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 Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/26/2022 2:03 pm 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. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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 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 01/01/2021 and ending 12/31/2021 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.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SIGNATURE STATEMENT	
1	Cara	a Breidster	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Cara Breidster			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-1, 120, 263	-1, 878, 611	0	0	1.00
2.00 Subprovider - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5. 00 Swi ng Bed - SNF	0	5, 339	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
200. 00 Total	0	-1, 114, 924	-1, 878, 611	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.

1100111	AL AND HOSPITAL HEALTH CARE COMPLEX	T D L IVITT	SATTON BATTA					Ferrod. From 01/01/ To 12/31/	2021	Part I Date/Ti 5/26/20		pared:
	1. 00		2. 00		3.00			4	1. 00			
	Hospital and Hospital Health Care Co Street: 1000 SOUTH MAIN STREET City: TIPTON		PO Box: State: IN	Zip Cod				y: TIPTON				1. 00 2. 00
		Comp	oonent Name	CCN Number	CBS Numb	ber	Provi der Type	Date Certi fi ed	T,	nt Syst 0, or XVIII	N) XIX	
			1. 00	2.00	3. (00	4. 00	5. 00	6. 00	7. 00	8. 00	
3. 00	Hospital and Hospital-Based Componer Hospital	I U HEALT HOSPITAL		151311	999	15	1	11/12/2005	N	0	0	3.00
4. 00 5. 00 6. 00 7. 00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF	IU HEALT	H TIPTON	15Z311	290)20		11/12/2005	N	0	N	4. 00 5. 00 6. 00 7. 00
3. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Swing Beds - NF Hospital-Based SNF Hospital-Based NF Hospital-Based OLTC Hospital-Based HHA Separately Certified ASC Hospital-Based Hospice Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I Renal Dialysis	HOSPI TAL										8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
19. 00	0ther							- Fram:		To		19.00
								From: 1.00		To 2. (
	Cost Reporting Period (mm/dd/yyyy)							01/01/20	021	12/31/		20.00
21.00	Type of Control (see instructions)							2				21.00
							1. 00	2. 00		3. (00	
	Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interimum	istment, or yes or 3412.106(or yes or	in accordance "N" for no. I c)(2)(Pickle a "N" for no.	with 42 CF s this mendment	R		N N	N N				22. 00
	cost reporting period? Enter in coluthe portion of the cost reporting period reporting period occurring on or aft is this a newly merged hospital that payments to be determined at cost reference in column 1, "Y" for yes or "N" cost reporting period prior to Octobor "N" for no, for the portion of the	umn 1, "Yeriod occi l" for no eer Octobe require eport set l" for no per 1. En	" for yes or " urring prior t for the porti er 1. (see ins s final uncomp tlement? (see , for the port ter in column	N" for no to October on of the structions) densated ca instruction tion of the 2, "Y" for	for 1. cost re ns)		N	N				22. 02
	October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in comparison for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	rds for decolumn 1, ag period no for the fer October 100 but	elineating sta "Y" for yes o prior to Octo he portion of er 1. (see ins not more than	atistical a or "N" for ober 1. Ent the cost structions) 499 beds (reas no er as		N	N		N		22. 03
	yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	delinea column 1 ng period no for t er Octob 100 but	tions for stat, "Y" for yes prior to Octohe portion of er 1. (see ins	istical ar or "N" for ober 1. Ent the cost structions) 499 beds (eas no er as		N	N		N		22. 04
	which method is used to determine Me below? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission of identification of identification of identification of the control of the control of the control of admission of admissi	sion, 2 if cer ifying the day sed in the pri	nsus days, vs in this or cost	or 3			3 N				23. 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

59.00

Ν

58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

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, Pt. I.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der Co	CN: 15-1311	Peri od:	Worksheet S-2	
					From 01/01/2021 To 12/31/2021	Part Date/Time Pre 5/26/2022 2:0	
				NAHE 413.89 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion	•
				1. 00	2. 00	Code 3. 00	
0. 00	Are you claiming nursing and allied health education	(NAHE)	costs for	N N	2.00	3.00	60.0
	any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	see If column 1				
	pay as tements. Enter 1 For yes on 10 For 10 For the Fire Con-	Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2. 00	3. 00	4. 00	5. 00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.0
1. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.0
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of						61.0
1. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
1. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. (
		Pro	gram Name	Program Coc	le Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
- 10			1. 00	2. 00	3. 00	4. 00	
1. 10	Of the FTEs in line 61.05, specify each new program 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				0.00	0.00	61. 1
	FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name.				0.00	0. 00	61. 2
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
						1. 00	
2. 00	ACA Provisions Affecting the Health Resources and Set Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai nec			eriod for which		62. C
			ng Health Cer	oter (THC) in	to your hospital	0.00	62.0
2. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of HRSA THC progression of HRSA THC progression of HRSA THC progression of the number of FTE residents in Nonprovide the number of FTE residents that rotated from a during the number of FTE residents that rotated from a during the number of FTE residents that rotated from a during the number of FTE residents that rotated from a during the number of FTE residents that rotated from a during the number of FTE residents that rotated from a during the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression in the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression in the number of FTE residents in the number of the number of FTE residents in the nu	ıram. (s	see instructio			0.00	02.0

	Financial Systems		TH TIPTON HOSPITAL	ON: 1E 1011		u of Form CMS-2	
HOSPI IA	L AND HOSPITAL HEALTH CARE COMP	LEX IDENIIFICATION DA	ATA Provi der CO		eriod: com 01/01/2021 o 12/31/2021	Worksheet S-2 Part I Date/Time Pre 5/26/2022 2:0	pared:
			,	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	Ş
la	Continu FEOA of the ACA Door Vos	n FTF Dooidanta in N	lanneavi dan Catti nga	1. 00	2.00	3.00	
	Section 5504 of the ACA Base Yea Deriod that begins on or after J			-inis base year	r is your cost	reporting	
64.00 E	Enter in column 1, if line 63 is n the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs	FTEs in	3/ (col. 3 +	
				Nonprovider Site	Hospi tal	col. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
65. 00 E	Enter in column 1, if line 63	1. 00	2.00	0.00			65. 00
1	s yes, or your facility trained residents in the base year period, the program name associated with primary care FTES for each primary care brogram in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTES that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	
l.	5504 . 6 . 1 . 101 0	V. ETE B. I.I. I.	N	1.00	2. 00	3.00	
	Section 5504 of the ACA Current Deginning on or after July 1, 20		n Nonprovider Setting	gsEffective f	for cost report	ing periods	
	Enter in column 1 the number of		ry care resident	0.00	0.00	0. 000000	66.00
	TEs attributable to rotations o						
	Enter in column 2 the number of FTEs that trained in your hospit						
	(column 1 divided by (column 1 +						
,		Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der	FTEs in Hospital	3/ (col. 3 + col. 4))	
				Si te	Hospi tai	(01. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	Enter in column 1, the program			0.00		0. 000000	67.00
V E C T C C C	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 6, the ratio of (column 3 + column 4)). (see instructions)						

	To 12/31/20)21 Da		me Pre	
	1	. 00	2. 00	3. 00	
Inpatient Psychiatric Facility PPS 0.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF su	hnrovi dor2	N		l	70. 0
Enter "Y" for yes or "N" for no.	bpi ovi dei ?	IN			70.0
1.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new tea program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reporti	no. (see chi ng no.			0	71.0
(see instructions) Inpatient Rehabilitation Facility PPS					-
5.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		N			75. C
subprovider? Enter "Y" for yes and "N" for no. 6.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes	or "N" for			0	76.0
no. Column 2: Did this facility train residents in a new teaching program in accordanc CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions	Υ,				
			1. C	00	1
Long Term Care Hospi tal PPS					
 0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reportin "Y" for yes and "N" for no. TEFRA Providers 	g period? En	ter	N N		80. C 81. C
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Secti §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87.0
1000(d)(1)(b)(vi): Litter i for yes or in for no.	V		XL	Χ	
Title V and VIV Carvings	1.00		2.0	00	
Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N		Υ		90. (
yes or "N" for no in the applicable column. 1.00 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		91. (
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see			N		92.0
instructions) Enter "Y" for yes or "N" for no in the applicable column. 3.00 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		93.
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.
5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N		O. C N		95. 96.
7.00 If line 96 is "Y", enter the reduction percentage in the applicable column. B.00 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. C Y		97. 98.
8.01 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.			Υ		98.
B. 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		98.
B.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 for title V, and in column 2 for title XIX.	N 1		N		98.
B. 04 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		98.
8.05 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 i column 2 for title XIX.			Υ		98.
B.O6 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		98.
Rural Providers O5.00 Does this hospital qualify as a CAH? O6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of paymen	t Y				105. 106.
for outpatient services? (see instructions) 07.00 (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				107.

IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-255	52-1
MPLEX IDENTIFICATION DATA Provider CCN: 15-1311 Period: Worksheet S-2 From 01/01/2021 Part I	
To 12/31/2021 Date/Time Prepared 5/26/2022 2:03 p	
V XIX	
fying for an exception to the CRNA fee schedule? See 42 N 10	08.00
"Y" for yes or "N" for no. Physical Occupational Speech Respiratory	
1.00 2.00 3.00 4.00	
a CAH or a cost provider, are N N N N 10 putside supplier? Enter "Y" therapy.	09. 00
in the Rural Community Hospital Demonstration project (§410A N 11	10. 00
cost reporting period? Enter "Y" for yes or "N" for no. If yes, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as	10.00
1.00 2.00	
a CAH, did it participate in the Frontier Community "HIP) demonstration for this cost reporting period? Enter column 1. If the response to column 1 is Y, enter the demoin which this CAH is participating in column 2. "Ambulance services; "B" for additional beds; and/or "C"	11. 00
1.00 2.00 3.00	
in the Pennsylvania Rural Health Model N of the current cost reporting period? so in column 1. If column 1 is "Y", enter sital began participating in the enter the date the hospital ceased stion, if applicable.	12. 00
nformation provider? Enter "Y" for yes or "N" for no N 011	15. 00
ss, enter the method used (A, B, or E only) ", enter in column 3 either "93" percent " percent for long term care (includes ad long term hospitals providers) based on , chapter 22, §2208.1.	
s a referral center? Enter "Y" for yes or N 11	16. 00
red to carry malpractice insurance? Enter N 11	17. 00
	18. 00
1.00 2.00 3.00	18. 0 ²
eiii uiis anu paru 1055e5. 31, 317 0 011	10.0
f yes, submit supporting schedule listing cost centers	18. 02
Ilifies for the Outpatient Hold Harmless provision in ACA N N 12 (see instructions) Enter in column 1, "Y" for yes or pospital with < 100 beds that qualifies for the Outpatient S §3121 and applicable amendments? (see instructions)	19. 00 20. 00
port costs for high cost implantable devices charged to Y 12	21. 00
	22. 00
ransplant center? Enter "Y" for yes and "N" for no. If N 12	25. 00
s) (mm/dd/yyyy) below.	26. 00
rte, if applicable, in column 2.	
d heart transplant center, enter the certification date 12 Ite, if applicable, in column 2.	27. 00
ed liver transplant center, enter the certification date 12	28. 00
	29. 00
	11:11:11:11:11:11:11:11:11:11:11:11:11:

Provider CCN: 15-	1011		eu of Form CMS	
		eriod: om 01/01/2021	Worksheet S- Part I	
	To	12/31/2021	Date/Time Pr 5/26/2022 2:	epared
			372072022 2.	J piii
	-4!	1. 00	2. 00	130.0
care certified pancreas transplant center, enter the certifical and termination date, if applicable, in column 2. care certified intestinal transplant center, enter the certified intestinal transplant center.				131. (
and termination date, if applicable, in column 2. care certified islet transplant center, enter the certification				132.0
reduced the restrict transplaint center, enter the centification date, if applicable, in column 2.	on date			133.
yeu gan procurement organization (OPO), enter the OPO number in col date, if applicable, in column 2.	lumn 1			134.
ated organization or home office costs as defined in CMS Pub. "Y" for yes or "N" for no in column 1. If yes, and home officer in column 2 the home office chain number. (see instructions)	ce costs	Y	15H059	140.
1.00 2.00 s part of a chain organization, enter on lines 141 through 1	43 the na	3.00 me and address	s of the home	
the home office contractor name and contractor number. WIVERSLITY HEALTH Contractor's Name: WPS Contractor's Name: Contractor's Name: Contractor's Name: Contractor's Name: Contractor's Name: Contractor's Name: Contractor N	on+roo+or	's Number: 081	01	141.
NOTE OF THE NAME O	ontractor	S Nulliber: 081	U I	141.0
LIS State: IN Z	ip Code:	462	02	143.
			1. 00	
ed physicians' costs included in Worksheet A?			Y	144.
		1. 00	2.00	
al services are claimed on Wkst. A, line 74, are the costs for es only? Enter "Y" for yes or "N" for no in column 1. If column ysis facility include Medicare utilization for this cost repor (" for yes or "N" for no in column 2. cation methodology changed from the previously filed cost reports.	rting	N		145. 146.
s or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §- oproval date (mm/dd/yyyy) in column 2.	4020) If			
ge in the statistical basis? Enter "Y" for yes or "N" for no.			1. 00 N	147.
ge in the statistical basis: Eller I To yes of N To Ho. ge in the order of allocation? Enter "Y" for yes or "N" for no. ge to the simplified cost finding method? Enter "Y" for yes or		20	N N	148.
Part A P	art B	Title V	Title XIX	117.
1.00 ty contain a provider that qualifies for an exemption from the	2. 00	3.00	4.00	
"Y" for yes or "N" for no for each component for Part A and				
N.	N	N	N	155.
= N N N N N N N N N	N N	N N	N N	156. 157.
IN I	IN	IN	IN	158.
N I	N	N	N	159.
CY N	N	N	N	160.
	N	N	N	161.
			1. 00	
	in differ	ent CBSAs?	N	165.
part of a Multicampus hospital that has one or more campuses i	ate Zip	Code CBSA 00 4.00	FTE/Campus 5.00	
part of a Multicampus hospital that has one or more campuses is or "N" for no. Name County Sta		4.00		00166.
part of a Multicampus hospital that has one or more campuses is or "N" for no. Name County Sta	00 3.			
part of a Multicampus hospital that has one or more campuses is or "N" for no. Name			1 00	
part of a Multicampus hospital that has one or more campuses is or "N" for no. Name	00 3.	Act	1.00	
part of a Multicampus hospital that has one or more campuses is or "N" for no. Name	nvestment or no.		1.00 Y	
part of a Multicampus hospital that has one or more campuses is or "N" for no. Name	nvestment or no. is "Y"),	enter the		167. 168.
part of a Multicampus hospital that has one or more sor "N" for no. Name	ry and Rei s or "N" fo	s or "N" for no.	s or "N" for no.	ry and Reinvestment Act s or "N" for no. Y

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In	Lieu of Form C	MS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	ENTIFICATION DATA	Provider CCN: 15-1311	Period: From 01/01/2	Worksheet	S-2
				2021 Date/Time	Prepared:
			1.0 12,01,1	5/26/2022	2: 03 pm
			Begi nni i	ng Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR begind period respectively (mm/dd/yyyy)			170. 00		
			1.00	2. 00	
171.00 If line 167 is "Y", does this provider	have any days for indi-	viduals enrolled in	Y		36 171. 00
section 1876 Medicare cost plans repor					
"Y" for yes and "N" for no in column 1		nter the number of secti	on		
1876 Medicare days in column 2. (see i	nstructions)				

Heal th	Financial Systems IU HEALTH TIP	TON HOSPITAL		In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od:	Worksheet S-:	
				From 01/01/2021 To 12/31/2021		epared:
				Y/N	5/26/2022 2:0	03 pm
				1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente			
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to th			N		1.00
	reporting period? If yes, enter the date of the change in	column 2. (see	1 '		\/ /I	
			1.00	2. 00	V/I 3. 00	
2. 00	Has the provider terminated participation in the Medicare	Program? If	N	2.00	0.00	2.00
	yes, enter in column 2 the date of termination and in colu	mn 3, "V" for				
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, includi	na management	Y			3.00
3. 00	contracts, with individuals or entities (e.g., chain home		'			3.00
	or medical supply companies) that are related to the provi					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth					
	relationships? (see instructions)	ei Silliiai				
			Y/N	Туре	Date	
	Figure in L. Date and Demonts		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Public	Υ	Α		4.00
00	Accountant? Column 2: If yes, enter "A" for Audited, "C"		·			
	or "R" for Reviewed. Submit complete copy or enter date av	ailable in				
5. 00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diff	erent from	N			5.00
5.00	those on the filed financial statements? If yes, submit re		IN IN			3.00
				Y/N	Legal Oper.	
	Approved Educational Activities			1. 00	2. 00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If ves. i:	s the provider	- N		6.00
	is the legal operator of the program?		o 11.0 p. 01. do.			0.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i			N		7.00
8. 00	Were nursing programs and/or allied health programs approv cost reporting period? If yes, see instructions.	ed and/or rene	wea auring the	e N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved	graduate medi	cal education	N		9.00
	program in the current cost report? If yes, see instructio					
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.		•			
					1. 00	
	Bad Debts				1.00	
	Is the provider seeking reimbursement for bad debts? If ye				Y	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection	policy change	during this co	ost reporting	N	13.00
14 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-paym	ents waived? L	fves see in	structions	N	14.00
	Bed Complement	cirto wai vou. T	1 yes, see 1116	structions.	14	111.00
15. 00	Did total beds available change from the prior cost report				N	15. 00
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3.00	4. 00	
	PS&R Data					
16. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Y	04/04/2022	Υ	04/04/2022	17. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.	I	I	1	I	I

