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 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1316 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 11:32 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/29/2024 Time: 11:32 am use only ] Manually prepared cost report Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (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 FRANKFORT HOSPITAL (15-1316) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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	SI GNATURE STATEMENT	
1	Todo	d Williams	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	Todd Williams			2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	182, 239	353, 692	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	149, 092	0		0	5. 00
6.00	SWING BED - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	TOTAL	0	331, 331	353, 692	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1316 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 11:32 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1300 SOUTH JACKSON STREET 1.00 PO Box: 1.00 State: IN 2.00 City: FRANKFORT Zip Code: 46041 County: CLINTON 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 IU HEALTH FRANKFORT 151316 99915 01/21/2003 Ν 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovi der - (Other) 6.00 Swing Beds - SNF IU HEALTH FRANKFORT 157316 99915 N 01/21/2003 N 0 7 00 7.00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital - Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2023 01/01/2023 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3 00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for Ν N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no 22.01 Ν N 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N 22 03 N N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 3 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

								Date/T	ime Pre	
		In-State Medicaid paid days	In-State Medicaid eligible	Out-of State Medicaid	Out-o Stat Medica	e ai d	Medicai HMO day	d C ys Me	024 11: Other di cai d days	32 am
			unpai d days	paid days	eligib unpai					
	T	1.00	2. 00	3. 00	4. 00		5. 00		6. 00	
25. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state					0		0	0	24. 00
	Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.									
					Urb	0an/Ru 1. 0	ural S 0	Date of 2.		
26. 00	Enter your standard geographic classification (not w cost reporting period. Enter "1" for urban or "2" fo		at the beg	ginning of 1	the		2			26. 00
27. 00	Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r	ural. If ap		st		2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status ir			0	F., 41		35. 00
						egi nn 1. 0		Endi 2.		
36. 00	Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		cript line	36 for numb	oer					36. 00
37. 00	If this is a Medicare dependent hospital (MDH), ente is in effect in the cost reporting period.		r of period	ds MDH statu	ıs		0			37. 00
37. 01										37. 01
38. 00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o									38. 00
	enter subsequent dates.					Y/N	N	Y	′N	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions) Is this hospital subject to the HAC program reductio	), (ii), or the mileage ii)? Enter	(iii)? Ent requiremer in column 2	er in colum nts in 2 "Y" for ye	mn es	1. O	0	2. ^		39. 00
40.00	"N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	r "Y" for y							40.00
							1. 00	2. 00	3. 00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	nt for disp	roportionat	e share in	accorda	ance	N	T N	l N	45. 00
	with 42 CFR Section §412.320? (see instructions)									45.00
	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					ugh	N	N	N	46. 00
46. 00 47. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, Pt. I capital? E	II and Wkst inter "Y for	L-1, Pt. yes or "N'	I throu	Ü	N N N			
46. 00 47. 00 48. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS	t. L, Pt. I capital? E t? Enter "	II and Wkst inter "Y for Y" for yes  ME programs	yes or "N' or "N" for	I thround for no.	o. i ng	N	N N	N N	46. 00 47. 00
46. 00 47. 00 48. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in	t. L, Pt. I capital? E t? Enter " approved G "Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir	II and Wkst Inter "Y for Y" for yes  ME programs or "N" for under 42 ( "Y", or if prior year	yes or "N" or "N" for "N" for cost on in colucter 413.78(this hospitor penultime.	for no no.  reportiumn 1. Fo (2), stal was mate year	ing For see	N N	N N	N N	46. 00 47. 00 48. 00
46. 00 47. 00 48. 00 56. 00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen Teaching Hospitals Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable)	capital? Et? Enter " approved G"Y" for yes r 27, 2020, olumn 1 is ams in the CRs) MA dir. er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	II and Wkst Inter "Y for Y" for yes  ME programs or "N" for under 42 ( "Y", or if prior year ect GME pay in approvec If column ing period? E-4. If co. For cost ()(1)(iv) ar f the respo	ryes or "N" or "N" for "N" for cost no in colucter 413.78(this hospit or penultingment reduct 1 is "Y", corresponding to (V), regainse to line oldete Worksh	I thrown on no.  reportiumn 1. Folicy, stal was mate year aid id 'for ye'n', periods ardless e 56 is neet E-4	ing For see ar, nter es, ined es or	N N	N N	N N	46. 00 47. 00 48. 00

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH FRANKFORT HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1316 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 11: 32 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 3.00 1.00 2.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. Y/N Direct GME IMF Direct GME IME 1. 00 2. 00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA Ν 0.00 0.00 61.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61 03 Enter the base line FTE count for primary care 61 03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 2.00 1.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

	your hospital received HRSA PCRE funding (see instructions)		
62. 01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital	0.00	62. 01
	during in this cost reporting period of HRSA THC program. (see instructions)		
	Teaching Hospitals that Claim Residents in Nonprovider Settings		ı
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter	N	63.00
	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)		

0.00 62.00

62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which

<u>Heal</u> th	n Financial Systems	IU HEALTH	H FRANKFORT HOSPITAL		<u>In L</u> ie	u of Form CMS-2	<u> 2552-1</u> 0
H0SPI	TAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA Provider C		eriod: rom 01/01/2023	Worksheet S-2 Part I	
					o 12/31/2023		pared: 32 am
				Unwei ghted	Unweighted FTEs in	Ratio (col. 1/	
				FTEs Nonprovi der	Hospi tal	(col. 1 + col. 2))	
				Si te			
	Soction FEOA of the ACA Base Von	r ETE Docidonts in No	annravi dar Catti nas	1.00	2.00	3.00	
	Section 5504 of the ACA Base Yea period that begins on or after J			inis base year	is your cost i	eportring	
64. 00	Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo	ber of unweighted nor tations occurring in number of unweighted	n-primary care all nonprovider d non-primary care	0.00	0.00	0. 000000	64. 00
	of (column 1 divided by (column	1 + column 2)). (see	instructions)				
		Program Name	Program Code	Unwei ghted		Ratio (col. 3/	
				FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
				Si te	nospi tui	.,,,	
		1.00	2. 00	3. 00	4.00	5. 00	
65. 00	is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to			0.00	0. 00	0. 000000	65. 00
	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)			Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te	0.00	2.00	-
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonnrovider Settina	1.00	2.00	3.00	
	beginning on or after July 1, 20		in Nonprovider Setting	js Effective i	or cost reporti	ng perrous	
66. 00	Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider settings. ry care resident 3 the ratio of structions)	0. 00			
		Program Name	Program Code	Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
				Si te			
47.00		1. 00	2. 00	3. 00	4.00	5. 00	/ 7 00
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	. 67. UC

97.00

0.00

0 00

applicable column.

97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.

111.00 If this facility qualifies as a CAH, did it participate in the Frontier Communi Health Integration Project (FCHIP) demonstration for this cost reporting period "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter integration prong of the FCHIP demo in which this CAH is participating in colum Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/for tele-health services.	l? Enter the nn 2.	1. 00 N	2.00	111. 00
	1. 00	2. 00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N	2.00	3.00	112. 00
Miscellaneous Cost Reporting Information				
15.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0 115. 00
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116. 00
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117. 00
18.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	2			118. 00

Health Financial Systems IU HEALTH FRANKFO	ORT HOSPITAL		In Lie	eu of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		Peri od: From 01/01/2023	Worksheet S	5-2
			To 12/31/2023		
	<u> </u>	Premi ums	Losses	Insurance	
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1. 00 24, 75	2.00	3.00	0 118. 01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost of			N N	2.00	118. 02
Administrative and General? If yes, submit supporting schedu and amounts contained therein.	ıle listing co	ost centers			
119.00 DO NOT USE THIS LINE			1		119. 00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in			N	N	120. 00
"N" for no. Is this a rural hospital with < 100 beds that qua	difies for th	ne Outpatient			
Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	S? (See Instr	ructions)			
121.00 Did this facility incur and report costs for high cost implan patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y		121. 00
122.00 Does the cost report contain healthcare related taxes as defi			Υ	5.00	122. 00
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	is "Y", enter	in column 2			
123.00 Did the facility and/or its subproviders (if applicable) purc			Υ	N	123. 00
services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization					
for yes or "N" for no.					
If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from u					
located in a CBSA outside of the main hospital CBSA? In colum					
"N" for no. Certified Transplant Center Information					
125.00 Does this facility operate a Medicare-certified transplant ce and "N" for no. If yes, enter certification date(s) (mm/dd/yy		'Y" for yes	N		125. 00
126.00 If this is a Medicare-certified kidney transplant program, en	iter the certi	fication date	e		126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare-certified heart transplant program, ent		fication date			127. 00
in column 1 and termination date, if applicable, in column 2.					
128.00 If this is a Medicare-certified liver transplant program, ent in column 1 and termination date, if applicable, in column 2.		fication date			128. 00
129.00 If this is a Medicare-certified lung transplant program, ente	er the certifi	cation date			129. 00
in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare-certified pancreas transplant program,		ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in colu 131.00 If this is a Medicare-certified intestinal transplant program		corti fi cati on			131. 00
date in column 1 and termination date, if applicable, in colu	ımn 2.				
132.00 If this is a Medicare-certified islet transplant program, ent in column 1 and termination date, if applicable, in column 2.		fication date			132. 00
133.00 Removed and reserved					133. 00
134.00 If this is a hospital-based organ procurement organization (0 in column 1 and termination date, if applicable, in column 2.		ne OPO number			134. 00
All Providers	C: I : OHC	D 1 45 4		4511050	
140.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y			Y	15H059	140. 00
are claimed, enter in column 2 the home office chain number.  1.00 2.00	(see instruct	tions)	3.00		
If this facility is part of a chain organization, enter on li	nes 141 throu	ugh 143 the n		of the	
home office and enter the home office contractor name and cor 141.00 Name: INDIANA UNIVERSITY HEALTH Contractor's Name: WPS	ntractor number		or's Number: 0810	)1	141. 00
142.00 Street: 340 WEST 10TH STREET PO Box:					142. 00
143. 00 Ci ty: I NDI ANAPOLI S State: IN		Zi p Code:	4620	)2	143. 00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet A?				Y	144. 00
			1. 00	2.00	
145.00 of costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in c					145. 00
no, does the dialysis facility include Medicare utilization f					
period? Enter "Y" for yes or "N" for no in column 2. 146.00Has the cost allocation methodology changed from the previous	sly filed cost	t report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15					
yes, enter the approval date (mm/dd/yyyy) in column 2.			I	I	I

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi de	er CCN	N: 15-131 <i>6</i>		iod: m 01/01/2023	Worksheet S- Part I	-2
					To	12/31/2023	Date/Time Pr	
							5/29/2024 11	:32 am
							1.00	
47.00 Was there a change in the statisti							N	147. 0
48.00 Was there a change in the order of					_		N	148. 0
49.00 Was there a change to the simplifi	ed cost finding metho						N	149. C
		Part A		Part		Title V	Title XIX	_
Dass this facility contain a provi	don that qualifies for	1.00		2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
55. 00 Hospi tal		N		N	<u> </u>	N	N	155. 0
56.00 Subprovi der - IPF		N	1	N		N	N	156. 0
57.00 Subprovider - IRF		N	1	N		N	N	157. (
58. 00 SUBPROVI DER								158. (
59. 00 SNF		N		N		N	N	159. (
60.00 HOME HEALTH AGENCY		N		N		N	N	160. 0
61. 00 CMHC				N		N	N	161. (
							1 00	_
Multicampus							1.00	
65.00 s this hospital part of a Multica	umpus hospital that ha	s one or more	campus	ses in di	fferen	t CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	impas nospi tai that na	is one or more	campas	oco in un	1101011	C OBONS.		100. 0
•	Name	County		State	Zip Co	ode CBSA	FTE/Campus	
	0	1. 00		2. 00	3.00	0 4.00	5. 00	
66.00 If line 165 is yes, for each							0.0	00 166. C
campus enter the name in column								
O, county in column 1, state in column 2, zip code in column 3,								
CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
cordina 3 (See Tristraetrons)								
							1.00	
Health Information Technology (HI	) incentive in the Am	neri can Recover	y and	Rei nvest	ment A	ct		
67.00 Is this provider a meaningful user							Υ	167. 0
68.00 If this provider is a CAH (line 10			(line	167 is "	Y"), ei	nter the		168. 0
reasonable cost incurred for the H								1,00
68.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)						nardsni p		168. 0
69.00 If this provider is a meaningful u						) antar the	0.0	00169. 0
transition factor. (see instruction		and 13 not a	CAII (I	1110 100	13 11	), circi tic	0. 0	39107. 0
transition ractor. (see instructive	, , , , , , , , , , , , , , , , , , ,					Begi nni ng	Endi ng	
						1. 00	2.00	
70.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	eginning date and end	ling date for t	he rep	porting				170. (
period respectivery (min/dd/yyyy)						1.00	2.00	
71 00 lf line 147 is "V" does this	il dan hava any dave f-	na i ndi vi dual -	oproli	ad in		1. 00 Y	2.00	19 171. (
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans i "Y" for yes and "N" for no in colu	reported on Wkst. S-3,	Pt. I, line 2	, col.	6? Ente		Y		19 1/1.(

