.00	Negative Cost Centers	n	n	n	n	Λ	201.00
202.00	TOTAL (sum lines 118 through 201)	755, 233	490, 305	1, 151, 892	1, 802, 409	1, 231, 077	1
	(, 000	.,, 0,2	.,, .07	., == ., 0,,	1

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10		
COST ALLOCATION CENERAL SERVICE COSTS	Provi don CCN: 15 1211	Pori od: Workshoot P		

From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am Cost Center Description **PHARMACY** Total Subtotal Intern & Resi dents Cost & Post Stepdown Adjustments 15. 00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1.01 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 7.01 00701 OPERATION OF PLANT - OFFSITE 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15.00 01500 PHARMACY 1, 537, 840 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 059 6, 697, 080 0 6, 697, 080 30.00 ANCILLARY SERVICE COST CENTERS 3, 078 05000 OPERATING ROOM 4, 500, 120 0 4, 500, 120 50.00 05300 ANESTHESI OLOGY 0 120, 360 53.00 120, 360 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 462 3, 002, 981 3, 002, 981 54.00 0 60.00 06000 LABORATORY 0 2, 289, 530 2, 289, 530 60.00 06500 RESPIRATORY THERAPY 991, 091 65.00 69 991, 091 65.00 66 00 06600 PHYSI CAL THERAPY 69 1, 564, 894 0 1, 564, 894 66 00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 518, 822 518, 822 67.00 68.00 06800 SPEECH PATHOLOGY 0 48, 806 48, 806 68.00 0 1, 279, 960 69.00 06900 ELECTROCARDI OLOGY 50 1, 279, 960 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 732, 930 71 00 0 732, 930 71 00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 2, 150, 467 2, 150, 467 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 172, 861 6, 280, 889 0 6, 280, 889 73.00 73.01 03480 ONCOLOGY 813 627, 833 0 627, 833 73.01 οl 73.02 07301 BLOOD DI SORDER DRUGS 351, 513 1, 882, 415 1, 882, 415 73 02 0 76.00 03160 CARDI OPULMONARY 76.00 07697 CARDIAC REHABILITATION 349, 794 349, 794 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 5.015 0 4, 123, 372 91.00 4, 123, 372 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 535, 992 0 37, 161, 344 37, 161, 344 118.00 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 OCCUPATI ONAL MEDI CLNE 1, 205, 042 1, 205, 042 192.00 1, 848 0 192.01 356, 431 356, 431 0 192. 02 19202 VACANT SPACE 0 C 0 192. 02 200.00 Cross Foot Adjustments 0 0 0 200.00 201.00 Negative Cost Centers 0 201.00 202.00 0 1, 537, 840 TOTAL (sum lines 118 through 201) 38, 722, 817 202.00 38, 722, 817

| Period: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time | Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

				To	12/31/2020	Date/Time Pre	pared:
			СДР	 ITAL RELATED CO	2720	7/9/2021 10: 1	/ am
			CAPITAL RELATED COSTS				
	Cost Center Description	Di rectly	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	Subtotal	
		Assigned New		INTERES			
		Capi tal					
		Related Costs					
		0	1. 00	1. 01	2. 00	2A	
	GENERAL SERVICE COST CENTERS	,					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 910	1	5, 256	12, 713	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	98, 019		74, 553	180, 332	5.00
7. 00	00700 OPERATION OF PLANT	0	375, 273	· · · · · · · · · · · · · · · · · · ·	285, 429	686, 769	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0	25, 490		19, 388	46, 896	8.00
9.00	00900 HOUSEKEEPI NG	0	15, 209		11, 568	27, 981	9.00
10.00	01000 DI ETARY	0	17, 985		13, 680	33, 089	10.00
11.00	01100 CAFETERI A	0	48, 672		37, 020	89, 545	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	34, 804		26, 472	64, 031	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	32, 988		25, 090 13, 776	60, 690	14. 00 15. 00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	U	18, 112	1, 434	13, 770	33, 322	15.00
30. 00	03000 ADULTS & PEDIATRICS	0	151, 293	11, 977	143, 711	306, 981	30. 00
30.00	ANCI LLARY SERVICE COST CENTERS	U	151, 273	11, 7//	143, 711	300, 701	30.00
50. 00	05000 OPERATING ROOM	0	192, 365	15, 229	146, 312	353. 906	50.00
53. 00	05300 ANESTHESI OLOGY	0	3, 626		2, 758	6, 671	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	100, 613		76, 526	185, 104	54.00
60.00	06000 LABORATORY	0	39, 311		29, 900	72, 323	60.00
65. 00	06500 RESPI RATORY THERAPY	0	2, 380		1, 810	4, 378	65.00
66.00	06600 PHYSI CAL THERAPY	0	55, 527		42, 233	99, 340	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	18, 390		13, 987	32, 900	67.00
68.00	06800 SPEECH PATHOLOGY	0	698		531	1, 249	68.00
69.00	06900 ELECTROCARDI OLOGY	0	26, 157	2, 071	19, 895	48, 123	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73. 01	03480 ONCOLOGY	0	15, 764	1, 248	11, 990	29, 002	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	0	0	0	0	73. 02
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABILI TATI ON	0	17, 160	1, 359	13, 052	31, 571	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	111, 379	8, 818	84, 714	204, 911	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	1, 408, 125	104, 051	1, 099, 651	2, 611, 827	118. 00
	NONREI MBURSABLE COST CENTERS	1					
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	136, 917		104, 138	244, 036	
	19201 OCCUPATI ONAL MEDI CI NE	0	14, 415	1	10, 964	26, 520	
	19202 VACANT SPACE	0	0	0	0		192. 02
200.00			_	_	_		200.00
201.00			0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 559, 457	108, 173	1, 214, 753	2, 882, 383	202.00

Provider CCN: 15-1311

				11	0 12/31/2020	7/9/2021 10:1	
	Cost Center Description	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF	LAUNDRY &	7 (3111
		BENEFITS	E & GENERAL	PLANT	PLANT -	LINEN SERVICE	
		DEPARTMENT			OFFSI TE		
		4. 00	5. 00	7. 00	7. 01	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	12, 713					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	856	181, 188				5. 00
7. 00	00700 OPERATION OF PLANT	991	31, 385				7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	-	0		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	66	1, 065		0	66, 686	8. 00
9.00	00900 HOUSEKEEPI NG	390	3, 048		0	0	9. 00
10.00	01000 DI ETARY	115	1, 658		0	0	10.00
11. 00	01100 CAFETERI A	312	3, 669	· ·	0	0	11.00
13. 00	01300 NURSING ADMINISTRATION	891	6, 885		0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	4, 594	24, 147	0	0	14.00
15.00	01500 PHARMACY	791	6, 148	13, 258	0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	2, 093	16, 668	110, 748	0	66, 686	30. 00
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	1, 123	10, 757		0		50.00
53.00	05300 ANESTHESI OLOGY	0	395		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 191	9, 846		0		54.00
60.00	06000 LABORATORY	0	8, 875		0	0	60.00
65.00	06500 RESPI RATORY THERAPY	593	4, 203		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	764	6, 119		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	264	2, 023		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	28	206		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	560	4, 178		0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2, 446		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	7, 177	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	23, 902	14 500	0	0	73.00
73. 01	03480 ONCOLOGY	240	1, 980		0	0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	7, 164		0	0	73.02
76.00	03160 CARDI OPULMONARY	0	0	_	0	0	76.00
76. 97	07697 CARDI AC REHABILITATION	88	801	12, 562	U	0	76. 97
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	1, 182	12, 800	81, 531	0	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 102	12, 000	01, 331	U	0	91.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		12, 538	177, 992	644, 264	0	66, 686	118 00
110.00	NONREI MBURSABLE COST CENTERS	12, 550	177, 772	044, 204	U	00,000	110.00
102 00	19200 PHYSI CLANS' PRI VATE OFFI CES	116	2, 300	64, 329	0	0	192. 00
	19201 OCCUPATI ONAL MEDI CI NE	59	896		0	l	192.00
	19201 OCCOPATIONAL MEDICINE	0	090		0		192.01
200.00			0		U		200.00
200.00	J	n	n	0	0	0	200.00
201.00		12, 713	181, 188	719, 145	0		
202.00	1.57.12 (56 1.1.55 116 till 64gil 201)	12,,10	101,100	1 ,1,,,,,,,,,		1 33, 300	

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

COST CENTER HOUSEKEEPING DIETARY CAFETERIA ANURSING CENTRAL SERVICES & SUPPLY					T	12/31/2020	Date/Time Pre	
CENERAL SERVICE COST CENTERS 9,00 10,00 11,00 13,00 14,00 14,00 10,00 10,00 11,00 13,00 14,00 14,00 10,00 10,00 11,00 13,00 14,00 14,00 10,00 10,00 10,00 11,00 13,00 14,00 10,00 10,00 10,00 11,00 10,00 10,00 14,00 10,00		Cost Center Description	HOUSEKEEPING	DIFTARY	CAFETERLA	NURSLNG		i / aiii
CEMBERAL SERVICE COST CENTERS 9.00 10.00 11.00 13.00 14.00 1.00		oust denter beschiption	HOUSEREELTHO	DI EI/III	ON ETERIN			
CEMBERAL SERVICE COST CENTERS								
1.00			9. 00	10. 00	11. 00			
1.01		GENERAL SERVICE COST CENTERS						
2.00	1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00		OO1O1 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
5.00								
7.00								
1.00		1 1						
B. 00 OGBOOL ALUMDRY & LINEN SERVICE		1						1
9.00 0,000 0,000 0,000 ETERP 10,00		1 1						
10.00 01000 017ACY 1.00 01100 017ACY 1.00		1 1						
11.00		1 1						1
13.00 01300 NURSI NG ADMINI STRATI ON 1, 426 0 7, 753 106, 463 13.00 14.00 CENTRAL SERVI CES & SUPPLY 1, 352 0 0 0 0 90, 783 14.00 15.00 01500 PHARIJACY 742 0 7, 899 0 1, 313 15.00 15.00 15.00 PHARIJACY 742 0 7, 899 0 1, 313 15.00 15.00 15.00 NURSI NG ADMINI SERVICE COST CENTERS 148, 765 30, 442 46, 461 3, 228 30.00 ANCILLARY SERVICE COST CENTERS 148, 765 30, 442 46, 461 3, 228 30.00 ANCILLARY SERVICE COST CENTERS 149, 149, 149, 149, 149, 149, 149, 149,		1 1		48, 765				1
14. 00 01400 CENTRAL SERVICES & SUPPLY 1, 352 0 7, 899 0 1, 313 15. 00				ŭ				
15. 00 01500 PIARMACY 742 0 7, 899 0 1, 313 15. 00 1, 313 15. 00 1, 317 15.				ŭ	7, 753			
NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 ABULTS & PEDIATRIC S 6,199 48,765 30,442 46,461 3,228 30.00 ABULTS & PEDIATRIC S 6,199 48,765 30,442 46,461 3,228 30.00 ABULTS & PEDIATRIC S 50.00 50.00 50.00 50.00 60.00		1 1		-	0	-1	· ·	
30.00	15. 00		742	0	7, 899	0	1, 313	15.00
ANCILLARY SERVICE COST CENTERS Solution Continue								
50.00	30.00		6, 199	48, 765	30, 442	46, 461	3, 228	30.00
53.00 05300 AMESTHESI OLOGY 149 0 968 0 0 53.00			7 000		44.044	20 (51	47.505	
54.00 05400 RADI OLOGY-DI AGNOSTI C 4,122 0 14,645 0 704 54.00 60.00 06000 LABORATORY 1,611 0 9,496 0 911 60.00 60.00 05500 RESPIRATORY THERAPY 98 0 6,398 0 1,370 65.00 65.00 06500 RESPIRATORY THERAPY 753 0 8,392 0 502 66.00 66.00 06000 PHYSI CAL THERAPY 753 0 3,156 0 24 67.00 67.00 06700 0CCUPATI ONAL THERAPY 753 0 3,156 0 24 67.00 69.00 06900 ELECTROCARDI OLOGY 29 0 281 0 1 68.00 69.00 06900 ELECTROCARDI OLOGY 1,072 0 5,750 7,925 352 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 15,501 71.00 73.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 45,478 72.00 73.00 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 45,478 72.00 73.01 03480 0NCOLOGY 646 0 2,865 3,111 505 73.01 73.02 0301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 0 76.00 76.00 76.00 76.90 0 0 0 0 0 0 0 0 0		1 1						
60. 00 06000 LABORATORY 1, 611 0 9, 496 0 911 60. 00 65. 00 06500 RESPIRATORY THERAPY 98 0 6,398 0 1,370 65. 00 66. 00 06600 PHYSI CAL THERAPY 2,275 0 8,392 0 502 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 753 0 3,156 0 24 67. 00 68. 00 06800 SPECH PATHOLOGY 29 0 281 0 1 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,072 0 5,750 7,925 352 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 15,501 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 45,478 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 01 03480 ONCOLOGY 646 0 2,865 3,111 505 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 76. 90 03160 CARDI OPULMONARY 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 703 0 997 2,349 38 76. 97 91. 00 09100 EMERGENCY 4,563 0 15,400 21,388 3,244 91. 00 99200 DRSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS		1 1	1	-		- 1		1
65. 00 06500 RESPIRATORY THERAPY 98 0 6,398 0 1,370 65. 00 66. 00 06600 PHYSI CAL THERAPY 2,275 0 8,392 0 502 66. 00 67. 00 06700 DCUPATI ONAL THERAPY 753 0 3,156 0 24 67. 00 68. 00 06800 SPECH PATHOLOGY 29 0 281 0 1 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1,072 0 5,750 7,925 352 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 15,501 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 01 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 01 03480 ONCOLOGY 646 0 2,865 3,111 505 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76. 07 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 70. 00 09200 DSERVATI ON BEDS (NON-DI STINCT PART SPECI AL PURPOSE COST CENTERS				0		۰		
66. 00 06600 PHYSI CAL THERAPY 2, 275 0 8, 392 0 502 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 753 0 3, 156 0 24 67. 00 68. 00 06800 SPEECH PATHOLOGY 29 0 281 0 1 68. 00 69. 00 06900 ELECTROCARDI OLOGY 1, 072 0 5,750 7, 925 352 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 15,501 71. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 45,478 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73. 01 03480 ONCOLOGY 646 0 2,865 3,111 505 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 76. 00 03160 CARDI OPULMONARY 0 0 0 0 77. 07. 0797 CARDI AC REHABILI TATI ON 703 0 997 2,349 38 76. 97 OTOPOTI EMERGENCY 4,563 0 15,400 21,388 3,244 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECI AL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 36,351 48,765 128,506 103,888 90,696 119. 00 19200 PHYSI CIANS* PRI VATE OFFICES 5,610 0 1,549 0 18 192. 00 19200 OCCUPATI ONAL MEDI CI NE 591 0 1,094 2,575 69 192. 01 192. 01 19201 OCCUPATI ONAL MEDI CI NE 591 0 1,094 2,575 69 192. 01 192. 02 1000 Negati ve Cost Centers 0 0 0 0 0 200. 00 0 0 0 0 0 0 0 200. 00 0 0 0 0 0 0 200. 00 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 0 201. 00 0 0 201. 00 0 0 200. 00 0 0 201. 00 0 0 201. 00 0 0 202.				0		۰		
67. 00 06700 OCCUPATI ONAL THERAPY 753 0 3, 156 0 24 67. 00 68. 00 06800 SPEECH PATHOLOGY 29 0 281 0 1 68. 00 68. 00 06800 SPEECH PATHOLOGY 29 0 281 0 1 68. 00 1 68. 00 1 68. 00 06900 ELECTROCARD IOLOGY 1, 072 0 5,750 7,925 352 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 15,501 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 45,478 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 45,478 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 73. 00 73. 01 03480 ONCOLOGY 646 0 2,865 3,111 505 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 76. 00 76. 00 03160 CARDI OPULMONARY 0 0 997 2,349 38 76. 97 00000000000000000000000000000000000				0		U O	· ·	
68.00 06800 SPEECH PATHOLOGY 29 0 281 0 1 68.00 69.00 69.00 ELECTROCARDI OLOGY 1,072 0 5,750 7,925 352 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 15,501 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 45,478 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 45,478 72.00 073.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 73.00 73.00 73.01 03480 ONCOLOGY 646 0 2,865 3,111 505 73.01 73.02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 0 0 73.02 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76.00 76.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1		0		U O		
69. 00		1 1		0		-1		
71. 00		1 1	1	0		-1		1
72. 00			1,072	0				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 73. 01 03480 ONCOLOGY 646 0 2, 865 3, 111 505 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LITATI ON 703 0 997 2, 349 38 76. 97 0017PATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 9. 0 15, 400 21, 388 3, 244 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART SPECIAL PURPOSE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 610 0 1, 549 0 18 192. 00 192. 01 19201 OCCUPATI ONAL MEDI CI NE 591 0 1, 094 2, 575 69 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 0 0 0 192. 02 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 201. 00			0	0		-1		
73. 01 03480 ONCOLOGY 646 0 2,865 3,111 505 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 703 0 997 2,349 38 76. 97 91. 00 09100 EMERGENCY 0920 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 NONREI MBURSABLE COST CENTERS 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 36, 351 48, 765 128, 506 103, 888 90, 696 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 610 0 1, 549 0 18 192. 00 192. 01 19201 OCCUPATI ONAL MEDI CI NE 591 0 1, 094 2, 575 69 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 0 0 0 0 0 0 0 201. 00 200. 00 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 201. 00			0	0		0		
73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 703 0 997 2, 349 38 76. 97 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 36, 351 48, 765 128, 506 103, 888 90, 696 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 610 0 1, 549 0 18 192. 00 192. 01 19201 OCCUPATI ONAL MEDI CI NE 591 0 1, 094 2, 575 69 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 0 0 0 192. 02 200. 00 Cross Foot Adj ustments 0 Negati ve Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			646	0	J	2 111	-	
76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 0 0 76. 00 76. 97 07697 CARDI AC REHABILITATION 703 0 997 2, 349 38 76. 97 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 9. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 09201. 00 09			040	0				
76. 97				0	_	۰	-	
OUTPATI ENT SERVI CE COST CENTERS 91.00 09100 EMERGENCY 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92.00 OSUBTOTALS (SUM OF LINES 1 through 117) 36,351 48,765 128,506 103,888 90,696 118.00 OSUBTOTALS (SUM OF LINES 1 through 117) 36,351 48,765 128,506 103,888 90,696 118.00 OSUBTOTALS (SUM OF LINES 1 through 117) OSUBTOTALS (SUM OF LINES 1 through 117) 36,351 48,765 128,506 103,888 90,696 118.00 OSUBTOTALS (SUM OF LINES 1 through 117) OSUBTOTALS (SUM OF LINES 1 through 118, OSUBTOTALS (SUM OF LINES 1 through 117) OSUBTOTALS (SUM OF LINES 1 through 117) OSUBTOTALS (1	703	-	-	٥	-	
91. 00	70.77		700	<u> </u>	771	2,017		70.77
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART	91.00		4, 563	0	15. 400	21, 388	3. 244	91.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 36,351 48,765 128,506 103,888 90,696 118.00			1, 555	Ŭ.	10, 100	21,000	0,2	1
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 36, 351 48, 765 128, 506 103, 888 90, 696 118. 00	,2,00							1 /2:00
NONRE MBURSABLE COST CENTERS 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5,610 0 1,549 0 18 192.00 192.01 19201 OCCUPATI ONAL MEDI CI NE 591 0 1,094 2,575 69 192.01 192.02 19202 VACANT SPACE 0 0 0 0 0 192.02 200.00 Cross Foot Adjustments 200.00 Negati ve Cost Centers 0 0 0 0 0 0 0 201.00	118.00		36, 351	48. 765	128, 506	103, 888	90, 696	118.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 5, 610 0 1, 549 0 18 192. 00 192. 01 19201 0CCUPATI ONAL MEDI CI NE 591 0 1, 094 2, 575 69 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0			20,000		1=0,700			1
192. 01 19201 OCCUPATI ONAL MEDI CI NE 591 0 1,094 2,575 69 192. 01 192. 02 19202 VACANT SPACE 0 0 0 0 0 192. 02 200. 00 Cross Foot Adj ustments 200. 00 0 0 0 0 0 0 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 0	192.00		5, 610	0	1, 549	0	18	192. 00
192. 02 19202 VACANT SPACE 0 0 0 0 192. 02 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0						2, 575		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0<			o	o	0			
201.00 Negative Cost Centers 0 0 0 0 201.00		1 1	1			آ ا		
		1 1	o	o	0	o	0	201.00
	202.00		42, 552	48, 765	131, 149	106, 463	90, 783	202.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	I	n Lieu of Form CMS-2552-10
ALLOCATION OF CARLTAL BELATED COSTS	Provi dor CCN: 15 1211	Pari ad:	Workshoot P