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Health Financial Systems	IU HEALTH TIF	PTON HOSPITAL		In Lie	u of Form CM	S-2552-10
20.00	HOSPITAL AND HOSPITAL HEALTH CARE REIMBL	JRSEMENT QUESTIONNAIRE			From 01/01/2021 To 12/31/2021	Part II Date/Time F 5/26/2022 2	Prepared:
20.00 If I I Ine 16 or 17 I is yes, were adjustments made to PSAR Report data for Other? Describe the other adjustments: V/N Date V/N							
Report data for Other? Describe the other adjustments: Y/R	20 00 If line 16 or 17 is yes were add	ustments made to DSAD		U			20.00
21.00 Was the cost report prepared only using the provider's 1.00 2.00 3.00 4.00					IN	l IN	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 Precentary If yes, see instructions. 1.00	The period and a real extremal Bessells of	no otnor daj aotmento.	Y/N	Date	Y/N	Date	
COMPLETED BY COST RELIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 1.00			1.00	2.00	3.00	4. 00	
COMPLETED BY COST RETURBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare purposes? If yes, see instructions 24.00 Ware new leaves and/or amendments to existing leaves entered into during this cost reporting period? N 24.00 25.00 Ware new leaves and/or amendments to existing leaves entered into during this cost reporting period? If yes, see instructions 25.00 Mare assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Ware assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. 28.00 Ware new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 29.00 Unit of the provider have a funded deprelation account and/or bond funds (bebt Service Reserve Fund) 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has changes or new agreements occurred in patient care services furnished through contractual N 32.00 Has changes or new agreements occurred in patient care services furnished through contractual N 33.00 If fine 21 is yes, were the requirements of Sec. 2153. 2 applied pertaining to competitive bidding? If yes, see Instructions. 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 fine 3d is yes, shas a home office cost statement been prepared by the home office? 36.00 Were home office costs claimed on the cost report? 37.00 If fine 3d is yes, has a home office cost statement been prepared by the home office? 38.00 If fine 3d is yes, has a home office cost statement been prepared by the home office? 39.00 If fine 3d is yes, did the provider render			N		N		21. 00
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1.23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 23.00		(=:::		,			
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 lifyes, see Instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 linstructions. 26.00 Were seasests subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 linstructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 coop. 28.00 Vere new Loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions nervigage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions as funded depreciation account? If yes, see instructions as funded depreciation account? If yes, see instructions 29.00 Did the provider have 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 with new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity with new debt? If yes, see N 31.00 instructions. 30.00 If I in 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no arrangements with suppliers of services? If yes, see instructions. 30.00 If I in 32 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 in the provider of the provider period? If yes, see instructions. 30.00 If I in 36 is yes, was there new agreements been prepared by the home office? Y 37.00 in yes, see instructions. 30.00 If I in 36 is yes, was the fiscal year end of the home office? If yes, see instructions. 30.00 If I in 36 is yes, did the provider render services to other chain components? If yes, yee I intructions. 40.00 Enter the end poyer/company name	22.00 Have assets been relifed for Medi	care purposes? If yes, se	ee 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. 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 instructions. 26.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. 28.00 Were new Leans, mortgage agreements or Letters of credit entered into during the cost reporting PN 28.00 Period? If yes, see Instructions. 29.00 Were new Leans, mortgage agreements or Letters of credit entered into during the cost reporting N 28.00 Period? If yes, see Instructions are instructions. 29.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions. 30.00 Has end loans, mortgage agreements or Letters of credit entered into during the cost reporting N 28.00 Period? If yes, see Instructions are instructions. 31.00 Has changes of Indeed agreeciation account? If yes, see Instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions. 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 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 If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 34.00 If yes, see instructions. 34.00 Were home office costs claimed on the cost report? 35.00 If line 36 is yes, was the fiscal year end of the home office? 37.00 If line 36 is yes, and the fiscal yea	23.00 Have changes occurred in the Medi	care depreciation expense	e due to apprai	sals made du	ing the cost	N	23. 00
If yes, see instructions 25.00 lave there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 N	reporting period? If yes, see ins	tructions.					
instructions. 2.0.00 Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see	If yes, see instructions	G	· ·				
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00		eases entered into durino	g the cost repo	rting period	? If yes, see	N N	25.00
Instructions. 27.00 Rote provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Rote 27.00 27.00 Rote 27.00 Rote 27.00 2		f DEEDA acquired during	the cost report	ing ported?	f voc. coo	N.	24 00
27.00 lass the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 copy. Interest Expense		DEFRA acquired during	the cost report	ing perrous	i yes, see	IN IN	20.00
Copy. Interest Expense		policy changed during th	ne cost reporti	na period? Li	ves submit	l N	27 00
Interest Expense 28.00 Nere new Joans, mortgage agreements or letters of credit entered into during the cost reporting N period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account? If yes, see instructions N 29.00 Treated as a funded depreciation account? If yes, see instructions N 29.00 N 29	·	perrey enanged during th	.o ooot . opo. t.	ng por our r	J 00 / 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		27.00
period? If yes, see instructions. 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions has else the provider been replaced prior to its scheduled maturity with new debt? If yes, see instructions has debt been recalled before scheduled maturity with new debt? If yes, see instructions has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions. 31.00 Have changes or new agreements occurred in patient care services furnished through contractual normal rangements with suppliers of services? If yes, see instructions. 32.00 Have changes or new agreements occurred in patient care services furnished through contractual normal rangements with suppliers of services? If yes, see instructions. 32.00 Frowider-Based Physicians 34.00 Frowider-Based Physicians 34.00 Frowider-Based Physicians 35.00 If Iine 32 is yes, were there new agreements or amended existing agreements with the provider-based physicians? Yif yes, see instructions. 35.00 If Iine 34 is yes, were there new agreements or amended existing agreements with the provider-based normal physicians during the cost reporting period? If yes, see instructions. 36.00 Were home office costs 37.00 If Iine 36 is yes, has a home office cost statement been prepared by the home office? Yif yes, see instructions. 38.00 If Iine 36 is yes, was the fiscal year end of the home office different from that of normal provider provider provider provider provider provider provider. 38.00 If Iine 36 is yes, did the provider render services to other chain components? If yes, yes enstructions. 38.00 If Iine 36 is yes, did the provider render services to the home office? If yes, see instructions. 38.00 If Iine 36 is yes, did the provider render services to the home office? If yes, see instructions. 38.00 If Iine 36 is yes, did the provider render services to the home office? If yes, see instructions. 41.00 Enter the first name, iast name and the title/position held by the cost re							
29.00 bid the provider have a funded depreciation account and/or bond Funds (Debt Service Reserve Fund) 10.00 treated as a funded depreciation account? If yes, see instructions. 10.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 10.00 Instructions. 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 No. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 10.00 Has existing debt been replaced prior to its scheduled maturity without issuance of new debt? If yes, see 10.00 If line 3 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, see instructions. 10.00 If line 3 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If yes, yet yes very see instructions. 10.00 If line 3 is yes, were there new agreements or amended existing agreements with the provider-based physicians? 10.00 If line 3 is yes, were there new agreements or amended existing agreements with the provider-based physicians? 10.00 If line 3 is yes, were there new agreements or amended existing agreements with the provider-based physicians? 10.00 If line 3 is yes, and a home office cost statement been prepared by the home office? 10.00 If line 3 is yes, and a home office cost statement been prepared by the home office. 10.00 If line 3 is yes, wer	28.00 Were new Loans, mortgage agreemen	ts or letters of credit o	entered into du	ring the cos	t reporting	N	28. 00
treated as a funded depreciation account? If yes, see instructions 30.00 30.00 30.00 30.00 30.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 31.00 32.00 33.00 34.00 34.00 35.00 36.00 37.00 37.00 38.0	period? If yes, see instructions.						
30.00 Has existing debt been repalaced prior to its scheduled maturity with new debt? If yes, see 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 31.00 Name of the provider 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. 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 Filine 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no. see instructions. 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians? If yes, see instructions or physicians during the cost reporting period? If yes, see instructions. 36.00 If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, see instructions. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, yes ensured in column 2 the fiscal year end of the home office? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see instructions. 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report INDIANA UNIVERSITY HEALTH preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER*IUHEALTH. ORG				ebt Service I	Reserve Fund)	N	29. 00
instructions. 31.00 Have 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 32.00 Have changes or new agreements occurred in patient care services furnished through contractual 33.00 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? 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? 35.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 36.00 If line 34 is yes, were there new agreements or amended existing agreements with the provider-based 36.00 Were home office costs claimed on the cost report? 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, as a home office cost statement been prepared by the home office? 37.00 If line 36 is yes, and the fiscal year end of the home office different from that of 38.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 38.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 38.00 If line 36 is yes, did the provider render services to the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year end of the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year end of the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year end of the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year end of the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year end of the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year end of the home office? If yes, see 38.00 If line 36 is yes, as the fiscal year e							
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no, see instructions. Provider-Based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 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							
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physicians during the cost reporting period? If yes, see instructions. Y/N Date							25.00
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Cost Report Preparer Contact Information 1.00 2.00		or rondor complete to	homo office?	If was as-	NI NI		40.00
Cost Report Preparer Contact Information 41.00 Enter the first name, I ast name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost 317.962.1093 1.00 2.00 41.00 bright Allondary A		er render services to the	e nome office?	ir yes, see	IN		40.00
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43.00 Enter the telephone number and email address of the cost 317.962.1093 RUTTER@IUHEALTH.ORG 43.00	. , , ,	f the cost report	INDIANA UNIVER	RSITY HEALTH			42.00
			047 046 1005		DUTTER	000	40.05
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	Treport preparer in columns I and	z, respectivery.	I		1		II

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ared: _pm
41.00
42.00
43.00

 Health Financial
 Systems
 IU HEALT

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

						То	12/31/2021	Date/Time P 5/26/2022 2		
								I/P Days /		, piii
								0/P Visits /	/	
								Tri ps		
	Component	Worksheet A Line Number	No	. of Beds	Bed Days Available		CAH Hours	Title V		
		1. 00		2. 00	3. 00		4. 00	5. 00		
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			25		25	62, 400. 00	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
2.00	HMO and other (see instructions)									2.00
3. 00	HMO IPF Subprovider									3. 00
4.00	HMO I RF Subprovi der									4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF								0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF			٥٦	0.1	25	(2, 400, 00		0	6.00
7. 00	Total Adults and Peds. (exclude observation			25	9, 1:	25	62, 400. 00		0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT									8. 00
9. 00	CORONARY CARE UNIT									9. 00
10.00	BURN INTENSIVE CARE UNIT								ł	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)			25	9, 1:	25	62, 400. 00		0	14. 00
15.00	CAH visits				· ·		,		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 SURGICAL CENTER (D. P.)									23. 00
24.00	HOSPI CE									24.00
24. 10	HOSPICE (non-distinct part)	30. 00								24. 10
25. 00	CMHC - CMHC									25.00
26. 00	RURAL HEALTH CLINIC	89. 00							0	26. 00 26. 25
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00		25					۷	26. 25
28.00	Observation Bed Days			23					0	28.00
29. 00	Ambulance 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)			0		0				32. 00
32. 01	Total ancillary labor & delivery room			S						32. 01
	outpatient days (see instructions)									-
33.00	LTCH non-covered days									33.00
33. 01	LTCH site neutral days and discharges								- 1	33. 01

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1311

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2021	Part
To 12/31/2021	Date/Time Prepared:
5/26/2022 2:03 pm	

				•		5/26/2022 2:0	3 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
		,		•		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	'			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 172	3	2, 592			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)	806	185				2.00
3.00	HMO IPF Subprovider	O	0				3.00
4.00	HMO IRF Subprovider	O	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	74	0	74			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	2			6.00
7.00	Total Adults and Peds. (exclude observation	1, 246	3	2, 668			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, 246	3	2, 668	0.00	175. 19	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						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)			8			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	175. 19	27.00
28.00	Observation Bed Days		0	311			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared:
 Health Financial
 Systems
 IU HEALT

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

				To	12/31/2021	Date/Time Pre 5/26/2022 2:0	
		Full Time	•	Di sch	arges		J
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	320	1	673	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)			178	46		2.00
3.00	HMO IPF Subprovider				0		3.00
4. 00	HMO I RF Subprovi der				0		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						9.00
	CORONARY CARE UNIT						
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
13. 00 14. 00	NURSERY	0. 00	0	320	1	673	14.00
15. 00	Total (see instructions) CAH visits	0.00	U	320	'	0/3	15.00
16. 00	SUBPROVIDER - IPF						16. 00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
	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
	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	1						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	1						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			33. 01

	Financial Systems IU HEALTH TIPTON H AL UNCOMPENSATED AND INDIGENT CARE DATA P	rovi der CCN: 15-	1311 F	Peri od:	u of Form CMS-2 Worksheet S-1				
	The street in the street street street street			rom 01/01/2021					
			1	o 12/31/2021	Date/Time Pre 5/26/2022 2:0				
					1. 00				
	Uncompensated and indigent care cost computation								
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	ided by line 20:	2 column	8)	0. 270586] 1.			
	Medicaid (see instructions for each line)								
00	Net revenue from Medicaid				3, 813, 981	2			
00	Did you receive DSH or supplemental payments from Medicaid?			. 10	N	3			
00 00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr		m wedica	10?	0	5			
00	Medicaid charges	oni medicard			27, 703, 116				
00	Medicaid cost (line 1 times line 6)				7, 496, 075				
00	Difference between net revenue and costs for Medicaid program (line 7 minus sur	m of lin	es 2 and 5; if	3, 682, 094				
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)							
00	Net revenue from stand-alone CHIP				0				
. 00	Stand-alone CHIP charges				0				
. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (lino 11 minus li	ino O. i	f . zoro thon	0	1			
. 00	enter zero)	illie II iiillius II	111e 9, 1	i < zero then	U	'2			
	Other state or local government indigent care program (see inst	ructions for eac	ch line)						
. 00	Net revenue from state or local indigent care program (Not incl)	2, 786	13			
. 00	Charges for patients covered under state or local indigent care	program (Not i	ncl uded	in lines 6 or	35, 601	14			
	10)								
. 00	State or local indigent care program cost (line 1 times line 14		(1.1.	. 45	9, 633				
. 00	Difference between net revenue and costs for state or local ind 13; if < zero then enter zero)	igent care progi	ram (III	e 15 minus iine	6, 847	16			
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state/Loca	al indio	ent care progra	ıms (see	l			
	instructions for each line)								
. 00	Private grants, donations, or endowment income restricted to fu				0				
3. 00	Government grants, appropriations or transfers for support of h			(6.11	0				
0. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care	programs	(sum of lines	3, 688, 941	19			
			nsured	Insured	Total (col. 1				
			tients	patients	+ col . 2)				
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00				
. 00	Charity care charges and uninsured discounts for the entire fac	ility 1	1, 684, 892	257, 963	1, 942, 855	20.			
	(see instructions)								
. 00	Cost of patients approved for charity care and uninsured discou	nts (see	455, 908	257, 963	713, 871	21			
2. 00	instructions) Payments received from patients for amounts previously written	off as	(0	0	22			
. 00	charity care	UII as	(,	U	22			
. 00	Cost of charity care (line 21 minus line 22)		455, 908	257, 963	713, 871	23			
					1. 00				
. 00	Does the amount on line 20 column 2, include charges for patien imposed on patients covered by Medicaid or other indigent care		Tength	of stay limit	N	24.			
. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit		program	's length of	0	25			
. 00	Total bad debt expense for the entire hospital complex (see ins	tructions)			3, 127, 820	26			
. 00	Medicare reimbursable bad debts for the entire hospital complex (see instructions) 1,002,223 27.								
. 01	Medicare allowable bad debts for the entire hospital complex (s	•			1, 541, 881	1			
	Non-Medicare bad debt expense (see instructions)				1, 585, 939	28			
3. 00 9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instr	uctions)		968, 791				
3. 00 9. 00 0. 00	. ,	•	ucti ons)		968, 791 1, 682, 662 5, 371, 603	30			

Heal th Financ	cial Systems	IU HEALTH TIPTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CA	TION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der Co	CN: 15-1311	Peri od:	Worksheet A	
					From 01/01/2021		
					To 12/31/2021	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	5/26/2022 2: 0 Reclassi fi ed	3 pm
	cost center bescription	Sal al Les	othei	+ col . 2)	i ons (See	Trial Balance	
				+ (01. 2)	A-6)	(col. 3 +-	
					A-0)	col . 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
GENERA	AL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	CAP REL COSTS-BLDG & FLXT		0		0 907, 564	907, 564	1.00
	CAP REL COSTS-BLDG & FIXT - INTERES		0		0 611, 654	611, 654	1. 01
	CAP REL COSTS-MVBLE EQUIP		0		0 1, 012, 932	1, 012, 932	2.00
	EMPLOYEE BENEFITS DEPARTMENT	98	8, 860			2, 329, 773	4.00
	ADMINISTRATIVE & GENERAL	669, 535	9, 109, 696			8, 336, 402	5.00
	OPERATION OF PLANT	645, 112	3, 206, 823				7. 00
	OPERATION OF PLANT - OFFSITE	043, 112	3, 200, 623 N		0 -217,000	3, 034, 209	7.00
	LAUNDRY & LINEN SERVICE	13, 984	105, 759		-	116, 306	8.00
	HOUSEKEEPI NG	399, 131				620, 266	9.00
		· ·	339, 154				
	DIETARY	401, 931	520, 772	1		347, 288	10.00
	CAFETERI A	0	0		0 467, 440		11.00
	NURSI NG ADMI NI STRATI ON	1, 141, 688	399, 680			687, 620	13.00
	CENTRAL SERVICES & SUPPLY	0	3, 898		•	544, 015	14.00
	PHARMACY	757, 444	5, 768, 749	6, 526, 19	3 -5, 342, 323	1, 183, 870	15.00
	ENT ROUTINE SERVICE COST CENTERS	2 141 417	1 220 215	2 2/0 72	1 140 010	2 220 710	30.00
	ADULTS & PEDIATRICS _ARY SERVICE COST CENTERS	2, 141, 416	1, 228, 315	3, 369, 73	1 -140, 013	3, 229, 718	30.00
	OPERATING ROOM	1, 288, 461	3, 461, 061	4, 749, 52	2 -2, 461, 869	2, 287, 653	50.00
	ANESTHESI OLOGY	106, 300	320, 694		· · ·		53.00
	RADI OLOGY-DI AGNOSTI C	1, 144, 470	911, 846			· ·	54.00
	LABORATORY	8, 657	1, 500, 435				60.00
	RESPI RATORY THERAPY	609, 363	228, 821	838, 18		765, 837	65.00
	PHYSI CAL THERAPY	776, 153	506, 654		•	801, 436	66.00
	OCCUPATIONAL THERAPY	181, 069	50, 851			247, 989	67.00
	SPEECH PATHOLOGY	24, 404	4, 455			29, 094	68.00
		· ·				· ·	
	ELECTROCARDI OLOGY	523, 430	280, 877	804, 30		669, 036	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 324, 735	324, 735	71.00
	I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0 1, 275, 247	1, 275, 247	72.00
	DRUGS CHARGED TO PATIENTS	0	00 457	054 (0	0 4, 570, 759	4, 570, 759	73.00
	ONCOLOGY	261, 232	90, 457		•	· ·	73. 01
	BLOOD DI SORDER DRUGS	0	0		0 824, 302	824, 302	73. 02
	CARDI OPULMONARY	0	0	١	0	0	76. 00
	CARDI AC REHABILITATION	102, 299	56, 762	159, 06	1 -48, 586	110, 475	76. 97
	FIENT SERVICE COST CENTERS	1 010 775	1 745 0/7	2.0/4.04	142 011	2 021 021	01 00
	EMERGENCY	1, 218, 775	1, 745, 267	2, 964, 04	-143, 011	2, 821, 031	91.00
	OBSERVATION BEDS (NON-DISTINCT PART AL PURPOSE COST CENTERS						92.00
	SUBTOTALS (SUM OF LINES 1 through 117)	12, 414, 952	29, 849, 886	42, 264, 83	8 153, 537	42, 418, 375	110 00
	MBURSABLE COST CENTERS	12,414,732	27,047,000	42, 204, 03	0 100, 007	42, 410, 373	1110.00
	PHYSI CI ANS' PRI VATE OFFI CES	102, 300	141, 712	244, 01	2 -122, 441	121, 571	192 00
	OCCUPATIONAL MEDICINE	78, 194	69, 963	1			
	VACANT SPACE	70, 174	07, 703	1	0 -31,090		192.01
	TOTAL (SUM OF LINES 118 through 199)	12, 595, 446	30, 061, 561		-	- 1	
	(, ., 0,	, ,	,,,	1	, 50., 507	

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

					e/Time Prepared: 6/2022 2:03 pm
	Cost Center Description	Adjustments	Net Expenses		0/2022 2. 03 piii
	oust defited beschiption	(See A-8)	For		
		()	Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FLXT	755, 164	1, 662, 728		1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	-373, 546	238, 108		1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	253, 862	1, 266, 794		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-8, 664	2, 321, 109		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-754, 709	7, 581, 693		5. 00
7.00	00700 OPERATION OF PLANT	15, 633	3, 649, 902		7.00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	116, 306		8.00
9.00	00900 HOUSEKEEPI NG	-57, 304	562, 962		9. 00
10.00	01000 DI ETARY	417	347, 705		10.00
11. 00	01100 CAFETERI A	-23, 844	443, 596		11.00
13.00	01300 NURSING ADMINISTRATION	45, 951	733, 571		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	544, 015		14.00
15.00	01500 PHARMACY	-36, 688	1, 147, 182		15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	-474, 952	2, 754, 766		30.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-314, 067	1	•	50.00
53.00	05300 ANESTHESI OLOGY	-363, 594	l .	•	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-186, 953			54.00
60.00	06000 LABORATORY	0	.,,		60.00
65.00	06500 RESPI RATORY THERAPY	0	765, 837	•	65.00
66. 00	06600 PHYSI CAL THERAPY	0	801, 436	•	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	247, 989	•	67.00
68. 00	06800 SPEECH PATHOLOGY	0	29, 094	•	68. 00
69. 00	06900 ELECTROCARDI OLOGY	-113, 543		•	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	324, 735		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 275, 247	•	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	4, 570, 759	•	73.00
73. 01	03480 ONCOLOGY	0	285, 269	•	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	824, 302		73. 02
76.00	03160 CARDI OPULMONARY	0	0		76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	110, 475		76. 97
01 00	OUTPATIENT SERVICE COST CENTERS	02/ 052	1 004 070	T	01.00
91.00	09100 EMERGENCY	-936, 053	1, 884, 978		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
110 0	SPECIAL PURPOSE COST CENTERS	2 572 000	20 045 405		110.00
118.00	,	-2, 572, 890	39, 845, 485		118. 00
102.00	NONREI MBURSABLE COST CENTERS	0	101 571		102.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	1=1, -11		192.00
	19201 OCCUPATI ONAL MEDI CI NE	0	117, 061 0	1	192. 01 192. 02
200.00	219202 VACANT SPACE TOTAL (SUM OF LINES 118 through 199)	-2, 572, 890	· -	1	200. 00
200.00	PI TOTAL (SUM OF LINES FIG THE OUGH 199)	-2,312,690	1 40,004,117	I	J200. 00