Heal th	Financial Systems IU HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-	2552-10
	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2023	Worksheet S-2	
				To 12/31/2023	Date/Time Pre	
				Y/N	5/29/2024 11: Date	32 am
	DART LL. HOCKLIAL AND HOCKLIAL HEATHCARE COMPLEY RELABILISES	MENT OUECTLONG	IALDE	1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.  COMPLETED BY ALL HOSPITALS			er all dates in t	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the			N		1.00
	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions) Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for	N Y			2.00
3.00	the provider involved in business transactions, including management ntracts, with individuals or entities (e.g., chain home offices, drug medical supply companies) that are related to the provider or its ficers, medical staff, management personnel, or members of the board directors through ownership, control, or family and other similar lationships? (see instructions)					3.00
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avacolumn 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4. 00
5.00	Are the cost report total expenses and total revenues differences on the filed financial statements? If you submit records		N			5. 00
	those on the filed financial statements? If yes, submit reconciliation.  Y/N					
	Approved Educational Activities			1. 00	2.00	
6. 00	Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	the provider	- N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		ved during the	N N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	•	al education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		he current	N		10. 00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	V/N	11. 00
					Y/N 1. 00	
40.00	Bad Debts					10.00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	Y N	12. 00 13. 00
14. 00		ance amounts wa	nived? If yes,	see	N	14. 00
15. 00	Did total beds available change from the prior cost reporti				N N	15. 00
		Y/N	t A Date	Y/N	t B Date	
	PS&R Data	1. 00	2. 00	3. 00	4.00	
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/01/2024	Υ	04/01/2024	17. 00
18. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

	Financial Systems IU HEALTH FRANK				u of Form CM	
HOSPI 1	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/29/2024 1	repared:
			i pti on	Y/N	Y/N	
20.00	If the 1/ on 17 is one of the DCOD		0	1.00	3.00	20.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4.00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)		1.00	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprais	sals made dur	ing the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases entered	ed into during	this cost re	porting period?	N	24. 00
25 00	If yes, see instructions	the cost ress	rting paried?	If you soo	N.I	25 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	ing period?	ri yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the	ne cost renorti	ina period? L	f ves. see	N	26. 00
20.00	instructions.	.5 5551 Topol ti	g porrou: 1	. ,00, 000		20.00
27. 00	Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit	N	27. 00
	copy.	·				
	Interest Expense					
28. 00	Were new loans, mortgage agreements or letters of credit er	ntered into du	ring the cost	reporti ng	N	28. 00
20.00	period? If yes, see instructions.	, ,	20.00			
29. 00	Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30.00			
30.00	instructions.	arrity with new	debt: 11 yes	, 366	IN IN	30.00
31. 00	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see	N	31. 00
	instructions.		,			
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual	N	32. 00
22.00	arrangements with suppliers of services? If yes, see instru		.a +o oomno+i	+ivo biddingO lf		22.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	orred pertainii	ng to competi	tive brading? II		33. 00
	Provi der-Based Physi ci ans					
34.00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	Υ	34.00
0 11 00	If yes, see instructions.	angomorre m	p. ov. do. 2	assa pinjer er ane.		0 00
35.00	If line 34 is yes, were there new agreements or amended exi	sting agreemen	nts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.				
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36.00
37. 00	If line 36 is yes, has a home office cost statement been pr	renared by the	home office?			37.00
37.00	If yes, see instructions.	cparca by the	nome office:	'		37.00
38. 00	If line 36 is yes, was the fiscal year end of the home off	ice different	from that of	N		38. 00
	the provider? If yes, enter in column 2 the fiscal year end					
39. 00	If line 36 is yes, did the provider render services to other	er chain compo	nents? If yes	, N		39. 00
:	see instructions.					
40. 00	If line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40. 00
	i nstructi ons.					
		1	. 00	2	00	
	Cost Report Preparer Contact Information		. 55	2.		
41. 00			41.00			
	held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		
	respecti vel y.					
42. 00	Enter the employer/company name of the cost report	INDIANA UNIVER	RSITY HEALTH			42. 00
40 ==	preparer.	047 554 5545		DUTTES	000	
43. 00		317. 556. 3910		RUTTER@I UHEALTI	H. ORG	43. 00
	report preparer in columns 1 and 2, respectively.	I		1		II

Heal th	Financial Systems IU HEALTH FRAN	NKFORT HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-1316	Peri od: From 01/01/2023	Worksheet S-2 Part II			
				Date/Time Prep 5/29/2024 11:3	oared: 32 am_		
		2.00					
		3. 00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	GOVERNMENT PROGRAMS DIRECT	OR		41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1316

						o 12/31/2023		
							5/29/2024 11:3 I/P Days / O/P	32 am
							Visits / Trips	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.		. 0. 5040	Avai I abl e	o, iii, itzii iiodi o		
		1.00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA							
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		12	4, 380	16, 536. 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 IRF Subprovider						o	4. 00 5. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			12	4, 380	16, 536. 00		7. 00
7.00	beds) (see instructions)			12	4, 300	10, 550. 00	U	7.00
8. 00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY							13.00
14.00	Total (see instructions)			12	4, 380	16, 536. 00	0	14.00
15.00	CAH visits						0	15.00
15. 10	REH hours and visits					0.00	0	15. 10
16. 00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE	404 00						21. 00
22. 00	HOME HEALTH AGENCY	101. 00					0	22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE							23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		12				27. 00
28. 00	Observation Bed Days						0	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)			0	C			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges	20		=	_		_	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	(	y	0	34. 00

Health Financial Systems IU HEALTH HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1316

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5//9/2024	11: 32 am

						5/29/2024 11:	32 am
		I/P Days	o / O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8.00	9. 00	10.00	
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	248	67	689			1. 00
2.00	HMO and other (see instructions)	256	82				2.00
3. 00	HMO IPF Subprovider	0	0				3.00
4. 00	HMO IRF Subprovider	ol	0				4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF	163	0	163	3		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	100	54	235			6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	411	121	1, 087			7. 00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	411	121	1, 087	0.00	99. 12	14.00
15.00	CAH visits	0	0	C			15. 00
15. 10	REH hours and visits	0	0	C			15. 10
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			29	9		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC			_			26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C		0.00	
27. 00	Total (sum of lines 14-26)		4.0		0.00	99. 12	
28. 00	Observation Bed Days		13	416			28. 00
29. 00	Ambul ance Trips	0					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF		0	(			31.00
32. 00	Labor & delivery days (see instructions)	0	0	(			32.00
32. 01	Total ancillary labor & delivery room			C	ή		32. 01
33. 00	outpatient days (see instructions)	o					33.00
33. 00	LTCH non-covered days LTCH site neutral days and discharges	0					33.00
	Temporary Expansi on COVID-19 PHE Acute Care	0	0	C			34. 00
34.00	Tremporary Expansion Covid-13 File Acute Care	ı Y	Ч	1	ή	1	1 34.00

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1316

				''	0 12/31/2023	5/29/2024 11:	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13.00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		C	96	2	240	1.00
2.00	HMO and other (see instructions)			80	26		2.00
3.00	HMO IPF Subprovider				0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ĭ		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00	C	96	2	240	1
15. 00	CAH visits				_		15. 00
15. 10	REH hours and visits	ŀ					15. 10
16. 00	SUBPROVIDER - IPF	ŀ					16. 00
17. 00	SUBPROVIDER - IRF	ŀ					17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	ŀ					19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0.00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
00.5-	outpatient days (see instructions)			_			
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	l l		I	l l		34.00

	<i></i>	H FRANKFORT HOSPITAL			u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co		Period: From 01/01/2023 To 12/31/2023		pared:
	DADT I HOODITAL AND HOODITAL CONDUCY DATA				1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA					1
1. 00	Uncompensated and Indigent Care Cost-to-Charge Ratio Cost to charge ratio (see instructions)				0. 369003	1.00
1.00					0.369003	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid				4 202 500	2.00
2.00		di ani dO			4, 203, 588	3.00
3.00	Did you receive DSH or supplemental payments from Me		- 6 N1:	: 40	N	
4.00	If line 3 is yes, does line 2 include all DSH and/or	11 1 3		10?	N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental Medicaid charges	payments from Medical	u		10 212 000	
6. 00 7. 00	Medicaid cost (line 1 times line 6)				18, 312, 080 6, 757, 212	
8. 00	Difference between net revenue and costs for Medicai	d program (see instru	ctions)		2, 553, 624	
0.00	Children's Health Insurance Program (CHIP) (see inst				2, 333, 024	0.00
9. 00	Net revenue from stand-alone CHIP	ructions for each fin	e)		0	9.00
10.00	Stand-alone CHIP charges					
11. 00	Stand-alone CHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-a	lone CHIP (see instru	ctions)		Ö	
12.00	Other state or local government indigent care progra					12.00
13. 00	Net revenue from state or local indigent care progra			)	278	13.00
14. 00	Charges for patients covered under state or local in				783	1
	10)	д рд (				
15. 00	State or local indigent care program cost (line 1 ti	mes line 14)			289	15.00
16.00	Difference between net revenue and costs for state o	or Local indigent care	program (see	instructions)	11	16.00
	Grants, donations and total unreimbursed cost for Me	dicaid, CHIP and stat	e/local indig	ent care program	ns (see	
	instructions for each line)					
17. 00	Private grants, donations, or endowment income restr				0	
18. 00	Government grants, appropriations or transfers for s				0	
19. 00	Total unreimbursed cost for Medicaid , CHIP and stat	e and local indigent	care programs	(sum of lines	2, 553, 635	19.00
	8, 12 and 16)				T     (   4	
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	pati ents 2.00	+ col . 2) 3.00	
	Uncompensated care cost (see instructions for each I	i no)	1.00	2.00	3.00	
20. 00	Charity care charges and uninsured discounts (see in		1, 900, 43	3 92, 186	1, 992, 619	20.00
21. 00	Cost of patients approved for charity care and unins		701, 26		786, 526	
21.00	instructions)	idi ca di scodifts (scc	701, 20	05, 201	700, 320	21.00
22. 00	Payments received from patients for amounts previous	ly written off as	1, 12	1 0	1, 121	22.00
	charity care	J	.,			
23. 00	Cost of charity care (see instructions)		700, 14	4 85, 261	785, 405	23.00
			·	•		
					1.00	
	Does the amount on line 20 col. 2, include charges f				N N	24. 00

		1.00	
24. 00		N	24. 00
	imposed on patients covered by Medicaid or other indigent care program?		l
25. 00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of	0	25. 00
	stay limit		l
25. 01	Charges for insured patients' liability (see instructions)	10, 974	25. 01
26.00	Bad debt amount (see instructions)	2, 263, 633	26. 00
27.00	Medicare reimbursable bad debts (see instructions)	292, 858	27. 00
27. 01	Medicare allowable bad debts (see instructions)	450, 550	27. 01
28.00	Non-Medicare bad debt amount (see instructions)	1, 813, 083	28. 00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)	826, 725	29. 00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)	1, 612, 130	30. 00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	4, 165, 765	31. 00

	Financial Systems IU HEALTH FRANKFORT F				eu of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN:	15-1316	Peri od: From 01/01/2023 To 12/31/2023		pared:
					1. 00	
	PART II - HOSPITAL DATA				1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					]
1.00	Cost to charge ratio (see instructions)					1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid					2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental		from Medica	ni d?		4.00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from	m Medicaid				5.00
6. 00	Medi cai d charges					6.00
7. 00	Medicaid cost (line 1 times line 6)					7. 00
8. 00	Difference between net revenue and costs for Medicaid program (se		ions)			8.00
0.00	Children's Health Insurance Program (CHIP) (see instructions for	each line)				4
9.00	Net revenue from stand-alone CHIP					9.00
	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					10.00
	Difference between net revenue and costs for stand-alone CHIP (se	oo instructi	i onc)			12.00
12.00	Other state or local government indigent care program (see instru					12.00
13. 00	Net revenue from state or local indigent care program (Not included in the inc					13.00
	Charges for patients covered under state or local indigent care p					14. 00
11.00	10)	program (No	t Theradea	111 111103 0 01		1 1.00
15. 00	State or local indigent care program cost (line 1 times line 14)					15.00
	Difference between net revenue and costs for state or local indic		rogram (see	e instructions)		16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP				ns (see	1
	instructions for each line)				·	
	Private grants, donations, or endowment income restricted to fund					17. 00
	Government grants, appropriations or transfers for support of hos					18.00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local i	indigent car	re programs	s (sum of lines		19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
		_	pati ents	pati ents	+ col . 2)	
	Uncompensated care cost (see instructions for each line)		1. 00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts (see instructions)					20.00
20.00	Cost of patients approved for charity care and uninsured discoun-	its (see				21. 00
21.00	instructions)	1.5 (366				21.00
22. 00	Payments received from patients for amounts previously written of	ff as				22. 00
	charity care					
23. 00	Cost of charity care (see instructions)					23. 00
				<u> </u>		
					1. 00	

24.00

25.00

25. 01

26.00

27. 00 27. 01

28.00

29.00

30.00

31.00

24.00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

imposed on patients covered by Medicaid or other indigent care program?