Heal th	Financial Systems	IU HEALIH IIPI	ON HOSPITAL		In Lieu	u of Form CMS-2552-	-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der C		eri od:	Worksheet B	
				To	rom 01/01/2020 12/31/2020	Part II Date/Time Prepared	·d·
					12/01/2020	7/9/2021 10: 17 am	<u>u.</u>
	Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
				Resi dents			
				Cost & Post			
				Stepdown			
		15.00	24. 00	Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	15. 00	24.00	25. 00	26. 00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT					1	00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES					1.	
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					· · · · · · · · · · · · · · · · · · ·	00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						00
5. 00	00500 ADMINISTRATIVE & GENERAL					· · · · · · · · · · · · · · · · · · ·	00
7. 00	00700 OPERATION OF PLANT						00
7. 01	00701 OPERATION OF PLANT - OFFSITE					7.	01
8.00	00800 LAUNDRY & LINEN SERVICE					8.	00
9.00	00900 HOUSEKEEPI NG					9.	00
10.00	01000 DI ETARY					10.	00
11.00	01100 CAFETERI A					11.	00
13.00	01300 NURSI NG ADMI NI STRATI ON					13.	00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.	00
15.00	01500 PHARMACY	63, 473				15.	00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	85	638, 356	0	638, 356	30.	00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	127	568, 852		568, 852	50.	
53. 00	05300 ANESTHESI OLOGY	0	10, 837		10, 837	53.	
54.00	05400 RADI OLOGY-DI AGNOSTI C	19	289, 281	0	289, 281	54.	
60.00	06000 LABORATORY	0	121, 992		121, 992	60.	
65.00	06500 RESPI RATORY THERAPY	3	18, 785		18, 785	65.	
66.00	06600 PHYSI CAL THERAPY	3	132, 001	0	132, 001	66.	
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	43, 958 1, 980		43, 958 1, 980	67.	
69.00	06900 ELECTROCARDI OLOGY	0	87, 109		87, 109	69.	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2	17, 947		17, 947	71.	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS		52, 655		52, 655	72.	
73. 00	07300 DRUGS CHARGED TO PATIENTS	48, 409	72, 311		72, 311	73.	
73. 01	03480 ONCOLOGY	34	49, 922		49, 922	73.	
73. 02	07301 BLOOD DI SORDER DRUGS	14, 508	21, 672		21, 672	73.	
76. 00	03160 CARDI OPULMONARY	0	0	- 1	0	76.	
76. 97	07697 CARDI AC REHABI LI TATI ON	l o	49, 109		49, 109	76.	
	OUTPATIENT SERVICE COST CENTERS	-1	,	-1	,		
91.00	09100 EMERGENCY	207	345, 226	0	345, 226	91.	00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0		92.	00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	63, 397	2, 521, 993	0	2, 521, 993	118.	00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	317, 958	0	317, 958	192.	00
	19201 OCCUPATI ONAL MEDICINE	76	42, 432		42, 432	192.	
	19202 VACANT SPACE	0	0		0	192.	
200.00	3		0	- 1	0	200.	
201.00		0	0	0	0	201.	
202.00	TOTAL (sum lines 118 through 201)	63, 473	2, 882, 383	0	2, 882, 383	202.	00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1311 Peri od: Worksheet B-1 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am CAPITAL RELATED COSTS BLDG & FIXT BLDG & FIXT -MVBLE EQUIP **EMPLOYEE** Reconciliatio Cost Center Description (SOUARE FEET) INTERES (SQUARE FEET) **BENEFITS** n (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1. 00 1. 01 2.00 4.00 5A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 196, 565 1 00 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1.01 172, 228 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 201.311 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 871 871 871 11, 443, 386 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 12, 355 12, 355 12, 355 770, 493 -8, 422, 463 5.00 7.00 00700 OPERATION OF PLANT 47, 302 41, 501 47, 302 891, 983 0 7.00 00701 OPERATION OF PLANT - OFFSITE 7 01 0 7 01 0 00800 LAUNDRY & LINEN SERVICE 59, 571 8.00 3, 213 3, 213 3, 213 0 8.00 9.00 00900 HOUSEKEEPI NG 1, 917 1, 917 1, 917 351, 341 0 9.00 10.00 01000 DI ETARY 2, 267 2, 267 2, 267 103, 891 0 10.00 01100 CAFETERI A 11 00 281, 182 0 11 00 6.135 6, 135 6.135 01300 NURSING ADMINISTRATION 13.00 4, 387 4, 387 4, 387 802, 245 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14.00 14.00 4.158 4. 158 4, 158 01500 PHARMACY 2, 283 2, 283 711, 978 0 15.00 15.00 2.283 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 070 19, 070 23, 816 1, 882, 063 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 24, 247 24, 247 n 50.00 24.247 1 010 847 53.00 05300 ANESTHESI OLOGY 457 457 457 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 12, 682 12, 682 12, 682 1, 072, 407 54.00 0 54.00 60.00 06000 LABORATORY 4, 955 4, 955 4, 955 0 60.00 06500 RESPIRATORY THERAPY 300 533, 410 65.00 300 300 0 65 00 6, 999 66.00 06600 PHYSI CAL THERAPY 2, 515 6, 999 687, 793 0 66.00 06700 OCCUPATI ONAL THERAPY 237, 318 67.00 2, 318 833 2, 318 0 67.00 06800 SPEECH PATHOLOGY 68.00 88 32 88 24.878 0 68.00 06900 ELECTROCARDI OLOGY 69.00 3, 297 3, 297 3.297 504, 218 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 C 0 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 03480 ONCOLOGY 73 01 1.987 1, 987 1.987 216, 393 0 73 01 07301 BLOOD DI SORDER DRUGS 0 73.02 73.02 03160 CARDI OPULMONARY 76.00 0 76.00 07697 CARDIAC REHABILITATION 2, 163 2, 163 76.97 79, 584 76.97 2, 163 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 14.039 14,039 14.039 1,063,963 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 177, 490 165, 664 182, 236 11, 285, 558 -8, 422, 463 118. 00 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 17, 258 4, 747 17, 258 0 192. 00 104, 443 192. 01 19201 OCCUPATIONAL MEDICINE 0 192.01 1,817 1, 817 1,817 53, 385 192. 02 19202 VACANT SPACE 0 192.02 Cross Foot Adjustments 200.00 200.00 201 00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 559, 457 108, 173 1, 214, 753 2, 579, 402 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 7. 933544 0.628080 6.034211 0. 225405 203.00 204.00 Cost to be allocated (per Wkst. B, 12,713 l<u>2</u>04. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001111 205.00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207. 00 207.00

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2020 Provider CCN: 15-1311

				T	o 12/31/2020		
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	·	E & GENERAL	PLANT	PLANT -	LINEN SERVICE	(SQUARE FEET)	
		(ACCUM. COST)	(SQUARE FEET)	OFFSI TE	(TOTAL		
					PATIENT DAYS)		
		5. 00	7. 00	7. 01	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS		1	ı			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	20 200 254	•				4.00
5.00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	30, 300, 354	l .				5.00
7. 00 7. 01	00700 OPERATION OF PLANT - OFFSITE	5, 249, 737	123, 831 0	1			7. 00 7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	178, 080	_				8.00
9. 00	00900 HOUSEKEEPI NG	509, 695	1			130, 907	9.00
10.00	01000 DI ETARY	277, 318	1		_	2, 267	1
11. 00	01100 CAFETERI A	613, 563	1	•	_	6, 135	1
13. 00	01300 NURSING ADMINISTRATION	1, 151, 298	1		_		1
14. 00	01400 CENTRAL SERVICES & SUPPLY	768, 264	1		-		1
	01500 PHARMACY	1, 028, 044	1		-		1
13.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,020,044	2, 203		0	2, 203	13.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 787, 330	19, 070	0	1, 938	19, 070	30.00
	ANCILLARY SERVICE COST CENTERS		,,		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,	1
50.00	05000 OPERATI NG ROOM	1, 798, 784	24, 247	0	0	24, 247	50.00
53.00	05300 ANESTHESI OLOGY	66, 090	1		0		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 646, 432	l .	0	0	12, 682	54.00
60.00	06000 LABORATORY	1, 484, 185	4, 955	0	0	4, 955	60.00
65.00	06500 RESPI RATORY THERAPY	702, 880	300	0	0	300	65.00
66.00	06600 PHYSI CAL THERAPY	1, 023, 246	2, 515	4, 484	0	6, 999	66.00
67.00	06700 OCCUPATI ONAL THERAPY	338, 259	833	1, 485	0	2, 318	67.00
68.00	06800 SPEECH PATHOLOGY	34, 498	32	56	0	88	68.00
69.00	06900 ELECTROCARDI OLOGY	698, 626	3, 297	0	0	3, 297	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	409, 034	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 200, 134	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 996, 998		0	0	0	
73. 01	03480 ONCOLOGY	331, 163	1, 987		_	1, 987	
73. 02	07301 BLOOD DI SORDER DRUGS	1, 197, 921	0		-	0	
	03160 CARDI OPULMONARY	0	0	·		-	
76. 97	07697 CARDI AC REHABI LI TATI ON	133, 881	2, 163	0	0	2, 163	76. 97
04.00	OUTPATIENT SERVICE COST CENTERS	0 440 405	14.000			44.000	04.00
	09100 EMERGENCY	2, 140, 435	14, 039	0	0	14, 039	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00		29, 765, 895	110, 937	6, 025	1, 938	111, 832	118 00
110.00	NONREI MBURSABLE COST CENTERS	27, 703, 073	110, 737	0,023	1, 730	111,032	1110.00
192 00	19200 PHYSI CI ANS' PRI VATE OFFI CES	384, 587	11, 077	6, 181	0	17 258	192. 00
	19201 OCCUPATI ONAL MEDICINE	149, 872			-		192. 01
	19202 VACANT SPACE	0	0				192. 02
200.00	1	_		_		_	200.00
201.00	1 1						201.00
202.00	9	8, 422, 463	6, 708, 980	0	401, 656	755, 233	1
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 277966			207. 252838	5. 769233	203.00
204.00	Cost to be allocated (per Wkst. B,	181, 188	719, 145		66, 686	42, 552	204.00
	Part II)						
205.00	, , , , , , , , , , , , , , , , , , , ,	0. 005980	5. 807471	0. 000000	34. 409701	0. 325055	205.00
00/ 00							00/ 00
206.00							206. 00
207.00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						
		i e	t .	1	ı l		1