Heal th	Financial Systems		IU HEALTH TIF	PTON HOSPITAL		In Lieu	of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provi der C	CN: 15-1311	Peri od: From 01/01/2021	Worksheet A-	6
						To 12/31/2021	Date/Time Pr	epared:
		Increases					5/26/2022 2:	03 pm
	Cost Center	Li ne #	Sal ary	Other				
	2. 00	3. 00	4. 00	5. 00				
1. 00	A - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	O	572, 725				1.00
2. 00	CAP REL COSTS-BEDG & TTXT	2. 00	0	1, 010, 879				2.00
3. 00		0.00	0	0				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	0	0				7.00
8. 00		0.00	0	0				8. 00
9.00		0.00	0	0				9.00
10. 00 11. 00	1	0. 00 0. 00	0	0				10. 00 11. 00
12. 00		0. 00	0	Ö				12.00
13.00		0. 00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
10.00			— — <u> </u>	1, 583, 604				10.00
	B - INTEREST							
1. 00	CAP REL COSTS-BLDG & FIXT -	1. 01	0	611, 654				1.00
2. 00	INTERES	0.00	0	0				2.00
	0			611, 654				
1 00	D - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4 00	0	2 25/ 012				1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	2, 256, 813 0				1. 00 2. 00
3. 00		0.00	0	0				3. 00
4.00		0.00	0	0				4. 00
5. 00		0.00	0	0				5.00
6. 00 7. 00		0. 00 0. 00	0	0				6. 00 7. 00
8. 00		0. 00	0	0				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	0	0				12.00
13.00		0. 00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00	1	0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0. 00	0	O				17. 00
18. 00		0. 00	0	0				18. 00
19. 00 20. 00		0. 00 0. 00	0	0				19. 00 20. 00
21. 00		0.00	0					21.00
22. 00		0.00	0	0				22. 00
	0		0	2, 256, 813				
1. 00	E - CAFETERIA CAFETERIA	11. 00	233, 884	233, 556				1.00
1. 00	0		233, 884					1.00
	F - MEDICAL SUPPLIES							4
1. 00 2. 00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO	14. 00 71. 00	0	540, 157 324, 735				1. 00 2. 00
∠. 00	PATIENT	71.00	U	324, 735				2.00
3.00	IMPL. DEV. CHARGED TO	72. 00	0	1, 275, 247				3. 00
4 00	PATIENTS	4 00	0	1.4				4 00
4. 00 5. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0	16 212				4. 00 5. 00
6. 00	OPERATION OF PLANT	7. 00	0	423				6.00
7. 00	LAUNDRY & LINEN SERVICE	8. 00	0	7				7. 00
8. 00 9. 00	HOUSEKEEPI NG	9. 00 10. 00	0	119 28				8. 00 9. 00
9. 00 10. 00	DI ETARY ANESTHESI OLOGY	53. 00	0	43				10.00
11. 00	SPEECH PATHOLOGY	68. 00	0	1				11.00
12.00		0.00	0	0				12.00
13. 00 14. 00	1	0. 00 0. 00	0	0				13. 00 14. 00
15. 00		0.00	0	0				15.00
	0			2, 140, 988				_
1 00	G - DRUGS PHARMACY	15. 00	0	95, 092				1.00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	5, 395, 061				2.00
3.00	ANESTHESI OLOGY	53. 00	0	724				3.00
4. 00		0. 00	0	0				4.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: | Provider CCN: 15-1311

					5/26/2022	2:03 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
5.00		0.00	0	0		5. 00
6.00		0. 00	0	0		6. 00
7.00		0. 00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15. 00
	0		0	5, 490, 877		
	H - ORTHOPEDIC CLERICAL STAFF					
1.00	OCCUPATI ONAL THERAPY	67. 00	46, 662	0		1.00
2.00	SPEECH PATHOLOGY		1, 994	0		2. 00
	0		48, 656	0		
	J - MAINTENANCE & LEASE EXPEN					
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	275, 798		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 651		2. 00
3. 00	OPERATION OF PLANT		•			3. 00
	0		0	284, 797		
4 00	L - PROPERTY INSURANCE	4 00		50.044		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	59, 041		1.00
2. 00	CAP REL COSTS-MVBLE EQUIP			(2, 053		2. 00
	U ACCRUED DEC		0	61, 094		
1 00	M - ACCRUED PTO	4 00	(2.00/	0		1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	63, 986	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	15, 771	0		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	5, 686	-		3.00
4.00	NURSI NG ADMI NI STRATI ON	13. 00 30. 00	10, 318	0		4.00
5. 00 6. 00	ADULTS & PEDIATRICS OCCUPATIONAL THERAPY		849 5, 457	0		5. 00 6. 00
7. 00	PHYSICIANS' PRIVATE OFFICES	67. 00 192. 00	4, 612	0		7.00
8. 00	OCCUPATIONAL MEDICINE	192. 00	985	0		8.00
9. 00	OCCUPATIONAL WEDICINE	0.00	963	0		9.00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0			12.00
12.00			107, 664	0		12.00
	N - INFUSION DRUGS		107,004	O _I		
1. 00	BLOOD DI SORDER DRUGS	73. 02	0	824, 302		1.00
1.00	TOTALS	— 70.02	— — ŏ	824, 302		1.00
	P - SURGE PREMIUM WAGES	<u> </u>	<u> </u>	32 1, 302		
1. 00	ADULTS & PEDIATRICS	30. 00	298, 304	22, 743		1.00
2. 00	OPERATING ROOM	50.00	28, 558	2, 177		2.00
3. 00	RESPIRATORY THERAPY	65.00	83, 541	6, 369		3.00
4. 00	EMERGENCY	91.00	177, 736	13, 550		4.00
1. 00	TOTALS	— — / 00	588, 139			1.00
500.00	Grand Total: Increases		978, 343	13, 532, 524		500.00
	1	1		, -02, 02 1	ı	, 200.00

Heal th	Financial Systems		IU HEALTH TIPT	ON HOSPITAL		In Lieu	of Form CMS-2552-10
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-1311		Worksheet A-6
						From 01/01/2021 To 12/31/2021 [Date/Time Prepared:
							5/26/2022 2: 03 pm
	01.01	Decreases	6.1	011		-1	
	Cost Center 6.00	Li ne # 7. 00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref 10.00	<u>. </u>	
	A - DEPRECIATION	7.00	8.00	9.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	O	702, 385	5	9	1.00
2. 00	OPERATION OF PLANT	7. 00	ő	34, 742		9	2.00
3. 00	DI ETARY	10.00	o	7, 629		o	3.00
4.00	NURSING ADMINISTRATION	13. 00	o	69, 876	5	o	4.00
5.00	PHARMACY	15. 00	0	23, 991	1	0	5. 00
6.00	ADULTS & PEDIATRICS	30. 00	0	40, 171		0	6.00
7. 00	OPERATING ROOM	50. 00	0	281, 453		0	7.00
8. 00	ANESTHESI OLOGY	53. 00	0	8, 988		0	8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	227, 342		0	9.00
10.00	RESPIRATORY THERAPY	65. 00	0	8, 269		0	10.00
11.00	PHYSI CAL THERAPY	66.00	0	56, 988		0	11.00
12. 00 13. 00	ELECTROCARDI OLOGY ONCOLOGY	69. 00 73. 01	0	44, 024 676			12. 00 13. 00
14. 00	CARDI AC REHABI LI TATI ON	76. 97	o	14, 177			14. 00
15. 00	EMERGENCY	91. 00	o	23, 653		0	15. 00
16. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	ő	39, 240		0	16.00
	0		— — 	1, 583, 604		7	
	B - INTEREST					•	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	611, 048	3 1	1	1.00
2.00	OPERATION OF PLANT		0_		<u> </u>	o	2.00
	0		0	611, 654	1		
	D - EMPLOYEE BENEFITS				.1	_	
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	85, 936		0	1.00
2.00	OPERATION OF PLANT	7. 00	0	147, 967		0	2.00
3. 00 4. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8. 00 9. 00	0	9, 130 108, 250		0	3. 00 4. 00
5. 00	DI ETARY	10. 00	o	99, 063			5.00
6. 00	NURSING ADMINISTRATION	13. 00	o	152, 663		0	6.00
7. 00	PHARMACY	15. 00	ő	109, 717		0	7.00
8. 00	ADULTS & PEDIATRICS	30.00	o	330, 372		o o	8.00
9.00	OPERATING ROOM	50.00	О	246, 195		o	9.00
10.00	ANESTHESI OLOGY	53.00	0	4, 827	7	0	10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	253, 561	1	0	11.00
12.00	LABORATORY	60. 00	0	324		0	12.00
13. 00	RESPI RATORY THERAPY	65. 00	0	114, 731		0	13.00
14.00	PHYSI CAL THERAPY	66. 00	0	171, 186		0	14.00
15.00	OCCUPATIONAL THERAPY	67. 00	0	36, 004		0	15.00
16. 00 17. 00	SPEECH PATHOLOGY ELECTROCARDI OLOGY	68. 00	0	1, 760		0	16.00
18.00	ONCOLOGY	69. 00 73. 01	0	66, 230 41, 415			17. 00 18. 00
19. 00	CARDI AC REHABI LI TATI ON	76. 97	o	31, 550		0	19. 00
20. 00	EMERGENCY	91.00	ő	191, 994		0	20.00
21. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	o	35, 754		o o	21. 00
22. 00	OCCUPATIONAL MEDICINE	192. 01	O	18, 184		o	22.00
				2, 256, 813			
	E - CAFETERIA						
1.00	DI ETARY	1000	233, 884	23 <u>3, 5</u> 56		<u>o</u>	1.00
	0		233, 884	233, 556	<u>5</u>		
1 00	F - MEDICAL SUPPLIES	12 00	<u></u>	0.546		0	1 00
1.00	NURSING ADMINISTRATION PHARMACY	13. 00 15. 00	0	8, 549 26, 191		0	1.00
2. 00 3. 00	ADULTS & PEDIATRICS	30. 00	0	26, 191 57, 813		0	3.00
4. 00	OPERATING ROOM	50.00	0	1, 889, 946		o o	4.00
5. 00	RADI OLOGY-DI AGNOSTI C	54. 00	o	1, 689, 940		o o	5.00
6. 00	LABORATORY	60.00	ő	21, 301		o	6.00
7. 00	RESPIRATORY THERAPY	65. 00	Ö	36, 047		o	7. 00
8. 00	PHYSI CAL THERAPY	66. 00	o	5, 937		o o	8.00
9. 00	OCCUPATI ONAL THERAPY	67. 00	o	46		0	9. 00
10.00	ELECTROCARDI OLOGY	69. 00	o	6, 045		0	10.00
11.00	ONCOLOGY	73. 01	O	7, 364		0	11. 00
12.00	CARDI AC REHABI LI TATI ON	76. 97	0	940		0	12.00
13.00	EMERGENCY	91.00	0	57, 573		U	13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	282		U	14.00
15. 00	OCCUPATI ONAL MEDI CI NE	1 <u>92.</u> 01		3, 325		<u> </u>	15. 00
	G - DRUGS		U	2, 140, 988)		
1. 00	PHARMACY	15. 00	0	5, 272, 139	9	0	1.00
2. 00	OPERATION OF PLANT	7. 00	0	2, 515		0	2.00
3. 00	CENTRAL SERVICES & SUPPLY	14. 00	o	40		o	3.00
4. 00	ADULTS & PEDIATRICS	30. 00	Ö	33, 553		o	4. 00
5. 00	OPERATI NG ROOM	50. 00	O	29, 774		o	5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	73, 701	1	0	6. 00
7. 00	LABORATORY	60. 00	0	Ę	5	0	7.00
				_			

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-1311 Pe

N: 15-1311	From 01/01/2021	worksneet A-	- Б
	To 12/31/2021	Date/Time Pr 5/26/2022 2:	
	1		

						 5/26/2022 2:03 pm
		Decreases				
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10.00	
8. 00	RESPI RATORY THERAPY	65. 00	0	959	0	8.00
9.00	PHYSI CAL THERAPY	66.00	O	233	o	9. 00
10.00	ELECTROCARDI OLOGY	69.00	O	16, 080	o	10.00
11.00	ONCOLOGY	73. 01	O	10, 216	o	11.00
12.00	CARDIAC REHABILITATION	76, 97	o	17	1	12.00
13.00	EMERGENCY	91.00	0	41, 070	0	13.00
14. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	ol	3	ol	14.00
15. 00	OCCUPATIONAL MEDICINE	192. 01	ol	10, 572	o	15. 00
	0		— — j	5, 490, 877		10.00
	H - ORTHOPEDIC CLERICAL STAFF	-	<u> </u>	0, 170, 077		
1.00	PHYSI CAL THERAPY	66. 00	48, 656	0	0	1.00
2.00	THISTORE THEIR I	0.00	10, 000			2.00
2.00		— — 	48, 656	0	 	2.00
	J - MAINTENANCE & LEASE EXPEN	NSF	40, 030		1	
1. 00	OPERATION OF PLANT	7.00	0	35, 112	14	1, 00
2. 00	PHYSI CAL THERAPY	66.00	0	197, 911		2.00
3. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	51, 774		3.00
3.00	n FITTS CLANS FRIVATE OFFICES		+			3.00
	L - PROPERTY INSURANCE		<u> </u>	204, 171		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	61, 094	12	1.00
2. 00	ADMINISTRATIVE & GENERAL	0. 00	0	01, 094	1	2.00
2.00				61, 094		2.00
	M - ACCRUED PTO		<u> </u>	61, 094		
1. 00	OPERATION OF PLANT	7. 00	4, 495	0	ol	1.00
2. 00	HOUSEKEEPI NG	9. 00	9, 888	0		2.00
3. 00	DI ETARY	10. 00	1, 311	0	1	3.00
	1			-	1	
4. 00	PHARMACY	15. 00	5, 377	0	1	4.00
5.00	OPERATING ROOM	50.00	45, 236	-	1	5.00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	7, 096	0		6.00
7.00	RESPIRATORY THERAPY	65. 00	2, 251	0	0	7. 00
8.00	PHYSI CAL THERAPY	66. 00	460	0	0	8.00
9.00	ELECTROCARDI OLOGY	69. 00	2, 892	0	0	9.00
10.00	ONCOLOGY	73. 01	6, 749	0	1	10.00
11.00	CARDI AC REHABI LI TATI ON	76. 97	1, 902	0	1	11.00
12.00	EMERGENCY	<u>91.</u> 00	2 <u>0, 0</u> 07	0	<u> </u>	12.00
	0		107, 664	0		
	N - INFUSION DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	7300	•	<u>824, 3</u> 02		1.00
	TOTALS		0	824, 302		
	P - SURGE PREMI UM WAGES				. 1	
1. 00	NURSING ADMINISTRATION	13. 00	588, 139	44, 839	1	1.00
2.00		0. 00	0	0	1	2.00
3.00		0. 00	0	0	0	3.00
4.00		0.00	0	0	<u> </u>	4.00
	TOTALS		588, 139	44, 839		
500.00	Grand Total: Decreases		978, 343	13, 532, 524		500.00

Provi der CCN: 15-1311

					To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
			<u> </u>	Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	0	0		0	0	1.00
2.00	Land Improvements	0	0		0	0	2.00
3.00	Buildings and Fixtures	0	0		0	0	3.00
4.00	Building Improvements	2, 872, 457	266, 722		0 266, 722	0	4. 00
5.00	Fixed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	11, 340, 408	542, 888		0 542, 888	628, 512	6. 00
7.00	HIT designated Assets	840, 651	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	15, 053, 516	809, 610		0 809, 610	628, 512	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	15, 053, 516	809, 610		0 809, 610	628, 512	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			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	0	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	3, 139, 179	372, 370				4. 00
5.00	Fi xed Equi pment	0	0				5.00
6.00	Movable Equipment	11, 254, 784	5, 941, 761				6.00
7.00	HIT designated Assets	840, 651	840, 651				7. 00
8.00	Subtotal (sum of lines 1-7)	15, 234, 614	7, 154, 782				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	15, 234, 614	7, 154, 782				10.00

	Financial Systems	IU HEALTH TIP				u of Form CMS-2	
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	CCN: 15-1311	Peri od:	Worksheet A-7	
					From 01/01/2021 To 12/31/2021		narod:
					10 12/31/2021	5/26/2022 2: 0	3 nm
			SI	UMMARY OF CAP	I TAL		
	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	RKSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	C	O	0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	C		0 0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	C		0	0	2.00
3.00	Total (sum of lines 1-2)	0	l c	0	0 0	0	3.00
		SUMMARY OF CAPITAL					
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUI	MN 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	(0			1.00
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	0	(C	0			1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	(0			2.00
3 00	Total (sum of lines 1-2)	1 0	1 ()			3 00

0 0 0

3.00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2021 To 12/31/2021	Worksheet A-7 Part III Date/Time Pre 5/26/2022 2:03		
		COMF	PUTATION OF RA	TI 0S	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance		
			Leases	(col. 1 -	Thisti de trons)			
		1. 00	2.00	col . 2) 3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	5.00		
1. 00	CAP REL COSTS-BLDG & FIXT	3, 979, 830	0	3, 979, 83	0. 261236	0	1.00	
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	0, 7, 7, 000		1	0. 000000		1. 01	
2. 00	CAP REL COSTS-MVBLE EQUIP	11, 254, 784	0	11, 254, 78			2.00	
3.00	Total (sum of lines 1-2)	15, 234, 614					3.00	
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL		
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease		
			Capi tal -Rel at					
			ed Costs	through 7)	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8.00	9.00	10.00		
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS 0	0		0 1, 358, 465	-30, 576	1. 00	
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	0	_		0 -33, 785		1. 00	
2. 00	CAP REL COSTS-MVBLE EQUIP	0			0 1, 264, 741	0	2.00	
3. 00	Total (sum of lines 1-2)	0			2, 589, 421	-30, 576	3. 00	
			Sl	JMMARY OF CAPI		22, 212		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)		
			(see	instructions)	Capi tal -Rel at			
			instructions)		ed Costs (see	9 through 14)		
		11 00	12.00	12.00	instructions)	15.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13.00	14. 00	15. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	ENTERS 0	59, 041		0 275, 798	1, 662, 728	1. 00	
1. 01	CAP REL COSTS-BLDG & FIXT - INTERES	271, 893		I	0 273,770	238, 108	1. 00	
2. 00	CAP REL COSTS-MVBLE EQUIP	271,075		1		1, 266, 794	2.00	
3. 00	Total (sum of lines 1-2)	271, 893			275, 798			
				•				

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 IU HEALTH TIPTON HOSPITAL Peri od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm

	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted						3 pm
				10/11 oill will cit the Allount 15	to be Aujusteu		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	occi conten becomparen	(2) 1. 00				Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1.00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT - INTERES	В	-339, 761	CAP REL COSTS-BLDG & FIXT - INTERES	1. 01	11	1. 01
2. 00	(chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -2, 256, 557		0. 00	0	9. 00 10. 00
	adjustment Sale of scrap, waste, etc.	7. 0 2	0		0. 00	0	
	(chapter 23) Rel ated organization	A-8-1	3, 389, 323		0.00	0	
	transactions (chapter 10)	N 0 1	0, 307, 323		0. 00		
14.00	Laundry and linen service Cafeteria-employees and guests		-23, 844	CAFETERI A	11. 00	0	14.00
	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than patients		0		0. 00	0	16. 00
17. 00	Sale of drugs to other than patients	В	-232, 458	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.) Vendi ng machi nes		0		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	therapy costs in excess of limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	А	782, 496	CAP REL COSTS-BLDG & FLXT	1. 00	9	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1. 01	0	26. 01
27. 00	COSTS-BLDG & FIXT - INTERES Depreciation - CAP REL	А	44, 742	INTERES CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
	COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00

From 01/01/2021 | WOLKSHEET A-0
From 01/01/2021 | Date/Time Prepared:

				To	12/31/2021	Date/Time Pre 5/26/2022 2:0	
				Expense Classification on	Worksheet A	3/20/2022 2.0	3 PIII
				To/From Which the Amount is			
				TOTTION WITCH THE AMOUNT IS	to be hajusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2)				Ref.	
		1. 00	2. 00	3. 00	4. 00	5. 00	
30.00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
00. 77	instructions)		Ü	ABOLIO A LEDIAMA OS	00.00		00. 77
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
31.00	pathology costs in excess of	H-0-3	U	SELECTI FATTIOLOGI	00.00		31.00
	limitation (chapter 14)						
22.00			0		0.00	0	22.00
32. 00	CAH HIT Adjustment for		0		0. 00	0	32.00
	Depreciation and Interest	_					
33. 00	LEASE REVENUE	В	·	CAP REL COSTS-BLDG & FIXT	1. 00	10	
33. 01	MI SCELLANEOUS I NCOME	В	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	INVESTMENT FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	MI SCELLANEOUS I NCOME	В	-57, 304	HOUSEKEEPI NG	9. 00	0	33. 03
33.04	MI SCELLANEOUS I NCOME	В	417	DI ETARY	10. 00	0	33.04
33.05	MI SCELLANEOUS I NCOME	В	-331	NURSING ADMINISTRATION	13. 00	0	33. 05
33. 06	MISCELLANEOUS INCOME	В		PHARMACY	15. 00	0	33.06
33. 07	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 07
33. 08	MI SCELLANEOUS I NCOME	В		ELECTROCARDI OLOGY	69. 00	0	33. 08
33. 09	MEDICALD HOSPITAL ASSESSMENT	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33.09		A	-1, 200, 441	ADWINISTRATIVE & GENERAL	3.00	U	33.09
00.40	FEE		405 777	OAD DEL COCTO DI DO A FLYT	4 00	0	00.40
33. 10	ASSISTED LIVING DEPRECIATION -	A	-125, ///	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 10
	BLDG	_				_	
33. 11	CRNA SALARY EXPENSE	Α	·	ANESTHESI OLOGY	53. 00	0	33. 11
33. 12	CRNA BENEFITS EXPENSE	A	·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 12
33. 13	PATIENT PHONES - SALARY	A	-2, 904	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	PATIENT PHONES - BENEFITS	Α	-564	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 14
33. 15	EMPLOYEE BENEFITS	Α	-2, 256, 877	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 15
33. 16	RECRUTI NG	Α	8, 571	ADULTS & PEDIATRICS	30. 00	0	33. 16
33. 17	LEASE DEPRECIATION - CARRY	Α		CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 17
	FORWARD		_*.			·	
33. 18	EQUIPMENT DEPRECIATION - CARRY	Α	0 682	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 18
33. 10	FORWA	^	7, 002	OAN REE COSTS WINDER EGOTT	2.00	,	33. 10
33. 19	MARKETI NG	Α	20 740	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
	1	A				ŭ	33. 19
33. 20	UNWONTED SITUATIONS	Α	-3,000	ADULTS & PEDIATRICS	30.00	0	
33. 21	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 21
	(3)						
33. 22	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 22
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-2, 572, 890				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 15-1311 Period: Worksheet A-8-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2023 2:03 pm

				10 12/31/2021	5/26/2022 2:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	•
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OR	R CLAIMED HOME	
	OFFICE COSTS:					
1. 00			HOME OFFICE ALLOCATION	360, 109	231, 372	1.00
2.00		l	HOME OFFICE ALLOCATION	577, 263	611, 048	2.00
3.00			HOME OFFICE ALLOCATION	199, 438	0	3.00
4.00		EMPLOYEE BENEFITS DEPARTMENT	l e e e e e e e e e e e e e e e e e e e	2, 269, 424	0	4.00
4. 01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6, 270, 411	5, 807, 058	4. 01
4. 02	54.00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE ALLOCATION	0	24, 619	4.02
4.03	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	180, 507	63, 730	4.03
4.04	7. 00		RELATED PARTY	21, 612	5, 979	4.04
4. 05			RELATED PARTY	57, 391	11, 109	4.05
4.06	15. 00	PHARMACY	RELATED PARTY	195, 773	0	4.06
4. 07			RELATED PARTY	19, 755	7, 445	4.07
4. 08	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	4, 368	4, 368	4.08
4. 09	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	185, 168	185, 168	4.09
4. 10	7. 00	OPERATION OF PLANT	SHARED EMPLOYEES	27, 094	27, 094	4. 10
4. 11	13. 00	NURSING ADMINISTRATION	SHARED EMPLOYEES	45, 437	45, 437	4. 11
4. 12	14. 00	CENTRAL SERVICES & SUPPLY	SHARED EMPLOYEES	73	73	4. 12
4. 13	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	488, 591	488, 591	4. 13
4. 14	50.00	OPERATING ROOM	SHARED EMPLOYEES	77, 617	77, 617	4.14
4. 15	53.00	ANESTHESI OLOGY	SHARED EMPLOYEES	100, 274	100, 274	4. 15
4. 16	54.00	RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEES	161, 772	161, 772	4. 16
4. 17	60.00	LABORATORY	SHARED EMPLOYEES	1, 446, 851	1, 446, 851	4. 17
4. 18	69. 00	ELECTROCARDI OLOGY	SHARED EMPLOYEES	283, 062	283, 062	4. 18
4. 19	91.00	EMERGENCY	SHARED EMPLOYEES	1, 263, 230	1, 263, 230	4. 19
4. 20	192. 01	OCCUPATIONAL MEDICINE	SHARED EMPLOYEES	28, 718	28, 718	4. 20
5.00	TOTALS (sum of lines 1-4).			14, 263, 938	10, 874, 615	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.