29.00 | Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00  $\mid$  Total unreimbursed and uncompensated care cost (line 19 plus line 30)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

25.00

25. 01

stay limit

Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

Heal th	Financial Systems I	U HEALTH FRANKFO	ORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					rom 01/01/2023		
				-	Γo 12/31/2023	Date/Time Pre	
					I	5/29/2024 11:	32 am
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		2, 510, 828	2, 510, 828	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	37, 694	37, 69	1, 278, 016	1, 315, 710	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	70, 977	8, 782, 737	8, 853, 71	4 -1, 150, 914	7, 702, 800	5.00
7. 00	00700 OPERATION OF PLANT	531, 982	2, 104, 626			1, 730, 602	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	00.1, 702	2, 101, 020		48, 889	48, 889	8. 00
9. 00	00900 HOUSEKEEPING	279, 356	355, 968			531, 576	9. 00
10.00	01000 DI ETARY		239, 805			203, 681	10.00
	1 1	217, 207	239, 805				
11.00	01100 CAFETERI A	0(4.470	005.000		100, 011	185, 611	11.00
13. 00	01300 NURSING ADMINISTRATION	861, 178	325, 322			1, 061, 966	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	143, 707	1		299, 253	14.00
15. 00	01500 PHARMACY	295, 927	1, 451, 048	1, 746, 97	-1, 023, 352	723, 623	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 001, 025	1, 123, 411	2, 124, 43	-303, 547	1, 820, 889	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	314, 987	696, 154	1, 011, 14	1 -356, 588	654, 553	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	856, 326	533, 236			1, 019, 367	54.00
60.00	06000 LABORATORY	0	2, 221, 996			2, 217, 045	60.00
66. 00	06600 PHYSI CAL THERAPY	l ö	687, 947			674, 349	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		196, 965			196, 965	67. 00
68. 00	06800 SPEECH PATHOLOGY	103, 215	20, 890			111, 111	68. 00
69. 00	06900 ELECTROCARDI OLOGY	68, 924	58, 330			86, 867	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		58, 691	58, 691	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		3, 110	3, 110	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		252, 896	252, 896	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0		862, 231	862, 231	73. 01
76.00	03160 CARDI OPULMONARY	675, 524	419, 436	1, 094, 96	-206, 895	888, 065	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90.00
91.00	09100 EMERGENCY	1, 255, 500	2, 654, 343	3, 909, 84	3 -484, 778	3, 425, 065	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 200, 000	_, -, -, -, -		1	-,,	92.00
, 2, 00	OTHER REIMBURSABLE COST CENTERS			l .			72.00
101 00	10100 HOME HEALTH AGENCY	0	0		ol ol	0	101. 00
	10200 OPI OI D TREATMENT PROGRAM	o	0				101.00
102.00	SPECIAL PURPOSE COST CENTERS	U U	0	'	J 0	U	102.00
110 00		( 522 120	22 052 (15	20 505 74		20 505 742	110 00
118.00		6, 532, 128	22, 053, 615	28, 585, 74	3 0	28, 585, 743	118.00
	NONREI MBURSABLE COST CENTERS			T	_1 _1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	0		190. 00
	19100 RESEARCH	0	0	1	이		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	0		192. 00
	2 19202 MOB	0	0	1	0	0	192. 02
193.00	19300 NONPALD WORKERS	O	0		o ol	0	193. 00
194.00	07950 LEASED SPACE	l ol	0		o  o	0	194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	6, 532, 128	22, 053, 615	28, 585, 74	3 0	28, 585, 743	200. 00
				•	1		•

Provi der CCN: 15-1316

				5/29/2024 1	
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	326, 364	2, 837, 192		1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-137, 895	1, 177, 815		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 415, 305	6, 287, 495		5. 00
7.00	00700 OPERATION OF PLANT	44, 862	1, 775, 464		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	48, 889		8. 00
9.00	00900 HOUSEKEEPI NG	0	531, 576		9. 00
10.00	01000 DI ETARY	0	203, 681		10. 00
11. 00	01100  CAFETERI A	0	185, 611		11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	189, 470	1, 251, 436		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	194, 277	493, 530		14. 00
15.00	01500 PHARMACY	170, 301	893, 924		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-276, 084	1, 544, 805		30. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000  OPERATI NG ROOM	105, 217	759, 770		50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	126, 914	1, 146, 281		54.00
60.00	06000 LABORATORY	0	2, 217, 045		60.00
66.00	06600 PHYSI CAL THERAPY	0	674, 349		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	196, 965		67. 00
68.00	06800 SPEECH PATHOLOGY	0	111, 111		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	86, 867		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58, 691		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 110		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	252, 896		73. 00
73. 01	07301 ONCOLOGY DRUGS	0	862, 231		73. 01
76.00	03160 CARDI OPULMONARY	18, 204	906, 269		76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000  CLI NI C	0	0		90.00
91. 00	09100 EMERGENCY	-241, 312	3, 183, 753		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
	OTHER REIMBURSABLE COST CENTERS				
	10100 HOME HEALTH AGENCY	0	0	l .	101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
	SPECIAL PURPOSE COST CENTERS				
118.00		-894, 987	27, 690, 756		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		l .	190. 00
	19100 RESEARCH	0	0	l .	191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
	19202 MOB	0	0	l .	192. 02
	19300 NONPALD WORKERS	0	0		193. 00
	07950 LEASED SPACE	0	0		194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-894, 987	27, 690, 756		200. 00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/29/2024 11: 32 am Provider CCN: 15-1316

COST_CONTEX*						12/ 51/ 2020	5/29/2024 11: 32 am	_
1			Increases	6.1	0.11			
A - CAPELENIA								
1.00			3.00	4.00	3.00			_
B	1.00		11. 00	100, 927	84, 684		1. 00	0
1.00   DAUGE STANDED TO PATTERIS   7.5.00   0   225,2915   2.00   3.00		0		100, 927	84, 684			
2 00 0 000_0CV_PRIOSS	4 00		70.00		050.007		1.00	
3 00			•					
A - 00		UNCOLOGY DRUGS	•					
5.00			•	o				
				o	0			
1.00	6.00		0.00	O	0		6. 00	0
C - MEDICAL SUPPLIES   14.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00   160,130   1.00	7.00		0.00	•	0		7. 00	0
1.00   CENTRAL SERVICES & SUPPLY   14.00   160,130   2.00   1.00   2.00   1.00   3.00   2.00   1.00   3.00   2.00   1.00   3.00   2.0		0 APPLICAL CURRENTES		0	1, 115, 127			
MEDICAL SUPPLIES CHARGED TO	1 00		14 00		160 120		1.00	Ω
A								
A	2.00		,		33, 37.		2.00	•
4.00 ADMINISTRATION	3.00	I MPL. DEV. CHARGED TO	72. 00		3, 110		3.00	0
5.00   QUESTING ALMIN STRATION   13.00   0   7     6.00   7   6.0					4.0			
6.00		1	l l					
7.00		NORSTING ADMINISTRATION		-				
B. 00			l l	o				
10.00				o				
1.00	9.00		0. 00	О	0		9. 00	0
0				0			10. 00	0
D - LAUNDRY   CAP REL COSTS-BLDG & FIXT   D.00	11. 00		0.00	•			11. 00	0
1.00				O	221, 981			
2.00 4.00 4.00 6.00 6.00 6.00 6.00 6.00 6	1. 00		8. 00	0	48. 889		1.00	0
A		Zionem a zimem semi se	•	-				
5.00				0	0			
6. 00	4.00			0	0		4. 00	0
7. 00								
B. 00				-				
1.00			•	-1	-			
CAP REL COSTS-BLDG & FIXT	0.00						0.00	U
2.00		E - DEPRECIATION			.5, 55.			
3. 00   3. 00   4. 00   5. 00   0   0   0   0   0   0   0   0   0		CAP REL COSTS-BLDG & FIXT	•					
4. 00   0. 0			•					
5.00								
6.00 7.00 8.00 7.00 8.00 9.00 9.00 10.00 9.00 11								
7. 00 8. 00 9. 00 10. 00 11. 00 11. 00 11. 00 11. 00 11. 00 11. 00 0. 00			•					
9.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 0			•	o				
10.00	8.00		0.00	О	0		8. 00	0
11.00				-				
CAP REL COSTS-BLDG & FIXT								
Tool   Cap Rel Costs-Bldg & FIXT   1.00   0   818,070   2.00   2.00   2.00   2.00   38,418   2.00   3.00   2.00   38,418   2.00   3.0	11.00						11.00	U
1.00 CAP REL COSTS-BLDG & FIXT		F - OTHER CAPITAL		U	1,037,077			
ADMINISTRATIVE & GENERAL   5.00   0   5,559   0   0   862,047	1.00		1.00	0	818, 070		1. 00	0
1.00   H - EMPLOYEE BENEFITS   H - O				0				
H - EMPLOYEE BENEFITS	3. 00	ADMI NI STRATI VE & GENERAL					3.00	0
1. 00 EMPLOYEE BENEFITS DEPARTMENT		H - EMPLOYEE RENEELTS		O	862, 047	 		
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 0 11. 00 12. 00 0 1. 00 12. 00 0 1. 00	1, 00		4.00	Ol	1, 278, 016		1 00	0
3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 10.00 10.00 11.00 12.00 1- HOUSEKEEPING 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.0				1				
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     0     1, 281, 078     1. 00       1. 00     1. 00     2. 00     0     0       3. 00     0. 00     0     0     0	3.00		0. 00		0		3.00	0
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 0 1 - HOUSEKEEPI NG 1 - HOUSEKEEPI NG 1 - O O O O O O O O O O O O O O O O O O			•		-			
7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 1 - HOUSEKEEPI NG 1 - HOUSEKEEPI NG 1 - O O O O O O O O O O O O O O O O O O			•	-				
8. 00 9. 00 10. 00 11. 00 11. 00 12. 00 1				O				
9. 00 10. 00 11. 00 11. 00 12. 00  1 - HOUSEKEEPI NG 1 - HOUSEKEEPI NG 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0				
10. 00 11. 00 12. 00 10. 00 10. 00 10. 00 11. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 11. 00 12. 00 12. 00 13. 626 1. 00 13. 00 14. 00 15. 00 15. 00 16. 00 17. 00 18. 00 19				ol				
12. 00 0 0 0 0 1, 281, 078 12. 00 1 0 0 0 0 1, 281, 078 12. 00 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				O				
O								
I - HOUSEKEEPING	12. 00		0.00				12.00	0
1. 00     HOUSEKEEPI NG     9. 00     0     3, 626       2. 00     0. 00     0     0       3. 00     0. 00     0     0		I - HOLISEKEEDI NG		0	1, 281, 078			
2. 00     0. 00     0     0     2. 00       3. 00     0. 00     0     0     0	1, 00		9.00	Ol	3. 626		1 00	0
			0. 00	•				
4.00   0.00  0 0 4.00								
	4.00	1	0. 00	이	0		4.00	<u>U</u>