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od: Worksheet B-1		
				From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
Overland Development	DIETADY	OAFFTED! A	NUDCINO	OFNEDAL	7/9/2021 10: 1	7 am
Cost Center Description	DI ETARY (MEALS	CAFETERI A (FTE' S)	NURSI NG ADMI NI STRATI (CENTRAL SERVICES &	PHARMACY (COSTED	
	SERVED)	(112 3)	N N	SUPPLY	REQUIS.)	
	,		(DI RECT	(COSTED		
			NURSI NG	REQUIS.)		
	10.00	11.00	HOURS)	14.00	45.00	
GENERAL SERVICE COST CENTERS	10. 00	11. 00	13. 00	14.00	15. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 0PERATI ON OF PLANT						7. 00
7. 01 00701 OPERATION OF PLANT - OFFSITE 8. 00 00800 LAUNDRY & LINEN SERVICE						7. 01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY	6, 594					10.00
11. 00 01100 CAFETERI A	0, 3,4	13, 549				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	l ol	801	97, 04	9		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	O	0		2, 395, 604		14.00
15. 00 01500 PHARMACY	0	816		34, 637	5, 240, 808	15. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 594	3, 145	42, 35	85, 193	7, 018	30.00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		1 452	20.45	1 462, 438	10, 491	50.00
50. 00 05000 OPERATI NG ROOM 53. 00 05300 ANESTHESI OLOGY	0	1, 453 100		0 402, 438	10, 491	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		1, 513	•	18, 579	1, 574	1
60. 00 06000 LABORATORY	l ol	981		24, 030	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	661		36, 164	235	
66. 00 06600 PHYSI CAL THERAPY	0	867		13, 238	234	66. 00
67.00 06700 OCCUPATIONAL THERAPY	0	326		621	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	29		23	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	594			171	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		409, 034	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		1, 200, 134	3, 996, 998	
73. 00 07300 DR003 CHARGED TO FATTENTS	0	296	2, 83	13, 336	2, 769	1
73. 02 07301 BLOOD DI SORDER DRUGS	o o	0		0 10,000	1, 197, 921	
76. 00 03160 CARDI OPULMONARY	0	0		o o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	103	2, 14	1 991	9	76. 97
OUTPATIENT SERVICE COST CENTERS	_1					
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 591	19, 49	85, 593	17, 090	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS						92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 594	13, 276	94, 70	2, 393, 306	5, 234, 510	118.00
NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	160		487		192.00
192. 01 19201 OCCUPATI ONAL MEDI CI NE	0	113	2, 34	7 1, 811		192. 01
192. 02 19202 VACANT_SPACE	0	0	1	이	0	192. 02
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	400 205	1 151 000	1 902 40	1 221 077	1, 537, 840	201.00
Part I)	490, 305	1, 151, 892	1, 802, 40	9 1, 231, 077	1, 557, 640	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	74. 356233	85. 016754	18. 57215	0. 513890	0. 293436	203. 00
204.00 Cost to be allocated (per Wkst. B,	48, 765	131, 149		I I		204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	7. 395359	9. 679607	1. 09700	0. 037896	0. 012111	205. 00
NAME adjustment amount to be allocated						204 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUT	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der 0		Period: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Pre 7/9/2021 10:1	
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	_					
	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	6, 697, 080		6, 697, 08	0	0	30.00
50.00	05000 OPERATING ROOM	4, 500, 120		4, 500, 12	0 0	0	50.00
53 00	05300 ANESTHESLOLOGY	120 360		120 36	n l	l n	53 00

					00313		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	,					
30.00	03000 ADULTS & PEDIATRICS	6, 697, 080		6, 697, 080	0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 500, 120		4, 500, 120	0	0	50.00
53.00	05300 ANESTHESI OLOGY	120, 360		120, 360	0	0	00.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 002, 981		3, 002, 981	0	0	54.00
60.00	06000 LABORATORY	2, 289, 530		2, 289, 530	0	0	60.00
65.00	06500 RESPI RATORY THERAPY	991, 091	0	991, 091	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 564, 894	0	1, 564, 894	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	518, 822	0	518, 822	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	48, 806	0	48, 806	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	1, 279, 960		1, 279, 960	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	732, 930		732, 930	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 150, 467		2, 150, 467	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 280, 889		6, 280, 889	0	0	73.00
73. 01	03480 ONCOLOGY	627, 833		627, 833	0	0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	1, 882, 415		1, 882, 415	0	0	73. 02
76.00	03160 CARDI OPULMONARY	0		0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	349, 794		349, 794	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	4, 123, 372		4, 123, 372	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 023, 458		1, 023, 458		0	92.00
200. C	O Subtotal (see instructions)	38, 184, 802	0	38, 184, 802	0	0	200.00
201.0	O Less Observation Beds	1, 023, 458		1, 023, 458		0	201.00
202.0	O Total (see instructions)	37, 161, 344	0	37, 161, 344	0	0	202. 00

Health Financial Systems	IU HEALTH TIPT			In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2020 Fo 12/31/2020	Worksheet C Part I Date/Time Pre 7/9/2021 10:1	
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7.00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 570, 756		4, 570, 756	5		30.00
ANCILLARY SERVICE COST CENTERS				_		
50.00 05000 OPERATING ROOM	4, 599, 178	20, 007, 066			0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	224, 787	1, 259, 903			0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	385, 667	7, 799, 822			0. 000000	
60. 00 06000 LABORATORY	713, 223	4, 018, 786	4, 732, 00		0. 000000	60.00
65. 00 06500 RESPIRATORY THERAPY	462, 482	499, 765			0. 000000	
66. 00 06600 PHYSI CAL THERAPY	589, 458	1, 405, 551	1, 995, 009	0. 784404	0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY	266, 486	463, 186	729, 672	0. 711035	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	33, 496	41, 728	75, 22	0. 648809	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	272, 272	3, 629, 773	3, 902, 04	0. 328023	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	923, 627	3, 013, 229	3, 936, 856	0. 186171	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 722, 284	7, 269, 787	13, 992, 07°	0. 153692	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 333, 335	17, 192, 145	19, 525, 480	0. 321677	0.000000	73.00
73. 01 03480 ONCOLOGY	840	2, 576, 705	2, 577, 545	0. 243578	0.000000	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0	10, 314, 240	10, 314, 240	0. 182506	0.000000	73. 02
76. 00 03160 CARDI OPULMONARY	0	0	(0.000000	0.000000	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	514, 367	514, 36	0. 680048	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
01 00 00100 EMERCENCY	217 400	11 706 706	12 114 104	0 240270	0 000000	I 01 00

317, 400

15, 975 22, 431, 266

22, 431, 266

11, 796, 706 1, 959, 019 93, 761, 778

93, 761, 778

12, 114, 106 1, 974, 994

116, 193, 044

116, 193, 044

0. 340378

0.518208

0.000000

0.000000

91.00

92.00

200.00

202.00

91.00

200.00

202.00

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Subtotal (see instructions)
Less Observation Beds

Health Financial Systems	IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-					
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311	Peri od: From 01/01/2020 To 12/31/2020	Worksheet C Part I Date/Time Prep 7/9/2021 10:1:	pared:	
		Title XVIII	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio 11.00					
INPATIENT ROUTINE SERVICE COST CENTERS	11100					
30. 00 03000 ADULTS & PEDIATRICS					30.00	
ANCILLARY SERVICE COST CENTERS	·					
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00	
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00	
60. 00 06000 LABORATORY	0. 000000				60.00	
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00	
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00	
73. 01 03480 ONCOLOGY	0. 000000				73.01	
73. 02 07301 BLOOD DI SORDER DRUGS	0. 000000				73.02	
76.00 03160 CARDI OPULMONARY	0. 000000				76.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97	
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00	
200.00 Subtotal (see instructions)					200. 00	
201.00 Less Observation Beds					201. 00	
202.00 Total (see instructions)					202.00	

91. 00 92. 00 200. 00 201. 00 202. 00

202.00

Total (see instructions)

Heal th	Financial Systems	IU HEALTH TIP	TON H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		F	Provi der CC	CN: 15-1311	Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
-							7/9/2021 10:1	7 am
				Ti tl	e XIX	Hospi tal	Cost	
						Costs		
	Cost Center Description	Total Cost	Ther	apy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.		Adj .		Di sal I owance		
		B, Part I,						
		col. 26)						
		1. 00		2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00	03000 ADULTS & PEDIATRICS	6, 697, 080)		6, 697, 08	0 0	6, 697, 080	30.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4, 500, 120)		4, 500, 12	0 0	4, 500, 120	50.00

				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
·	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	6, 697, 080		6, 697, 080	0	6, 697, 080	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	4, 500, 120		4, 500, 120	0	4, 500, 120	50.00
53. 00 05300 ANESTHESI OLOGY	120, 360		120, 360	0	120, 360	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 002, 981		3, 002, 981	0	3, 002, 981	54.00
60. 00 06000 LABORATORY	2, 289, 530		2, 289, 530	0	2, 289, 530	60.00
65. 00 06500 RESPI RATORY THERAPY	991, 091	0	991, 091	0	991, 091	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 564, 894	0	1, 564, 894	0	1, 564, 894	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	518, 822	0	518, 822	0	518, 822	67.00
68. 00 06800 SPEECH PATHOLOGY	48, 806	0	48, 806	0	48, 806	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 279, 960		1, 279, 960	0	1, 279, 960	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	732, 930		732, 930	0	732, 930	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	2, 150, 467		2, 150, 467	0	2, 150, 467	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 280, 889		6, 280, 889	0	6, 280, 889	73.00
73. 01 03480 ONCOLOGY	627, 833		627, 833	0	627, 833	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	1, 882, 415		1, 882, 415	0	1, 882, 415	73. 02
76. 00 03160 CARDI OPULMONARY	0		0	0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	349, 794		349, 794	0	349, 794	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	4, 123, 372		4, 123, 372	0	4, 123, 372	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 023, 458		1, 023, 458		1, 023, 458	
200.00 Subtotal (see instructions)	38, 184, 802		38, 184, 802		38, 184, 802	
201.00 Less Observation Beds	1, 023, 458		1, 023, 458		1, 023, 458	
202.00 Total (see instructions)	37, 161, 344	0	37, 161, 344	0	37, 161, 344	202.00

Health Financial Cyatama	III UEALTU TIDT	ON HOSDITAL		ام الما	. of Form CMC	DEED 10
Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	IU HEALTH TIPT	Provi der C		Period: From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6. 00	7. 00	8.00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	4, 570, 756		4, 570, 75	6		30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	4, 599, 178	20, 007, 066	24, 606, 24	4 0. 182885	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	224, 787	1, 259, 903	1, 484, 69	0. 081067	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	385, 667	7, 799, 822	8, 185, 48	9 0. 366866	0.000000	54.00
60. 00 06000 LABORATORY	713, 223	4, 018, 786	4, 732, 00	9 0. 483839	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	462, 482	499, 765	962, 24	7 1. 029976	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	589, 458	1, 405, 551	1, 995, 00	9 0. 784404	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	266, 486	463, 186	729, 67	0. 711035	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	33, 496	41, 728	75, 22	0. 648809	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	272, 272	3, 629, 773	3, 902, 04	5 0. 328023	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	923, 627	3, 013, 229	3, 936, 85	6 0. 186171	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 722, 284	7, 269, 787	13, 992, 07	0. 153692	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 333, 335	17, 192, 145	19, 525, 48	0. 321677	0.000000	73.00
70 04 00 400 01001 001/	1 0.40					

840

317, 400

15, 975 22, 431, 266

22, 431, 266

0

0

17, 192, 145 2, 576, 705

10, 314, 240

11, 796, 706

1, 959, 019

93, 761, 778

93, 761, 778

514, 367

2, 577, 545

514, 367

10, 314, 240

12, 114, 106

1, 974, 994

116, 193, 044

116, 193, 044

0. 243578

0. 182506

0.000000

0. 680048

0. 340378

0.518208

0.000000

0.000000

0.000000

0.000000

0.000000

0.000000

73.01

73.02

76.00

76. 97

91.00

92.00

200.00

201.00

202.00

73.01

73.02

76.00

76. 97

91.00

200.00

201.00

202.00

03480 ONCOLOGY

09100 EMERGENCY

07301 BLOOD DI SORDER DRUGS

07697 CARDIAC REHABILITATION
OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

03160 CARDI OPULMONARY

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311	Peri od:	Worksheet C	
			From 01/01/2020 To 12/31/2020	Part I Date/Time Pre	narod:
			10 12/31/2020	7/9/2021 10: 1	pareu. 7 am
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient		<u> </u>		
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATI NG ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73. 01 03480 ONCOLOGY	0. 000000				73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 000000				73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000				76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
OUTPATIENT SERVICE COST CENTERS					
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLARY	SERVICE CAPITAL COSTS Provider CCN: 15	-1311 Period: Worksheet D

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 01/01/2020 To 12/31/2020		
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	568, 852		•			
53. 00 05300 ANESTHESI OLOGY	10, 837		•		1, 065	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	289, 281	8, 185, 489	l .		5, 627	
60. 00 06000 LABORATORY	121, 992					
65. 00 06500 RESPIRATORY THERAPY	18, 785					
66. 00 06600 PHYSI CAL THERAPY	132, 001	1, 995, 009			19, 509	
67. 00 06700 OCCUPATI ONAL THERAPY	43, 958				7, 940	
68.00 06800 SPEECH PATHOLOGY	1, 980	75, 224	0. 02632	19, 434	512	68.00
69. 00 06900 ELECTROCARDI OLOGY	87, 109	3, 902, 045	0. 02232	4 127, 216	2, 840	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17, 947	3, 936, 856	0. 00455	9 601, 302	2, 741	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	52, 655	13, 992, 071	0. 00376	3 4, 736, 867	17, 825	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	72, 311	19, 525, 480	0. 00370	1, 085, 241	4, 019	73.00
73. 01 03480 ONCOLOGY	49, 922	2, 577, 545	0. 01936	8 0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	21, 672	10, 314, 240	0. 00210	1 0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0	0	0.00000	0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	49, 109	514, 367	0. 09547	5 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	345, 226	12, 114, 106	0. 02849	8 2, 839	81	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	97, 555	1, 974, 994	0. 04939	5 0	0	92.00
200.00 Total (lines 50 through 199)	1, 981, 192	111, 622, 288		10, 922, 743	145, 831	200.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1311	Peri od: Worksheet D
THROUGH COSTS		From 01/01/2020 Part IV

THROOG	30010			-	Го 12/31/2020	Date/Time Pre 7/9/2021 10:1	
			Title	xVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(0	0	00.00
53. 00	05300 ANESTHESI OLOGY	0	0	(0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	0	54.00
60.00	06000 LABORATORY	0	0	(0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	0	(0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
73. 01	03480 ONCOLOGY	0	0	(0	0	73. 01
	07301 BLOOD DI SORDER DRUGS	0	0	(0	0	73. 02
76. 00	03160 CARDI OPULMONARY	0	0	(0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		1		1		1
91.00	09100 EMERGENCY	0	0	(0		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	72.00
200.00	Total (lines 50 through 199)	0	0	(0	0	200.00