Has	not been posted to worksneet A,	corunitis i ariu/or 2, the aniou	iit airowabie si	noura de rharcatea in corumn	4 OF LIIIS PAFL.			
				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	F	0. 00 I U WEST 100. 00	7.00
8. 00	F	0. 00 I U NORTH 100. 00	8.00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

					To 12/31/2021	Date/Time Prepared: 5/26/2022 2:03 pm
	Net	Wkst. A-7 Ref.				0, 20, 2022 21 00 piii
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6. 00	7. 00				
		RED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF TR	ANSACTIONS WITH RELATED (ORGANI ZATI ONS OR	CLAIMED HOME
	OFFICE COSTS:					
1.00	128, 737					1.00
2.00	-33, 785					2.00
3.00	199, 438					3.00
4.00	2, 269, 424	0				4.00
4.01	463, 353	0				4. 01
4.02	-24, 619	0				4. 02
4.03	116, 777					4. 03
4.04	15, 633					4.04
4.05	46, 282					4. 05
4.06	195, 773					4.06
4.07	12, 310	0				4.07
4.08	0	0				4. 08
4.09	0	0				4. 09
4. 10	0	0				4. 10
4. 11	0	0				4. 11
4. 12	0	0				4. 12
4. 13	0	0				4. 13
4. 14	0	0				4. 14
4. 15	0	0				4. 15
4. 16	0	0				4. 16
4. 17	0	0				4. 17
4. 18	0	0				4. 18
4. 19	0	0				4. 19
4. 20	0	1				4. 20
5.00	3, 389, 323	1.4.6				5.00

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

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

The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish 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	HOME OFFICE		6.00
7.00	HEALTHCARE		7.00
8.00	HEALTHCARE		8.00
9.00			9.00
9. 00 10. 00			10.00
100.00		1	100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1311

							To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration		essi onal	Provider Component	RCE Amount	Physician/Provider Component	
		T deliter i i e	Remarier a troit		пропент	Component		Hours	
	1. 00	2.00	3. 00		4. 00	5. 00	6. 00	7. 00	
1.00	30.00	ADULTS & PEDIATRICS	480, 523	3	480, 523	C	0	0	1.00
2.00	50. 00	OPERATING ROOM	314, 067	'	314, 067	C	0	0	2.00
3.00		ANESTHESI OLOGY	257, 294		257, 294		0	1	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	174, 619		174, 619	C	0	0	4. 00
5.00		ELECTROCARDI OLOGY	94, 001		94, 001	C	1	0	5. 00
6. 00		EMERGENCY	1, 263, 230		936, 053	327, 177	0	0	6. 00
7. 00	0. 00		0		0	C	0	0	7. 00
8.00	0.00		0		0	C	0	0	8. 00
9. 00	0.00		0		0	C	0	0	9. 00
10.00	0. 00		0)	0	C	0	0	10.00
200.00			2, 583, 734		2, 256, 557			0	200.00
	Wkst. A Line #	J	Unadjusted RCE			Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t			Memberships &		of Malpractice	
				[_i mi t	Continuing	Share of col.	Insurance	
	1.00	2.00	0.00		0.00	Education	12 13. 00	14.00	
1. 00	1.00	2.00 ADULTS & PEDIATRICS	8. 00		9. 00	12. 00		14.00	1. 00
2. 00		OPERATING ROOM	0		0	_	1	_	2.00
3. 00		ANESTHESI OLOGY			0	_	1	_	3.00
4. 00		RADI OLOGY-DI AGNOSTI C			0			_	4.00
5. 00		ELECTROCARDI OLOGY		ál –	0			1	5.00
6. 00		EMERGENCY		()	0			0	6.00
7. 00	0.00				0			0	7. 00
8. 00	0.00				0			0	8.00
9. 00	0.00				0			0	9. 00
10.00	0.00				0			0	10.00
200.00	0.00		0	5	0		0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adi u	sted RCE	RCE	Adjustment	-	
		I denti fi er	Component		_i mi t	Di sal I owance			
			Share of col.						
			14						
	1. 00	2. 00	15. 00	1	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	0		0	_	,	•	1.00
2.00		OPERATING ROOM	0		0	_	0.17007	•	2.00
3.00		ANESTHESI OLOGY	0		0	_	20,,2,1	•	3. 00
4.00		RADI OLOGY-DI AGNOSTI C	0		0	C	1 ., ., 0 . ,		4. 00
5.00		ELECTROCARDI OLOGY	0		0	C	94, 001		5. 00
6.00		EMERGENCY	0		0	C	936, 053	•	6. 00
7. 00	0.00		0		0	C	0	1	7. 00
8. 00	0. 00		0		0	I -	0		8. 00
9. 00	0.00		0)	0	C	0		9. 00
10.00	0. 00		0		0	C	0		10.00
200.00			0)	0	(2, 256, 557		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1311

				T ₀	o 12/31/2021	Date/Time Pre 5/26/2022 2:0	pared:
			CAP	TAL RELATED CO	OSTS	37 207 2022 2.0) piii
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT - INTERES	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	
		0	1. 00	1. 01	2. 00	4. 00	
·	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 662, 728	1, 662, 728				1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	238, 108	0	238, 108			1. 01
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	1, 266, 794			1, 266, 794		2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 321, 109	7, 252			2, 335, 072	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	7, 581, 693	103, 918			128, 275	
7. 00	00700 OPERATION OF PLANT	3, 649, 902	410, 842		· · · · · · · · · · · · · · · · · · ·	120, 421	7.00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	_	· ·	0	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	116, 306	26, 899			3, 697	8. 00
9. 00	00900 HOUSEKEEPI NG	562, 962	16, 064			73, 168	
10.00	01000 DI ETARY	347, 705	29, 113			31, 342	
11. 00	01100 CAFETERI A	443, 596	40, 835			43, 965	
13. 00	01300 NURSING ADMINISTRATION	733, 571	37, 330			105, 993	
14.00	01400 CENTRAL SERVICES & SUPPLY	544, 015	34, 522			0	
15. 00	01500 PHARMACY	1, 147, 182	19, 113	3, 127	14, 562	141, 371	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	2, 754, 766	164, 667	26, 937	125, 456	458, 772	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	1, 973, 586	200, 972			239, 065	
53.00	05300 ANESTHESI OLOGY	50, 352	3, 790			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 288, 034	104, 151			213, 799	
60.00	06000 LABORATORY	1, 487, 462	42, 687			1, 627	60.00
65. 00	06500 RESPIRATORY THERAPY	765, 837	2, 498			129, 826	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	801, 436	60, 430			136, 666	
68. 00	06800 SPEECH PATHOLOGY	247, 989	18, 088			43, 834	1
69.00	06900 ELECTROCARDI OLOGY	29, 094	775			4, 962 97, 849	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	555, 493 324, 735	27, 364 0			97, 849	71.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 275, 247	0	_	_	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 570, 759	0	0	· ·	0	1
73. 00	03480 ONCOLOGY	285, 269	16, 546	_	12, 606	47, 837	
73. 01	07301 BLOOD DI SORDER DRUGS	824, 302	10, 540		l '	47,037	1
76. 00	03160 CARDI OPULMONARY	024, 302	0		_	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	110, 475	17, 941	2, 935	·	18, 872	1
70. 77	OUTPATIENT SERVICE COST CENTERS	110, 475	17, 741	2, 755	13, 007	10, 072	70. 77
91. 00	09100 EMERGENCY	1, 884, 978	116, 881	19, 120	89, 049	258, 750	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,001,770	110,001	17, 120	07,017	200, 700	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		39, 845, 485	1, 502, 678	229, 257	1, 144, 856	2, 300, 091	118 00
110.00	NONREI MBURSABLE COST CENTERS	07,010,100	1,002,070	227,207	1, 111, 000	2,000,071	1110.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	121, 571	143, 160	6, 088	109, 070	20. 097	192. 00
	19201 OCCUPATI ONAL MEDI CI NE	117, 061	16, 890				192. 01
	19202 VACANT SPACE	0	0				192. 02
200.00	1 1		O	I		· ·	200.00
201.00	1 1		0	0	o	0	201.00
202.00		40, 084, 117	1, 662, 728	238, 108	1, 266, 794		
	1 (3.4 -3.7)		, ,			, ,	

Provider CCN: 15-1311

| Peri od: | Worksheet B | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared:

				11	0 12/31/2021	5/26/2022 2:0	
	Cost Center Description	Subtotal	ADMI NI STRATI V	OPERATION OF	OPERATION OF	LAUNDRY &	J pili
	oust deliter beschiptron	Subtotal	E & GENERAL	PLANT	PLANT -	LINEN SERVICE	
			L d CENEIULE		OFFSI TE	Linen oenni oe	
		4A	5. 00	7. 00	7. 01	8. 00	
	GENERAL SERVICE COST CENTERS	*					
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 910, 059	7, 910, 059				5.00
7. 00	00700 OPERATION OF PLANT	4, 553, 213	1, 119, 417	5, 672, 630			7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0		0		7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	171, 796	42, 236	147, 110	0	361, 142	8.00
9. 00	00900 HOUSEKEEPI NG	667, 061	163, 998		0	0	9.00
10. 00	01000 DI ETARY	435, 102			0	Ö	
11. 00	01100 CAFETERI A	566, 187	139, 198	· ·	0	0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	911, 442			0	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	610, 485			0	1	14.00
15. 00	1				0	0	15.00
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	1, 325, 355	325, 841	104, 527	0	0	15.00
30. 00	03000 ADULTS & PEDIATRICS	3, 530, 598	868, 005	900, 563	0	361, 142	30.00
30.00	ANCILLARY SERVICE COST CENTERS	3, 330, 396	000,000	900, 303		301, 142	30.00
50. 00	05000 OPERATING ROOM	2, 599, 615	639, 121	1, 099, 112	0	0	50.00
53. 00	05300 ANESTHESI OLOGY	2, 599, 615 57, 649			0		53.00
54. 00	1 1	·			0	0	54.00
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 702, 372			0	0	60.00
	1 1	1, 571, 281	386, 303		0	0	
65.00	06500 RESPIRATORY THERAPY	900, 473	l '		0	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 048, 065	l '		O	-	66.00
67.00	06700 OCCUPATI ONAL THERAPY	324, 737	79, 837		0	0	67.00
68.00	06800 SPEECH PATHOLOGY	35, 467	8, 720		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	706, 030			0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	324, 735			0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 275, 247			0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4, 570, 759			0	0	73.00
73. 01	03480 ONCOLOGY	364, 965		· ·	0	0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	824, 302			0	0	73. 02
76. 00	03160 CARDI OPULMONARY	0	1	-	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	163, 892	40, 293	98, 121	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					_	
91.00	09100 EMERGENCY	2, 368, 778		639, 221	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
440.0	SPECIAL PURPOSE COST CENTERS	00 510 //5	7 774 000	5 000 000		0/4 440	
118.00	1 2 2 2 7	39, 519, 665	7, 771, 288	5, 082, 822	0	361, 142	118.00
	NONREI MBURSABLE COST CENTERS					_	
	19200 PHYSICIANS' PRIVATE OFFICES	399, 986			0		192.00
	19201 OCCUPATI ONAL MEDI CI NE	164, 466	40, 434		0		192. 01
	19202 VACANT_SPACE	0	0	0	0	0	192. 02
200.00	1 1	0					200.00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	40, 084, 117	7, 910, 059	5, 672, 630	0	361, 142	202.00

Provi der CCN: 15-1311

					o 12/31/2021	Date/Time Pre 5/26/2022 2:0	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	J piii
					ADMI NI STRATI O	SERVICES &	
		0.00	10.00	44.00	N 10.00	SUPPLY	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11. 00	13.00	14. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT				1		1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						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	918, 911					9. 00
10.00	01000 DI ETARY	24, 370	725, 660				10.00
11. 00	01100 CAFETERI A	34, 182	0	962, 894			11.00
13.00	01300 NURSING ADMINISTRATION	31, 248	0	42, 040	1, 412, 965		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	28, 898	0	0	-	978, 271	14.00
15. 00	01500 PHARMACY	15, 999	0	60, 118	0	11, 968	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	137, 840	722, 255	212, 207	740, 286	21, 953	30.00
F0 00	ANCILLARY SERVICE COST CENTERS	440.004	ام	400 700	004 577	470 50/	F0 00
50.00	05000 OPERATING ROOM	168, 231	0	120, 738		170, 536	
53.00	05300 ANESTHESI OLOGY	3, 172	0	4, 807		0 135	53.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	87, 183 35, 733	0	105, 171 68, 727		9, 135 8, 952	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	2, 091	0	49, 788		16, 115	1
66. 00	06600 PHYSI CAL THERAPY	50, 585	0	69, 803		508	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	15, 141	0	23, 459		0	67.00
68. 00	06800 SPEECH PATHOLOGY	649	0	2, 152		0	68.00
69. 00	06900 ELECTROCARDI OLOGY	22, 906	o	42, 183		2, 856	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	o	0		144, 204	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o	0	o	566, 295	
73.00	07300 DRUGS CHARGED TO PATIENTS	o	o	0	o	0	73.00
73. 01	03480 ONCOLOGY	13, 850	0	21, 952	39, 962	1, 341	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	o	0	o	0	73. 02
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	15, 018	0	8, 752	33, 407	366	76. 97
	OUTPATIENT SERVICE COST CENTERS				,		
91. 00	09100 EMERGENCY	97, 839	3, 405	109, 403	254, 319	22, 405	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
440.00	SPECIAL PURPOSE COST CENTERS	704 005	705 ((0	0.11 0.00	1 000 447	07/ /04	
118.00	, , , , , , , , , , , , , , , , , , ,	784, 935	725, 660	941, 300	1, 399, 117	976, 634	118.00
400.00	NONREI MBURSABLE COST CENTERS	440.007		44 550	100	454	100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	119, 837	0	11, 550			192.00
	19201 OCCUPATI ONAL MEDICINE	14, 139	0	10, 044			192.01
200.00	19202 VACANT SPACE Cross Foot Adjustments	١	U	0	0		192. 02 200. 00
200.00	1 1		0	0			200.00
201.00		918, 911	725, 660	962, 894	1, 412, 965	978, 271	
202.00	TOTAL (Sum Times The timough 201)	710, 711	, 23, 000	702, 074	1,412,700	710, 211	1202.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1311	Peri od:	Worksheet B

COST AL	LOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-1311	Peri od: From 01/01/2021 To 12/31/2021	Worksheet B Part I Date/Time Pre 5/26/2022 2:0	epared:
	Cost Center Description	PHARMACY	Subtotal	Intern &	Total		
				Resi dents			
				Cost & Post			
				Stepdown			
		45.00	0.4.00	Adjustments			
	CENEDAL CEDULCE COCT CENTERS	15. 00	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS						1 00
	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 00 1. 01
	00200 CAP REL COSTS-BLDG & FIXT - INTERES						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	·					4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - OFFSITE						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	D1100 CAFETERI A						11.00
	D1300 NURSI NG ADMINI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	D1500 PHARMACY	1, 843, 808					15.00
-	INPATIENT ROUTINE SERVICE COST CENTERS	1,043,000					13.00
	03000 ADULTS & PEDIATRICS	9, 661	7, 504, 510		0 7, 504, 510		30.00
	ANCILLARY SERVICE COST CENTERS	9,001	7, 304, 310		0 7, 304, 310		30.00
	D5000 OPERATING ROOM	5, 751	5, 094, 681		0 5, 094, 681		50.00
	05300 ANESTHESI OLOGY	3, 731	100, 527		0 100, 527		53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 661	2, 894, 088		0 2, 894, 088		54.00
	06000 LABORATORY	1,001	2, 304, 451		0 2, 304, 451		60.00
	06500 RESPI RATORY THERAPY	0	1, 203, 511		0 1, 203, 511		65.00
	06600 PHYSI CAL THERAPY	11	1, 543, 415		0 1, 543, 415		66.00
	06700 OCCUPATI ONAL THERAPY	.,	478, 126		0 478, 126		67.00
	06800 SPEECH PATHOLOGY		48, 495		0 48, 495		68.00
	06900 ELECTROCARDI OLOGY	286	1, 136, 625		0 1, 136, 625		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	548, 776		0 548, 776		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o o	2, 155, 064		0 2, 155, 064		72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 535, 040	7, 229, 531		0 7, 229, 531		73.00
	03480 ONCOLOGY	2, 937	625, 224		0 625, 224		73. 01
	07301 BLOOD DI SORDER DRUGS	276, 833	1, 303, 791		0 1, 303, 791		73. 02
	03160 CARDI OPULMONARY	0	0		0 0		76.00
	07697 CARDI AC REHABI LI TATI ON	2	359, 851		0 359, 851		76. 97
	OUTPATIENT SERVICE COST CENTERS		007,001		0077001		1
	09100 EMERGENCY	11, 626	4, 089, 365		0 4, 089, 365		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	,	.,,		0		92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 843, 808	38, 620, 031		0 38, 620, 031		118. 00
	NONREI MBURSABLE COST CENTERS	, , , , , , , , ,			,		1
	19200 PHYSICIANS' PRIVATE OFFICES	0	1, 127, 493		0 1, 127, 493		192. 00
	19201 OCCUPATI ONAL MEDI CI NE	ol	336, 593		0 336, 593		192. 01
	19202 VACANT SPACE	ol	0	1	0 0		192. 02
200.00	Cross Foot Adjustments		0		0 0		200.00
201. 00	Negative Cost Centers	ol	0		0 0		201. 00
202.00	TOTAL (sum lines 118 through 201)	1, 843, 808	40, 084, 117		0 40, 084, 117		202.00
- 1				•			

| Period: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Provider CCN: 15-1311