						5/29/2024 11	:32 am
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	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
	0		0	3, 626			
500.00	Grand Total: Increases		100, 927	5, 277, 331			500.00

RECLASSI FI CATIONS

Provider CCN: 15-1316

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:

5/29/2024 11:32 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 100, 927 84, 684 0 1.00 84, 684 100, 927 B - DRUGS 1.00 PHARMACY 15.00 950, 669 0 1.00 ADULTS & PEDIATRICS 0 0 2.00 30.00 17, 285 2.00 3.00 OPERATING ROOM 50.00 ol 13.802 0 3.00 0 RADI OLOGY-DI AGNOSTI C 54.00 0 4.00 61, 378 4.00 5.00 PHYSICAL THERAPY 66.00 0 131 0 5.00 CARDI OPULMONARY 9, 568 6.00 76.00 0 0 6.00 7 00 EMERGENCY 91.00 0 6<u>2, 2</u>94 0 7 00 0 1, 115, 127 - MEDICAL SUPPLIES 1.00 OPERATION OF PLANT 7.00 20, 401 0 1.00 9.00 HOUSEKEEPI NG 0 2 00 528 2 00 0 3.00 PHARMACY 15.00 5, 941 3.00 4.00 ADULTS & PEDIATRICS 30.00 37, 031 0 4.00 0 5.00 OPERATING ROOM 50.00 63.073 5.00 0 6.00 RADI OLOGY-DI AGNOSTI C 54.00 1.264 6.00 7.00 LABORATORY 60.00 4, 951 0 7.00 PHYSICAL THERAPY 3, 051 0 8.00 66.00 8.00 0 ELECTROCARDI OLOGY 69.00 9.00 9.00 5.456 10.00 CARDI OPULMONARY 76.00 10, 410 0 10.00 EMERGENCY 69, 875 11.00 91.00 0 11.00 221, 981 D - LAUNDRY 1.00 CENTRAL SERVICES & SUPPLY 14.00 4, 584 0 1.00 2.00 PHARMACY 15.00 1, 273 0 2.00 0 ADULTS & PEDIATRICS 30.00 3.00 8.552 3.00 2, 938 4 00 OPERATING ROOM 50 00 4 00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 7, 111 0 5.00 6.00 PHYSICAL THERAPY 66.00 3,504 0 6.00 0 7.00 ELECTROCARDI OLOGY 69.00 773 7.00 8.00 EMERGENCY 91.00 20, 154 0 8.00 48, 889 DEPRECIATION ADMINISTRATIVE & GENERAL 1.00 1.00 5.00 303.090 0 0 2.00 OPERATION OF PLANT 7.00 735, 718 2.00 3.00 NURSING ADMINISTRATION 13.00 0 190 0 3.00 0 0 4.00 PHARMACY 15.00 5, 812 4.00 ADULTS & PEDIATRICS 0 0 5.00 30.00 66, 191 5.00 0 6.00 OPERATING ROOM 50.00 0 234, 082 6.00 o 0 7.00 RADI OLOGY-DI AGNOSTI C 54.00 174, 417 7.00 PHYSICAL THERAPY 66.00 0 6.882 0 8.00 8.00 ELECTROCARDI OLOGY 0 0 9.00 69.00 21,849 9.00 10.00 CARDI OPULMONARY 76.00 o 53, 039 0 10.00 11.00 EMERGENCY 91.00 0 58, 629 0 11.00 0 1, 659, 899 F - OTHER CAPITAL 0 1.00 ADMINISTRATIVE & GENERAL 5.00 818, 070 11 1.00 ADMINISTRATIVE & GENERAL 2 00 5 00 38 418 12 2 00 0 3.00 CAP REL COSTS-BLDG & FIXT 1.00 5, 559 13 3.00 862, 047 H - EMPLOYEE BENEFITS 1.00 7. 00 OPERATION OF PLANT 0 149 887 n 1 00 2.00 HOUSEKEEPI NG 9.00 0 106, 846 0 2.00 3.00 DI ETARY 10.00 o 67, 720 0 3.00 0 4.00 NURSING ADMINISTRATION 13.00 0 124, 351 4.00 0 PHARMACY 0 5.00 15.00 58, 647 5 00 6.00 ADULTS & PEDIATRICS 30.00 0 173, 623 0 6.00 7.00 OPERATING ROOM 50.00 o 42, 539 0 7.00 RADI OLOGY-DI AGNOSTI C 54.00 0 125, 899 0 8.00 8.00 01 0 SPFECH PATHOLOGY 68.00 12, 994 9 00 9 00 10.00 ELECTROCARDI OLOGY 69.00 0 12, 309 0 10.00 CARDI OPULMONARY o 11.00 76.00 133, 836 0 11.00 0 12.00 EMERGENCY 91.00 0 27<u>2, 4</u>27 12.00 ō 1, 281, 078 - HOUSEKEEPING 1.00 PHARMACY 15. 00 0 1, 010 0 1.00 ADULTS & PEDIATRICS 30.00 2.00 0 0 2.00 865 0 0 3.00 OPERATING ROOM 50.00 154 3.00 RADI OLOGY-DI AGNOSTI C 54.00 0 0 4.00 4.00 126 PHYSI CAL THERAPY 66, 00 0 0 5.00 30 5.00 CARDI OPULMONARY 6.00 76.00 42 0 6.00

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-1316 Period: Worksheet A-6
From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 32 am

							5/29/2024 11:	32 am
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref	<u>.                                     </u>		
	6. 00	7.00	8. 00	9. 00	10. 00			
7.00	EMERGENCY	91. 00	0	1, 399		0		7. 00
	0		0	3, 626				
500.00	Grand Total: Decreases		100, 927	5, 277, 331				500. 00

Provider CCN: 15-1316

| Period: | Worksheet A-7 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared:

				To	12/31/2023	Date/Time Pre 5/29/2024 11:	
				Acqui si ti ons		5/29/2024 11:	32 8111
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances	r ur chases	Donati on	10 tui	Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
-	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	1, 030, 133	0	0	0	0	1. 00
2.00	Land Improvements	23, 434	0	0	0	0	2. 00
3.00	Buildings and Fixtures	27, 513, 288	0	0	0	0	3. 00
4.00	Building Improvements	1, 856, 024	0	0	0	0	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	9, 257, 007	349, 648	0	349, 648	23, 924	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	39, 679, 886	349, 648	0	349, 648	23, 924	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	39, 679, 886	349, 648	0	349, 648	23, 924	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
		6.00	Assets 7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		7.00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	1, 030, 133	1, 030, 133				1. 00
2.00	Land Improvements	23, 434	1,030,133				2.00
3.00	Buildings and Fixtures	27, 513, 288	1, 646				3. 00
4. 00	Building Improvements	1, 856, 024	471, 471				4.00
5.00	Fi xed Equi pment	1, 830, 024	471, 471				5. 00
6. 00	Movable Equipment	9, 582, 731	4, 976, 253				6.00
7. 00	HIT designated Assets	7,302,731	4, 770, 233				7. 00
8. 00	Subtotal (sum of lines 1-7)	40, 005, 610	6, 479, 503				8. 00
9. 00	Reconciling Items	0	0, 177, 000				9. 00
10.00	Total (line 8 minus line 9)	40, 005, 610	6, 479, 503				10.00
	1		.,,				

Heal th	Financial Systems	U HEALTH FRANKFORT HOSPITAL			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CO	CN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023		pared:	
			SU	JMMARY OF CAP	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00	
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1. 00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00	
3. 00	Total (sum of lines 1-2)	0	0				3. 00	

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2023 To 12/31/2023		pared:
	COMI	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1. 00	2. 00	3. 00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FLXT	40, 005, 611				0	1. 00
3.00 Total (sum of lines 1-2)	40, 005, 611		40, 005, 61			3. 00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other Capi tal-Relate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS	<u> </u>	•	<u> </u>		
1.00 CAP REL COSTS-BLDG & FLXT	0	0		0 1, 803, 011	0	1. 00
3.00 Total (sum of lines 1-2)	0	0		0 1, 803, 011	ol	3. 00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	,		Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	44.00	10.00	10.00	instructions)	45.00	
DADT III DECONCILIATION OF CARLTAL COCTO O	11. 00	12.00	13. 00	14. 00	15. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		20.440	F 55		2 027 400	1 00
1.00 CAP REL COSTS-BLDG & FIXT 3.00 Total (sum of lines 1-2)	1, 001, 322				2, 837, 192	1.00
	1, 001, 322	38, 418	-5, 55	9 0	2, 837, 192	3.00

Provider CCN: 15-1316 

					0 12/31/2023	Date/lime Prep 5/29/2024 11:3	
				Expense Classification on	Worksheet A	0,2,,2021 111	<u> </u>
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL	В	743, 670	CAP REL COSTS-BLDG & FIXT	1. 00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2.00	o	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		· ·	Sost conten perced	2.00	Ĭ	2.00
3.00	Investment income - other		0		0.00	O	3.00
	(chapter 2)		_			_	
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	di scounts (chapter 8) Refunds and rebates of		0		0.00	o	5. 00
0.00	expenses (chapter 8)		3		0.00		0.00
6.00	Rental of provider space by		0		0.00	O	6.00
7.00	suppliers (chapter 8)		Ō		0.00		7.00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8.00	Television and radio service		0		0.00	О	8. 00
	(chapter 21)						
9.00	Parking lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-602, 357			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	o	11. 00
	(chapter 23)		_			آ ا	
12.00	Related organization	A-8-1	1, 870, 457			O	12.00
	transactions (chapter 10)		_			_	
13.00	Laundry and linen service		0		0.00	0	13.00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0 0	14. 00 15. 00
13.00	and others		U		0.00	Ĭ	13.00
16.00	Sale of medical and surgical		0		0.00	o	16. 00
	supplies to other than						
47.00	patients						47.00
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0.00	o	18. 00
	abstracts		_				
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0.00	Ö	21. 00
	interest, finance or penalty		_			آ ا	
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to						
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	*** Cost Center Deleted ***	65. 00		23. 00
20.00	therapy costs in excess of	7, 0, 0	· ·	Sost conten perced	00.00		20.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
23.00	physicians' compensation		O	cost conter bereted	114.00		23.00
	(chapter 21)						
26. 00	Depreciation - CAP REL	A	81, 202	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
27.00	COSTS-BLDG & FIXT		0	*** Coot Conton Doloted ***	2.00		27.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29.00	Physicians' assistant		0		0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30.00
	therapy costs in excess of						
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		^	ADULTS & PEDIATRICS	30. 00		30. 99
JU. 77	instructions)		U	INDUCTO & LEDIATRICO	30.00		JU. 77
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of		_				
00.00	limitation (chapter 14)		_		2	_	00.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	EMPLOYEE BENEFITS	A	-1, 278, 016	EMPLOYEE BENEFITS DEPARTMENT	4. 00	n	33. 00
	·	. '		·		1	

Hoal th	Financial Systems	1	U HEALTH FRANK	FORT HOSPITAL	In lie	eu of Form CMS-2	2552_10
	MENTS TO EXPENSES	<u> </u>	O HEALTH TRAIN	Provi der CCN: 15-1316	Peri od:	Worksheet A-8	
ADSOST	WENTS TO EXILENSES			Trovider con. 13 1310	From 01/01/2023		
					To 12/31/2023	Date/Time Pre	
						5/29/2024 11:	32 am
				Expense Classification			
				To/From Which the Amount	s to be Adjusted		
	Cost Center Description	Paci c/Codo (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	cost center bescription						
22.01	MEDICALD HAE FEEC	1.00	2.00	3. 00	4. 00	5. 00	22.01
	MEDICAID HAF FEES	A		ADMINISTRATIVE & GENERAL	5. 00		00.0.
33. 02	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	l	33. 02
33. 03	MI SCELLANEOUS I NCOME	В	-2, 000	EMERGENCY	91.00	0	33. 03
33.04	CONTRIBUTION EXPENSE	A	-360	PHARMACY	15. 00	0	33. 04
33. 05	CONTRIBUTION EXPENSE	A	-5, 604	ADMINISTRATIVE & GENERAL	5. 00	0	33. 05
33.06	DEPRECIATION ON CAPITALIZED	A	61, 910	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 06
	ASSETS		•				
33. 07	START UP COST NEW HOSPITAL	A	276, 621	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33. 08	TELEPHONE EQUIPMENT	A	-1, 192	EMERGENCY	91.00	0	33. 08
33. 09	MARKETI NG	A	-750	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
	MARKETI NG	A		OPERATING ROOM	50.00	l	33. 10
		1	l	1		1	1 11 11

50.00

50.00 | TOTAL (sum of lines 1 thru 49)

<sup>(</sup>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.