Health Financial Systems	IU HEALTH TIPTO	ON HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1311	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Prepared: 7/9/2021 10:17 am
		Title XVIII	Hospi tal	Cost

				0 12/31/2020	7/9/2021 10:1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	(24, 606, 244		
53. 00 05300 ANESTHESI OLOGY	0	0	(1, 484, 690		l
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	(8, 185, 489		
60. 00 06000 LABORATORY	0	0	(4, 732, 009		60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	(962, 247		
66. 00 06600 PHYSI CAL THERAPY	0	0	(1, 995, 009		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	(729, 672		
68.00 06800 SPEECH PATHOLOGY	0	0	(75, 224		ł
69. 00 06900 ELECTROCARDI OLOGY	0	0	(3, 902, 045		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(3, 936, 856		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(13, 992, 071		1
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	(19, 525, 480		
73. 01 03480 ONCOLOGY	0	0	(2, 577, 545		
73. 02 07301 BLOOD DI SORDER DRUGS	0	0	(10, 314, 240		
76. 00 03160 CARDI OPULMONARY	0	0	(0	0.000000	1
76. 97 O7697 CARDIAC REHABILITATION	0	0	(514, 367	0.000000	76. 97
OUTPATIENT SERVICE COST CENTERS				T		
91. 00 09100 EMERGENCY	0	0	(,,		1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(1
200.00 Total (lines 50 through 199)	0	0	(111, 622, 288		200. 00

Health Financial Systems	ı	U HEALTH T	I PTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERV	ICE OTHER	PASS	Provi der	CCN: 15-1311	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV Date/Time Pre 7/9/2021 10:1	
				Ti t	e XVIII	Hospi tal	Cost	
Cost Contor Doscription		Outpation	+	Innationt	Innationt	Outpationt	Outpationt	

				10	3 12/31/2020	7/9/2021 10: 1	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS			,			
1	05000 OPERATING ROOM	0. 000000	3, 029, 493		0	0	50.00
	05300 ANESTHESI OLOGY	0. 000000	145, 967		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	159, 211		0	0	54.00
	06000 LABORATORY	0. 000000	343, 150		0	0	60.00
	06500 RESPI RATORY THERAPY	0. 000000	245, 379		0	0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	294, 847		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	131, 797		0	0	67.00
1	06800 SPEECH PATHOLOGY	0. 000000	19, 434		0	0	68.00
	06900 ELECTROCARDI OLOGY	0. 000000	127, 216		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	601, 302		0	0	71.00
1	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 736, 867		0	0	72.00
1	07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 085, 241	0	0	0	73.00
73. 01	03480 ONCOLOGY	0. 000000	0	0	0	0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0. 000000	0	0	0	0	73.02
76.00	03160 CARDI OPULMONARY	0. 000000	0	0	0	0	76.00
-	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0. 000000	2, 839	0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	0	0	0	92.00
200.00	Total (lines 50 through 199)		10, 922, 743	0	0	0	200. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der C		Period: From 01/01/2020 To 12/31/2020		epared:
		Title	e_XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 182885	 	3, 303, 37		0	
53. 00 05300 ANESTHESI OLOGY	0. 081067		128, 12		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 366866	1	2, 325, 82		0	
60. 00 06000 LABORATORY	0. 483839	1	1, 229, 36		0	
65. 00 06500 RESPI RATORY THERAPY	1. 029976	1	183, 63		0	
66. 00 06600 PHYSI CAL THERAPY	0. 784404	1	471, 94		0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 711035	1	97, 47		0	
68. 00 06800 SPEECH PATHOLOGY	0. 648809	l control of the cont	12, 82		0	
69. 00 06900 ELECTROCARDI OLOGY	0. 328023	l control of the cont	1, 255, 63		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 186171	l control of the cont	803, 64		0	
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 153692	l control of the cont	1, 356, 83		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 321677	l .	9, 553, 68		l .	
73. 01 03480 ONCOLOGY	0. 243578	l control of the cont	1, 181, 21		0	
73. 02 07301 BLOOD DI SORDER DRUGS	0. 182506		3, 402, 07	8 0	0	
76. 00 03160 CARDI OPULMONARY	0. 000000)	0	0	
76. 97 07697 CARDIAC REHABILITATION	0. 680048	3 0	196, 93	9 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 340378					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 518208	8 0				
200.00 Subtotal (see instructions)		0	29, 701, 89	5 1, 773	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges 202.00 Net Charges (line 200 - line 201)			29, 701, 89	1, 773	1	202. 00
202.00 Net charges (Time 200 - Time 201)	1	1	27, ۱۰۱, ۵۶	١, //٥	i	1202.00

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

Form 01/01/2020 Part V To 12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 604, 138 50.00 05300 ANESTHESI OLOGY 10, 386 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 853, 265 0 54.00 60.00 06000 LABORATORY 594, 817 0 60.00 65.00 06500 RESPIRATORY THERAPY 189, 137 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 370, 193 66.00 06700 OCCUPATI ONAL THERAPY 67.00 69, 310 67.00 68.00 06800 SPEECH PATHOLOGY 8, 320 68.00 06900 ELECTROCARDI OLOGY 0 69.00 411, 877 69.00 149, 615 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 208, 535 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 073, 201 48 73.00 03480 ONCOLOGY 73.01 287.718 0 73.01 07301 BLOOD DI SORDER DRUGS 73.02 620, 900 0 73.02 76.00 03160 CARDI OPULMONARY 0 76.00 07697 CARDIAC REHABILITATION 133, 928 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 1, 180, 340 437 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 379, 105 176 92.00 200.00 200.00 Subtotal (see instructions) 9, 144, 785 661 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 9, 144, 785 661 202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2020	Worksheet D Part V	
				To 12/31/2020	Date/Time Pre	
					7/9/2021 10:1	7 am
		Ti tl	e XIX	Hospi tal	Cost	
0	0	DDC	Charges	0 - 1	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see		Services Not		
	Worksheet C, Part I, col.	inst.)	Subject To Ded. & Coins.	Subject To Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1, 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 182885	0	283, 02	5 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 081067	l .	37, 84		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 366866		39, 52		0	54.00
60. 00 06000 LABORATORY	0. 483839		28, 63		0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 029976		2, 52		Ō	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 784404	0	1, 60		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 711035	l .	1, 58		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 648809	0	28		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 328023	0	26, 76	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 186171	0	66	9 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 153692	0	95	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 321677	0	29, 30	4 0	0	73.00
73. 01 03480 ONCOLOGY	0. 243578	0	21, 44	8 0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 182506	0		0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 680048	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	T					
91. 00 09100 EMERGENCY	0. 340378		138, 35	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 518208	0	1	0	0	92.00
200.00 Subtotal (see instructions)		0	612, 51	1 0		200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges		_			_	
202.00 Net Charges (line 200 - line 201)	l	0	612, 51	1 0	0	202. 00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1311	Peri od: From 01/01/2020	Worksheet D

12/31/2020 Date/Time Prepared: 7/9/2021 10:17 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 51, 761 50.00 05300 ANESTHESI OLOGY 3, 068 0 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 14, 502 54.00 60.00 06000 LABORATORY 13,854 0 60.00 65.00 06500 RESPIRATORY THERAPY 2, 598 0 65.00 66.00 06600 PHYSI CAL THERAPY 1, 256 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 1, 124 67.00 68.00 06800 SPEECH PATHOLOGY 186 68.00 06900 ELECTROCARDI OLOGY 0 69.00 8,778 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 125 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 147 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 9, 426 0 73.00 03480 ONCOLOGY 0 73.01 73.01 5, 224 07301 BLOOD DI SORDER DRUGS 73.02 0 0 73.02 76.00 03160 CARDI OPULMONARY 0 0 76.00 07697 CARDIAC REHABILITATION 76.97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 47, 091 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 Subtotal (see instructions) 200.00 200.00 159, 140 0 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 159, 140 0 202.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1311	Period: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre	
		10 12/31/2020	7/9/2021 10: 1	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

		T		7/9/2021 10: 1	7 am
	Coot Contar Deceription	Title XVIII	Hospi tal	Cost	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	rs, excluding newborn)		2, 588	1.00
2.00	Inpatient days (including private room days, excluding swing-			2, 328	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation b		04 . 6 . 11	1, 938	4.00
5. 00	Total swing-bed SNF type inpatient days (including private reporting period	om days) through Decembe	er 31 of the cost	224	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	nom days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	36	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	5			
9. 00	Total inpatient days including private room days applicable t newborn days) (see instructions)	o the Program (excluding	g swing-bed and	1, 146	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private m	room days)	224	10.00
10.00	through December 31 of the cost reporting period (see instruc		oom days)	224	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14. 00
15. 00	Total nursery days (title V or XIX only)	aii (exertaing swriig bea	uays)	0	15.00
	Nursery days (title V or XIX only)			0	16.00
	SWI NG BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17.00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 21 of	- the cost	0.00	19. 00
19.00	reporting period	is through becember 31 of	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
	reporting period				
21. 00				6, 697, 080	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
22.00	5 x line 17)	. 21 -6 +1+		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	ng period (line 6	0	23. 00
24. 00		r 31 of the cost reporti	na period (line	0	24. 00
21.00	7 x line 19)	. Or or the cost report.	ng perrou (rrne	· ·	21.00
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
	Total swing-bed cost (see instructions)			587, 832	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		6, 109, 248	27.00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had sk	orgos)	0	28. 00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	d and observation bed cr	iai yes)	0	29.00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0. 00	
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private "	fforonti -1 (1)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrerential (IINe	6, 109, 248	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 624. 25	38. 00
39. 00	' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	,		3, 007, 391	39. 00
	Medically necessary private room cost applicable to the Progr			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		3, 007, 391	41.00

	Financial Systems	IU HEALTH TIPT				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-1 Date/Time Pre	
						7/9/2021 10:1	7 am
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
	·	I npati ent	Inpatient	Diem (col. 1		(col . 3 x	
		1.00	2. 00	÷ col . 2)	4. 00	col . 4) 5.00	
42.00	NURSERY (title V & XIX only)		=: ==				42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1			43.00
44. 00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			<u>'</u>		1.00	
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)			1. 00 2, 612, 411	48. 00
	Total Program inpatient costs (sum of lines			ons)		5, 619, 802	•
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routino	sorvi cos (fr	om Wkst D su	m of Parts I and	0	50.00
30.00	[111]	attent routine	services (Tro	JIII WKST. D, SU	ii or raits i and	0	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (1	from Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu	ding capital re	elated, non-ph	nysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					1
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	55. 00 56. 00
56. 00 57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount ((line 56 minus	line 53)	0	1
58.00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		.3 (11163 54 7	(00), 01 1% 0	i the target		
62.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	unt (coo instru	ictions)			0	1
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	lent (see mistro	icti ons)			0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost report	ing period (See	587, 832	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportin	g period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costs (line	44 plus line	4E) (+i +l o VVI	II only) For	587, 832	44 00
00.00	CAH (see instructions)	THE COSTS (TITHE	64 prus irrie	65)(title xvi	ii diliy). Foi	367, 632	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	e costs after D	December 31 of	f the cost rep	orting period	0	68. 00
(0.00	(line 13 x line 20)		(1: /7 1:-	(0)	0.	0	(0.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N		•			0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	ıtine service	cost (line 37)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	e 2)			71.00
73.00	Medically necessary private room cost applic	abĺe to Program		•			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		*	Part II column		74. 00 75. 00
75.00	26, line 45)	Toutine service	COSTS (110III	worksneet b,	rait II, Column		75.00
76. 00 77. 00	Per diem capital related costs (line 75 ÷ li	,					76.00
78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces	, ,		,	70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost ilmitatio	ווע (ווne /8 mi	nus iine 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ıs)				83. 00 84. 00
85.00	Utilization review - physician compensation		ons)				85.00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					390	87.00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				2, 624. 25	88. 00
89. UU	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 023, 458	89.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	638, 356	6, 697, 080	0. 09531	9 1, 023, 458	97, 555	90.00
91.00 Nursing School cost	0	6, 697, 080	0.00000	1, 023, 458	0	91.00
92.00 Allied health cost	0	6, 697, 080	0.00000	1, 023, 458	0	92.00
93.00 All other Medical Education	0	6, 697, 080	0.00000	1, 023, 458	0	93.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1311	From 01/01/2020	Date/Time Pre	pared:
			7/9/2021 10:1	7 am
	Title XIX	Hospi tal	Cost	
Cost Center Description				