				To	12/31/2021	Date/Time Pre	pared:
			СДР	 ITAL RELATED CO	STS	5/26/2022 2:0	3 pm
			CAI	ITAL KELATED CO	,515		
	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	OO101 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	7, 252		5, 525	13, 963	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	103, 918		79, 173	200, 091	5.00
7. 00	00700 OPERATION OF PLANT	0	410, 842	· · · · · · · · · · · · · · · · · · ·	313, 012	782, 890	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	0	26, 899		20, 494	51, 793	8.00
9.00	00900 HOUSEKEEPI NG	0	16, 064		12, 239	30, 931	9.00
10.00	01000 DI ETARY	0	29, 113		22, 180	56, 055	10.00
11.00	01100 CAFETERI A	0	40, 835		31, 111	78, 626	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	37, 330		28, 441	71, 878	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	34, 522		26, 301 14, 562	66, 470	14.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	U	19, 113	3, 127	14, 502	36, 802	15. 00
30. 00	03000 ADULTS & PEDIATRICS	0	164, 667	26, 937	125, 456	317, 060	30. 00
30.00	ANCI LLARY SERVI CE COST CENTERS	U	104, 007	20, 737	123, 430	317,000	30.00
50. 00	05000 OPERATI NG ROOM	0	200, 972	32, 876	153, 116	386, 964	50.00
53. 00	05300 ANESTHESI OLOGY	0	3, 790		2, 887	7, 297	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	104, 151		79, 350	200, 539	54.00
60.00	06000 LABORATORY	0	42, 687		32, 522	82, 192	60.00
65. 00	06500 RESPI RATORY THERAPY	0	2, 498		1, 903	4, 810	65.00
66.00	06600 PHYSI CAL THERAPY	0	60, 430		46, 040	109, 963	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	18, 088		13, 781	32, 914	67.00
68.00	06800 SPEECH PATHOLOGY	0	775		591	1, 411	68.00
69.00	06900 ELECTROCARDI OLOGY	0	27, 364	4, 476	20, 848	52, 688	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73.00
73. 01	03480 ONCOLOGY	0	16, 546	2, 707	12, 606	31, 859	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	0	0	o	0	73.02
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76.00
76. 97	07697 CARDIAC REHABILITATION	0	17, 941	2, 935	13, 669	34, 545	76. 97
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	116, 881	19, 120	89, 049	225, 050	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
	SPECIAL PURPOSE COST CENTERS						
118. 00		0	1, 502, 678	229, 257	1, 144, 856	2, 876, 791	118. 00
	NONREI MBURSABLE COST CENTERS			1			
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	143, 160		109, 070	258, 318	
	19201 OCCUPATI ONAL MEDI CI NE	0	16, 890	1	12, 868	32, 521	
	19202 VACANT SPACE	0	0	0	0		192. 02
200.00	, , , , , , , , , , , , , , , , , , ,		_	_	_		200.00
201.00	1 1 3		0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 662, 728	238, 108	1, 266, 794	3, 167, 630	202.00

| Period: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1311

				T	o 12/31/2021	Date/Time Pre 5/26/2022 2:0	
	Cost Center Description	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF	LAUNDRY &	<u> </u>
	·	BENEFITS	E & GENERAL	PLANT	PLANT -	LINEN SERVICE	
		DEPARTMENT			OFFSI TE		
	T	4. 00	5. 00	7. 00	7. 01	8. 00	
4 00	GENERAL SERVI CE COST CENTERS		I	ı	I	I	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	13, 963					2.00 4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	767	200, 858				5.00
7. 00	00700 OPERATION OF PLANT	707		•			7.00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	20, 420		0		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	22	1, 073	_	_	73, 947	8.00
9. 00	00900 HOUSEKEEPI NG	438				0	9.00
10. 00	01000 DI ETARY	187	2, 716			Ö	10.00
11. 00	01100 CAFETERI A	263	3, 535			0	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	634	5, 690			0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	3, 811		0	0	14.00
15. 00	01500 PHARMACY	845	8, 274		0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS				<u>'</u>	<u> </u>	
30.00	03000 ADULTS & PEDIATRICS	2, 745	22, 042	128, 915	0	73, 947	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 429					50.00
53.00	05300 ANESTHESI OLOGY	0	360				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 278					54.00
60. 00	06000 LABORATORY	10	1				60.00
65.00	06500 RESPI RATORY THERAPY	776				_	65.00
66. 00	06600 PHYSI CAL THERAPY	817	6, 543			0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	262					67.00
68.00	06800 SPEECH PATHOLOGY	30		216		0	68.00
69.00	06900 ELECTROCARDI OLOGY	585		•		1	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 027 7, 961	0 0	_	1	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	28, 532			0	73.00
73. 00	03480 ONCOLOGY	286	2, 278			0	73.00
73. 01	07301 BLOOD DI SORDER DRUGS	200	5, 146			1	73.01
76. 00	03160 CARDI OPULMONARY	0	3, 140		_	1	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	113	1, 023	14, 046	_		76. 97
, 0. , ,	OUTPATIENT SERVICE COST CENTERS		1,7020	1 17 0 10			70.77
91.00	09100 EMERGENCY	1, 547	14, 788	91, 504	0	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)	13, 754	197, 334	727, 605	0	73, 947	118. 00
	NONREI MBURSABLE COST CENTERS						
192.00	19200 PHYSICIANS' PRIVATE OFFICES	120	2, 497	71, 208	0	0	192.00
192. 01	19201 OCCUPATI ONAL MEDI CI NE	89	1, 027	13, 223	0	0	192. 01
	19202 VACANT SPACE	0	0	0	0		192. 02
200.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					l .	200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	13, 963	200, 858	812, 036	0	73, 947	202. 00

| Period: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Provi der CCN: 15-1311

				Т	o 12/31/2021	Date/Time Pre 5/26/2022 2:0	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	
		9. 00	10. 00	11. 00	13.00	14. 00	
-	GENERAL SERVICE COST CENTERS	1					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE						7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG	48, 109					9. 00
10.00	01000 DI ETARY	1, 276	83, 026				10.00
11. 00	01100 CAFETERI A	1, 790	0	116, 183			11.00
13.00	01300 NURSING ADMINISTRATION	1, 636	0	5, 073			13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 513	0	C	_	98, 821	14.00
15. 00	01500 PHARMACY	838	0	7, 254	0	1, 209	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	7, 217	82, 636	25, 603	59, 798	2, 218	30.00
FO 00	ANCILLARY SERVICE COST CENTERS	0.000	ام	44.576	00 550	47.007	
50.00	05000 OPERATING ROOM	8, 808	0	,		17, 227	
53. 00 54. 00	05300 ANESTHESI OLOGY	166	0	580		0	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	4, 564	O O	12, 690		923	1
60. 00 65. 00	06500 RESPIRATORY THERAPY	1, 871 109	0	8, 293 6, 007		904 1, 628	1
66.00	06600 PHYSI CAL THERAPY	2, 648	0	8, 422		1, 626	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	793	0	2, 831		0	67.00
68. 00	06800 SPEECH PATHOLOGY	34	0	2, 031		0	1
69. 00	06900 ELECTROCARDI OLOGY	1, 199	o	5, 090		289	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 177	0	3, 070		14, 567	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	C	_	57, 205	1
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		_	0 0	1
73. 01	03480 ONCOLOGY	725	0	2, 649	'l "	135	
73. 02	07301 BLOOD DI SORDER DRUGS	0	o	2,0.7	0	0	73. 02
76. 00	03160 CARDI OPULMONARY	o	o	C	ol	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	786	o	1, 056	2, 699	37	
	OUTPATIENT SERVICE COST CENTERS			,			
91.00	09100 EMERGENCY	5, 122	390	13, 201	20, 543	2, 263	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	SPECIAL PURPOSE COST CENTERS						1
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	41, 095	83, 026	113, 577	113, 017	98, 656	118. 00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	6, 274	ol	1, 394	16	15	192. 00
	19201 OCCUPATIONAL MEDICINE	740	Ö	1, 212			192.01
	19202 VACANT SPACE	,40	0	1, 212			192.01
200.00			٩		ή	0	200.00
201.00	J	٥	ol	C	ار	Ω	201.00
202.00		48, 109	83, 026	116, 183	114, 136		202.00
					1		• • • • • • • • • • • • • • • • • • • •

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	eu of Form CMS-2552-10	
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1311	Peri od:	Worksheet B	

ALLOCA	TITON OF CAPITAL RELATED COSTS		Provider C		From 01/01/2021 To 12/31/2021	Part II Date/Time Pr 5/26/2022 2:	repared: 03 pm
	Cost Center Description	PHARMACY	Subtotal	Intern & Residents 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
1. 01	OO101 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 & LI NEN SERVI CE						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 01400 CENTRAL SERVI CES & SUPPLY						13.00
14. 00 15. 00	1 1	70 105					14. 00 15. 00
13.00	O1500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	70, 185					15.00
30. 00	03000 ADULTS & PEDIATRICS	368	722, 549		0 722, 549		30.00
30.00	ANCI LLARY SERVICE COST CENTERS	300	122, 347		0 722, 349		30.00
50. 00	05000 OPERATING ROOM	219	626, 334		0 626, 334		50.00
53. 00	05300 ANESTHESI OLOGY	217	11, 370		0 11, 370		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	63	312, 258		0 312, 258		54.00
60.00	06000 LABORATORY	0	136, 499		0 136, 499		60.00
65. 00	06500 RESPI RATORY THERAPY	0	20, 908		0 20, 908	1	65.00
66.00	06600 PHYSI CAL THERAPY	o	145, 160		0 145, 160		66.00
67.00	06700 OCCUPATI ONAL THERAPY	O	43, 830		0 43, 830		67.00
68.00	06800 SPEECH PATHOLOGY	О	2, 172		0 2, 172		68. 00
69.00	06900 ELECTROCARDI OLOGY	11	88, 854		0 88, 854		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 594		0 16, 594		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	65, 166		0 65, 166		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	58, 431	86, 963		0 86, 963		73.00
73. 01	03480 ONCOLOGY	112	54, 226		0 54, 226		73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	10, 538	15, 684		0 15, 684		73. 02
76. 00	03160 CARDI OPULMONARY	0	0		0	l .	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	54, 305		0 54, 305		76. 97
	OUTPATIENT SERVICE COST CENTERS			Г		Г	
91.00	09100 EMERGENCY	443	374, 851		0 374, 851		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
118. 00	SPECIAL PURPOSE COST CENTERS	70, 185	2, 777, 723		0 2,777,723		118.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	70, 185	2, 111, 123		0 2, 777, 723		118.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	339, 842		0 339, 842		192. 00
192. 01	19201 OCCUPATI ONAL MEDI CI NE	О	50, 065		0 50, 065		192. 01
	19202 VACANT SPACE	o	0		0		192. 02
200.00	Cross Foot Adjustments		0		0 0		200.00
201.00	Negative Cost Centers	o	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	70, 185	3, 167, 630		0 3, 167, 630		202. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1311 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm 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 SALARIES) 1. 00 1. 01 2.00 4. 00 5A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 193, 044 1 00 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1.01 168, 990 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 193.044 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 842 842 842 12, 422, 158 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 12,065 12,065 12,065 682, 402 -7, 910, 059 5.00 7.00 00700 OPERATION OF PLANT 47, 699 41,898 47, 699 640, 617 7.00 00701 OPERATION OF PLANT - OFFSITE 7 01 0 0 7 01 00800 LAUNDRY & LINEN SERVICE 8.00 3, 123 3, 123 3, 123 19,670 0 8.00 9.00 00900 HOUSEKEEPI NG 1,865 1, 865 1,865 389, 243 0 9.00 10.00 01000 DI ETARY 3, 380 3, 380 3, 380 166, 736 0 10.00 01100 CAFETERI A 4, 741 4,741 11 00 4.741 233 884 0 11 00 13.00 01300 NURSING ADMINISTRATION 4, 334 4, 334 4, 334 563, 867 0 13.00 01400 CENTRAL SERVICES & SUPPLY 4,008 4,008 4,008 0 14.00 14.00 01500 PHARMACY 2, 219 752, 067 0 15.00 15.00 2.219 2.219 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 19, 118 19, 118 19, 118 2, 440, 569 0 30.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 23, 333 1. 271, 783 n 50.00 23.333 23.333 53.00 05300 ANESTHESI OLOGY 440 440 440 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 12, 092 12, 092 12,092 1, 137, 374 0 54.00 54.00 60.00 06000 LABORATORY 4, 956 4, 956 4, 956 8, 657 0 60.00 06500 RESPIRATORY THERAPY 290 290 690, 653 65.00 290 0 65 00 66.00 06600 PHYSI CAL THERAPY 7,016 2, 479 7,016 727,037 0 66.00 06700 OCCUPATI ONAL THERAPY 233, 188 67.00 2, 100 742 2, 100 0 67.00 06800 SPEECH PATHOLOGY 68.00 90 32 90 26, 398 0 68.00 520, 538 06900 ELECTROCARDI OLOGY 69.00 3, 177 3, 177 3.177 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 71.00 0 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 \mathcal{C} 0 0 03480 ONCOLOGY 73 01 1.921 1, 921 1.921 254, 483 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, 083 100, 397 76.97 2,083 2,083 76.97 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 13.570 13, 570 13.570 1, 376, 504 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 SPECIAL PURPOSE COST CENTERS -7, 910, 059 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 174, 462 162, 708 174, 462 12, 236, 067 NONREIMBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 4, 321 106, 912 0 192. 00 16, 621 16, 621 192. 01 19201 OCCUPATIONAL MEDICINE 0 192.01 1, 961 1, 961 1, 961 79, 179 192. 02 19202 VACANT SPACE 0 192.02 Cross Foot Adjustments 200.00 200.00 201 00 201 00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 1, 662, 728 238, 108 1, 266, 794 2, 335, 072 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 8. 613207 1.409006 0.187976 203.00 6.562203 204.00 Cost to be allocated (per Wkst. B, 13, 963 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001124 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 IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1311 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm Cost Center Description ADMINISTRATIV OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG LINEN SERVICE (SQUARE FEET) E & GENERAL PLANT PLANT (ACCUM. COST) (SQUARE FEET) OFFSI TE (TOTAL (SQUARE FEET) PATIENT DAYS) 5. 00 7. 00 9. 00 7.01 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1 01 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1 01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 32, 174, 058 5.00 00700 OPERATION OF PLANT 7 00 4, 553, 213 120, 424 7 00 7.01 00701 OPERATION OF PLANT - OFFSITE 12,014 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 171, 796 3, 123 0 2,592 8.00 00900 HOUSEKEEPI NG 667, 061 127, 450 9.00 9.00 1, 865 0 0 01000 DI ETARY 3, 380 0 10.00 435, 102 0 3, 380 10.00 11.00 01100 CAFETERI A 566, 187 4,741 0 0 4,741 11.00 13.00 01300 NURSING ADMINISTRATION 911, 442 4, 334 0 0 4, 334 13.00 01400 CENTRAL SERVICES & SUPPLY 610, 485 4,008 14.00 4,008 0 0 14.00 15.00 01500 PHARMACY 1, 325, 355 2, 219 0 2, 219 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 0 30.00 03000 ADULTS & PEDIATRICS 3, 530, 598 19, 118 2, 592 19, 118 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 599, 615 23, 333 0 23, 333 50.00 05300 ANESTHESI OLOGY 0 0 53.00 57, 649 440 440 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 702, 372 12,092 0 12,092 54.00 0 54.00 06000 LABORATORY 1, 571, 281 0 4, 956 60.00 4, 956 0 60.00 65.00 06500 RESPIRATORY THERAPY 900, 473 290 0 0 290 65.00 06600 PHYSI CAL THERAPY 2, 479 0 66.00 1, 048, 065 4,537 7,016 66.00 0 67 00 06700 OCCUPATIONAL THERAPY 324, 737 742 1 358 2, 100 67 00 06800 SPEECH PATHOLOGY 68.00 35, 467 32 58 90 68.00 69.00 06900 ELECTROCARDI OLOGY 706, 030 0 3, 177 69.00 3.177 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 324, 735 0 C 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 1, 275, 247 C 0 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 570, 759 0 0 73.00 0 73.01 03480 ONCOLOGY 364, 965 1, 921 0 1, 921 73.01 73 02 07301 BLOOD DI SORDER DRUGS 824.302 O 0 73 02 0 03160 CARDI OPULMONARY 0 76.00 0 Λ 76.00 07697 CARDIAC REHABILITATION 163, 892 2,083 0 2, 083 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 91 00 13, 570 O 0 91 00 09100 EMERGENCY 2.368.778 13.570 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 609, 606 107, 903 5, 953 2, 592 108, 868 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 399, 986 10, 560 6, 061 16, 621 192. 00 192. 01 19201 OCCUPATI ONAL MEDI CI NE 164, 466 1, 961 0 0 1, 961 192. 01 192. 02 19202 VACANT SPACE 0 192. 02 0 0 200,00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 7, 910, 059 5, 672, 630 O 361, 142 918, 911 202. 00 Part I) 0. 245852 47 105477 139. 329475 7. 209973 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000

200, 858

0.006243

812, 036

6.743141

0.000000

73, 947

28. 528935

48, 109 204. 00

206.00

207.00

0. 377474 205. 00

204.00

205.00

206,00

207.00

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

NAHE unit cost multiplier (Wkst. D,

NAHE adjustment amount to be allocated

Part II)

(per Wkst. B-2)

Parts III and IV)

II)

COST ALLO	CATION - STATISTICAL BASIS	-	Provi der C		eri od:	Worksheet B-1	
					rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/26/2022 2:0	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(FTE'S)	ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	
				(DI RECT	(COSTED	,	
				NURSI NG	REQUIS.)		
		10. 00	11. 00	HOURS) 13. 00	14.00	15. 00	
	NERAL SERVICE COST CENTERS						
	100 CAP REL COSTS-BLDG & FLXT						1.00
	101 CAP REL COSTS-BLDG & FIXT - INTERES 200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
	400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	500 ADMINISTRATIVE & GENERAL						5.00
	700 OPERATION OF PLANT 701 OPERATION OF PLANT - OFFSITE						7. 00 7. 01
1	BOO LAUNDRY & LINEN SERVICE						8.00
9.00 009	POO HOUSEKEEPI NG						9. 00
	DOO DI ETARY	9, 802	40.400				10.00
	100 CAFETERIA 300 NURSING ADMINISTRATION	0	13, 422 586				11. 00 13. 00
	400 CENTRAL SERVICES & SUPPLY	o	0				14.00
	500 PHARMACY	0	838	<u> </u>	26, 952	5, 490, 153	15.00
	PATIENT ROUTINE SERVICE COST CENTERS DOO ADULTS & PEDIATRICS	9, 756	2, 958	56, 130	49, 437	28, 766	30.00
	CILLARY SERVICE COST CENTERS	7, 750	2, 730	50, 130	47, 437	28, 700	30.00
	OOO OPERATING ROOM	0	1, 683		l ' '	17, 125	1
	300 ANESTHESI OLOGY	0	67			_	
	400 RADI OLOGY-DI AGNOSTI C DOO LABORATORY	0	1, 466 958		I	4, 946 0	1
	500 RESPI RATORY THERAPY	o	694		I		1
	600 PHYSI CAL THERAPY	0	973		.,		
	700 OCCUPATI ONAL THERAPY 300 SPEECH PATHOLOGY	0	327 30		-	0	67. 00 68. 00
	900 ELECTROCARDI OLOGY	0	588		_	851	69.00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	1
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		, , ,	0	
	BOO DRUGS CHARGED TO PATIENTS ONCOLOGY	0	0 306		-	.,,	1
	BO1 BLOOD DI SORDER DRUGS	Ö	0			824, 302	1
	160 CARDI OPULMONARY	0	0		0	0	
	697 CARDIAC REHABILITATION TPATIENT SERVICE COST CENTERS	0	122	2, 533	824	7	76. 97
	100 EMERGENCY	46	1, 525	19, 283	50, 453	34, 618	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	9, 802	13, 121	106, 084	2, 199, 296	5, 490, 153	110 00
	NREIMBURSABLE COST CENTERS	7, 802	13, 121	100,004	2, 199, 290	5, 470, 153] 118.00
192. 00 192	200 PHYSICIANS' PRIVATE OFFICES	0	161		340		192. 00
	201 OCCUPATI ONAL MEDI CI NE	0	140	1			192.01
200.00	202 VACANT SPACE Cross Foot Adjustments	U	0		0	0	192. 02 200. 00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B, Part I)	725, 660	962, 894	1, 412, 965	978, 271	1, 843, 808	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	74. 031830	71. 739979				
204. 00	Cost to be allocated (per Wkst. B,	83, 026	116, 183	114, 136	98, 821	70, 185	204.00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part	8. 470312	8. 656162	1. 065357	0. 044858	0. 012784	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)			l			1

He	alth Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
C	OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	Provi der CCN: 15-1311		Worksheet C Part I Date/Time Pre 5/26/2022 2:0	pared: 3 pm
_			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	0.00 03000 ADULTS & PEDIATRICS	7, 504, 510		7, 504, 51	0 0	0	30.00
	ANCILLARY SERVICE COST CENTERS						
50	0.00 05000 OPERATING ROOM	5, 094, 681		5, 094, 68	0	0	50.00
53	B. 00 05300 ANESTHESI OLOGY	100, 527		100, 52	27 0	0	53.00
54	I. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 894, 088		2, 894, 08	0	0	54.00
	0. 00 06000 LABORATORY	2, 304, 451		2, 304, 45		0	00.00
	5. 00 06500 RESPIRATORY THERAPY	1, 203, 511	0	1, 203, 51		0	00.00
	5. 00 06600 PHYSI CAL THERAPY	1, 543, 415		1, 543, 41		0	00.00
	7. 00 06700 OCCUPATI ONAL THERAPY	478, 126		478, 12		0	07.00
	3. 00 06800 SPEECH PATHOLOGY	48, 495		48, 49		0	68. 00
	P. 00 06900 ELECTROCARDI OLOGY	1, 136, 625		1, 136, 62		0	07.00
	.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	548, 776		548, 77		0	,
	2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 155, 064		2, 155, 06		0	,
	3. 00 07300 DRUGS CHARGED TO PATIENTS	7, 229, 531		7, 229, 53		0	73.00