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

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

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

Provider CCN: 15-1316

Worksheet A-8-1 From 01/01/2023

				To 12/31/2023	Date/Time Pre 5/29/2024 11:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
1.00	l		HOME OFFICE	257, 652	818, 070	1.00
2.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	1, 140, 121	0	2. 00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	4, 691, 753	4, 727, 427	3. 00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	1, 177, 817	789, 258	3. 01
3.02	7. 00	OPERATION OF PLANT	RELATED PARTY	100, 001	55, 139	3. 02
4.00			RELATED PARTY	263, 858	74, 388	4. 00
4. 01	14. 00	CENTRAL SERVICES & SUPPLY	RELATED PARTY	331, 884	137, 607	4. 01
4.02	15. 00	PHARMACY	RELATED PARTY	434, 705	264, 044	4. 02
4.03			RELATED PARTY	62, 136	35, 952	4. 03
4.04	50.00	OPERATING ROOM	RELATED PARTY	200, 658	57, 040	4. 04
4.05	54. 00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	126, 914	0	4. 05
4.06	76. 00	CARDI OPULMONARY	RELATED PARTY	75, 409	57, 205	4. 06
4.07	91. 00	EMERGENCY	RELATED PARTY	63, 690	40, 011	4. 07
4.08	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	318, 592	318, 592	4. 08
4.09	50.00	OPERATING ROOM	SHARED EMPLOYEES	38, 290	38, 290	4. 09
4. 10	60.00	LABORATORY	SHARED EMPLOYEES	2, 079, 588	2, 079, 588	4. 10
4. 11	69. 00	ELECTROCARDI OLOGY	SHARED EMPLOYEES	188	188	4. 11
4. 12	91. 00	EMERGENCY	SHARED EMPLOYEES	1, 853, 096	1, 853, 096	4. 12
5.00	TOTALS (sum of lines 1-4).			13, 216, 352	11, 345, 895	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.

 been posted to norksheet 71,					
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	В	IU HEALTH	100.00	0.00	6.00
7.00	В	IUH ARNETT	1.00	0.00	7.00
8.00			0.00	0. 00	8.00
9. 00			0.00	0. 00	9.00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

4 07

4.08

4.09

4.10

4. 11

4.12

5.00

	ated Organization(s) nd/or Home Office		
	Type of Business		
	6. 00		
B. INT	ERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		6. 00
7. 00		7. 00
8. 00		8. 00
9. 00		9. 00
10. 00		10. 00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00		100.00

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

0

0

0

0

0

- 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.

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23,679

1,870,457

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Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1316

						To 12/31/2023	B Date/Time Pre 5/29/2024 11:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		ADULTS & PEDIATRICS	302, 268		0			1. 00
2.00	50.00	OPERATING ROOM	38, 290				0	2. 00
3.00		EMERGENCY	1, 773, 101	261, 799	1, 511, 302	C	0	3. 00
4.00	0.00		0	0	0	C	0	4. 00
5.00	0.00		0	0	0	C	0	5. 00
6.00	0.00		0	0	0	C	0	6. 00
7.00	0.00		0	0	0	C	0	7. 00
8.00	0.00		0	0	0	C	0	8. 00
9.00	0.00		0	0	0	C	0	9. 00
10.00	0.00		0	0	0	C	0	10. 00
200.00			2, 113, 659	602, 357	1, 511, 302		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	0	-	-			
2.00		OPERATING ROOM	0	1	0	C	_	2. 00
3. 00		EMERGENCY	0	0	0	C	0	3. 00
4.00	0. 00		0	0	0	C	0	4. 00
5. 00	0. 00		0	0	0	C	0	5. 00
6. 00	0. 00		0	0	0	C	0	6. 00
7. 00	0.00		0	0	0	C	0	7. 00
8.00	0. 00		0	0	0	C	0	8. 00
9. 00	0.00		0	0	0	C	0	9. 00
10. 00	0. 00		0	0	0	C	0	10. 00
200.00			0	0	0		0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Li mi t	Di sal I owance			
			Share of col.					
	1. 00	2. 00	14 15. 00	16. 00	17. 00	18. 00		
1.00		ADULTS & PEDIATRICS	15.00					1. 00
2.00		OPERATING ROOM					1	2. 00
3. 00		EMERGENCY			-	261, 799		3.00
4. 00	0.00	MEROENCI		0	-	201, 799		4. 00
5. 00	0.00			0				5. 00
6.00	0.00			0				6.00
7. 00	0.00			0				7. 00
8. 00	0.00			0				8. 00
9. 00	0.00			J 0				9. 00
9. 00 10. 00	0.00							10.00
200.00	0.00				0	602, 357		200.00
200.00	I I		1	1	ı U	002,357	I	200.00

Heal th	Financial Systems	U HEALTH FRANKI	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10	
REASON	NABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provi der C	CN: 15-1316	Peri od:	Worksheet A-8	-3	
OUTSLE	DE SUPPLIERS				From 01/01/2023 To 12/31/2023		oared:	
					10 12/01/2020	5/29/2024 11:		
					Physical Therapy	Cost		
						1. 00		
	DADT I CENEDAL INFORMATION							
PART I - GENERAL INFORMATION						52	1. 00	
1.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see mstruc	tions)			780		
2. 00 3. 00	, , ,	cor or thoronic	t was an aroui	dor sito (so	o instructions)	780 301	3.00	
4.00	Number of unduplicated days in which supervisions Number of unduplicated days in which therapy					245		
4.00	nor therapist was on provider site (see insti		on provider si	te but her th	ei supeivisoi	243	4.00	
5.00	Number of unduplicated offsite visits - super		anists (see in	structions)		0	5. 00	
6. 00	Number of unduplicated offsite visits - there		,	,	by therapy	0	6. 00	
	assistant and on which supervisor and/or the					_	1	
	instructions)		p	,	,, (		l	
7.00	Standard travel expense rate					6. 55	7. 00	
8.00	Optional travel expense rate per mile					0.00	8. 00	
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees		
		1.00	2. 00	3.00	4. 00	5. 00		

	instructions)	rapist was not p	present during	the visit(s))	(See		
7.00	Standard travel expense rate					6. 55	7. 00
8.00	Optional travel expense rate per mile					0.00	8. 00
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
	I <del>-</del>	1.00	2.00	3.00	4. 00	5. 00	
9.00	Total hours worked	0.00	6, 928. 71	· ·	0.00		9.00
10. 00 11. 00	AHSEA (see instructions)	0. 00 48. 81	97. 62 48. 81		0.00	0.00	10. 00 11. 00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	48. 81	48. 81	31.73			11.00
	one-half of column 3, line 10, column 3,						
12. 00	Number of travel hours (provider site)	0	0	0			12. 00
12. 01	Number of travel hours (offsite)		0	-			12. 01
	Number of miles driven (provider site)	0	0	-			13. 00
	Number of miles driven (offsite)	O	0	О			13. 01
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14. 00	Supervisors (column 1, line 9 times column 1	line 10)				0	14. 00
15. 00	Therapists (column 2, line 9 times column 2,					676, 381	15. 00
16. 00	Assistants (column 3, line 9 times column 3,	,				124, 960	16. 00
17. 00	Subtotal allowance amount (sum of lines 14 au		ratory therapy	or lines 14-16	for all	801, 341	17. 00
	others)						
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18. 00
19.00	Trainees (column 5, line 9 times column 5, li	i ne 10)				0	19. 00
20.00	Total allowance amount (sum of lines 17-19 for					801, 341	20. 00
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than	· ·	no entries on	lines 21 and 22	and enter on	line 23	
21 00	the amount from line 20. Otherwise complete		-111111			0.00	21 00
21.00	Weighted average rate excluding aides and tra			m or columns I	and 2, line 9	0.00	21. 00
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					ol	22. 00
23. 00	Total salary equivalency (see instructions)	ees (IIIIe 2 LIIII	es iiile 21)			801, 341	
23.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	NANCE AND TRAVEL	EXPENSE COMP	UTATION - PROVI	DER SLITE	001, 541	25.00
	Standard Travel Allowance						
24.00	Therapists (line 3 times column 2, line 11)					14, 692	24.00
25.00	Assistants (line 4 times column 3, line 11)					7, 774	25. 00
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	II others)		22, 466	26. 00
27. 00	Standard travel expense (line 7 times line 3	for respiratory	y therapy or s	um of lines 3 a	nd 4 for all	3, 576	27. 00
	others)						
28. 00	Total standard travel allowance and standard 27)	travel expense	at the provid	er site (sum of	Tines 26 and	26, 042	28. 00
	Optional Travel Allowance and Optional Travel	Expense					
29. 00	Therapists (column 2, line 10 times the sum		d 2. line 12 )			0	29. 00
30.00	Assistants (column 3, line 10 times column 3					0	30.00
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	II others)		0	31. 00
32.00	Optional travel expense (line 8 times columns	s 1 and 2, line	13 for respir	atory therapy o	r sum of	0	32.00
	columns 1-3, line 13 for all others)						
33. 00	Standard travel allowance and standard travel					26, 042	
34. 00	Optional travel allowance and standard trave					0	34.00
35. 00	Optional travel allowance and optional trave				50 0UTOLD5 DD	0	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	ANCE AND TRAVEL	EXPENSE COMPU	TATION - SERVIC	ES OUTSIDE PRO	OVI DER SITE	
27 00	Standard Travel Expense						2/ 00
36.00	Therapists (line 5 times column 2, line 11)					0 0	36.00
37. 00 38. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)						37. 00 38. 00
39. 00	1 '	m of lines 5 and	4 6)			0	39.00
37.00	Optional Travel Allowance and Optional Travel		u 0)			<u> </u>	37.00
40. 00	Therapists (sum of columns 1 and 2, line 12.0		2. line 10)			0	40. 00
41. 00	Assistants (column 3, line 12.01 times column		,				41.00
42. 00	· ·	3,					42.00
43. 00	Optional travel expense (line 8 times the sur	m of columns 1-3	3, line 13.01)			Ö	43.00
	Total Travel Allowance and Travel Expense - (			e of the follow	ing three line		
	or 46, as appropriate.						
44.00	Standard travel allowance and standard trave	l expense (sum o	of lines 38 an	d 39 – see inst	ructions)		44. 00
45.00	Optional travel allowance and standard travel	l expense (sum o	of lines 39 an	d 42 – see inst	ructions)	0	45. 00

REASON	Financial Systems I ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	U HEALTH FRANKI FURNI SHED BY	Provi der CC	N: 15-1316	Period: From 01/01/2023 To 12/31/2023		-3 pared:
					Physical Therapy		
						1. 00	
46. 00	Optional travel allowance and optional travel		of lines 42 and	d 43 – see ir	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2. 00	3. 00	4. 00	5. 00	
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0. 00	0. 0		0.00	47. 00
48. 00 49. 00	Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0. 00 0. 00	0. 0 0. 0			48. 00 49. 00
	allowance) (multiply line 47 times line 48)   CALCULATION OF LIMIT						
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0. 0	0.00	0. 00	50. 00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	0.0	0.00	0.00	51. 00
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	97. 62	63. 45	0. 0	0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0	0.0	0 0		53. 00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 00
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			801, 341	
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00	7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 9.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 0.00 Overtime allowance (from column 5, line 56) 1.00 Equipment cost (see instructions) 2.00 Supplies (see instructions)						57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
64.00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63	,	enter zero)			663, 340 0	
	LINE 33 CALCULATION  Line 26 = line 24 for respiratory therapy or	<u> </u>	,	II others		22, 466	
100.01	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others		100. 01
101.01	Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
102.00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				ımns 1-3, line	0	102. 00 102. 01