DAGE 1 - ALL PROVIDER COMPONENTS IMPARIENT LANS IMPARIENT LA			Title XIX	Hospi tal	7/9/2021 10:1 Cost	7 am
NAME Color NAME		Cost Center Description	THE XIX	поэрт саг	0031	
IRRATIEST DAYS		DADT I ALL DROWNED COMPONENTO			1. 00	
Inpatient days (including private room days and swing-bed days, excluding newborn)						
Inspatient days (including private room days, excluding swing-bed and newborn days) 1 you have room days, excluding swing-bed and observation bed days. In you have room days (seed using swing-bed and observation bed days). In you have not private room days. 1,338 4,05	1.00		s, excluding newborn)		2, 588	1.00
do not complete this line. 4.00 Semi-private room days (excluding swing-bed and observation bed days) 7.00 Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SR type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed SR type inpatient days (including private room days) after December 31 of the cost reporting period on the program (excluding swing-bed and period on the program (excluding swing-bed and period days) (see instructions) 9.00 Saing-bed SR type inpatient days applicable to the Program (excluding swing-bed and period days) (see instructions) 9.01 Saing-bed SR type inpatient days applicable to title XVIII only (including private room days) after ship the period swing-bed SR type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see Instruction this line) 10.00 Saing-bed SR type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Saing-bed SR type inpatient days applicable to title XVIII only (including private room days) 10.00 Saing-bed SR type inpatient days applicable to the Program (excluding swing-bed days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Saing-bed SR type inpatient days applicable to services after December 31 of the cost reporting period (if the SR type services applicable to services through December 31 of the cost reporting period (including private room days) 10.00 Saing-bed SR type inpatient days applicable to services after Decem	2.00					2. 00
5.00	3.00		ys). If you have only pr	ivate room days,	0	3.00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4 00	1	ad daya)		1 020	4 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of the cos				or 31 of the cost	· ·	
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 7.00 NF type inpatient days (including private room days) after December 31 of the cost 7.00 NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XX only (including private room days) 15.00 Total nursery days (title V or XX only) 16.00 Nursery days (title V or XX only) 17.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost 10.00 Nursery days (title V or XX only) 18.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost 10.00 Nursery days (title V or XX only) 18.00 Medicare rate for swing-bed SWF services applicable to services through December 31 of the cost 10.00 Nursery days (title V or XX only) 19.00 Medicare rate for swing-bed SWF services applicable to services after December 31 of the cost 10.00 Nursery days (title V or XX only) 19.00 Medicare rate for swing-bed SWF services after December 31 of the cost 10.00 Nursery days (title V or XX only) 19.00 Medicare rate for swing-bed SWF services after December 31 of the cost reporting period (line 10.00 Nursery days (title V or XX only) 19.00 Medicare rate for swing-bed SWF services after December 31	3.00		om days) trii ough beecimbe	1 31 01 the cost	227	3.00
Total swing-bed NF type inpatient days (including private room days) afrough December 31 of the cost reporting period (17 cal endar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (17 cal endar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and room of the cost reporting period (11 only (including private room days) Total inpatient days applicable to the the Program (excluding swing-bed and room days) Total inpatient days applicable to the trough period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Through December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year, enter 0 on this line) December 31 of the cost reporting period (if cal endar year) December 31 of the cost reporting period (i	6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see Instructions) 10. 00 Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after period (including private room days) (including p						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Cal endar year, enter 0 on this line) 7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8. O Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 8. O Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (including private room days) after through December 31 of the cost reporting period (including private room days) 8. O Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 8. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 8. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 9. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 10. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 11. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 12. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 13. O Swing-bed NF type inpatient days applicable to title XV or XX only (including private room days) 14. O Medically necessary private room days applicable to title XV or XX only (including private room days) 15. O Swing-bed NF type inpatient days applicable to services after December 31 of the cost reporting period (including private room days) 15. O Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days SWing-bed Cost applicable to SNF type services through December 31 of the cost repor	7. 00		m days) through December	31 of the cost	36	7. 00
reporting period (if calendar year, enter 0 on this Iline) 9 .00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10 .00 Swing-bed SNF type inpatient days applicable to litle XVIII only (including private room days) after through December 31 or the cost reporting period (see instructions) 11 .00 Excender 31 or the cost reporting period (see instructions) 12 .00 Swing-bed NF type inpatient days applicable to litle XVIII only (including private room days) after through December 31 or the cost reporting period (if calendar year, enter 0 on this line) 13 .00 Swing-bed NF type inpatient days applicable to litles V or XIX only (including private room days) 14 .00 Medically necessary private room days applicable to the Program (excluding private room days) 15 .00 Total nursery days (title V or XIX only) 16 .00 Nursery days (title V or XIX only) 17 .00 SWINDS BED ADUSTINENT 18 .00 Medicar rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18 .00 Medicar rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19 .00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19 .00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20 .00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost or period green and applicable to SNF type services through December 31 of the cost or period green and period (line or period green and period green and period green and period green and period green and period green and period green and period green and period green and period green and period green and period green and period green and green g	8 00		m days) after December 3	11 of the cost	0	8.00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed MF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicaid rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (including private room days) 19.00 Medicaid rate for swing-bed SMF services applicable to services after December 31 of the cost reporting period (line 8 x including swing-bed not applicable to SMF type services through December 31 of the cost reporting period (line 8 x including swing-bed not applicable to SMF type services after December 31 of the cost reporting period (line 8 x including swing-bed cost applicable to SMF type services after December 31 of the cost reporting period (line 8 x including swing-bed cost applicable to SM	0.00		iii days) arter becember e	or the cost	G	0.00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) on through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) on 15.00 after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 17.00 New Control of the SMF SMF Services applicable to services through December 31 of the cost reporting period (if the SMF SMF SMF SMF SMF SMF SMF SMF SMF SMF	9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	4	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1.00 Medical ly necessary private room days applicable to the Program (excluding swing-bed days) 1.00 Medical ly necessary private room days applicable to the Program (excluding swing-bed days) 1.00 No Nursery days (title V or XIX only) 1.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 1.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of SX Iline 17) 2.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of SX Iline 17) 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of SX Iline 17) 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of SX Iline 17) 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of SX Iline 17) 2.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of SX Iline 18) 2.00 Swing-bed cos	40.00				0	10.00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (Including private room days) 15.00 North days applicable to titles V or XIX only (Including private room days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (title	10.00			room days)	Ü	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical in years private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 No Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medical dar er are for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical dar for swing-bed NF services applicable to services after December 31 of the cost or reporting period 21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost of the cost reporting period (line of Sxiline 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 17) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 17) 25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 17) 26.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 17) 27.00 Control of Sxiline 17) 28.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 17) 28.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of Sxiline 18) 29.0	11. 00			room davs) after	0	11.00
through December 31 of the cost reporting period 13.00 Singh-ped NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 21.00 Total ageneral inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line Swing-bed cost Swing-bed cost applicable to NF type s						
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00	12.00		X only (including privat	e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 16.00 Nosery days (title V or XIX only) 16.00 17.00 Modicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (lacer erate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (lacer erate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (lacer erate for swing-bed NF services applicable to services after December 31 of the cost reporting period (lacer erate for swing-bed NF services applicable to services after December 31 of the cost reporting period (lacer erate for swing-bed NF services applicable to services after December 31 of the cost (see instructions) 17.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost (see instructions) 18.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line swing-bed cost	12 00		V only (including privat	a room dovo)	0	12.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 Total nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 0 15.00 Nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Program period 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Program period 19.00 Nurservices applicable to SNF type services after December 31 of the cost 19.00 Program period 19.00 Nurservices applicable to SNF type services through December 31 of the cost reporting period (line 6 X line 17) SN Nurservices applicable to SNF type services after December 31 of the cost reporting period (line 6 X line 18) SN Nurservices applicable to NF type services after December 31 of the cost reporting period (line 7 X line 19) SN Nurservices after December 31 of the cost reporting period (line 8 X line 20) SN Nurservices applicable to NF type services after December 31 of the cost reporting period (line 8 X line 20) SN Nurservice Cost (see instructions) SN Nurservice Program period (line 8 X line 20) SN Nurservice Cost period Program period (line 8 X line 20) SN Nurservice Cost period Program Pr	13.00				U	13.00
15.00 Total nursery days (title V or XIX only) 10.00 Total nursery days (title V or XIX only) 10.00 Total services applicable to services through December 31 of the cost reporting period reporting period period reporting period needs applicable to services after December 31 of the cost reporting period needs applicable to services after December 31 of the cost reporting period needs are rate for swing-bed NF services applicable to services after December 31 of the cost reporting period needs applicable to services after December 31 of the cost reporting period needs applicable to services after December 31 of the cost reporting period needs applicable to services after December 31 of the cost reporting period needs applicable to SNF type services after December 31 of the cost reporting period needs applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 21.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 23.00 x line 18) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 2 23.00 x line 19) 23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 28.00 General inpattent routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 Opticate of the swing-bed cost (line 21 minus line 26) 28.0	14. 00				0	14.00
SWING BED ADJUSTMENT	15.00	Total nursery days (title V or XIX only)	, 3 3	<i>3</i> ,	0	15.00
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18. 00 19. 00	16. 00				0	16. 00
reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 6,697,080 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 24.00 Total swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Swing-bed cost (see instructions) 28.00 Total swing-bed cost (see instructions) 29.00 Total swing-bed cost (see instructions) 29.00 Fixe-Brivate ROOM DIFFERENTIAL ADJUSTMENT 29.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Fixe-Brivate room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 20.00 Average perivate room peridiem charge (line 29 + line 3) 20.00 Average perivate room peridiem charge (line 29 + line 3) 20.00 Average peridiem private room charge differential (line 32 minus line 33) (see instructions) 20.00 Average peridiem private room charge differential (line 34 x line 31) 20.00 Average peridiem private room cost differential (line 3 x line 31) 20.00 Average peridiem private room cost differential (line 3 x line 35) 20.00 Average peridiem private room cost differential (line 3 x line 35) 20.00	17 00		+b	£ 111		17.00
18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21.00 Total general inpatient routine service cost (see instructions) 6.697.080 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 2.20 2.00	17.00		es through December 31 d	or the cost		17.00
reporting period Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting period (2.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost (5.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost (5.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (1.00 Total general inpatient routine service cost (see instructions) (5.00 Ming-bed cost applicable to SNF type services through December 31 of the cost reporting period (1.00 Single Single Ming-bed cost applicable to SNF type services after December 31 of the cost reporting period (1.00 Single Ming-bed cost applicable to NF type services through December 31 of the cost reporting period (1.00 Single Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (1.00 Single Ming-bed cost (3.00 Single Ming-bed cost (3.00 Single Mingle M	18. 00		es after December 31 of	the cost		18. 00
reporting period Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1. 00 Total general inpatient routine service cost (see instructions) 2. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 3. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 0 23.00 x line 18) 4. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 0 24.00 7 x line 18) 5. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 0 24.00 7 x line 19) 5. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 6. 00 Total swing-bed cost (see instructions) 6. 00 Total swing-bed cost (see instructions) 7. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 7. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 8. 00 Semi-private room charges (excluding swing-bed charges) 9. 00 Private room charges (excluding swing-bed charges) 9. 00 Openeral inpatient routine service cost/charge ratio (line 27 + line 28) 9. 00 Average private room per diem charge (line 29 + line 3) 9. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 9. 00 Average per diem private room cost differential (line 34 x line 31) 9. 00 Average per diem private room cost differential (line 34 x line 31) 9. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 27 minus line 36) 9. 01 Average per diem private room cost differential (line 34 x line 31) 9. 00 Average per diem private room cost differential (line 34 x line 31) 9. 00 Average per diem private room cost differential (line 34 x line 31) 9. 00 General inpatient routine service cost						
20. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 21. 00 Total general inpatient routine service cost (see instructions) 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 120) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32. 00 Average private room per diem charge (line 29 + line 3) 33. 00 Average per diem private room per diem charge (line 30 + line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35. 00 Average per diem private room cost differential (line 32 minus line 33) 36. 00 Average per diem private room cost differential (line 34 x line 31) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 34 x line 31) 38. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost per diem (see instru	19. 00		s through December 31 of	the cost	0. 00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 22.00 23.00 34.00 35.00 36.00 37.00 37.00 37.00 38.00 39.0	20.00		s ofter December 21 of t	ho cost	0.00	20.00
21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 X line 20) 25.00 Swing-bed cost (see instructions) 587,832 26.00 27.00 Seenaral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 587,832 26.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 29.	20.00		s arter becember 31 or r	THE COST	0.00	20.00
5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Frivate room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 29) 31.00 Average per ivate room per diem charge (line 30 + line 4) 32.00 Average per diem private room cost differential (line 3 x line 31) 31.00 Average per diem private room cost differential (line 3 x line 31) 32.00 Private room cost differential adjustment (line 3 x line 35) 33.00 Private room cost differential adjustment (line 3 x line 35) 34.00 Average per diem private room cost differential (line 3 x line 35) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 10, 40) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Program general inpatient routine service cost (line 9	21.00		s)		6, 697, 080	21.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line of x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 20.01 Ocentral inpatient routine service cost reporting period (line of the	22. 00		er 31 of the cost report	ing period (line	. 0	22. 00
x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 587,832 26.00 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6,109,248 27.00 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Private room charges (excluding swing-bed charges) 0 29.00 30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 31.00 32.00 Average private room per diem charge (line 29 + line 3) 0.00 32.00 33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 3 x line 31) 0.00 35.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0 36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 10, 497 39.00 40.00 Medically recessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	00.00		21 . 6 . 11			00.00
24. 00 24. 00 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	23.00		31 of the cost reportin	ng period (line e	0	23.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 587, 832 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 6, 109, 248 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Comparison of General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 0.000000 32.00 Average private room per diem charge (line 29 + line 3) 0.00 31.00 33.00 Average semi-private room per diem charge (line 30 + line 4) 0.00 32.00 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00 34.00 35.00 Average per diem private room cost differential (line 34 x line 31) 0.00 36.00 Private room cost differential adjustment (line 3 x line 35) 0.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 37.00 27. minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 624.25 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00	24. 00		r 31 of the cost reporti	na period (line	0	24.00
x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 624. 25 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0, 40, 00 0] 3		3 1 1 1		
Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 87.832 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ± line 28) 30.00 Average private room per diem charge (line 29 + line 3) 4.00 Average semi-private room per diem charge (line 29 ± line 3) 4.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 37.00 Average per diem private room cost differential (line 34 x line 31) 38.00 PRAT II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 Ceneral inpatient routine service cost (line 9 x line 38) 0 2.00 Ceneral inpatient routine service cost (line 9 x line 38) 0 40.00 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.400 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.497 Ceneral inpatient routine service cost (line 9 x line 38) 10.400 Ceneral inpatient routine service cost (line 9 x line	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 10	24 00				E07 022	24 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 10. 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 30. 00 30. 00 30. 00 30. 00 30. 00 31. 00 32. 00 32. 00 32. 00 33. 00 Average per diem private room cost differential (line 34 x line 35) 0 36. 00 37. 00 38. 00 39. 00 39. 00 39. 00 39. 00 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00		, ,	(line 21 minus line 26)		· ·	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room charge differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 3 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 20.00 20.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 38.00 39.00 39.00 39.00 40.00 40.00	27.00		(TITIE 21 IIII III 20)		0, 107, 210	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 and 27 minus line 36) PART II - HOSPI TAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 10.00 000000 31.00 0 0.00 32.00 0	28. 00		d and observation bed ch	narges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Private room cost differential adjustment (line 3 x line 35) 34.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 0.00 32.00 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 34.00 0.00 34.00 0.00 35.00 0.00 34.00 0.00 35.00 0.00 36.00 0.0						
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 and 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.00 0.00 32.00 0.00 33.00 0.00 34.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 35.00 0.00 36.00			1: 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 and 109, 248 and 109, 248 and 109, 248 and 109, 248 and 109, 248 and 109, 248 and 109, 249 and		,	÷ Tine 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 6, 109, 248 37.00) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 36.00 6, 109, 248 37.00 2, 624. 25 38.00 10, 497 39.00			nus line 33)(see instruc	ctions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 624.25 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		Average per diem private room cost differential (line 34 x li				
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				EE	-	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 39.00 Program general inpatient routine service cost per diem (see instructions) 2,624.25 38.00 Program general inpatient routine service cost (line 9 x line 38) 10,497 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		and private room cost di	TTERENTIAL (line	6, 109, 248	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 39.00 Program general inpatient routine service cost per diem (see instructions) 2, 624.25 38.00 Program general inpatient routine service cost (line 9 x line 38) 10, 497 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,624.25 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 2,624.25 38.00 10,497 39.00			USTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	38. 00				2, 624. 25	38. 00
		, ,	•			
41. 00 Total Frogram general impatrent routine service cost (Title 39 + Title 40) 10, 49/ 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	Tiotal Trogram general impatrent routine service cost (IIIIe 39	+ 1111C 40)		10, 497	41.00

Heal th	Financial Systems	IU HEALTH TIPTO	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST	10 11212111 11111	Provi der C		Peri od:	Worksheet D-1	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
			T; +1	e XIX	Hospi tal	7/9/2021 10:1 Cost	7 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
	<u>'</u>	I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		1.00	<u>Days</u> 2. 00	÷ col. 2) 3.00	4. 00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT						43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45.00
46. 00	SURGI CAL INTENSI VE CARE UNI T						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00							48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructi	ons)		13, 716	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst D sur	n of Parts I and	0	50.00
30.00		atrent routine s	services (110	iii wkst. b, sui	ii Oi Tui ta Tanc	Ĭ	30.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	y services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anestl	netist, and	Ö	53.00
	medical education costs (line 49 minus line	52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge					-	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00	Difference between adjusted inpatient operat	ing cost and tar	rget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period 6	endi na 1996	undated and co	ompounded by the	0.00	58. 00 59. 00
07.00	market basket	por tring perrou	sharing 1770,	apaarea ana e	simpodriaca by the	0.00	07.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	ı
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		3 (TINES 54 A	00), 01 1% 01	the target		
62. 00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of th	e cost reporti	ng period (See	0	64.00
4F 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to often Decembe	on 21 of the	oost roperting	noried (Coo	0	4F 00
65. 00	instructions)(title XVIII only)	ts after Decembe	er 31 OF the	cost reporting	g period (see	0	65. 00
66.00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a costs through	December 31	of the cost re	enorting period	_	67. 00
07.00	(line 12 x line 19)	e costs through	December 31	or the cost re	sporting perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (1	ine 67 + lin	e 68)		0	69. 00
07.00	PART III - SKILLED NURSING FACILITY, OTHER N						07.00
70.00	Skilled nursing facility/other nursing facil	,		` ,)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ne /0 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applic	•	(line 14 x l	ine 35)			73.00
74. 00	Total Program general inpatient routine serv			•			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from	Worksheet B, A	Part II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	· .					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		sovi don rocon	de)			78. 00 79. 00
80.00	Total Program routine service costs for comp				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi	tati on		•	ŕ		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I						82. 00 83. 00
83.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		<i>3)</i>				84.00
85.00	Utilization review - physician compensation		ns)				85.00
86.00			ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					390	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			2, 624. 25	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 023, 458	89.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/9/2021 10:1	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	638, 356	6, 697, 080	0. 09531	9 1, 023, 458	97, 555	90.00
91.00 Nursing School cost	0	6, 697, 080	0.00000	0 1, 023, 458	0	91.00
92.00 Allied health cost	0	6, 697, 080	0.00000	0 1, 023, 458	0	92.00
93.00 All other Medical Education	О	6, 697, 080	0. 00000	0 1, 023, 458	0	93.00