1, 303, 791

4, 089, 365

39, 403, 959 783, 928

38, 620, 031

783, 928

625, 224

359, 851

1, 303, 791

4, 089, 365

39, 403, 959

38, 620, 031

0

625, 224

359, 851

783, 928

783, 928

0

0

0 73.01

0 73.02

0 76.00

0 76. 97

0 91.00 0 92.00 0 200.00

0 201.00

0 202.00

03480 ONCOLOGY

73. 02 07301 BLOOD DI SORDER DRUGS

03160 CARDI OPULMONARY

07697 CARDIAC REHABILITATION

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Less Observation Beds

Subtotal (see instructions)

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

73.01

76.00

76. 97

200.00

201.00

202.00

Health Financial Customs	IU HEALTH TIPT	ON HOCDITAL		la li o	u of Form CMC 1	DEE2 10
Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1311			Peri od:	u of Form CMS-2 Worksheet C	2552-10
				From 01/01/2021 To 12/31/2021	Part I Date/Time Pre 5/26/2022 2:0	pared:
		Title	XVIII	Hospi tal	Cost	5 piii
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				.1		
30. 00 03000 ADULTS & PEDIATRICS	6, 843, 038		6, 843, 038	3		30. 00
ANCILLARY SERVICE COST CENTERS	0 407 450	00 4/4 705	00 050 47	-	0.00000	
50. 00 05000 OPERATING ROOM	2, 497, 450	28, 461, 725			0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	128, 703	2, 008, 475	2, 137, 178		0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	691, 563	10, 641, 964		1	0. 000000	
60. 00 06000 LABORATORY	1, 133, 242	5, 096, 284	6, 229, 520	1	0. 000000	
65. 00 06500 RESPIRATORY THERAPY	843, 548	989, 658			0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	558, 909	1, 995, 165		1	0. 000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	247, 741	580, 786	828, 52	1	0. 000000	
68. 00 06800 SPEECH PATHOLOGY	38, 525	65, 031	103, 556		0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	494, 091	4, 582, 245		1	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	553, 024	4, 356, 373		1	0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	3, 016, 850	12, 375, 865		1	0. 000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 733, 515	18, 813, 004		1	0. 000000	
73. 01 03480 0NCOLOGY	0	2, 712, 224	2, 712, 22		0. 000000	
73. 02 07301 BLOOD DI SORDER DRUGS	0	10, 621, 709	10, 621, 709			
76. 00 03160 CARDI OPULMONARY	0	0	()		0. 000000	76.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	806, 898	806, 898	0. 445968	0. 000000	76. 97

643, 637

21, 423, 836

21, 423, 836

15, 231, 637 1, 964, 330 121, 303, 373

121, 303, 373

15, 875, 274

1, 964, 330 142, 727, 209

142, 727, 209

0. 257593

0. 399082

0.000000

0.000000

91.00

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

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (see instructions)

Subtotal (see instructions)
Less Observation Beds

09100 EMERGENCY

91.00

200.00

202.00

Health Financial Systems	IU HEALTH TIPTON	HOSDI TAI	In Lio	u of Form CMS-2	0552 10
COMPUTATION OF RATIO OF COSTS TO CHARGES	TO HEACHT TIPTON	Provi der CCN: 15-1311	Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 2:0	pared:
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					00.00
50.00 O5000 OPERATING ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
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 O7200 MPL. 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

0. 000000 0. 000000

0.000000

0.000000

76. 00 76. 97

91.00

92. 00 200. 00

201. 00 202. 00

76. 00 03160 CARDI OPULMONARY
76. 97 07697 CARDI AC REHABI LI TATI ON
0UTPATI ENT SERVI CE COST CENTERS
91. 00 09100 EMERGENCY

201.00

202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions)

Total (see instructions)

Less Observation Beds

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In lie	u of Form CMS-2	2552_10
COMPUTATION OF RATIO OF COSTS TO CHARGES	TO HEALIN TIT	Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre 5/26/2022 2:0	pared:
		Title XIX Hospital				
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2, 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	7, 504, 510		7, 504, 510	0	7, 504, 510	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	5, 094, 681		5, 094, 68	1 0	5, 094, 681	50.00
53. 00 05300 ANESTHESI OLOGY	100, 527		100, 52	7 0	100, 527	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 894, 088		2, 894, 08	3 0	2, 894, 088	54.00
60. 00 06000 LABORATORY	2, 304, 451		2, 304, 45	1 0	2, 304, 451	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 203, 511	0	1, 203, 51		1, 203, 511	
66. 00 06600 PHYSI CAL THERAPY	1, 543, 415		1, 543, 41!		1, 543, 415	
67. 00 06700 OCCUPATI ONAL THERAPY	478, 126		478, 120		478, 126	
68.00 06800 SPEECH PATHOLOGY	48, 495	l e	48, 49		48, 495	
69. 00 06900 ELECTROCARDI OLOGY	1, 136, 625		1, 136, 62	5 0	1, 136, 625	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	548, 776		548, 776	6 0	548, 776	71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	2, 155, 064		2, 155, 06	4 0	2, 155, 064	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	7, 229, 531		7, 229, 53	1 0	7, 229, 531	73.00
73. 01 03480 ONCOLOGY	625, 224		625, 22	4 0	625, 224	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	1, 303, 791		1, 303, 79 ⁻	1 0	1, 303, 791	73. 02
76. 00 03160 CARDI OPULMONARY	0			0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	359, 851		359, 85°	1 0	359, 851	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	4, 089, 365		4, 089, 36	5 0	4, 089, 365	91.00
92 OO OO2OO ORSERVATION REDS (NON_DISTINCT PART	783 928		783 929	al l	783 928	92 NN

783, 928 39, 403, 959 783, 928 38, 620, 031

783, 928 39, 403, 959 783, 928

38, 620, 031

0

4, 089, 365 91. 00 783, 928 92. 00 39, 403, 959 200. 00 783, 928 201. 00 38, 620, 031 202. 00

0

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions)
Less Observation Beds

Total (see instructions)

202.00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/26/2022 2:03 pm	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	I npati ent	Charges 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 & PEDIATRICS	6, 843, 038		6, 843, 03	8		30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	2, 497, 450	28, 461, 725			0.000000	
53. 00 05300 ANESTHESI OLOGY	128, 703	2, 008, 475			0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	691, 563	10, 641, 964				54.00
60. 00 06000 LABORATORY	1, 133, 242	5, 096, 284			0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	843, 548	989, 658			0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	558, 909	1, 995, 165			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	247, 741	580, 786				67.00
68.00 06800 SPEECH PATHOLOGY	38, 525	65, 031			0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	494, 091	4, 582, 245			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	553, 024	4, 356, 373	4, 909, 39	7 0. 111781	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	3, 016, 850	12, 375, 865	15, 392, 71	0. 140005	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 733, 515	18, 813, 004		9 0. 320650	0.000000	
73. 01 03480 ONCOLOGY	0	2, 712, 224	2, 712, 22	4 0. 230521	0.000000	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0	10, 621, 709	10, 621, 70	9 0. 122748	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	806, 898	806, 89	0. 445968	0. 000000	76. 97
OUTPATIENT SERVICE COST CENTERS						
01 00 00100 EMEDCENCY	642 627	15 221 627	15 075 27	0 257502	0 000000	01 00

643, 637

21, 423, 836

21, 423, 836

15, 231, 637 1, 964, 330 121, 303, 373

121, 303, 373

15, 875, 274

1, 964, 330 142, 727, 209

142, 727, 209

0. 257593

0. 399082

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		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311	Peri od:	Worksheet C	
			From 01/01/2021 To 12/31/2021	Part I Date/Time Pre	narad.
			10 12/31/2021	5/26/2022 2:0	
		Title XIX	Hospi tal	Cost	о рііі
Cost Center Description	PPS Inpatient				
, , , , , , , , , , , , , , , , , , ,	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
ANCILLARY SERVICE COST CENTERS					
50.00 O5000 OPERATING ROOM	0. 000000				50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 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 BL00D DI SORDER DRUGS	0. 000000				73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000				76. 00
76. 97 O7697 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 TIPT	ON HO	SPI TAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	NCILLARY SERVICE CAPITAL COSTS		Provider CCN: 15-1311		Peri od: Worksheet D From 01/01/2021 Part II To 12/31/2021 Date/Ti me Prepare 5/26/2022 2:03 pm		
			Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total	Charges	Ratio of Co	st Inpatient	Capital Costs	

					From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I npati ent	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	
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	626, 334		•	· · · · ·		1
	ANESTHESI OLOGY	11, 370	2, 137, 178	•			
	RADI OLOGY-DI AGNOSTI C	312, 258	11, 333, 527	•			54.00
60.00 06000	LABORATORY	136, 499	6, 229, 526	0. 02191	2 461, 220	10, 106	60.00
65.00 06500	RESPI RATORY THERAPY	20, 908	1, 833, 206	0. 01140	5 378, 290	4, 314	65.00
	PHYSI CAL THERAPY	145, 160	2, 554, 074	0. 05683	5 266, 899	15, 169	66.00
67.00 06700	OCCUPATI ONAL THERAPY	43, 830	828, 527	0.05290	1 127, 488	6, 744	67.00
68.00 06800	SPEECH PATHOLOGY	2, 172	103, 556	0. 02097	4 18, 884	396	68. 00
69.00 06900	ELECTROCARDI OLOGY	88, 854	5, 076, 336	0. 01750	4 215, 604	3, 774	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	16, 594	4, 909, 397	0.00338	331, 889	1, 122	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	65, 166	15, 392, 715	0.00423	4 2, 167, 851	9, 179	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	86, 963	22, 546, 519	0.00385	7 1, 319, 349	5, 089	73.00
73. 01 03480	ONCOLOGY	54, 226	2, 712, 224	0. 01999	3 0	0	73. 01
73. 02 07301	BLOOD DI SORDER DRUGS	15, 684	10, 621, 709	0.00147	7 0	0	73. 02
76.00 03160	CARDI OPULMONARY	0	0	0.00000	0	0	76.00
76. 97 07697	CARDIAC REHABILITATION	54, 305	806, 898	0.06730	1 0	0	76. 97
OUTPA	TIENT SERVICE COST CENTERS						
91.00 09100	EMERGENCY	374, 851	15, 875, 274	0. 02361	2 15, 788	373	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	75, 478	1, 964, 330	0. 03842	4 0	0	92.00
200. 00	Total (lines 50 through 199)	2, 130, 652	135, 884, 171		6, 987, 766	91, 184	200.00

Health Financial Systems	IU HEALTH TIF	PTON HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PA	ASS Provider CCN: 15-1311	Peri od: Worksheet D From 01/01/2021 Part IV To 12/31/2021 Date/Time Prepared:

				10 12/31/2021	5/26/2022 2: 0	
		Title	xVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	C	0		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	C	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0		0	0	54.00
60. 00 06000 LABORATORY	C	0	1	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	C	0	1	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	C	0	1	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	C	0	1	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	C	0	1	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	C	0	1	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	1	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	0	1	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C	0	1	0	0	73. 00
73. 01 03480 ONCOLOGY	C	0	1	0	0	73. 01
73. 02 07301 BL00D DI SORDER DRUGS	C	0	1	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	C	0		0 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	C	0	1	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C)		0	0	92.00
200.00 Total (lines 50 through 199)	(C	0		0 0	0	200. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS				Period: From 01/01/2021 To 12/31/2021	Worksheet D Part IV Date/Time Pre 5/26/2022 2:0	pared:
	_	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)	0 30, 959, 175		l
53. 00 05300 ANESTHESI OLOGY	0	0)	0 2, 137, 178	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0 11, 333, 527	0.000000	54.00
60. 00 06000 LABORATORY	0	0)	0 6, 229, 526	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0)	0 1, 833, 206	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 554, 074	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 828, 527	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0)	0 103, 556	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 5, 076, 336	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 4, 909, 397	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 15, 392, 715	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 22, 546, 519	0.000000	73.00
73. 01 03480 ONCOLOGY	0	0		0 2, 712, 224	0.000000	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0	0		0 10, 621, 709	0.000000	73. 02
76. 00 03160 CARDI OPULMONARY	0	0		0	0.000000	76.00
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15, 875, 274

1, 964, 330

135, 884, 171

806, 898

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76.97

91.00

92.00

200.00

76. 97

91. 00 09100 EMERGENCY

03160 CARDI OPULMONARY 07697 CARDI AC REHABI LI TATI ON

OUTPATIENT SERVICE COST CENTERS

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

					6.5. 0110	
Health Financial Systems	IU HEALTH TIPTO				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co		Period: From 01/01/2021	Worksheet D	
THROUGH COSTS				From 01/01/2021 To 12/31/2021		nared:
				10 12/31/2021	5/26/2022 2: 0	3 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati 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	3	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						
50.00 05000 OPERATING ROOM	0. 000000	1, 355, 469		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	70, 569		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	258, 466		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	461, 220		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	378, 290		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	266, 899		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	127, 488		0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	18, 884		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	215, 604		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	331, 889		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	2, 167, 851		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	1, 319, 349		0	0	73.00
73. 01 03480 ONCOLOGY	0.000000	0		0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 000000	0		0	0	73. 02
76.00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
OUTDATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1

0. 000000 0. 000000

15, 788 0

6, 987, 766

0 0 0

0 0 0

0 91.00 0 92.00 0 200.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/26/2022 2:0	
		Title	XVIII	Hospi tal	Cost	
			Charges	_	Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Rei mbursed	Reimbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	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		_		_1	_	
50. 00 05000 OPERATI NG ROOM	0. 164561		4, 858, 49		0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 047037		191, 94		1	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 255356		2, 859, 12		0	54.00
60. 00 06000 LABORATORY	0. 369924		1, 274, 64		0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 656506		351, 61		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 604295		707, 48		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 577080		158, 30		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 468297		11, 33		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 223907		1, 498, 92	1 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 111781	0	1, 031, 01	4 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 140005	0	3, 311, 77	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 320650	0	9, 505, 32	8 5, 523	0	73.00
73. 01 03480 0NCOLOGY	0. 230521	0	1, 303, 80	4 0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 122748	0	3, 599, 16	7 0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0. 445968	0	383, 40	9 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 257593	0	3, 580, 57	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399082	0	312, 68	4 3, 601	0	92.00
200.00 Subtotal (see instructions)		0	34, 939, 62	6 9, 124	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	34, 939, 62	6 9, 124	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	Provider CCN: 15-1311	Peri od:	Worksheet D

Peri od: From 01/01/2021 Part V To 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 799, 519 50.00 05300 ANESTHESI OLOGY 9, 028 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 730, 094 0 54.00 54.00 60.00 06000 LABORATORY 471, 523 0 60.00 65.00 06500 RESPIRATORY THERAPY 230, 838 65.00 06600 PHYSI CAL THERAPY 427, 531 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 91, 356 67.00 68.00 06800 SPEECH PATHOLOGY 5, 306 68.00 06900 ELECTROCARDI OLOGY 0 69.00 335, 619 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 115, 248 0 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 463, 665 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 047, 883 73.00 03480 ONCOLOGY 300, 554 73 01 Ω 73 01 73.02 07301 BLOOD DI SORDER DRUGS 441, 791 0 73.02 76.00 03160 CARDI OPULMONARY 0 76.00 07697 CARDIAC REHABILITATION 170, 988 76.97 0 76.97 OUTPATIENT SERVICE COST CENTERS 91.00 91.00 09100 EMERGENCY 922, 330 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 124, 787 1, 437 92.00 200.00 200.00 Subtotal (see instructions) 8, 688, 060 3, 208 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 8, 688, 060 3, 208 202.00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
				From 01/01/2021 To 12/31/2021	Part V Date/Time Pre	narod:
				10 12/31/2021	5/26/2022 2: 0	3 pm
		Ti tl	e XIX	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	Servi ces	Servi ces Not		
	Worksheet C,	inst.)	Subject To	Subj ect To		
	Part I, col.		Ded. & Coins.	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. 164561	0	784, 89	1 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 047037	0	101, 43	4 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 255356	0	52, 68	7 0	0	54.00
60. 00 06000 LABORATORY	0. 369924	0	36, 49	6 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 656506	0	60	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 604295	0	2, 97	8 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 577080	0	4, 37	6 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 468297	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 223907	0	18, 33	7 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 111781	0	30, 01	2 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 140005	0	68, 56	3 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 320650	0	361, 00	1 0	0	73.00
73. 01 03480 ONCOLOGY	0. 230521	0	44, 13	6 0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 122748	0		o o	0	73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000	0		o o	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 445968	0		o o	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 257593	0	103, 77	9 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 399082	0	9, 88	9 0	0	92.00
200.00 Subtotal (see instructions)		0	1, 619, 18	1 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1, 619, 18	1 0	0	202. 00

Peri od: Worksheet D From 01/01/2021 Part V To 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm Provider CCN: 15-1311

Cost Center Description						5/26/2022 2:0)3 pm
Cost Center Description			Ti tl	e XIX	Hospi tal	Cost	
Rei mbursed Servi ces Subject To Ded. & Coins. (See Inst.) Ded. & Coins. Ded.		Cos	sts				
Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. (see inst.)	Cost Center Description	Cost	Cost				
Subject To Ded. & Coin ns. (see inst.) Subject To Ded. & Coin ns. (see inst.)		Rei mbursed	Rei mbursed				
Ded. & Coins. (see inst.)							
See inst. (see inst.) (see inst.)							
ANCI LLARY SERVI CE COST CENTERS 50.00 55.00 55.00 56.00 5							
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM 129, 162 0 53. 00 05300 ANESTHESI OLOGY 4, 771 0 53. 00 05400 RADI OLOGY-DI AGNOSTI C 13, 454 0 0 0 0 0 0 0 0 0		6. 00	7. 00				
53. 00 05300 ANESTHESI OLOGY 4, 771 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 13, 454 0 60. 00 65. 00 06500 RESPI RATORY THERAPY 395 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 800 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 2, 525 0 66. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 4, 106 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3, 355 0 72. 00 07200 MPLD. DEV. CHARGED TO PATI ENTS 9, 599 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 115, 755 0 73. 01 03480 0NCOLOGY 10, 174 0 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 76. 07 07697 CARDI OPULMONARY 0 0 76. 97 0017PATI ENT SERVI CE COST CENTERS 91. 00 09200 BSERVATI ON BEDS (NON-DI STI NCT PART 3, 947 0 200. 00 001 Charges 0 201. 00 Valarges 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 0 201. 00 201. 00 0 201. 00 0 201. 00 201.		_					_
54. 00			0				
60.00 06000 LABORATORY 113,501 0 60.00 65.00 RESPIRATORY THERAPY 395 0 65.00 66.00 RESPIRATORY THERAPY 395 0 65.00 66.00 RESPIRATORY THERAPY 1,800 0 66.00 RESPIRATORY THERAPY 1,800 0 66.00 RESPIRATORY THERAPY 2,525 0 67.00 67.00 OCCUPATIONAL THERAPY 2,525 0 67.00 68.00 RESPIRATHOLOGY 0 0 0 68.00 RESPIRATHOLOGY 0 0 0 68.00 RESPIRATHOLOGY 0 0 0 68.00 RESPIRATION RES			1				
65. 00 06500 RESPIRATORY THERAPY 395 0 66. 00 660 0 PHYSI CAL THERAPY 1,800 0 66. 00 6670 0 OCCUPATI ONAL THERAPY 2,525 0 67. 00 6800 SPEECH PATHOLOGY 0 0 0 6800 SPEECH PATHOLOGY 0 0 68. 00 669. 00 6900 ELECTROCARDI OLOGY 4,106 0 669. 00 671. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 3,355 0 71. 00 772. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 9,599 0 772. 00 773. 00 07300 DRUGS CHARGED TO PATI ENTS 115,755 0 73. 00 733. 01 03480 ONCOLOGY 10,174 0 73. 01 03480 ONCOLOGY 10,174 0 73. 01 03480 ONCOLOGY 10,174 0 73. 01 03480 ONCOLOGY 0 10,174 0 73. 01 03480 ONCOLOGY 10,174 0 0 73. 01 03480 ONCOLOGY 10,174 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				
66. 00			0				
67. 00							
68. 00		1, 800	0				
69. 00		2, 525	0				
71. 00		0	0				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 599 0 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 01 73. 01 73. 01 73. 02 73. 01 8L00D DI SORDER DRUGS 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 0 76. 97 00 00 00 00 00 00 00							
73. 00 07300 DRUGS CHARGED TO PATIENTS 115, 755 0 73. 00 73. 01 03480 ONCOLOGY 10, 174 0 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0 0 0 0 0 0		3, 355	0				
73. 01							
73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 73. 02 76. 00 03160 CARDI OPULMONARY 0 0 0 0 76. 97 07697 CARDI AC REHABI LITATION 0 0 0 91. 00 09100 EMERGENCY 26, 733 0 91. 00 92. 00 09200 OSSERVATI ON BEDS (NON-DI STINCT PART 3, 947 0 200. 00 Subtotal (see instructions) 339, 277 0 201. 00 Only Charges 0 0 001 Only Charges 0 0 73. 02 73. 02 74. 00 0 0 75. 00 0 0 76. 00 76. 00 76. 00 76. 00 76. 00 0		115, 755	0				
76. 00	73. 01 03480 ONCOLOGY	10, 174	0				
76. 97 O7697 CARDI AC REHABILITATION 0 0 0 0 76. 97 OUTPATIENT SERVICE COST CENTERS 91. 00 O9100 EMERGENCY 26, 733 0 91. 00 92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART 3, 947 0 92. 00 200. 00 Subtotal (see instructions) 339, 277 0 200. 00 201. 00 Less PBP Clinic Lab. Services-Program 0 Only Charges		0	0				
OUTPATIENT SERVICE COST CENTERS		0	0				
91. 00	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
92. 00							
200.00 Subtotal (see instructions) 339,277 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0		26, 733	0				
201.00 Less PBP Člinic Lab. Servićes-Program 0 0 201.00	· ·		0				
Only Charges		339, 277	0				1
		0					201.00
202.00 Net Charges (line 200 - line 201) 339,277 0 202.00							
	202.00 Net Charges (line 200 - line 201)	339, 277	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	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Pre 5/26/2022 2:0	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