0 102. 02

13 for all others 102.02 Line 35 = sum of lines 31 and 32

UTSI D	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CCI	N: 15-1316	Peri od: From 01/01/2023				
					To 12/31/202:	5/29/2024 11:			
					Occupati onal Therapy	Cost			
						1. 00			
00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruct	i ons)			52	1.		
00	Line 1 multiplied by 15 hours per week					780	1		
00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy					147 211	1		
	nor therapist was on provider site (see inst	ructions)	·						
00 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - there	0	1						
	assistant and on which supervisor and/or the instructions)	rapist was not p	resent during	the visit(s)	)) (see				
00	Standard travel expense rate		6. 55	1					
00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.		
. 00	Total hours worked	1.00	2. 00 1, 486. 91	3. 00 1, 825.	4. 00 74 0. 0	5. 00 0 0. 00	9.		
0. 00	AHSEA (see instructions)	0.00	97. 62	67.					
1. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	48. 81	48. 81	33.	68		11.		
	one-half of column 3, line 10)								
2. 00 2. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12.		
3. 00	Number of miles driven (provider site)	0	O		0		13.		
3. 01	Number of miles driven (offsite)	0	0		0		13.		
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00			
. 00	Supervisors (column 1, line 9 times column 1	•				0			
5. 00 5. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					145, 152 122, 982			
7. 00	Subtotal allowance amount (sum of lines 14 a	268, 134	1						
3. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.		
9. 00	Trainees (column 5, line 9 times column 5, l	i ne 10)		47 140	6 11 11 1	0			
0. 00	Total allowance amount (sum of lines 17-19 for the sum of columns 1 and 2 for respirators						20.		
	occupational therapy, line 9, is greater that the amount from line 20. Otherwise complete		o entries on I	ines 21 and	22 and enter or	n line 23			
1. 00	Weighted average rate excluding aides and tr	ainees (line 17		of columns	1 and 2, line 9	0.00	21.		
2. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train	0	22.						
3. 00	Total salary equivalency (see instructions)	Total salary equivalency (see instructions)							
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	NANCE AND TRAVEL	EXPENSE COMPO	TATION - PRO	DVIDER SITE				
4. 00 5. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					7, 175 7, 106			
6. 00	Subtotal (line 24 for respiratory therapy or	14, 281							
7. 00	Standard travel expense (line 7 times line 3 others)	2, 345	27.						
3. 00	Total standard travel allowance and standard	travel expense	at the provide	er site (sum	of lines 26 and	16, 626	28.		
	27) Optional Travel Allowance and Optional Travel	Expense							
9. 00 0. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		2, line 12 )			0	1		
1. 00	Subtotal (line 29 for respiratory therapy or	sum of lines 29				0	31.		
2. 00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respira	itory therapy	y or sum of	0	32.		
3. 00	Standard travel allowance and standard trave					16, 626			
1. 00 5. 00	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	1		
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				/ICES OUTSIDE PF	ROVI DER SITE			
5. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.		
	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	1		
	Standard travel expense (line 7 times the su	m of lines 5 and	6)			0			
7. 00 8. 00 9. 00		Evnonco					40.		
3. 00 9. 00	Optional Travel Allowance and Optional Travel		2 line 10)			^			
3. 00		01 times column	2, line 10)			0 0	41.		
3. 00 9. 00 0. 00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.	01 times column n 3, line 10)					41. 42.		

	Financial Systems I ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	FURNI SHED BY	Provider Co	Provider CCN: 15-1316		Worksheet A-8-3 Parts I-VI Date/Time Prepared 5/29/2024 11:32 am	
					Occupati onal Therapy	Cost	
						1. 00	
45. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	d 42 - see ir	nstructions)	0	45. 00
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. 0	0.00	0. 00	47. 00
48. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00
49. 00	Total overtime (including base and overtime	0. 00	0. 00	0.0	0.00		49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0. 0	0.00	0.00	50.00
51. 00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51. 00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00 53. 00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	97. 62 0	67. 36 0		0.00		52. 00 53. 00
54. 00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
55. 00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55. 00
56. 00	hourly computation at the AHSEA (multiply line 47 times line 52) Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56. 00
30.00	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	O			0	30.00
						1 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	AD HISTMENT			1. 00	
	Salary equivalency amount (from line 23)	27.0200 0001	71500071112117			268, 134	57. 00
	Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions)	•		)		16, 626 0 0 0 0	59. 00 60. 00 61. 00
	Total allowance (sum of lines 57-62)					284, 760	
64. 00 65. 00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	,	, enter zero)			196, 965 0	65.00
100.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others		14, 281	100. 00
100. 01 100. 02	2, 345 16, 626	100. 01 100. 02					
	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				others		101. 00 101. 01
101. 02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						101. 01
	Line 31 = line 29 for respiratory therapy or						102. 00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 for respira	tory therapy o	r sum of colu	ımns 1-3, line	0	102. 01

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1316 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 11:32 am CAPI TAL RELATED COSTS ADMI NI STRATI VE Cost Center Description Net Expenses **EMPLOYEE** Subtotal BLDG & FIXT for Cost BENEFITS & GENERAL DEPARTMENT Allocation (from Wkst A col. 7) 1.00 4.00 5. 00 4A GENERAL SERVICE COST CENTERS 1 00 2, 837, 192 1 00 00100 CAP REL COSTS-BLDG & FLXT 2, 837, 192 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 177, 815 5, 552 1, 183, 367 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 6, 287, 495 447, 710 12, 858 6, 748, 063 6, 748, 063 5.00 00700 OPERATION OF PLANT 1, 775, 464 96, 374 2, 176, 419 701, 277 7 00 304, 581 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 48,889 48, 889 15, 753 8.00 9.00 00900 HOUSEKEEPI NG 531, 576 42, 501 50, 608 624, 685 201, 284 9.00 10.00 01000 DI ETARY 203, 681 60, 631 21,065 285, 377 91, 953 10.00 01100 CAFETERIA 185, 611 18, 284 250, 032 80, 564 11 00 11 00 46, 137 01300 NURSING ADMINISTRATION 13.00 1, 251, 436 39, 356 156, 012 1, 446, 804 466, 183 13.00 01400 CENTRAL SERVICES & SUPPLY 589, 046 189, 800 14.00 493, 530 95, 516 14.00 15.00 01500 PHARMACY 53, 610 15.00 893, 924 70, 114 1, 017, 648 327, 902 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1,544,805 403, 046 181, 347 2, 129, 198 686, 062 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 759, 770 316, 767 57,063 1, 133, 600 365, 264 50 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 146, 281 190, 394 1, 491, 808 480, 684 155, 133 54.00 60.00 06000 LABORATORY 2, 217, 045 76, 796 0 2, 293, 841 739, 112 60.00 06600 PHYSI CAL THERAPY 674, 349 66.00 178, 504 0 852, 853 274, 803 66,00 06700 OCCUPATIONAL THERAPY 67.00 196, 965 11, 104 Λ 208, 069 67,043 67.00 12, 136 45, 737 06800 SPEECH PATHOLOGY 111, 111 18, 699 141, 946 68.00 68.00 109, 082 69.00 06900 ELECTROCARDI OLOGY 86, 867 9, 729 12, 486 35, 148 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58, 691 58, 691 18, 911 71.00 C 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 110 0 0 3, 110 1,002 72.00 07300 DRUGS CHARGED TO PATIENTS 252, 896 252, 896 81, 487 73.00 0 73.00 73.01 07301 ONCOLOGY DRUGS 862, 231 0 862, 231 277, 825 73.01 03160 CARDI OPULMONARY 76.00 906, 269 148, 188 122, 379 1, 176, 836 379, 195 76.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 09100 EMERGENCY 3, 183, 753 378, 430 227, 449 3, 789, 632 91.00 91.00 1, 221, 074 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 6, 748, 063 118. 00 118.00 27, 690, 756 2, 837, 192 1, 183, 367 27, 690, 756 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 191.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192, 00

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27, 690, 756

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2, 837, 192

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1, 183, 367

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27, 690, 756

0 192. 02

0 193. 00

0 194 00

0 201.00

6, 748, 063 202. 00

200.00

192. 02 19202 MOB

200.00

201.00

202.00

193. 00 19300 NONPALD WORKERS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