Heal th	Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 15-1311	Peri od:	Worksheet D-3	
					From 01/01/2020 To 12/31/2020	Date/Time Pre	
						7/9/2021 10:1	7 am
			Ti t	e XVIII	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		Inpatient	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x	
				1.00	2. 00	col . 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
20 00	03000 ADULTS & PEDIATRICS				2, 553, 933		30.00
30.00	ANCILLARY SERVICE COST CENTERS				2, 555, 755		30.00
50 00	05000 OPERATING ROOM			0. 1828	3, 029, 493	554, 049	50.00
	05300 ANESTHESI OLOGY			0. 0810		11, 833	
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0. 3668	· ·	58, 409	
60.00	06000 LABORATORY			0. 4838			
65. 00	06500 RESPIRATORY THERAPY			1. 0299			
66.00	06600 PHYSI CAL THERAPY			0. 7844		231, 279	66.00
67.00	06700 OCCUPATI ONAL THERAPY			0. 7110	35 131, 797	93, 712	67.00
68.00	06800 SPEECH PATHOLOGY			0. 6488	09 19, 434	12, 609	68.00
69.00	06900 ELECTROCARDI OLOGY			0. 3280	23 127, 216	41, 730	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 1861	71 601, 302	111, 945	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 1536		728, 019	
73.00	07300 DRUGS CHARGED TO PATIENTS			0. 3216		349, 097	
73. 01	03480 ONCOLOGY			0. 2435		0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS			0. 1825		0	73. 02
76. 00	03160 CARDI OPULMONARY			0.0000		0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON			0. 6800	48 0	0	76. 97
04 00	OUTPATIENT SERVICE COST CENTERS			0.0400	7.0	0//	04.00
	09100 EMERGENCY			0. 3403		l	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0(+b		0. 5182		0	92.00
200.00			(line 41		10, 922, 743	2, 612, 411	200.00
201. 00 202. 00		ogram om y charges	(iine bi	<i>'</i>	10, 922, 743		201.00
202.00	INEL CHAI GES (TITTE 200 IIII HUS TITTE 201)			I	10, 922, 743	I	1202.00

NPATI ENT ANCI LLARY SERVICE COST APPORTIONMENT								
Title XVIII Swing Beds - SNF Cost Cost Center Description Title XVIII Swing Beds - SNF Cost Cost Center Description Title XVIII Swing Beds - SNF Cost Cost Center Description Ratio of Cost To Charges C			IU HEALTH TIPTON			In Lie		
Component CCN: 15-Z311 To	INPATIENT ANCILLARY SER	₹VICE COST APPORTIONMENT		Provi der C	CN: 15-1311			
Title XVIII				C	CON 15 7011			
Title XVIII Swing Beds - SNF Cost				component	CCN: 15-Z311	10 12/31/2020		
NPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00				Ti tl e	XVIII	Swina Beds - SNE		/ alli
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	Cost Center	Description						
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	5551 5511151	2000 p t. o				The state of the s		
INPATIENT ROUTINE SERVICE COST CENTERS					'' '' ''			
INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00						3.1		
30. 00					1.00	2. 00		
NCILLARY SERVICE COST CENTERS	INPATIENT ROUTIN	E SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM 0.182885 3,060 560 50. 00 53. 00 05300 ANESTHESI OLOGY 0.081067 0 0 53. 00 05300 ANESTHESI OLOGY 0.081067 0 0 53. 00 05300 ANESTHESI OLOGY 0.081067 0 0 53. 00 05400 RADIO LOGY-DI AGNOSTI C 0.366866 4,044 1,484 54. 00 06000 LABORATORY 0.483839 18,755 9,074 60. 00 06000 CABORATORY 1.029976 17,547 18,073 65. 00 06500 RESPI RATORY THERAPY 0.784404 100,927 79,168 66. 00 06000 06000 CUPATI IONAL THERAPY 0.711035 51,842 36,861 67. 00 06000 SPEECH PATHOLOGY 0.648809 2,973 1,929 68. 00 06800 SPEECH PATHOLOGY 0.328023 7,214 2,366 69. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.186171 0 0 71. 00 072. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0.153692 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.243578 0 0 73. 01 07300 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.3400000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 03000 ADULTS & PI	DI ATRI CS				0		30.00
53. 00 05300 ANESTHESI OLOGY 0.081067 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.366866 4, 044 1, 484 54. 00 60. 00 06000 LABORATORY 0.483839 18, 755 9, 074 60. 00 65. 00 06500 RESPI RATORY THERAPY 1.029976 17, 547 18, 073 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.784404 100, 927 79, 168 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.711035 51, 842 36, 861 67. 00 68. 00 O6800 SPECH PATHOLOGY 0.648809 2, 973 1, 929 68. 00 69. 00 O6900 ELECTROCARDI OLOGY 0.328023 7, 214 2, 366 69. 00 71. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.186171 0 0 71. 00 72. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0.321677 76, 581 24, 634 73. 00 73. 01 O3480 NCOLOGY 0.243578 0 0 0 <	ANCILLARY SERVIC	E COST CENTERS						
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.366866 4,044 1,484 54.00 60.00 06000 LABORATORY 0.483839 18,755 9,074 60.00 65.00 06500 RESPI RATORY THERAPY 1.029976 17,547 18,073 65.00 66.00 06600 PHYSI CAL THERAPY 0.784404 100,927 79,168 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.711035 51,842 36,861 67.00 68.00 06800 SPEECH PATHOLOGY 0.648809 2,973 1,929 68.00 69.00 06900 ELECTROCARDI OLOGY 0.328023 7,214 2,366 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.186171 0 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.153692 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.321677 76,581 24,634 73.00 73.01 03480 ONCOLOGY 0.32480 ONCOLOGY 0.243578 0 0 73.01 76.09 07070 CARDI AC REHABI LI TATI ON 0.680048 0 0 76.97 90 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.518208 0	50.00 05000 OPERATING I	ROOM			0. 18288	3, 060	560	50.00
60. 00 06000 LABORATORY 0. 483839 18, 755 9, 074 60. 00 6500 RESPI RATORY THERAPY 1. 18, 073 65. 00 6500 RESPI RATORY THERAPY 1. 18, 073 65. 00 66. 00 06600 PHYSI CAL THERAPY 0. 78, 18, 073 65. 00 67. 00 6700 OCCUPATI ONAL THERAPY 0. 774, 18, 073 65. 00 67. 00 6700 OCCUPATI ONAL THERAPY 0. 774, 18, 073 65. 00 67. 00 6700 OCCUPATI ONAL THERAPY 0. 774, 18, 073 65. 00 68. 00 6800 SPEECH PATHOLOGY 0. 784404 100, 927 79, 168 66. 00 68. 00 6800 SPEECH PATHOLOGY 0. 648809 2, 973 1, 929 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0. 328023 7, 214 2, 366 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 186171 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0. 15692 0 0 0. 72. 00 73. 01 07300 DRUGS CHARGED TO PATIENTS 0. 321677 76, 581 24, 634 73. 00 73. 01 03480 ONCOLOGY 0. 243578 0 0 73. 01 03480 ONCOLOGY 0. 328023 7. 214 24, 634 73. 00 73. 01 03480 ONCOLOGY 0. 328023 7. 214 24, 634 73. 00 73. 01 03480 ONCOLOGY 0. 328023 7. 214 2. 366 69. 00 73. 01 73. 01 03480 ONCOLOGY 0. 328023 7. 214 2. 366 69. 00 73. 01 03480 ONCOLOGY 0. 328023 7. 214 2. 366 69. 00 0. 328023 7.	53. 00 05300 ANESTHESI 01	_OGY			0. 08106	57 0	0	53.00
65. 00	54. 00 05400 RADI OLOGY-I)I AGNOSTI C			0. 36686	4, 044	1, 484	54.00
66. 00	60. 00 06000 LABORATORY				0. 48383	18, 755	9, 074	60.00
67. 00	65. 00 06500 RESPI RATOR	/ THERAPY			1. 02997	76 17, 547	18, 073	65.00
68. 00	66.00 06600 PHYSI CAL TI	HERAPY			0. 78440	100, 927	79, 168	66.00
69. 00	67. 00 06700 OCCUPATI ON	AL THERAPY			0. 71103	51, 842	36, 861	67.00
71. 00	68. 00 06800 SPEECH PATE	lOLOGY			0. 64880)9 2, 973	1, 929	68. 00
72. 00	69. 00 06900 ELECTROCARI)I OLOGY			0. 32802	7, 214	2, 366	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.321677 76,581 24,634 73.00 73.01 03480 0NCOLOGY 0.243578 0 0 0 73.01 73.02 07301 BLOOD DI SORDER DRUGS 0.182506 0 0 0 73.02 76.00 03160 CARDI OPULMONARY 0.000000 0 0 0 76.00 76.97 OTOPATIENT SERVICE COST CENTERS 0 09100 EMERGENCY 0.340378 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0.518208 0 0 92.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00	71.00 07100 MEDICAL SUF	PLIES CHARGED TO PATIENT			0. 18617	71 0	0	71.00
73. 01	72.00 07200 I MPL. DEV.	CHARGED TO PATIENTS			0. 15369	92 0	0	72.00
73. 02 07301 BLOOD DI SORDER DRUGS 0.182506 0 0.73. 02 76. 00 03160 CARDI OPULMONARY 0.000000 0 0 76. 00 76. 97 07697 CARDI AC REHABI LITATION 0.680048 0 0 0 76. 97 00UTPATI ENT SERVI CE COST CENTERS 0.340378 0 0 91. 00 791. 00 09200 08SERVATI ON BEDS (NON-DI STINCT PART 0.518208 0 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 282, 943 174, 149 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00	73.00 07300 DRUGS CHAR	GED TO PATIENTS			0. 32167	77 76, 581	24, 634	73.00
76. 00							0	
76. 97 O7697 CARDI AC REHABILITATION O. 680048 O O 76. 97 OUTPATIENT SERVICE COST CENTERS O O9100 EMERGENCY O. 340378 O O 91. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART O. 518208 O O92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART O. 518208 O O92. 00 O9200							0	
91. 00 09100 EMERGENCY 0.340378 0 0 91. 00 092. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.518208 0 0 92. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 00	76. 00 03160 CARDI OPULM	NARY					0	
91. 00 09100 EMERGENCY 0.340378 0 0 91. 00 092.00 0920					0. 68004	18 0	0	76. 97
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.518208 0 92. 00 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 282, 943 174, 149 200. 00 201. 00 201. 00 0 201. 00 201. 00 201. 00 0 201. 00		CE COST CENTERS						
200.00 Total (sum of lines 50 through 94 and 96 through 98) 282,943 174,149 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							0	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00					0. 51820			
						282, 943		
202.00 Net charges (line 200 minus line 201) 282,943 202.00			rogram only charges	(line 61)		0	1	
	202.00 Net charges	(line 200 minus line 201)				282, 943		202.00