		Title XVIII	Hospi tal	5/26/2022 2: 0: Cost	3 pm
	Cost Center Description	THE WITT	1103pi tui		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day			2, 979	1.00
2. 00	Inpatient days (including private room days, excluding swing-	3 /		2, 903	2. 00
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		2, 592	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	74	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om dava) after December	21 of the cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	olli days) ai tei beceilbei	31 Of the Cost	١	0.00
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	2	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m daya) after December 3	01 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ili days) arter beceilber s	of the cost	١	0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 172	9. 00
10.00	newborn days) (see instructions)	nly (including private r	saam daya)	7.4	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		oolii days)	74	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, e				10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	.e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	231. 10	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line	7, 504, 510 9 0	21.00
22.00	5 x line 17)	ci oi oi the cost report	ing period (ind	١	22.00
23. 00		31 of the cost reportir	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	462	24. 00
21.00	7 x line 19)		g poou (o	.02	
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			186, 992	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 317, 518	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and observation had sh	orgos)	0	28. 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	u anu observation beu ci	iai yes)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nua lina 22) (ana inatrus	+: ono)	0.00	
34.00	Average per diem private room charge differential (line 32 mi		ti ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	116 31)		0. 00 0	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
200	27 minus line 36)			., 3, 510	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	HETMENTE			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			2 520 77	20 00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 520. 67 2, 954, 225	38.00
	Medically necessary private room cost applicable to the Progr	•		2, 934, 223	40.00
	Total Program general inpatient routine service cost (line 39	,		2, 954, 225	

	Financial Systems TATION OF INPATIENT OPERATING COST	IU HEALTH TIPT	ON HOSPITAL Provider C	CN: 15-1311	In Lie Period:	u of Form CMS-2 Worksheet D-1		
JOINI UT			ovidei C		From 01/01/2021 Fo 12/31/2021	Date/Time Pre		
			Ti +Lc	XVIII	Hospi tal	5/26/2022 2:0 Cost		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42 00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00	
	Intensive Care Type Inpatient Hospital Units							
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00	
	Cost Center Description	-		ı		1 00		
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. (3, line 200)			1. 00 1, 771, 043	48. 00	
	Total Program inpatient costs (sum of lines			ons)		4, 725, 268		
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sun	n of Parts I and	0	50.00	
F1 00							F1 00	
51. 00	Pass through costs applicable to Program inpa and IV)	atrent ancilia	ry services (r	rom wkst. D, s	sum of Parts II	0	51.00	
52. 00 53. 00	Total Program excludable cost (sum of lines		alatad nan ah	uni ni nn annath	atiot and	0		
55.00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		erateu, non-pn	ysiciali allesti	letist, and	O	33.00	
54 OO	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00	
55. 00						0.00		
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and to	arget amount (line 56 minus	line 53)	0		
58. 00		ing cost and to	arget amount (Title 50 illitius	11116 33)	0		
59. 00								
60.00		cost report, up	odated by the	market basket		0. 00	60.00	
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00	
	amount (line 56), otherwise enter zero (see		ts (Thes 54 X	00), 01 1% 01	the target			
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymonth.	ent (see instru	uctions)			0		
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	·					
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	186, 530	64.00	
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the	cost reportino	period (See	0	65. 00	
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus line	65)(title XVII	I only). For	186, 530	66.00	
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	o costs through	n Docombor 21	of the cost re	porting poriod	0	67.00	
	(line 12 x line 19)	o o						
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after [December 31 of	the cost repo	orting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00	
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.00	
71. 00	Adjusted general inpatient routine service co	ost per diem (I					71.00	
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	m (line 14 x l	ine 35)			72. 00 73. 00	
74.00	Total Program general inpatient routine servi	ice costs (line	e 72 + line 73)			74.00	
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	e costs (from	Worksheet B, F	art II, column		75. 00	
76.00	Per diem capital related costs (line 75 ÷ lin						76.00	
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00	
79.00	Aggregate charges to beneficiaries for excess	, ,		,	nus Lino 70)		79.00	
80. 00 81. 00	Total Program routine service costs for comparing the routine service cost per diem limit		Jose Trilli tatl O	1 (11116 10 IIII)	ius IIIIC /9)		80.00	
02 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (* .				82. 00 83. 00	
82.00			13)				84.00	
82. 00 83. 00 84. 00	Program inpatient ancillary services (see ins							
83. 00 84. 00 85. 00	Utilization review - physician compensation	•					85.00	
83. 00 84. 00	Utilization review - physician compensation	of lines 83 th					85.00	
83. 00 84. 00 85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	of lines 83 th S THROUGH COST)	nrough 85)			311 2, 520. 67	86. 00 87. 00	

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
		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	722, 549	7, 504, 510	0. 09628	783, 928	75, 478	90.00
91.00 Nursing Program cost	0	7, 504, 510	0.00000	783, 928	0	91.00
92.00 Allied health cost	0	7, 504, 510	0.00000	783, 928	0	92.00
93.00 All other Medical Education	0	7, 504, 510	0.00000	783, 928	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	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Pre 5/26/2022 2:0	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

		Title XIX	Hospi tal	5/26/2022 2: 0 Cost	3 piii
	Cost Center Description	THE XIX	Поэрт саг	0031	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	s. excluding newborn)		2, 979	1.00
2. 00	Inpatient days (including private room days, excluding swing-	,		2, 903	2.00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	3	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	2, 589 74	4. 00 5. 00
3.00	reporting period	om days) trii odgir becembe	si 31 oi the cost	, , ,	3.00
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 (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	2	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	dayo, arto. boodbor	0. 1 0001		0.00
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	3	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	soom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oolii days)	U	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom 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 through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13. 00	1 91	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y			_	
14. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15. 00 16. 00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to servic	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 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instruction	5)		7, 504, 510	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22.00
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23. 00
24. 00		r 31 of the cost reporti	na period (line	0	24.00
	7 x line 19)		3		
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			186, 541	26.00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 317, 969	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	narges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lina 22)(saa instrus	stions)	0.00	1
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		, LI UIIS)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	7, 317, 969	37. 00
	27 minus line 36) 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, 520. 83	38.00
39. 00	Program general inpatient routine service cost (line 9 x line	•		7, 562	
40.00	Medically necessary private room cost applicable to the Progr			7 562	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ 11116 40 <i>)</i>		1, 302	41.00

Provider COS 15-031 Principle (1972) Principl		Financial Systems	IU HEALTH TIPT				u of Form CMS-	
Title NIX Nocquiril Nocq	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der (Worksheet D-1	
Total Inpatient Inpatien							Date/Time Pre 5/26/2022 2:0	pared: 03 pm
		Cost Center Description	Total	_				
1.00 2.00 3.00 4.00 5.00 1.00 2.00 3.00 4.00 5.00 1.00		Sost Gonter Beschiptron	I npati ent	Inpatient	Diem (col. 1		(col. 3 x	
						4 00		
	42. 00			2.00	3.00	4.00	3.00	42.00
44.00 CORONARY CARE UNIT	42 00				1			12 00
46.00 SIRGICAL INTERSIVE CARE UNIT								1
17.00 OTHER SPECIAL CARE (SPECIFY)								
Cost Center Description								1
Program Inpatient and Illary service cost (Wkst. P.3. col. 3. Illne 200)			· · · · · · · · · · · · · · · · · · ·		'	-		
10.00 Program inpatient costs (sum of Fines 41 through 48) (see instructions) 10.00 Pass through costs applicable to Program inpatient routine services (from Wkst. 0, sum of Parts I and 11) Program inpatient ancillary services (from Wkst. 0, sum of Parts I and 11) Program excludable cost (sum of Fines 50 and 51) 10.00 Total Program excludable cost (sum of Fines 50 and 51) 10.01 Total Program excludable cost (sum of Fines 50 and 51) 10.00 Program inpatient operating cost excluding capital related, non-physician anesthetist, and 10.00 program inpatient operating cost excluding capital related, non-physician anesthetist, and 10.00 program discharges 10.00 Pr	48 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)				48 00
50.00 Passs through costs applicable to Program inpatient routine services (from West. D, sum of Parts Land 10) 50.00 and (IV) 51.00 and (IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 51.00 and (IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 51.00 fortal Program excludable cost (sum of lines 50 and 51) 51.00 fortal Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0.52.00 52.00 52.00 fortal Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0.53.00 fortal Program inpatient operating cost excluding capital related, non-physician anesthetist, and 0.54.00 Fortal anount per discharge 0.00 55.00 Fortal Program discharges 0.00 55.00 Fortal Program discharges 0.00 55.00 Fortal Program of Scharges 0.00 Fortal Program of Fortal Program of Fortal Program of Fo		Total Program inpatient costs (sum of lines			ons)		· ·	1
111	50.00		ationt routino	sorvi cos (fro	om Wket D su	m of Darts L and	0	50.00
and IV) 0	30.00	, , , , , , , , , , , , , , , , , , , ,	attent routine	services (iii	Jili WKST. D, Sui	ii Oi Faits i aiic	0	30.00
1	51. 00	1 9 11	atient ancillar	ry services (f	from Wkst. D,	sum of Parts II	0	51.00
53.00 Total Program Inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) FRACET ANDUMY AND CHMIT COMPUTATION TARGET ANDUMY AND CHMIT COMPUTATION 55.00 Program discharge 56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 59.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket 61.00 Lister of lines 53/54 or 55 from prior year cost report, updated by the market basket 62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) 64.00 Relief payment (see instructions) 65.00 Relief payment (see instructions) 66.00 Total Relief (and the cost of see instructions) 67.00 Title Vill only) 68.00 Title Vill only) 69.00 Total Middicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 69.00 Total Middicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) 69.00 Total routine SWI Line 190 69.00 Total flow or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 69.00 Total flow or XIX swing-bed NF inpatient routine costs (line 67 - line 68) 69.00 Total routine service costs (line 75 + line 2) 70.00 SKI Line 190 70.00 SKI Line 190 70.00 Program capital related costs (line 75 + line 2) 70.00 Program capital related costs (line 75 + line 2) 70.00 Program capital related costs (line 75 + line 2) 70.00 Program capital related costs (line 75 + line 2) 70.00 Program i	52. 00	1 ,	50 and 51)				0	52.00
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Program of Ischarges 0.0 54.00 55.00 Target amount per discharges 0.00 55.00 55.00 Target amount per discharges 0.00 55.00 55.00 Target amount (line 54 x line 55) 0.56.00 55.00 57.00 0.57.00			52)					-
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62.00 Relief payment (see instructions) 0 62.00	61.00						0	61.00
Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST		amount (line 56), otherwise enter zero (see		•	•	3		(0.00
PROGRAM INPATIENT ROUTINE SWING BED COST			ent (see instru	ıcti ons)				1
instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions) Total Medicare swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) 8.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 20) 9.01 Total ittle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 9.02 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICE/IID DNIY 9.00 Adjusted general inpatient routine service cost (line 67 + line 68) 9.01 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 9.02 Program routine service cost (line 9 x line 71) 9.03 Adjusted general inpatient routine service costs (line 72 + line 73) 9.04 Total Program general inpatient routine service costs (line 72 + line 73) 9.05 Cost Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 9.00 Program capital -related costs (line 9 x line 76) 9.00 Program capital -related costs (line 75 + line 2) 9.00 Program capital -related costs (line 74 minus line 77) 9.00 Ogram capital related costs (line 74 minus line 77) 9.00 Ogram capital related costs (line 74 minus line 77) 9.00 Ogram capital related costs (line 74 minus line 77) 9.00 Ogram capital related costs (line 74 minus line 77) 9.00 Ogram capital related costs (line 75 + line 2) 9.00 Ogram capital related costs (line 75 + line 2) 9.00 Ogram capital related costs (line 75 + line 2) 9.00 Ogram capital related costs (line 75 + line 2) 9.00 Ogram capital related costs (line 75 + line 2) 9.00 Ogram capital related costs (line 75 + line 2) 9.00		PROGRAM INPATIENT ROUTINE SWING BED COST				1 1 (0		
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(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND LOF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 74 minus line 76) 77.00 Program capital related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Reasonable inpatient exervice costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Expression bed days (see instructions) 81.10 Adjusted general inpatient routine cost per diem (line 27 + line 2) 89.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	67.00		le costs till ougi	i becember 31	of the cost in	eporting perrou	U	67.00
69. 00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70. 00 Skilled nursing facility/other nursing facility/lCF/IID routine service cost (line 37) 70. 00 71. 00 72. 00 73. 00 74. 00 Program routine service cost (line 9 x line 71) 75. 00 75. 00 76. 00 77. 00 77. 00 77. 00 78. 00 79. 00 70. 00 7	68. 00		e costs after D	ecember 31 of	f the cost rep	orting period	0	68. 00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 75 * line 2) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient routine service cost (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine service cost per diem (line 27 + line 2) 89.00 Computation of the cost per diem (line 27 + line 2) 89.00 Computation of the cost per diem (line 27 + line 2) 89.00 Cost (line 74 minus 2) 89.00 Cost (line 75 + line 2) 89.00 Cost (li	69. 00	1 7	routine costs (line 67 + lir	ne 68)		0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 87.00 Total observation bed days (see instructions)	70.00					\		70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2))		1
Total Program general inpatient routine service costs (line 72 + line 73) 74.00 75.00 76.00 76.00 76.00 77.00 78.00 78.00 78.00 79.00 70.0		, ,	,	. (1: 14 1	! 2F)			1
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 76.00 Program capital-related costs (line 9 x line 76) 77.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Majusted general inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 75.00 Value (special costs) 76.00 Value (special costs) 76.00 Value (special costs) 76.00 Value (special costs) 77.00 Value (special costs) 78.00 Value (special costs) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 75.00 Value (special costs) 76.00 Value (special costs) 77.00 Value (special costs) 78.00 Value		, , , , , , , , , , , , , , , , , , , ,		•				1
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 76.00 77.00 77.00 77.00 78.00 77.00 78.00 77.00 79.	75.00	Capital-related cost allocated to inpatient				Part II, column		75. 00
77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) 79. 00 Aggregate charges to beneficiaries for excess costs (from provider records) 80. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation 82. 00 Inpatient routine service cost limitation (line 9 x line 81) 83. 00 Reasonable inpatient routine service costs (see instructions) 84. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,520. 83 88. 00	76. 00		ne 2)					76. 00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Reasonable inpatient routine service cost (see instructions) 79.00 Reasonable inpatient ancillary services (see instructions) 79.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Reasonable inpatient ancillary services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 79.00 Reasonable inpatient routine service costs (limitation (line 78 minus line 79) 82.00 Reasonable inpatient routine service costs (limitation (line 79 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Reasonable inpatient operating costs (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Reasonable inpatient operating costs (sum of lines 83 through 85) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service cost per diem (line 27 ÷ line 2) 89.00 Reasonable inpatient routine service cost limitation (line 79 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 79 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 79 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 79 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 79 minus line 79) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reasonable inpatient routine service cost limitation (line 9 x line 81) 89.00 Reaso	77. 00	Program capital-related costs (line 9 x line	76)					77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 Utilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,520.83 88.00				rovi der recor	rds)			1
82.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 83.00 Reasonable inpatient routine service costs (see instructions) 83.00 Program inpatient ancillary services (see instructions) 84.00 85.00 University Total Program inpatient operating costs (sum of lines 83 through 85) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 311 87.00 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,520.83 88.00	80.00	Total Program routine service costs for comp	arison to the c		,	nus line 79)		80.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 83.00 84.00 85.00 86.00 86.00 87.00 87.00 88.00		1 .)				
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Aginated general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Aginated general inpatient routine cost per diem (line 27 ÷ line 2)	83.00	1 .		* .				83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Agiusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Agiusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Agiusted general inpatient routine cost per diem (line 27 ÷ line 2)				une)				1
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,520.83 88.00			•					1
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 2,520.83 88.00	07.00	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				041	
		1	•	· line 2)				•
		, ,	•					•

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 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
		Ti tl	e XIX	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	722, 549	7, 504, 510	0. 09628	783, 978	75, 483	90.00
91.00 Nursing Program cost	0	7, 504, 510	0.00000	783, 978	0	91.00
92.00 Allied health cost	0	7, 504, 510	0.00000	783, 978	0	92.00
93.00 All other Medical Education	0	7, 504, 510	0.00000	783, 978	0	93.00

Heal th	Financial Systems	IU HEALTH TIPTON	HOSPI TAL		In Li∈	u of Form CMS-:	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 15-1311	Peri od:	Worksheet D-3	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
						5/26/2022 2:0	
			Ti t	le XVIII	Hospi tal	Cost	
	Cost Center Description			Ratio of Cos		I npati ent	
				To Charges		Program Costs	
					Charges	(col . 1 x	
				1.00	0.00	col . 2)	
	INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3. 00	
20.00	03000 ADULTS & PEDIATRICS				2 004 104		30.00
30.00	ANCILLARY SERVICE COST CENTERS				2, 986, 184		30.00
50 00	05000 OPERATING ROOM			0. 1645	61 1, 355, 469	223, 057	50.00
53. 00	05300 ANESTHESI OLOGY			0. 1043			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C			0. 2553			1
60.00	06000 LABORATORY			0. 3699			
65. 00	06500 RESPIRATORY THERAPY			0. 6565			
66. 00	06600 PHYSI CAL THERAPY			0. 6042			1
	06700 OCCUPATI ONAL THERAPY			0. 5770			
68.00	06800 SPEECH PATHOLOGY			0. 4682			68.00
69.00	06900 ELECTROCARDI OLOGY			0. 2239	07 215, 604	48, 275	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 1117	81 331, 889	37, 099	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 1400		303, 510	
	07300 DRUGS CHARGED TO PATIENTS			0. 3206		423, 049	
	03480 ONCOLOGY			0. 2305		0	
	07301 BLOOD DI SORDER DRUGS			0. 1227		0	
76. 00	03160 CARDI OPULMONARY			0.0000		0	
76. 97	07697 CARDI AC REHABI LI TATI ON			0. 4459	68 C	0	76. 97
04 00	OUTPATIENT SERVICE COST CENTERS			0.0575	00 45 700	1 0/7	04.00
	09100 EMERGENCY			0. 2575			
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0(+ - 00)		0. 3990		_	1
200. 00 201. 00			(line 41		6, 987, 766	1, 771, 043	200.00
201.00		ogram om y charges	(TITIE 61	<i>'</i>	6, 987, 766		201.00
202.00	INEL Charges (Time 200 millias Time 201)			I	0, 707, 700	I	1202.00

Usal the Eine	and a Country To Drow I	IOCDI TAI		1 1:-	£ F CMC	2552 40
	ncial Systems IU HEALTH TIPTON H NCILLARY SERVICE COST APPORTIONMENT		CN: 15-1311	Period:	u of Form CMS-2 Worksheet D-3	
		Component	CCN: 15-Z311	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
		Title	XVIII	Swing Beds - SNI		
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
			1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS					30.00
	LARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 16456		1	50.00
4	ANESTHESI OLOGY		0. 04703		0	53.00
4	RADI OLOGY-DI AGNOSTI C		0. 25535			54.00
	LABORATORY		0. 36992			
	RESPI RATORY THERAPY		0. 65650			
	PHYSI CAL THERAPY		0. 60429			
4	OCCUPATI ONAL THERAPY		0. 57708			
4	SPEECH PATHOLOGY		0. 46829			68. 00
4	ELECTROCARDI OLOGY		0. 22390		1	69.00
1	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 11178			71.00
	IMPL. DEV. CHARGED TO PATIENTS		0. 14000		1	72.00
	DRUGS CHARGED TO PATIENTS		0. 32065		3, 021	73.00
	ONCOLOGY		0. 23052		0	73. 01
4	BLOOD DI SORDER DRUGS		0. 12274		0	73.02
	CARDI OPULMONARY		0.00000		0	76.00
	CARDI AC REHABI LI TATI ON		0. 44596	58 C	0	76. 97
	ATIENT SERVICE COST CENTERS			vol		
	EMERGENCY		0. 25759			
	OBSERVATION BEDS (NON-DISTINCT PART		0. 39908		0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1: (3)		73, 439	·	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(iine 61)		72 400		201.00
202. 00	Net charges (line 200 minus line 201)		I	73, 439	I	202. 00