194.00 07950 LEASED SPACE

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1316

COST Center Description					10	12/31/2023	Date/IIme Pre 5/29/2024 11:	
PLANT   LINEN SERVICE		Cost Center Description	ODEDATION OF	I VIINDDA 8	HUISEKEEDI NG	DIFTADV		JZ dili
Company   Comp		cost center bescription			HOUSEKEELLING	DILIANI	CALLILITA	
SEMERAL SERVICE COST CENTRES					9 00	10.00	11 00	
1.00		CENEDAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
4. 00	1 00							1 00
5. 00   00500 AMM INSTRATIVE & CEMBERAL   2,877,696   8.00   0.000   00500   PERATION OF PENNT   2,877,696   8.00   0.0000   CHANTON OF PENNT   2,877,696   8.00   0.0000   0.0000   CHANTON OF PENNT   2,877,696   8.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.0000000   0.00000000		· · · · · · · · · · · · · · · · · · ·						
7. 00		· · · · · · · · · · · · · · · · · · ·						
8.00   00800 LAUINRY & LINEN SERVICE   0   64,642   884,788   9,00   10.00   10100   1		· · · · · · · · · · · · · · · · · · ·	2 077 /0/					
9.00   00900   HOUSEKEEPING		l	2,877,090	l				
10.0   01000   01000   0157APY   10.0   0.0   26.338   487,578   487,578   10.0   0.0   10.0   0.0   0.0   0.0   0.0   14.4,488   11.0   0.0   13.0   0.0			50.010	1	004 700			
11.0   0   1010   CAFETRIA				0		407 570		
13. 00   01300 NURSI NG ADMINISTRATION   54, 467   0   17, 096   0   42, 506   13. 00   14. 00   14. 00   14. 00   14. 00   15. 00   0				0		487, 578		
14. 00		· · · · · · · · · · · · · · · · · · ·		0		0		
15. 00				0		0	•	
16. 00     01600   MEDICAL RECORDS & LIBRARY   0   0   0   0   0   0   0   0   0				0		0		
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   300.00   AULITS & PEDIATRICS   557,790   64,642   175,080   487,578   73,259   30.00   30.0				0		0		1
30. 00 03000 ADULTS & PEDIATRICS	16. 00		0	0	0	0	0	16. 00
ANCILLARY SERVICE COST CENTERS								
50.00	30. 00		557, 790	64, 642	175, 080	487, 578	73, 259	30. 00
54.00   05400   RADI OLOGY - DI AGNOSTI C   263, 494   0   82, 705   0   54, 367   54, 00								
60.00				l		-		
66.00   06600   PHYSI CAL THERAPY   247,039   0   77,540   0   0   66.00   67.00   06700   06700   00   00   00   0   0   0   0   0				0		0		1
67. 00   06700   0CCUPATI ONAL THERAPY   15,368   0   4,824   0   0   67.00   68. 00   06800   SPEECH PATHOLOGY   16,796   0   5,272   0   5,367   68. 00   06900   SEECTROCARDI OLOGY   13,464   0   4,226   0   4,240   69. 00   06900   ELECTROCARDI OLOGY   13,464   0   4,226   0   4,240   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   07301   0NCOLOGY DRUGS   0   0   0   0   0   0   74. 00   07301   0NCOLOGY DRUGS   0   0   0   0   0   0   75. 01   07301   0NCOLOGY DRUGS   0   0   0   0   0   0   76. 00   03160   CARDI DULMONARY   205,083   0   64,372   0   43,633   76.00   77. 00   07700   ALLOGENEI C HSCT ACQUI SITI ON   0   0   0   0   0   0   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0   0   0   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   0   79. 00   09000   CLI NI C   0   0   0   0   0   70   09100   DEBREGENCY   0   0   0   0   0   70   09100   DEBREGENCY   0   0   0   0   0   70   07100   09100   DEBREGENCY   0   0   0   0   0   70   09100   DEBREGENCY   0   0   0   0   0   70   09100   DEBREGENCY   0   0   0   0   0   70   09100   OUTER REI MBURSABLE COST CENTERS    118. 00   SUBSTATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   71   0.00   10000   OUTER REI MBURSABLE COST CENTERS   719. 00   19000   OUTER REI MBURSABLE COST CENTERS   0   0   0   0   0   719. 00   19000   OUTER REINGROWERS   0   0   0   0   0   719. 00   19000   OUTER REINGROWERS   0   0   0   0   0   719. 00   19000   OUTER REINGROWERS   0   0   0   0   719. 00   19000   OUTER REINGROWERS   0   0   0   0   0   719. 00   19000   OUTER REINGROWERS   0   0   0   0   0   719. 00   19000   OUTER REINGROWERS   0   0   0   0   0   719. 00   19000   OUTER REING		· ·		0		0		
68.00   06800   SPEECH PATHOLOGY   16,796   0   5,272   0   5,367   68.00   69.00   06900   ELECTROCARDI OLOGY   13,464   0   4,226   0   4,240   69.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   73.01   07301   ONCOLOGY DRUGS   0   0   0   0   0   0   75.00   07310   ONCOLOGY DRUGS   0   0   0   0   0   0   76.00   07310   ONCOLOGY DRUGS   0   0   0   0   0   0   77.00   07700   ALDGENEIC ENSCT ACQUISITION   0   0   0   0   0   0   78.00   07800   CART -CELL IMMUNOTHERAPY   0   0   0   0   0   0   78.00   07800   CART -CELL IMMUNOTHERAPY   0   0   0   0   0   0   78.00   09000   CLINI C   0   0   0   0   0   0   79.00   09000   DERRIGENCY   0   0   0   0   0   0   79.00   09000   DERRIGENCY   0   0   0   0   0   0   79.00   09000   DERRIGENCY   0   0   0   0   0   70.00   07000   DERRIGENCY   0   0   0   0   0   70.00   07000   DIRDEMENT PROGRAM   0   0   0   0   0   70.00   07000   ONE MEDICAL SUMPLINE S				l e		0		
69, 00 6900   ELECTROCARDIOLOGY   13, 464   0   4, 226   0   4, 240   69, 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   0   72. 00   73. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   73. 00   73. 01   07301   0NCOLOGY DRUGS   0   0   0   0   0   0   0   0   0		ł I		0		0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 72. 00 73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 73. 01 07301 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 73. 00 76. 00 03160 CARDI OPULMONARY 205,083 0 64,372 0 43,633 76. 00 77. 00 07500 ALCROENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 78. 00  0000 CLINIC SERVICE COST CENTERS  101. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68. 00	06800 SPEECH PATHOLOGY	16, 796	0	5, 272	0	5, 367	68. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   72. 00	69. 00		13, 464	0	4, 226	0	4, 240	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 73. 01 07301 ONCOLOGY DRUGS 0 0 0 0 0 0 0 73. 01 73. 01 07301 ONCOLOGY DRUGS 0 0 0 0 0 0 0 73. 01 76. 00 03160 CARDIO POLLMONARY 205,083 0 64,372 0 43, 633 76. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00  UNITATIENT SERVICE COST CENTERS  90. 00 09000 CLINIC 0 0 0 0 0 0 0 90. 0 91. 00 99200 DEMERGENCY 523, 724 0 164, 386 0 92, 740 91. 00 92. 00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 101. 00  101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 101. 00 102. 00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 0 0 0 101. 00  SPECIAL PURPOSE COST CENTERS  118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 877, 696 64, 642 884, 788 487, 578 414, 488 118. 00  NONTHE MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 0 191. 00 191. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 0 192. 02 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 0 192. 02 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 19500 LEASED SPACE 0 0 0 0 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 0 0 0 0 1940. 00 201. 00 Nongative Cost Centers	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
73. 01 07301 ONCOLOGY DRUGS  76. 00 03160 CARDI OPULMONARY  77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON  78. 00 07800 CAR T - CELL I IMUNOTHERAPY  90. 00 07800 CAR T - CELL I IMUNOTHERAPY  90. 00 0900 CLI NI C  90. 00 09100 EMERGENCY  91. 00 09100 EMERGENCY  92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)  01. 00 10100 HOME HEALTH AGENCY  101. 00 10200 OPI OID TREATMENT PROGRAM  102. 00 10200 OPI OID TREATMENT PROGRAM  103. 00 10200 OPI OID TREATMENT PROGRAM  104. 00 10200 OPI OID TREATMENT PROGRAM  105. 00 10200 OPI OID TREATMENT PROGRAM  106. 00 10200 OPI OID TREATMENT PROGRAM  107. 00 10200 OPI OID TREATMENT PROGRAM  108. 00 10200 OPI OID TREATMENT PROGRAM  109. 00 10200 OPI OID TREATMENT PROGRAM  100. 00 10200 OPI	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
76. 00	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
77. 00   07700   ALLOGENEI C HSCT ACQUISITION   0   0   0   0   0   0   0   77. 00   78. 00   07800   CAR T-CELL I IMMUNOTHERAPY   0   0   0   0   0   0   0   0   0	73. 01	07301 ONCOLOGY DRUGS	0	0	0	0	0	73. 01
78. 00	76.00	03160 CARDI OPULMONARY	205, 083	0	64, 372	0	43, 633	76. 00
OUTPATIENT SERVICE COST CENTERS   O   O   O   O   O   O   O   O   O	77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	o	0	77. 00
90. 00	78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
91. 00		OUTPATIENT SERVICE COST CENTERS						
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   OTHER REIMBURSABLE COST CENTERS   101. 00   10100   HOME HEALTH AGENCY   0   0   0   0   0   0   102. 00     102. 00   10200   OPI OI D TREATMENT PROGRAM   0   0   0   0   0   0   102. 00     SPECIAL PURPOSE COST CENTERS   118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   2,877,696   64,642   884,788   487,578   414,488   118. 00     NONREI MBURSABLE COST CENTERS   109. 00   0   0   0   0   190. 00     191. 00   19100   RESEARCH   0   0   0   0   0   0   191. 00     192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   0   0   0   0   192. 00     192. 02   19202   MOB   0   0   0   0   0   193. 00     193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   0   193. 00     194. 00   07950   LEASED SPACE   0   0   0   0   0   194. 00     200. 00   Cross Foot Adjustments   200. 00   0   0   201. 00     102. 00   103. 00   Negative Cost Centers   0   0   0   0   0   0     103. 00   103. 00   Negative Cost Centers   0   0   0   0   0   0     104. 00   105. 00   0   0   0   0   0     105. 00   0   0   0   0   0   0     106. 00   0   0   0   0     107. 00   0   0   0   0     108. 00   0   0   0   0     109. 00   0   0   0     109. 00   0   0     109. 00   0   0     109. 00   0   0     109. 00   0   0     109. 00   0   0     109. 00   0     109. 00   0   0     109. 00   0     109. 00   0     109. 00   0   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00   0     109. 00     109. 00   0     109. 00     109. 00   0     109. 00     109. 00     109. 00   0     109. 00	90.00	09000 CLI NI C	0	0	0	0	0	90. 00
OTHER REIMBURSABLE COST CENTERS   101.00   10100   HOME HEALTH AGENCY   0   0   0   0   0   101.00   102.00   102.00   102.00   102.00   102.00   0   0   0   0   0   0   102.00   10	91.00	09100 EMERGENCY	523, 724	0	164, 386	0	92, 740	91.00
101. 00   10100   HOME   HEALTH   AGENCY   0   0   0   0   0   101. 00   102. 00   1	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
102.00   10200   OPI 0I D TREATMENT PROGRAM   O   O   O   O   102.00		OTHER REIMBURSABLE COST CENTERS						
SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)   2,877,696   64,642   884,788   487,578   414,488   4	101.0	0 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   2,877,696   64,642   884,788   487,578   414,488   118. 00   NONREI MBURSABLE COST CENTERS   190. 00 19100   RESEARCH   0   0   0   0   0   0   191. 00   191. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0   0   192. 00   192. 02   19202   MOB   0   0   0   0   0   0   192. 02   19202   MOB   0   0   0   0   0   0   193. 00   193. 00   19300   NONPAI D WORKERS   0   0   0   0   0   0   194. 00   194. 00   195. 0	102.0	O 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   0   190. 00		SPECIAL PURPOSE COST CENTERS						
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   190. 00   191. 00   191. 00   191. 00   191. 00   191. 00   0   0   0   0   0   191. 00   192. 00   192. 00   192. 00   192. 00   192. 02   19202   MOB   0   0   0   0   0   0   192. 02   193. 00   19300   NONPAID WORKERS   0   0   0   0   0   0   193. 00   193. 00   19300   19	118.0	O SUBTOTALS (SUM OF LINES 1 through 117)	2, 877, 696	64, 642	884, 788	487, 578	414, 488	118. 00
191. 00   19100   RESEARCH		NONREI MBURSABLE COST CENTERS						
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 192.02 19202 MOB 0 0 0 0 0 192.02 193.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 0 0 194.00 200.00 Cross Foot Adjustments 0 Negative Cost Centers 0 0 0 0 0 0 0 0 0 201.00	190.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 02 19202 MOB 0 0 0 0 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 194. 00 1950 LEASED SPACE 0 0 0 0 0 194. 00 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 201. 00	191.0	0 19100 RESEARCH	0	0	0	0	0	191. 00
193. 00   19300   NONPAI D WORKERS	192.0	0 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
194.00     07950     LEASED SPACE     0     0     0     0     194.00       200.00     Cross Foot Adjustments     200.00       201.00     Negative Cost Centers     0     0     0     0     0     0     0	192.0	2 19202 MOB	0	0	0	o	0	192. 02
200.00       Cross Foot Adjustments       200.00         201.00       Negative Cost Centers       0       0       0       0       0       0       201.00	193.0	O 19300 NONPALD WORKERS	0	0	0	o	0	193. 00
201.00   Negative Cost Centers   0   0   0   0   201.00	194.0	0 07950 LEASED SPACE	0	0	0	o	0	194. 00
201.00   Negative Cost Centers   0   0   0   0   201.00	200.0	O Cross Foot Adjustments						200. 00
	201.0	1 1	0	0	0	o	0	201. 00
	202.0	0 TOTAL (sum lines 118 through 201)	2, 877, 696	64, 642	884, 788	487, 578	414, 488	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1316

				То	12/31/2023	Date/Time Pre 5/29/2024 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	Subtotal	JZ UIII
		13.00	14. 00	15. 00	16. 00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2 027 05/					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 027, 056	050 507				13.00
14. 00 15. 00	O1400   CENTRAL SERVI CES & SUPPLY   O1500   PHARMACY	0	952, 526				14. 00
16. 00		0	26, 539 0		o		15. 00 16. 00
16.00	01600 MEDICAL RECORDS & LIBRARY I NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	0	U U	······································		16.00
30. 00	03000 ADULTS & PEDIATRICS	836, 307	130, 383	16, 568	ol	5, 156, 867	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	030, 307	130, 303	10, 300	9	3, 130, 007	30.00
50.00	05000 OPERATING ROOM	124, 179	155, 830	12, 346	ol	2, 387, 707	50.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	22, 724		o	2, 401, 183	
60.00	06000 LABORATORY	0	22, 183		o o	3, 257, 303	
66. 00	06600 PHYSI CAL THERAPY	0	3, 651	0	0	1, 455, 886	
67. 00	06700 OCCUPATI ONAL THERAPY	o	0, 551	0	0	295, 304	
68. 00	06800 SPEECH PATHOLOGY	0	0	Ō	0	215, 118	1
69. 00	06900 ELECTROCARDI OLOGY	o	24, 818	l o	0	190, 978	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	260, 335		o	337, 937	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 795		0	17, 907	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	320, 228	0	654, 611	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0		0	2, 231, 846	
76.00	03160 CARDI OPULMONARY	367	47, 981	1, 084	0	1, 918, 551	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	O	0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	O	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
91. 00	09100 EMERGENCY	1, 066, 203	244, 287	67, 512	0	7, 169, 558	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10100 HOME HEALTH AGENCY	0	0		0		101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS	0.007.05/	050 507	4 544 000		07 (00 75)	440 00
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	2, 027, 056	952, 526	1, 514, 929	0	27, 690, 756	1118.00
100.00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	l ol	0	0	ol		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		ol Ol		190.00
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		191.00
	19200 PHISICIANS PRIVATE OFFICES		0	0	0		192. 00
	19202  MOB   19300  NONPALD WORKERS		0	0	0		192. 02
	07950 LEASED SPACE		0	0	0		194. 00
200.00			U		٩		200. 00
200.00	,		0				200.00
201.00		2, 027, 056	952, 526	1, 514, 929	0	27, 690, 756	
202.00	1 1.0 (Sum 111105 110 till Sugil 201)	2, 327, 030	752, 520	1,011,727	9	27, 070, 700	1232.00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1316 Peri od: Worksheet B From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/29/2024 11:32 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 5, 156, 867 30.00 ANCILLARY SERVICE COST CENTERS 2, 387, 707 50.00 05000 OPERATING ROOM 50.00 0000000000000 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 401, 183 54.00 60.00 06000 LABORATORY 3, 257, 303 60.00 66. 00 06600 PHYSI CAL THERAPY 1, 455, 886 66.00 06700 OCCUPATIONAL THERAPY 67 00 295, 304 67 00 68.00 06800 SPEECH PATHOLOGY 215, 118 68.00 69.00 06900 ELECTROCARDI OLOGY 190, 978 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 337, 937 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 907 72.00 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 654, 611 73.00 07301 ONCOLOGY DRUGS 2, 231, 846 73.01 73.01 03160 CARDI OPULMONARY 1, 918, 551 76.00 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 Ω 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 91.00 7, 169, 558 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 27, 690, 756 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 191. 00 19100 RESEARCH 0000000 0 191. 00 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 02 19202 MOB 0 192. 02 193. 00 19300 NONPALD WORKERS 0 193.00 194.00 07950 LEASED SPACE 0 194. 00 200.00 Cross Foot Adjustments 200. 00 0 201.00 Negative Cost Centers 201.00 202.00 TOTAL (sum lines 118 through 201) 27, 690, 756 202.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1316