Title XIX	Health Financia		IU HEALTH TIPTON				u of Form CMS-2	2552-10
To 12/31/2020 Date/Time Prepared 7/9/2021 10:17 am Title XIX Hospital Cost Cost Center Description Ratio of Cost To Charges Program Program Costs (col. 1 x col. 2) 1.00 2.00 3.00	INPATIENT ANCI	LLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1311	Peri od:	Worksheet D-3	,
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.							Date/Time Pre	pared:
Ratio of Cost Inpatient Program (costs (col 1 x col 2)							7/9/2021 10:1	
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00				Ti tl				
INPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3	Co	st Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS 1,764 30,00					To Charges			
NPATIENT ROUTINE SERVICE COST CENTERS 1,764 30.00 30.0						Charges		
NPATIENT ROUTINE SERVICE COST CENTERS 1,764 30. 0 3000 ADULTS & PEDIATRICS 1,764 30. 0 ANCILLARY SERVICE COST CENTERS 366866 2,549 9.35 54. 0 66. 0 0. 6000 ANCILLARY AND ANCILLARY 0. 483839 253 122 60. 0 66. 0					1 00	0.00		
30. 00	LNDATIEN	IT DOUTLING CERVILOR COCT OFNITERS			1.00	2.00	3.00	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.182885 284 52 50.00 53.00 05300 ANSTHESI OLOGY 0.081067 0 0.53.00 05400 RADI OLOGY-DI AGNOSTI C 0.366866 2,549 935 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.366866 2,549 935 54.00 06000 LABORATORY 0.483839 253 122 60.00 06000 LABORATORY 0.08600 RESPIRATORY THERAPY 0.784404 0 0.66.00 06000 DESCRIPTIONAL THERAPY 0.784404 0 0.66.00 06000 DESCRIPTIONAL THERAPY 0.711035 0 0.67.00 06800 SPEECH PATHOLOGY 0.328023 0 0.69.00 06900 ELECTROCARDI OLOGY 0.328023 0 0.69.00 06900 ELECTROCARDI OLOGY 0.328023 0 0.69.00 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.186171 0 0.71.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.153692 0 0.72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.321677 1,186 382 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.321677 1,186 382 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.321677 1,186 382 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.321677 1,186 382 73.00 074.00 074.00 074.00 074.00 074.00 074.00 074.00 074.00 074.00 074.00 075.00 0					1			
50. 00 05000 OPERATI NG ROOM 0. 182885 284 52 50. 0 53. 00 05300 ANESTHESI OLOGY 0. 081067 0 0 53. 0 53. 0 05300 ANESTHESI OLOGY 0. 366866 2, 549 935 54. 0 0 06000 CARDI OLOGY-DI AGNOSTI C 0. 366866 2, 549 935 54. 0 0 06000 CARDIA OLOGY-DI AGNOSTI C 0. 483839 253 122 60. 0 0 06500 RESPI RATORY THERAPY 0. 483839 253 122 60. 0 0 65. 00 0 06500 PHYSI CAL THERAPY 0. 784404 0 0 65. 00 0 067. 00 0 0 66. 00 0 0 0 66. 00 0 0 0 66. 00 0 0 0 66. 00 0 0 0 66. 00 0 0 0 66. 00 0 0 0 66. 00 0 0 0 0 66. 00 0 0 0 0 66. 00 0 0 0 66. 00 0 0 0 0 0 0 0 0 0 0 0						1, /64		30.00
53. 00 05300 ANESTHESI OLOGY 0.081067 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.366866 2,549 935 54. 0 60. 00 0.6000 LABORATORY 0.483839 253 122 60. 0 66. 00 66. 00 0.6500 RESPI RATORY THERAPY 0 0 65. 00 0 0.794404 0 0 0 66. 00 0 0 0 66. 00 0 0 0 0 66. 00 0 0 0 0 0 0 66. 00 0 <td></td> <td></td> <td></td> <td></td> <td>0.4000</td> <td>25 204</td> <td></td> <td></td>					0.4000	25 204		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.366866 2,549 935 54. 0 60. 00 06000 LABORATORY 0.483839 253 122 60. 0 65. 00 06500 RESPI RATORY THERAPY 0.784404 0 0 66. 0 66. 00 06600 PHYSI CAL THERAPY 0.711035 0 0 66. 0 67. 00 06700 OCCUPATI ONAL THERAPY 0.711035 0 0 66. 0 68. 00 06800 SPEECH PATHOLOGY 0.648809 0 0 67. 0 69. 00 06900 ELECTROCARDI OLOGY 0.328023 0 0 69. 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.186171 0 0 71. 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.153692 0 0 72. 0 73. 01 033480 ONCOLOGY 0.321677 1, 186 382 73. 0 73. 02 07301 BLOOD DI SORDER DRUGS 0.182506 0 0 73. 0 76. 07 O7697 CARD								1
60. 00 06000 LABORATORY 0. 483839 253 122 60. 00 65. 00 06500 RESPI RATORY THERAPY 1. 029976 0 0 0 65. 00 06500 06500 06500 070000 07000 07000 07000 07000 07000 07000 07000 070000 07000 07000 07000 070000 070000 0700000 07000000 0700000 0700000 07000000 07000000 07000000 070000000 07000000 070000000 070000000 070000000 0700000000								
65. 00 06500 RESPIRATORY THERAPY 1. 029976 0 0 65. 0 066. 00 06600 PHYSI CAL THERAPY 0. 784404 0 0 0 66. 0 067. 00 06700 0CCUPATI ONAL THERAPY 0. 711035 0 0 0 07. 00 068. 00 06800 SPECH PATHOLOGY 0. 648809 0 0 0 0 0 0 0 0 0								
66. 00 06600								
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 01 07300 DRUGS CHARGED TO PATI ENTS 73. 01 07400 DRUGS CHARGED TO PATI ENTS 74. 00 07300 DRUGS CHARGED TO PATI ENTS 75. 01 07400 DRUGS CHARGED TO PATI ENTS 76. 00 07301 BLOOD DI SORDER DRUGS 77. 00 07301 CARDI AC REHABI LI TATI ON 76. 97 07697 CARDI AC REHABI LI TATI ON 77. 00 07400 DRUGS CHARGED TO PATI ENTS 78. 01 07400 DRUGS CHARGED TO PATI ENTS 79. 00 07400 DRUGS								
68. 00 06800 SPEECH PATHOLOGY 0. 648809 0 0 68. 0 69. 00 06900 ELECTROCARDI OLOGY 0. 328023 0 0 0 69. 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 186171 0 0 71. 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 153692 0 0 72. 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 321677 1, 186 382 73. 0 73. 01 03480 ONCOLOGY 0. 243578 0 0 73. 0 73. 02 07301 BLOOD DI SORDER DRUGS 0. 182506 0 0 73. 0 76. 00 03160 CARDI OPULMONARY 0. 000000 0 0 0 76. 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 680048 0 0 0 0UTPATIENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 340378 5, 076 1, 728 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 518208 0 0 0 92. 0 200. 00 Total (sum of lines 50 through 94 and 96 through 98)							_	
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 153692 0 0 0 72. 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 321677 1., 186 382 73. 01 03480 ONCOLOGY 0. 323578 0 0 0 73. 0 73. 01 03480 ONCOLOGY 0. 323578 0 0 0 73. 0 75. 00 03160 CARDI OPULMONARY 0. 000000 0 0 0 73. 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 09100 EMERGENCY 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 200. 00 10 07100 MEDI CARGED TO PATI ENT 10 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 10 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 10 0 09100 EMERGENCY 10 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 10 0 09200 Total (sum of lines 50 through 94 and 96 through 98)							_	
71. 00							_	
72. 00					l .		-	
73. 00							-	
73. 01 03480 0NCOLOGY 0. 243578 0 0 73. 0 73. 02 07301 BLOOD DI SORDER DRUGS 0. 182506 0 0 73. 0 76. 00 03160 CARDI OPULMONARY 0. 000000 0 0 76. 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 680048 0 0 0UTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 340378 5, 076 1, 728 91. 0 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0. 518208 0 0 92. 0 200. 00 Total (sum of lines 50 through 94 and 96 through 98) 9, 348 3, 219 200. 0					l .			
73. 02 07301 BLOOD DI SORDER DRUGS 0. 182506 0 0 73. 0 76. 00 03160 CARDI OPULMONARY 0. 000000 0 0 76. 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 680048 0 0 0 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09100 EMERGENCY 0. 340378 5, 076 1, 728 91. 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 518208 0 0 9, 348 3, 219 200. 0					l .			
76. 00					l .		-	1
76. 97 07697 CARDIAC REHABILITATION 0. 680048 0 0 76. 9 0UTPATIENT SERVICE COST CENTERS 91. 00 09100 EMERGENCY 0. 340378 5, 076 1, 728 91. 0 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0. 518208 0 9, 348 3, 219 200. 0							_	
OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 0.340378 5,076 1,728 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.518208 0 0 92.0 200.00 Total (sum of lines 50 through 94 and 96 through 98) 9,348 3,219 200.0							0	76. 97
91.00								
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.518208 0 0 92.0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0. 3403	78 5, 076	1, 728	91.00
200.00 Total (sum of lines 50 through 94 and 96 through 98) 9,348 3,219 200.0	92. 00 09200 0B	SERVATION BEDS (NON-DISTINCT PART			l .			1
	200. 00 To	otal (sum of lines 50 through 94 and 9	96 through 98)			9, 348	3, 219	200.00
	201.00 Le	ess PBP Clinic Laboratory Services-Pro	ogram only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201) 9,348 202.0			. , ,			9, 348		202.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1:	From 01/01/2020	Worksheet E Part B Date/Time Prepared: 7/9/2021 10:17 am

			10 12/31/2020	7/9/2021 10: 1	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00	Medical and other services (see instructions)			9, 145, 446	
2. 00	Medical and other services reimbursed under OPPS (see instruc	tions)		0	
3. 00	OPPS payments			0	
4. 00	Outlier payment (see instructions)			0	
4. 01	Outlier reconciliation amount (see instructions)			0	
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	1
6. 00	Line 2 times line 5			0	
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	1
8. 00	Transitional corridor payment (see instructions)			0	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
10. 00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			9, 145, 446	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
40.00	Reasonable charges				10.00
	Ancillary service charges			0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
45.00	Customary charges			0	45 00
15.00	Aggregate amount actually collected from patients liable for			0	
16. 00	Amounts that would have been realized from patients liable fo		n a chargebasis	0	16. 00
17.00	had such payment been made in accordance with 42 CFR §413.13(e)		0.000000	17 00
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	1
	Total customary charges (see instructions)	ly if line 10 avecade li	no 11) (coo	0	
19.00	Excess of customary charges over reasonable cost (complete on	Ty IT TIME 18 exceeds IT	ne ii) (see	U	19.00
20. 00	instructions) Excess of reasonable cost over customary charges (complete on	Ly if line 11 exceeds li	no 10) (coo	0	20.00
20.00	instructions)	Ty IT TITLE IT exceeds IT	ile io) (see	U	20.00
21 00	Lesser of cost or charges (see instructions)			9, 236, 900	21.00
	Interns and residents (see instructions)			9, 230, 900	1
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		0	1
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			U	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instruction	e)		37, 869	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on lin	•	ructions)	5, 607, 162	1
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			3, 591, 869	
27.00	instructions)	prus the sum of filles 22	and 25] (366	3, 371, 007	27.00
28 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	1
	Subtotal (sum of lines 27 through 29)			3, 591, 869	1
	Primary payer payments			2, 087	1
	Subtotal (line 30 minus line 31)			3, 589, 782	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		2,722.,7.22	
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33.00
	Allowable bad debts (see instructions)			232, 175	
	Adjusted reimbursable bad debts (see instructions)			150, 914	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		32, 236	
	Subtotal (see instructions)	•		3, 740, 696	
	MSP-LCC reconciliation amount from PS&R			0	1
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
	Demonstration payment adjustment amount before sequestration			0	1
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instruc	tions)	0	ı
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	*	0	1
40.00	Subtotal (see instructions)			3, 740, 696	40.00
40. 01	Sequestration adjustment (see instructions)			24, 689	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40.03
41.00	Interim payments			4, 672, 270	41.00
41.01	Interim payments-PARHM				41.01
42.00				0	42.00
42.01					42. 01
43.00	`			-956, 263	43.00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	271, 443	44.00
	§115. 2		·]
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	The rate used to calculate the Time Value of Money			0. 00	
	Time Value of Money (see instructions)			0	1
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems IU H Peri od: Worksheet E-1 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: Provider CCN: 15-1311

					7/9/2021 10: 1	7 am
		Title	: XVIII	Hospi tal	Cost	
		I npati en	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider	11.00	4, 282, 16		4, 522, 270	1. 00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				0	2. 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER	08/31/2020	177, 90	08/31/2020	150, 000	3. 01
3. 02					0	3. 02
3. 03				o O	l ol	3. 03
3. 04				0	0	3. 04
3. 05				Ö	o o	3. 05
0.00	Provider to Program			<u> </u>		0.00
3. 50	ADJUSTMENTS TO PROGRAM			O	0	3. 50
3. 51				0	l ol	3. 51
3. 52				o O	0	3. 52
3. 53				o o	0	3. 53
3. 54)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		177, 90	-	150, 000	3. 99
3. 99	3. 50-3. 98)		177, 90	3	150,000	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 appropriate)		4, 460, 06	1	4, 672, 270	4.00
	TO BE COMPLETED BY CONTRACTOR		Т			
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER)	0	5. 01
5.02				0	ol	5.02
5.03				0	ol	5.03
	Provider to Program		<u>'</u>	<u>'</u>		
5. 50	TENTATI VE TO PROGRAM			O	0	5.50
5. 51				o o	o	5. 51
5. 52				0	l ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			o O	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		867, 49	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		007,47	ก	956, 263	6. 02
7. 00	Total Medicare program liability (see instructions)		5, 327, 55	9	3, 716, 007	7. 00
7.00	Total modical or program frability (300 first doll ons)		5,527,55	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Health Financial Systems IU H

		Component	CCN. 13-2311	10 12/31/2020	7/9/2021 10: 1	
		Title	XVIII S	wing Beds - SNF		
		I npati en	t Part A	Par	rt B	
		/- - /	A +		A	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00	Total interim payments paid to provider	1.00	615, 613		4.00	1.00
2. 00	Interim payments payable on individual bills, either		(0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	l				
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3.02			(0	3. 02
3. 03			(0	3. 03
3.04			(0	3. 04
3. 05			()	0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM			J	0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM					3. 50 3. 51
3. 52					0	3. 52
3. 53					l ol	3. 53
3.54					0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		615, 613	3	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(0	5. 01
5. 02 5. 03			(0	5. 02 5. 03
5.05	Provider to Program			<u>/ </u>	0	5.03
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51					o	5. 51
5.52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		(0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		148, 383	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		(0	6. 02
7. 00	Total Medicare program liability (see instructions)		763, 996		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor	l		1		8. 00

Heal th	Financial Systems IUI	HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-	-2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1311 Period: W From 01/01/2020 P. To 12/31/2020 D.					epared:
			Title XVIII	Hospi tal	Cost	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COS					4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND					4
1. 00	Total hospital discharges as defined in AARA §41			e 14		1.00 2.00
2. 00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6.					3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum	·	-12			4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col.					5. 00
6. 00	Total hospital charity care charges from Wkst. S					6. 00
7. 00	CAH only - The reasonable cost incurred for the	purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168					
8. 00	Calculation of the HIT incentive payment (see in					8. 00
9. 00	Sequestration adjustment amount (see instruction	,				9. 00
10. 00	Calculation of the HIT incentive payment after s		(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					4
	Initial/interim HIT payment adjustment (see inst	ructions)				30.00
	Other Adjustment (specify)					31.00
32. 00	Balance due provider (line 8 (or line 10) minus	line 30 and li	ine 31) (see instruction	ns)		32.00

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1311	Peri od: From 01/01/2020	Worksheet E-2
		Component CCN: 15-Z311		

			To 12/31/2020	Date/Time Pre 7/9/2021 10:1	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		593, 710	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	175, 890	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi	ng-bed pass-through, see			
2 01	instructions)				2 01
3. 01 4. 00	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teach	ing program (soo		0.00	3. 01 4. 00
4.00	instructions)	ing program (see		0.00	4.00
5.00	Program days		224	0	5.00
6.00	Interns and residents not in approved teaching program (see i	nstructions)		0	6.00
7. 00	Utilization review - physician compensation - SNF optional me	thod only	0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		769, 600	0	
9. 00 10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		769, 600	0	
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	709, 000	0	11.00
00	professional services)	sazi e te pilyer er all		ū	
12.00	Subtotal (line 10 minus line 11)		769, 600	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	528	0	13.00
14.00	for physician professional services)			0	14.00
14.00	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		769, 072	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		709, 072	0	1
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		ū	16. 50
16. 55	Rural community hospital demonstration project (§410A Demonst		o		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	l ő	0	1
	Total (see instructions)	,	769, 072	0	1
19. 01	Sequestration adjustment (see instructions)		5, 076	0	19. 01
	Demonstration payment adjustment amount after sequestration)		0	0	
	Sequestration adjustment-PARHM pass-throughs		/1F /12	0	19.03
	Interim payments Interim payments-PARHM		615, 613	U	20.00
	Tentative settlement (for contractor use only)		o	0	1
	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	148, 383	0	
22. 01	Balance due provider/program-PARHM (see instructions)	111 ONC D 1 45 0	04.004		22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda chapter 1, §115.2	nce with CMS Pub. 15-2,	24, 394	0	23. 00
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.]
201 00	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from	Wkst D 1 Dt II line			201.00
201.00	66 (title XVIII hospital))	wkst. D-1, Pt. 11, Tille			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line			202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the surror	at 5 year demons		204. 00
	period)	Trist year or the curren	it 5-year deliloris	ti ati on	
205.00	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see inst	•	,		207. 00
∠∪8. UU	Medicare swing-bed SNF inpatient service costs (from Wkst. E- and 3)	z, cor. i, sum of lines			208. 00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
	Reserved for future use	, 			210.00
04	Comparision of PPS versus Cost Reimbursement	000			
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	209 plus line 210) (see			215. 00
	Thisti dott ons)		1		I

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1311	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Pre 7/9/2021 10:1	pared:
	Title XVIII	Hospi tal	Cost	
			1. 00	
DADT V CALCULATION OF DELMDIDSEMENT SETT	TEMENT FOR MEDICADE DART A SERVICES COS	T DELMBIIDSEMENT		

PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		Title XVIII Hospital	Cost	
PART Y - CALCULATION OF RELIMBURSEMENT SETTLEMENT FOR MEDICABE PART A SERVICES - COST RELIMBURSEMENT 5, 619, 802 1.00 1.			1.00	
Inpatient services		DART V _ CALCILLATION OF RELMBLIRSEMENT SETTLEMENT FOR MEDICARE DART A SERVICES _ COST RELMBLIRSEMENT	1.00	
Nursing and Allied Health Managed Care payment (see instructions)	1 00		5 619 802	1 00
Organ acquisition S. 619, 802 4.00				
Subtotal (sum of lines 1 through 3) 5,619,802 4,00 6.00 Primary payer payments 5,676,000 5,676,000 6.00 Total cost (line 4 less line 5). For CAH (see instructions) 5,676,000 6.00 COMPUTATION OF LESSER OF COST OR CHARGES 7.00 7.00 Routine service charges 0 0 7.00 Routine service charges 0 0 0.000 0.00 0.00				
Primary payer payments				
Total Cost (I Ine 4 less line 5). For CAH (see instructions)				
Reasonable charges 0 0 0 0 0 0 0 0 0	6.00		5, 676, 000	6.00
7.00		COMPUTATION OF LESSER OF COST OR CHARGES		
Ancil lary service charges 0		Reasonable charges		
0.00 Total customary charges 0 0.00	7.00	Routine service charges		7.00
10.00 Customary charges		Ancillary service charges		
100				
11.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 11.00	10. 00		0	10.00
12.00			_	
had such payment been made in accordance with 42 CFR 413.13(e) 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 13.00 Total customary charges (see instructions) 0.000000 13.00 14.00 15.00				
13.00 Ratio of Line 11 to line 12 (not to exceed 1.000000) 13.00 14.00	12.00		0	12.00
14.00 Total customary charges (see instructions) 14.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 15.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess reasonable cost in a teaching hospital (see instructions) 17.00 Excess readonable cost (sum of lines 6, 17 and 18) 18.00 19.00 Excess reasonable cost (from line 16) 18.00 19.00	12 00		0.000000	12 00
15.00 Excess of cust omary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 16.00 16.00 16.00 17.		1		
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 16.00 16.00 17.				
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.00 17.00 17.00 18.00 18.00 19.0	13.00		O O	13.00
Instructions Cost of physicians' services in a teaching hospital (see instructions) To 0 To	16 00		0	16 00
17. 00				10.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT	17. 00		0	17.00
19.00 Cost of covered services (sum of lines 6, 17 and 18) 5,676,000 19.00 333,652 20.00				
19.00 Cost of covered services (sum of lines 6, 17 and 18) 5,676,000 19.00 333,652 20.00	18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 5,342,348 22.00 23.00 Coinsurance 0 23.00 24.00 Subtotal (line 22 minus line 23) 5,342,348 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 31,702 25.00 26.00 Adjusted relimbursable bad debts (see instructions) 20,600 26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 20,600 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 20,600 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 5,362,954 28.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.50 29.99 Demonstration payment adjustment amount before sequestration 29.50 29.99 29.90	19.00		5, 676, 000	19.00
22.00 Subtotal (line 19 minus line 20 and 21) 5, 342, 348 22.00 23.00 Coinsurance 5, 342, 348 24.00 23.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 31, 702 25.00 20.00 Adjusted reimbursable bad debts (see instructions) 20, 606 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 20, 606 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 20, 606 26.00 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 5, 362, 954 28.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.00 29.90 29.90 29.90 29.90 29.00 29.9	20.00	Deductibles (exclude professional component)	333, 652	20.00
23.00 Coinsurance		Excess reasonable cost (from line 16)		
24.00 Subtotal (line 22 minus line 23) 5,342,348 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 31,702 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 20,606 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 16,211 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 5,362,954 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.90 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 30.00 Subtotal (see instructions) 5,362,954 30.00 30.01 Sequestration adjustment (see instructions) 35,362,954 30.01 30.02 Sequestration adjustment amount after sequestration 0 30.02 30.03 Sequestration adjustment amount after sequestration 0 30.02 31.00 Interim payments 4,460,061 31.01 Interim payments 4,460,061 31.01 Tentative settlement (for contractor use only) 32.00 32.01 Balance due provi der/program (line 30 minus lines 30.01, 30.02, 31, and 32) 3				
25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 31,702 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 20,606 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 16,211 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 5,362,954 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 30.01 Subtotal (see instructions) 0 29.50 30.02 Subtotal (see instructions) 5,362,954 30.00 30.01 Sequestration adjustment (see instructions) 5,362,954 30.00 30.02 Demonstration payment adjustment amount after sequestration 0 29.50 30.02 Demonstration payment adjustment amount after sequestration 0 30.02 31.00 Interim payments 4,460,061 31.00 31.01 Interim payments 4,460,061 31.01 32.01 Tentative settlement (for contractor use only) 32.01 33.01				
26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 30. 00 Subtotal (see instructions) 29. 99 30. 00 Subtotal (see instructions) 29. 99 30. 00 Subtotal (see instructions) 29. 99 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Sequestration adjustment (see instructions) 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 31. 01 Interim payments Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) 33. 00 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 38. 00 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 39. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 26. 00 27. 00 5, 362, 954 28. 00 5, 362, 954 28. 00 29. 0				
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 16, 211 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 5, 362, 954 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 29. 90 29. 99 Demonstration payment adjustment amount before sequestration 0 29. 90 30. 01 Sequestration adjustment (see instructions) 35, 362, 954 30. 00 30. 02 Demonstration payment adjustment amount after sequestration 0 35, 395 30. 01 30. 02 Sequestration adjustment-PARHM 30. 02 30. 02 31. 00 Interim payments 4, 460, 061 31. 00 31. 01 Interim payments-PARHM 31. 00 32. 01 Tentative settlement (for contractor use only) 32. 01 33. 00 Balance due provi der/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 867, 498 33. 01 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34. 00				
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 30.03 Interim payments 31.00 Interim payments 31.01 Interim payments 32.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5, 362, 954 28.00 5, 362, 954 28.00 0 29.00 0 29.5				
29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 02 Demonstration payment adjustment ese instructions) 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments Interim payments-PARHM 31. 01 Tentative settlement (for contractor use only) 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34. 00				
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 1. Interim payments 1. Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34.00				
29. 99 Demonstration payment adjustment amount before sequestration 0 29. 99 30. 00 Subtotal (see instructions) 5, 362, 954 30. 00 30. 01 Sequestration adjustment (see instructions) 35, 395 30. 01 30. 02 Demonstration payment adjustment amount after sequestration 0 30. 02 30. 03 Sequestration adjustment-PARHM 30. 03 31. 01 Interim payments 4, 460, 061 31. 00 31. 01 Interim payments-PARHM 31. 01 31. 01 32. 00 Tentative settlement (for contractor use only) 0 32. 01 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 867, 498 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 33. 01 33. 01 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34. 00		, , , , ,		
30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34. 00				
30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34. 00				
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments-PARHM 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34.00				
30. 03 Sequestration adjustment-PARHM 30. 03 31. 00 Interim payments Interim payments-PARHM 4, 460, 061 31. 00 31. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 32. 01 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 867, 498 33. 00 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 33. 01 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34. 00				
31.00 Interim payments 4,460,061 31.00 31.01 32.00 Tentative settlement (for contractor use only) 0 32.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175,678 34.00		' ' '	ı .	
31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175, 678 34.00		1 '	4, 460, 061	
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175,678 34.00		1	1, 122, 331	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175,678 34.00			o	
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 867,498 33.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 75,678 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175,678 34.00		·		
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175,678 34.00			867, 498	
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 175,678 34.00				
§115. 2	34.00		175, 678	34.00
		§115. 2		

Health Financial Systems

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

Provi der CCN: 15-1311 Peri From

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

onl y)			10	12/31/2020	7/9/2021 10: 1	
		General Fund	Specific	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS				_	
1.00	Cash on hand in banks	41, 706, 628	0	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable) 		0	0	3.00
4. 00	Accounts receivable	5, 940, 100	0	0	0	4.00
5. 00	Other recei vabl e	-1, 811, 257	Ö	Ö	0	
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7. 00	Inventory	1, 015, 955	0	0	0	7. 00
8.00	Prepai d expenses	141, 328	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	46, 992, 754		0	0	11.00
	FI XED ASSETS		-1			1
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0 21/ 225	0	0	0	14.00
15. 00 16. 00	Buildings Accumulated depreciation	9, 316, 325	0	0	0	15. 00 16. 00
17. 00	Leasehold improvements	2, 872, 457		0	0	17. 00
18. 00	Accumulated depreciation	-1, 433, 128	Ö	Ö	0	18.00
19.00	Fi xed equipment	0	0	0	0	19.00
20. 00	Accumulated depreciation	0	0	0	0	20.00
21. 00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23. 00 24. 00	Major movable equipment Accumulated depreciation	12, 175, 222 -9, 624, 310	0	0	0	23.00
25. 00	Mi nor equi pment depreciable	-9, 024, 310 0		0	0	25. 00
26. 00	Accumulated depreciation	0	Ö	Ö	0	26.00
27. 00	HIT designated Assets	0	О	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e		0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	13, 306, 566	0	0	0	30.00
31. 00	OTHER ASSETS Investments	955, 708	O	O	0	31.00
32. 00	Deposits on Leases	0	Ö	Ö	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	14, 777, 828		0	0	34.00
35.00	Total other assets (sum of lines 31-34)	15, 733, 536		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	76, 032, 856	0	0	0	36.00
37. 00	Accounts payable	1, 202, 807	O	O	0	37.00
38. 00	Salaries, wages, and fees payable	1, 514, 089		Ö	0	38.00
39.00	Payrol I taxes payable	0	0	0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	7, 779, 802			0	42.00
43. 00 44. 00	Due to other funds Other current liabilities	4, 327, 025		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	14, 823, 723		0		
.0.00	LONG TERM LIABILITIES	11,020,720	<u> </u>	<u> </u>		10.00
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	12, 935, 000	1	0	0	
48. 00	Unsecured Loans	0	0	0	0	
49.00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	508, 503		0	0	1
50. 00 51. 00	Total liabilities (sum of lines 45 and 50)	13, 443, 503 28, 267, 226		0	0	50. 00 51. 00
01.00	CAPI TAL ACCOUNTS	20, 201, 220	<u> </u>	_I		01.00
52.00	General fund balance	47, 765, 630				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			U	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
25.00	replacement, and expansion					-3.00
59. 00	Total fund balances (sum of lines 52 thru 58)	47, 765, 630	0	0	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	76, 032, 856	0	0	0	60.00
	[59]	l	ı İ	l		I

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 01/01/2020 Date/Time Prepared: 7/0/2021 10:17 am Provider CCN: 15-1311

					То	12/31/2020	Date/Time Pre 7/9/2021 10:1	
		General	Fund	Speci al I	Pur	pose Fund	Endowment	
							Fund	
		1. 00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period		39, 686, 882	l .		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		6, 464, 100	l .				2.00
3. 00	Total (sum of line 1 and line 2)		46, 150, 982		_	0	_	3. 00
4.00	DONATED PROP., PLANT, EQUIP.	11, 039			0		0	
5.00		0			0		0	
6. 00 7. 00		0			0		0	
8. 00					0		0	
9. 00		0			0		0	
10.00	Total additions (sum of line 4-9)	٥	11, 039		0	o	O	10.00
11. 00	Subtotal (line 3 plus line 10)		46, 162, 021			ol Ol		11.00
12. 00	Deductions (debit adjustments) (specify)	0	10, 102, 021		0	Ĭ	0	1
13. 00	bedder one (dear trady detimente) (epoetry)	o o			0		0	
14.00	PERM RESTRICTED	-1, 800			0		0	1
15.00	TEMP RESTRICTED	-1, 601, 809			0		0	15. 00
16.00		0			0		0	16.00
17.00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		-1, 603, 609			0		18. 00
19. 00	Fund balance at end of period per balance		47, 765, 630			0		19. 00
	sheet (line 11 minus line 18)							
		Endowment	PI ant	Fund				
		Fund		I				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2.00
3. 00	Total (sum of line 1 and line 2)	0			0			3.00
4. 00	DONATED PROP., PLANT, EQUIP.		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					9.00
10.00	Total additions (sum of line 4-9)	0	0		0			10.00
11. 00	Subtotal (line 3 plus line 10)				0			11.00
12. 00	Deductions (debit adjustments) (specify)	Ĭ	0					12.00
13. 00	bedder one (dear trady detiments) (epoetry)		0					13.00
14. 00	PERM RESTRICTED		0					14.00
15. 00	TEMP RESTRICTED		0					15.00
16.00			0					16.00
17.00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	0			0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

| Peri od: | Worksheet G-2 | From 01/01/2020 | Parts | & II | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems INSTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1311

			То	12/31/2020	Date/Time Pre 7/9/2021 10:1	
	Cost Center Description	Inpatient		Outpati ent	Total	/ alli
	oust defiter bescription	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1 11 00		2.00	0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	4, 348, 9	76		4, 348, 976	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF	221, 7	80		221, 780	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	4, 570, 7	756		4, 570, 756	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11.00
12. 00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0		0	16. 00
47.00	11-15)					47.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4, 570, 7		00 00/ 050	4, 570, 756	
18.00	Ancillary services	17, 527, 1		80, 006, 052	97, 533, 187	18.00
19. 00 20. 00	Outpatient services RURAL HEALTH CLINIC	333, 3	0	13, 755, 725 0	14, 089, 100	19.00 20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	20.00
22. 00	HOME HEALTH AGENCY		U	٩	U	21.00
23. 00	AMBULANCE SERVICES					23.00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26. 00	HOSPI CE					26.00
27. 00	NONALLOWABLE REVENUE		0	1, 913, 192	1, 913, 192	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 22, 431, 2		95, 674, 969	118, 106, 235	
20.00	G-3, line 1)	22, 101, 2	.00	70, 07 1, 707	110, 100, 200	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			41, 890, 779		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36. 00
37.00	DEDUCT (SPECIFY)		0			37.00
38.00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	nster		41, 890, 779		43. 00
	to Wkst. G-3, line 4)	I	-	ı		l

Heal th	Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-1311	Peri od:	Worksheet G-3	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/9/2021 10:1	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)				118, 106, 235	1.00
2.00	Less contractual allowances and discounts on patients' accounts				71, 912, 123	2.00
3.00	Net patient revenues (line 1 minus line 2)				46, 194, 112	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				41, 890, 779	4.00
5.00					4, 303, 333	5.00
	OTHER INCOME					
6.00					0	6.00
7.00	0 Income from investments				0	7.00
8.00	OD Revenues from telephone and other miscellaneous communication services				0	8. 00
9.00	.00 Revenue from television and radio service				0	9. 00
10.00	10.00 Purchase di scounts				0	10.00
11.00	1.00 Rebates and refunds of expenses				0	11.00
12.00	Parking Lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	00 Revenue from meals sold to employees and guests				0	14.00
15.00	00 Revenue from rental of living quarters				0	15.00
16.00	NO Revenue from sale of medical and surgical supplies to other than patients				0	16.00
17.00	O Revenue from sale of drugs to other than patients				0	17.00
18.00	Revenue from sale of medical records and abstracts				0	18.00
19.00	O Tuition (fees, sale of textbooks, uniforms, etc.)				0	19.00
20.00	00 Revenue from gifts, flowers, coffee shops, and canteen				0	20.00
21.00	00 Rental of vending machines				0	21.00
22.00	00 Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	23. 00
24.00	MI SCELLANEOUS I NCOME				1, 798, 932	24.00
24. 50	60 COVI D-19 PHE Fundi ng				361, 835	24. 50
25.00	0 Total other income (sum of lines 6-24)				2, 160, 767	25. 00
	00 Total (line 5 plus line 25)				6 464 100	26 00

6, 464, 100 26. 00

0 0 28.00 6, 464, 100 29.00

27.00

24.00 MISCELLANEOUS INCOME
24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)