Health Financial Systems	IU HEALTH TIPTON H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	F	Provi der C	CN: 15-1311	Peri od:	Worksheet D-3	
				From 01/01/2021 To 12/31/2021	Date/Time Pre	nared:
				10 12/31/2021	5/26/2022 2: 0	
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
LABORTH FAIT DOUTLAND OFFINE OF COOT OFFITEDO			1. 00	2. 00	3. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS			1	45.444		
30. 00 03000 ADULTS & PEDIATRICS				15, 144		30.00
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM			0. 1645	11	0	
53. 00 05300 ANESTHESI OLOGY			0. 16450		0	
54. 00 05400 RADI OLOGY 54. 00 05400 RADI OLOGY DI AGNOSTI C			0. 0470.			
60. 00 06000 LABORATORY			0. 2553		539	
65. 00 06500 RESPI RATORY THERAPY			0. 65650		2, 719	
66. 00 06600 PHYSI CAL THERAPY			0. 6042		474	
67. 00 06700 OCCUPATI ONAL THERAPY			0. 5770		0	
68. 00 06800 SPEECH PATHOLOGY			0. 46829		Ö	
69. 00 06900 ELECTROCARDI OLOGY			0. 22390		53	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0. 11178		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 14000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 3206!	50 2, 162	693	73.00
73. 01 03480 ONCOLOGY			0. 2305	21 0	0	73. 01
73. 02 07301 BL00D DI SORDER DRUGS			0. 1227	18 0	0	73. 02
76. 00 03160 CARDI OPULMONARY			0.0000	00	0	76.00
76. 97 O7697 CARDIAC REHABILITATION			0. 4459	68 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY			0. 2575		692	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			0. 39908		0	1 /2:00
200.00 Total (sum of lines 50 through 94 and				11, 993		200.00
201.00 Less PBP Clinic Laboratory Services-Pr	rogram only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)				11, 993		202.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-	From 01/01/2021	Worksheet E Part B Date/Time Prepared: 5/26/2022 2:03 pm

			10 12/31/2021	5/26/2022 2: 0	
		Title XVIII	Hospi tal	Cost	<u>o piii</u>
				1. 00	
-	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			8, 691, 268	1.00
2.00	·				2.00
3. 00	OPPS payments			0	3.00
4. 00	Outlier payment (see instructions)			0	4.00
4. 01					4. 01
5.00					5.00
6.00	Line 2 times line 5			0 00	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00 0	7. 00 8. 00
9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt.	IV col 12 lino 200		0	9. 00
10. 00	Organ acquisitions	1 V, COI. 13, 111le 200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			8, 691, 268	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0, 071, 200	11.00
	Reasonable charges				
12.00	Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, II	ine 69)		0	
	Total reasonable charges (sum of lines 12 and 13)	ŕ		0	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services o	n a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)			
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	19. 00
20.00	instructions) Excess of reasonable cost over customary charges (complete on	ly if line 11 eyeede li	no 10) (coo		20.00
20. 00	instructions)	ry ii iine ii exceeds ii	ne 18) (See	0	20. 00
21. 00	Lesser of cost or charges (see instructions)			8, 778, 181	21. 00
	Interns and residents (see instructions)			0, 770, 101	22. 00
	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	. 401. 5.13)		0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	s)		28, 592	25.00
	Deductibles and Coinsurance amounts relating to amount on line	•	uctions)	6, 609, 929	26.00
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			2, 139, 660	27.00
	instructions)				
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	29. 00
	Subtotal (sum of lines 27 through 29)			2, 139, 660	
	Primary payer payments			1, 487	
32. 00	Subtotal (line 30 minus line 31)	250)		2, 138, 173	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIO	JES)	1		22.00
	Composite rate ESRD (from Wkst. I-5, line 11)			1 502 201	33. 00 34. 00
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 503, 301 977, 146	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		1, 246, 814	
	Subtotal (see instructions)	ructions)		3, 115, 319	
	MSP-LCC reconciliation amount from PS&R			0, 113, 317	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			o o	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		١	39. 50
39. 97	Demonstration payment adjustment amount before sequestration	-,		0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•	, i	0	39. 99
40.00	Subtotal (see instructions)			3, 115, 319	40.00
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs				40.03
	Interim payments			4, 993, 930	41.00
	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-1, 878, 611	
43. 01	Balance due provider/program-PARHM (see instructions)			000 707	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance 2	nce with CMS Pub. 15-2,	cnapter I,	282, 737	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)			0.00	93.00
	Total (sum of lines 91 and 93)				94.00
			'		•

Heal th Financial Systems

IU HEALTH TIPTON HOSPITAL

In Lieu of Form CMS-2552-10

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 15-1311

From 01/01/2021

To 12/31/2021

Part I
Date/Time Prepared: 5/26/2022 2:03 pm

Title XVIII

Hospital

Cost

Inpatient Part A

Part B

In Lieu of Form CMS-2552-10

Worksheet E-1
Part I
Date/Time Prepared: 5/26/2022 2:03 pm

Mm/dd/yyyy

Amount

1.00 2.00 3.00 4.00

1.00 Total interim payments paid to provider
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,

		Inpatien	t Part A	Par	rt 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	1.00	4, 771, 960	3.00	4, 993, 930	1. 00
2. 00	Interim payments payable on individual bills, either		4, 771, 700		4, 773, 730	2. 00
2.00	submitted or to be submitted to the contractor for		O			2.00
	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					
3. 01	ADJUSTMENTS TO PROVIDER	11/14/2021	771, 700		0	3. 01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		o	3.04
3.05			0		o	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3. 51			0		0	3. 51
3. 52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		771, 700		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		5, 543, 660		4, 993, 930	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	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)					
- 04	Program to Provi der					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Described to Describe		0		0	5. 03
F F0	Provi der to Program				0	F F0
5. 50 5. 51	TENTATI VE TO PROGRAM		0			5. 50 5. 51
5. 51			0		0	5. 51
5. 52 5. 99	Subtatal (sum of lines E O1 E 40 minus sum of lines		0		0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		U		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		1, 120, 263		1, 878, 611	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 423, 397		3, 115, 319	7. 00
7.00	Tracal mean early program fruitifity (each fried dott one)		1, 120, 077	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•	,			

Health Financial Systems IU HANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 IU HEALTH TIPTON HOSPITAL Peri od: Worksheet E-1
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm Provider CCN: 15-1311 Component CCN: 15-Z311 Title XVIII Swing Beds - SNF Cost Inpatient Part A Part 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	219, 566		0	1.00
2.00	Interim payments payable on individual bills, either	c	1	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				
3. 01	ADJUSTMENTS TO PROVIDER			0	3. 01
3. 02)	0	3. 02
3. 03)	0	3. 03
3.04		C C		0	3.04
3. 05		C		0	3. 05
	Provider to Program				
3. 50	ADJUSTMENTS TO PROGRAM	C		0	3. 50
3. 51)	0	3. 51
3. 52				0	3. 52
3. 53		C		0	3. 53
3.54		C		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	C		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)	219, 566	,	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as				
	appropri ate)				
	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				0	5. 02
5. 03		C		0	5.03
	Provider to Program				
5. 50	TENTATI VE TO PROGRAM			0	5. 50
5. 51				0	5. 51
5. 52		C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	C		0	5. 99
6.00	Determined net settlement amount (balance due) based on				6.00
	the cost report. (1)				
6. 01	SETTLEMENT TO PROVIDER	5, 339		0	6. 01
6. 02	SETTLEMENT TO PROGRAM	0)	0	6.02
7. 00	Total Medicare program liability (see instructions)	224, 905		0	7.00
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	In the second second	0	1.00	2. 00	
8. 00	Name of Contractor		1		8. 00

Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-25						2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provi der CCN: 15-1311	Peri od:	Worksheet E-1	
				From 01/01/2021	Part II	
				To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
			Title XVIII	Hospi tal	Cost	/о рііі
					1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDAR	RD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	ON AND CALCULATION				
1.00	Total hospital discharges as defined in AAR	A §4102 from Wkst.	S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (Wkst. S-3, Pt. I, col. 6, su		8 through 12, and plus 1	for cost		2.00
	reporting periods beginning on or after 10/					
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, co					3.00
4. 00	Total inpatient days (Wkst. S-3, Pt. I, col		1, and 8 through 12, and	d plus for cost		4. 00
	reporting periods beginning on or after 10/					
5. 00	Total hospital charges from Wkst C, Pt. I,					5.00
6. 00	Total hospital charity care charges from Wk			WI		6.00
7. 00	CAH only - The reasonable cost incurred for line 168	the purchase of c	ertified Hii technology	WKST. S-2, PT. I		7.00
8. 00	Calculation of the HIT incentive payment (s	oo instructions)				8.00
9. 00	Sequestration adjustment amount (see instru					9.00
10.00			(see instructions)			10.00
10.00	INPATIENT HOSPITAL SERVICES UNDER THE IPPS &		(See Tristructions)			10.00
30 00	Initial/interim HIT payment adjustment (see					30.00
	Other Adjustment (specify)	111311 4011 0113)				31.00
	Balance due provider (line 8 (or line 10) m	inus line 30 and L	ine 31) (see instruction	ns)		32.00
22. 30	,		, (222 111211 4011 0	-/		1

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1311		Worksheet E-2
		Component CCN: 15-Z311	From 01/01/2021	Date/Time Prepared:
		Component Con. 13-2311		E/2//2022 2 02

		Component CCN: 15-Z311	To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
		Title XVIII	Swing Beds - SNF		3 piii
		<u> </u>	Part A	Part B	
	PONULTATION OF HET COOT OF COVERED OFFINACE		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		188, 395	0	1.00
2. 00	Inpatient routine services - swing bed-size (see instructions)		100, 393	U	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A, and sum of Wkst. D,	38, 736	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi				
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)			0.00	3. 01
4. 00	Per diem cost for interns and residents not in approved teach instructions)	ing program (see		0. 00	4.00
5. 00	Program days		74	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)		227, 131	0	8. 00
9.00	Primary payer payments (see instructions)		0	0	9.00
10. 00 11. 00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts appli	cable to physician	227, 131	0	10. 00 11. 00
11.00	professional services)	cable to physician			11.00
12.00	Subtotal (line 10 minus line 11)		227, 131	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	2, 226	0	13.00
44.00	for physician professional services)				44.00
14. 00 15. 00	80% of Part B costs (line 12 x 80%) Subtotal (see instructions)		224, 905	0	14. 00 15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		224, 903	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		Ŭ	16.50
16. 55	Rural community hospital demonstration project (§410A Demonst		0		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00 17. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	17. 00 17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
19. 00	Total (see instructions)		224, 905	0	19.00
19. 01	Sequestration adjustment (see instructions)		0	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19.03
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		219, 566	0	19. 25 20. 00
20. 01	Interim payments-PARHM		217, 300		20.00
21.00	Tentative settlement (for contractor use only)		o	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	5, 339	0	22.00
22. 01 23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nco with CMS Dub 1E 2	7 174	0	22. 01 23. 00
23.00	chapter 1, §115.2	fice with two Pub. 15-2,	7, 176	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	riod under the 21st			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 Pt II line			201. 00
201.00	66 (title XVIII hospital))	wkst. b i, it. ii, iiie			201.00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line	e		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203. 00 204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demons	tration	204.00
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	•	1		207.00
200.00	and 3)	2, 301. 1, 3um 01 111le3	.		_ 55. 55
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210. 00
215 02	Comparision of PPS versus Cost Reimbursement	200 plus line 210) (215 00
∠15.UC	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	207 prus 1111e 210) (See			215. 00
	1				

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1311	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E-3 Part V Date/Time Prepared: 5/26/2022 2:03 pm
	Title XVIII	Hospi tal	Cost

				5/26/2022 2:0	3 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1. 00	Inpatient services			4, 725, 268	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00	Organ acquisition			0	3.00
4. 00	Subtotal (sum of lines 1 through 3)			4, 725, 268	4.00
5. 00	Primary payer payments			385	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 772, 136	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7. 00	Routine service charges			0	7.00
8. 00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9.00
10. 00	Total reasonable charges			0	10.00
44 00	Customary charges				14 00
11.00	Aggregate amount actually collected from patients liable for			0	11.00
12. 00	Amounts that would have been realized from patients liable fo		on a cnarge basis	0	12.00
13. 00	had such payment been made in accordance with 42 CFR 413.13(e	:)		0. 000000	13.00
14. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	14.00
15. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if line 14 eyecode li	no 4) (coo	0	15.00
13.00	instructions)	iry ir fille 14 exceeds fi	ne o) (see	U	15.00
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 eveneds lin	na 14) (saa	0	16.00
10.00	instructions)	if y it time o exceeds iti	16 14) (366	0	10.00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1 40 (1 0113)			17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4 line 49)		0	18.00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	.,		4, 772, 136	
20. 00	Deductibles (exclude professional component)			373, 816	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 398, 320	22.00
23. 00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			4, 398, 320	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		38, 580	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	, ,		25, 077	
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		14, 688	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	,		4, 423, 397	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			4, 423, 397	30.00
30. 01	Sequestration adjustment (see instructions)			0	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			5, 543, 660	31.00
31. 01	Interim payments-PARHM				31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0			-1, 120, 263	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m				33. 01
34. 00		nce with CMS Pub. 15-2,	chapter 1,	154, 099	34.00
	§115. 2				l

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 od: From 01/01/2021 To 12/31/2021 Date/Time Prepared: 5/26/2022 2:03 pm

oni y)					5/26/2022 2:0	3 pm
		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	46, 139, 504	0	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0	0	0	0	2. 00 3. 00
4. 00	Accounts receivable	6, 729, 642	_	0	0	4.00
5. 00	Other recei vabl e	344, 548	1	0	0	
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
7.00	Inventory	1, 059, 929	0	0	0	7. 00
8.00	Prepai d expenses	116, 527	0	0	0	
9. 00 10. 00	Other current assets Due from other funds	0		0	0	9.00
11. 00	Total current assets (sum of lines 1-10)	54, 390, 150	- 1	0	-	11.00
11.00	FIXED ASSETS	01,070,100	9			11.00
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14. 00	Accumulated depreciation	0	0	0	-	14.00
15.00	Buildings	0	0	0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	3, 139, 179	0	0	0	16. 00 17. 00
18. 00	Accumul ated depreciation	-1, 611, 187		0	0	18.00
19. 00	Fi xed equipment	0	Ö	0	ő	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	5, 837	0	0	0	21.00
22. 00	Accumulated depreciation	-5, 837	0	0	0	22. 00
23. 00	Major movable equipment	14, 232, 529		0	0	23.00
24. 00 25. 00	Accumulated depreciation	-10, 006, 678	1	0	0	24. 00 25. 00
26. 00	Minor equipment depreciable Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	Ö	27.00
28. 00	Accumulated depreciation	Ö	o	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	5, 753, 843	0	0	0	30.00
21 00	OTHER ASSETS			0	0	21 00
31. 00 32. 00	Investments Deposits on Leases	0	0	0	0 0	31.00
33. 00	Due from owners/officers	0		0	0	33.00
34. 00	Other assets	27, 239, 520	Ō	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	27, 239, 520	0	0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	87, 383, 513	0	0	0	36.00
07.00	CURRENT LI ABI LI TI ES	F 040 050		0		07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	5, 819, 052 920, 846		0	0 0	37. 00 38. 00
39. 00	Payroll taxes payable	920, 646		0	0	39.00
40.00	Notes and Loans payable (short term)	0	0	0	Ö	40.00
41.00	Deferred income	Ö	o	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	
44.00	Other current liabilities	7, 633, 466	-	0		
45. 00	Total current liabilities (sum of lines 37 thru 44)	14, 373, 364	0	0	0	45.00
46. 00	LONG TERM LIABILITIES Mortgage payable	11, 965, 000	0	0	0	46. 00
47. 00	Notes payable	11, 703, 000		0		
48. 00	Unsecured Loans	329, 542		0	Ö	48. 00
49.00	Other long term liabilities	0	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	12, 294, 542	1	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	26, 667, 906	0	0	0	51.00
52. 00	CAPITAL ACCOUNTS	40 71E 407				52.00
52.00	General fund balance Specific purpose fund	60, 715, 607				53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
E0 00	replacement, and expansion	60 715 407		0	_	50.00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	60, 715, 607 87, 383, 513	1	0	0 0	59. 00 60. 00
55. 55	[59]	07, 303, 313]	J		55.55
	1 7	•	'		•	•

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1311

Peri od: Worksheet G-1 From 01/01/2021 To 12/31/2021 Date/Time Prepared:

5/26/2022 2:03 pm General Fund Special Purpose Fund Endowment Fund 5.00 1. 00 2.00 3. 00 4.00 1.00 Fund balances at beginning of period 47, 765, 630 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 10, 871, 990 2.00 2.00 Total (sum of line 1 and line 2) 3.00 58, 637, 620 ol 3.00 DONATED PROP., PLANT, EQUIP. 4.00 14, 205 0 4.00 0 5.00 TEMP RESTRICTED 1, 106, 721 0 5.00 PERM RESTRICTED 957, 039 0 6.00 0 6.00 0 7.00 ROUNDI NG 22 0 7.00 0 8.00 0 0 8.00 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) 2,077,987 0 10.00 Subtotal (line 3 plus line 10) 60, 715, 607 0 11.00 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 13.00 0000 0 0 13.00 14.00 0 0 14.00 15.00 0 15.00 16.00 0 16.00 17.00 17.00 18.00 18.00 Total deductions (sum of lines 12-17) 0 Fund balance at end of period per balance 60, 715, 607 19.00 19.00 sheet (line 11 minus line 18) Endowment Plant Fund Fund 6.00 8.00 7.00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 0 0 3.00 3.00 Total (sum of line 1 and line 2) DONATED PROP., PLANT, EQUIP. 4.00 0 4.00 5.00 TEMP RESTRICTED 0 5.00 PERM RESTRICTED 6.00 0 6.00 01 ROUNDI NG 7.00 7.00 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 Subtotal (line 3 plus line 10) 0 11.00 Deductions (debit adjustments) (specify) 12.00 12.00 13.00 0 13.00 14.00 0 14.00 15.00 15.00 16.00 0 16.00 17.00 17.00 C Total deductions (sum of lines 12-17) 18.00 0 18.00 Fund balance at end of period per balance 0 0 19.00 sheet (line 11 minus line 18)

Health Financial Systems INSTATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1311

				0 12/31/2021	5/26/2022 2:0	
	Cost Center Description	Inpa	ti ent	Outpati ent	Total	O PIII
			00	2.00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	6,	774, 258		6, 774, 258	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		68, 780		68, 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)	6	843, 038		6, 843, 038	10.00
10.00	Intensive Care Type Inpatient Hospital Services	, ,	010,000		0,010,000	10.00
11. 00	INTENSIVE CARE UNIT					11. 00
12. 00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGI CAL INTENSI VE CARE UNI T					14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15.00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes	0		0	16. 00
10.00	11-15)	11103	Ü		Ŭ	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	6	843, 038		6, 843, 038	17. 00
18. 00	Ancillary services		937, 161		118, 044, 567	18. 00
19. 00	Outpatient services	10,	643, 637		17, 839, 604	19.00
20. 00	RURAL HEALTH CLINIC		043, 037		0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	- 1	0	21.00
22. 00	HOME HEALTH AGENCY		U	ď	O	22.00
23. 00	AMBULANCE SERVICES					23. 00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26. 00	HOSPI CE					26.00
27. 00	NONALLOWABLE/PHYSI CI AN REVENUE		0	1, 730, 254	1, 730, 254	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst 21	423, 836		144, 457, 463	28. 00
20.00	G-3, line 1)	0 WK31. 21,	423, 030	123, 033, 027	144, 437, 403	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			42, 657, 007		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00	(SI EGITT)		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)		U	٥		36.00
37. 00	DEDUCT (SPECIFY)		0	ď		37.00
38. 00	DEBOCT (SECTET)		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)		U	۸		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		42, 657, 007		43.00
45.00	to Wkst. G-3, line 4)	((((((((((((((((((((42,037,007		73.00
	10 mor. 0 0, 1110 T)	ı		ı	ı	

Heal th	n Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1311	Peri od:	Worksheet G-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/26/2022 2:0	
				3/20/2022 2.0	J piii
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part	t I, column 3, line 28)		144, 457, 463	1.00
2.00	Less contractual allowances and discounts or	n patients' accounts		96, 343, 294	2.00
3.00	Net patient revenues (line 1 minus line 2)			48, 114, 169	3.00
4.00	Less total operating expenses (from Wkst. G-			42, 657, 007	
5.00	Net income from service to patients (line 3	minus line 4)		5, 457, 162	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellane	eous communication services		0	
9. 00	Revenue from television and radio service			0	
10.00				0	
11.00				0	
12.00				0	
13.00	,			0	
14.00	1 9	ests		0	14.00
15. 00 16. 00	3 1	unnline to other them noticets		0	
16.00				- 1	17.00
17.00	3			-	
19.00				0	19.00
20.00				0	•
21. 00		and Carreen		0	
22. 00	S .			0	22.00
23. 00	· · ·			0	•
24. 00				1, 216, 334	
24. 50	·			4, 198, 494	
25. 00	9			5, 414, 828	
	Total (line 5 plus line 25)			10, 871, 990	l
27. 00				0, 071, 770	1
	Total other expenses (sum of line 27 and suk	oscrints)		0	28.00
	Net income (or loss) for the period (line 26			10, 871, 990	