				To	12/31/2023	Date/Time Pre 5/29/2024 11:	
			CAPI TAL			3/29/2024 11.	32 dili
			RELATED COSTS				
	Cost Center Description	Di rectly	BLDG & FLXT	Subtotal	EMPLOYEE	ADMI NI STRATI VE	
	oost conten bosci i pti on	Assigned New	DEDG & TTXT	Subtotal	BENEFI TS	& GENERAL	
		Capi tal			DEPARTMENT	Q 02.12.012	
		Related Costs			DEI / III / III EI II		
		0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	5, 552	5, 552	5, 552		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	447, 710	447, 710	60	447, 770	5. 00
7.00	00700 OPERATION OF PLANT	0	304, 581	304, 581	452	46, 534	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	1, 045	8. 00
9.00	00900 HOUSEKEEPI NG	0	42, 501	42, 501	237	13, 356	9. 00
10.00	01000 DI ETARY	0	60, 631	60, 631	99	6, 102	10. 00
11. 00	01100 CAFETERI A	0	46, 137	46, 137	86	5, 346	11. 00
13.00	01300 NURSING ADMINISTRATION	0	39, 356		732	30, 934	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	95, 516		0		14. 00
15. 00	01500 PHARMACY	0	70, 114	·	252	21, 758	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0			0		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		<u>'</u>				
30.00	03000 ADULTS & PEDI ATRI CS	0	403, 046	403, 046	851	45, 524	30.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	316, 767	316, 767	268	24, 238	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	190, 394		728	31, 896	54.00
60.00	06000 LABORATORY	0	76, 796	76, 796	0	49, 045	60.00
66.00	06600 PHYSI CAL THERAPY	0	178, 504		0	18, 235	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	11, 104	11, 104	0	4, 449	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	12, 136		88	3, 035	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	9, 729	9, 729	59	2, 332	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	1, 255	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	66	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	5, 407	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0	0	0	18, 435	73. 01
76. 00	03160 CARDI OPULMONARY	0	148, 188	148, 188	574	25, 162	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS		•				
90.00	09000 CLI NI C	0	0	0	0	0	90. 00
91.00	09100 EMERGENCY	0	378, 430	378, 430	1, 066	81, 022	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0			92. 00
	OTHER REIMBURSABLE COST CENTERS						
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		0	2, 837, 192	2, 837, 192	5, 552	447, 770	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-		0		190. 00
	19100 RESEARCH	0	0		0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	-	0		192. 00
	19202 MOB	0	0	0	0		192. 02
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 LEASED SPACE	0	0	0	0	0	194. 00
200.00	1 1			0			200. 00
201.00	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	0	2, 837, 192	2, 837, 192	5, 552	447, 770	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1316

				To	12/31/2023	Date/Time Pre 5/29/2024 11:	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DIETARY	CAFETERI A	32 8111
	cost center bescriptron	PLANT	LINEN SERVICE	HOUSEKEELLING	DILIANI	CALLILITA	
		7.00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	351, 567					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	1, 045				8. 00
9.00	00900 HOUSEKEEPI NG	7, 186	0	63, 280			9. 00
10.00	01000 DI ETARY	10, 251	0	1, 884	78, 967		10.00
11.00	01100 CAFETERI A	7, 801	0	1, 433	0	60, 803	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 654	0	1, 223	0	6, 235	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	16, 149	0	2, 967	0	0	14. 00
15.00	01500 PHARMACY	11, 855	0	2, 178	0	2, 252	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	68, 146	1, 045	12, 522	78, 967	10, 747	30. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	53, 557	0	9, 841	0	3, 007	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	32, 191	0	5, 915	0	7, 975	54.00
60.00	06000 LABORATORY	12, 984	0	2, 386	0	9, 172	60.00
66. 00	06600 PHYSI CAL THERAPY	30, 181	0	5, 546	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 877	0	345	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	2, 052	0	377	0	787	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 645	0	302	0	622	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01	07301 ONCOLOGY DRUGS	0	0	0	0	0	
76. 00	03160 CARDI OPULMONARY	25, 055	0	4, 604	0	6, 401	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	-	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	ı					4
90.00	09000 CLI NI C	0	1	- 1	0	0	
91. 00	09100 EMERGENCY	63, 983	0	11, 757	0	13, 605	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS	_			ما		
	10100 HOME HEALTH AGENCY	0	·		0		101. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS	054 547			70.047	40.000	
118.00		351, 567	1, 045	63, 280	78, 967	60, 803	118. 00
400.00	NONREI MBURSABLE COST CENTERS				اء		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	ľ	- 1	0		190. 00
	19100 RESEARCH	0	0		0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
	19202 MOB	0	0	0	0		192. 02
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	07950 LEASED SPACE	0	0	0	O	O	194. 00
200.00	J		_				200. 00
201.00	1 1 9	0	1 045	(2.222	70.07		201. 00
202.00	TOTAL (sum lines 118 through 201)	351, 567	1, 045	63, 280	78, 967	60, 803	202. 00

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1316

				To	12/31/2023	Date/Time Pre 5/29/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	Subtotal	32 aiii
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
		40.00	SUPPLY	45.00	LI BRARY	04.00	
	GENERAL SERVICE COST CENTERS	13. 00	14. 00	15. 00	16. 00	24. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13. 00	01300 NURSING ADMINISTRATION	85, 134					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	127, 226				14. 00
15. 00	01500 PHARMACY	l ol	3, 545				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	l ol	0		o		16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-,		
30.00	03000 ADULTS & PEDI ATRI CS	35, 124	17, 415	1, 224	0	674, 611	30.00
	ANCILLARY SERVICE COST CENTERS	· · · · · ·	·				
50.00	05000 OPERATI NG ROOM	5, 215	20, 814	912	0	434, 619	50.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	3, 035	399	0	272, 533	54.00
60.00	06000 LABORATORY	0	2, 963	0	0	153, 346	60.00
66.00	06600 PHYSI CAL THERAPY	0	488	0	0	232, 954	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	17, 775	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	18, 475	
69. 00	06900 ELECTROCARDI OLOGY	0	3, 315		0	18, 004	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	34, 770		0	36, 025	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 843		0	1, 909	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	,	0	29, 072	•
73. 01	07301 ONCOLOGY DRUGS	0	0	,	0	99, 120	
76. 00	03160 CARDI OPULMONARY	15	6, 409		0	216, 488	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	-	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS				ما		00.00
90.00	09000 CLINIC	0	0		0	(22.2(1	90.00
91. 00 92. 00	09100 EMERGENCY	44, 780	32, 629	4, 989	o <sub>l</sub>	632, 261	91.00
92.00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS						92. 00
101 00	10100 HOME HEALTH AGENCY	0	0	O	0	0	101. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	<u> </u>		102.00
118.00		85, 134	127, 226	111, 954	0	2, 837, 192	118 00
110.00	NONREI MBURSABLE COST CENTERS	05, 154	127, 220	111, 754	<u> </u>	2,037,172	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0		o		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	o	0		o		192. 00
	19202 MOB	O	0	0	O		192. 02
	19300 NONPALD WORKERS		0	o	o		193. 00
	07950 LEASED SPACE	0	0	0	o		194. 00
200.00	Cross Foot Adjustments					0	200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	85, 134	127, 226	111, 954	0	2, 837, 192	202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1316 Peri od: Worksheet B From 01/01/2023 Part II 12/31/2023 Date/Time Prepared: 5/29/2024 11:32 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPING 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 674, 611 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 434, 619 05400 RADI OLOGY-DI AGNOSTI C 54.00 272, 533 54.00 60.00 06000 LABORATORY 153, 346 60.00 000000000000 66. 00 06600 PHYSI CAL THERAPY 232, 954 66.00 17, 775 06700 OCCUPATIONAL THERAPY 67 00 67 00 06800 SPEECH PATHOLOGY 68.00 18, 475 68.00 69.00 06900 ELECTROCARDI OLOGY 18,004 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 36, 025 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 909 72.00 72 00 07300 DRUGS CHARGED TO PATIENTS 73.00 29, 072 73.00 07301 ONCOLOGY DRUGS 99, 120 73.01 73.01 03160 CARDI OPULMONARY 76.00 76.00 216, 488 77.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 90.00 09100 EMERGENCY 91.00 632, 261 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 2, 837, 192 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0000000 0 191. 00 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 02 19202 MOB 0 192. 02 193. 00 19300 NONPALD WORKERS 0 193.00 194.00 07950 LEASED SPACE 0 194. 00 200.00 Cross Foot Adjustments 200. 00 0

Ω

2, 837, 192

201.00

202.00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Heal th	Financial Systems	IU HEALTH FRANKF	FORT HOSPITAL		In Lie	u of Form CMS-	<u> 2552-10</u>
COST A	LLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared:
					10 12/31/2023	5/29/2024 11:	
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliation	n ADMI NI STRATI VE	OPERATION OF	
	·	(SQUARE FEET)	BENEFITS		& GENERAL	PLANT	
			DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS		(	, ,	
			SALARI ES)				
		1.00	4.00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	57, 744					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	113	6, 532, 128	3			4.00
5.00	00500 ADMINISTRATIVE & GENERAL	9, 112	70, 977		3 20, 942, 693		5. 00
7.00	00700 OPERATION OF PLANT	6, 199	531, 982	1	0 2, 176, 419		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	0	1	0 48, 889		1
9. 00	00900 HOUSEKEEPI NG	865	279, 356	1	0 624, 685	865	1
10.00	01000 DI ETARY	1, 234	116, 280	1	0 285, 377	1, 234	1
11. 00	01100 CAFETERI A	939	100, 927		0 250, 032	939	
13. 00	01300 NURSING ADMINISTRATION	801	861, 178	1	0 1, 446, 804	801	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 944	001, 170	1	0 589, 046	1, 944	1
15. 00	01500 PHARMACY	1	295, 927	1			
		1, 427		1			1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	/	0 0	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.202	1 001 005	-T	0 2 120 100	0.202	20.00
30. 00	03000 ADULTS & PEDI ATRI CS	8, 203	1, 001, 025		0 2, 129, 198	8, 203	30.00
F0 00	ANCILLARY SERVICE COST CENTERS		044.007	, I	0 4 400 (00		
50.00	05000 OPERATING ROOM	6, 447	314, 987	1	0 1, 133, 600	6, 447	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 875	856, 326	1	0 1, 491, 808		1
60.00	06000 LABORATORY	1, 563	0	1	0 2, 293, 841	1, 563	1
66. 00	06600 PHYSI CAL THERAPY	3, 633	0	1	0 852, 853	3, 633	1
67. 00	06700 OCCUPATI ONAL THERAPY	226	0	1	0 208, 069	226	
68. 00	06800 SPEECH PATHOLOGY	247	103, 215		0 141, 946	247	1
69. 00	06900 ELECTROCARDI OLOGY	198	68, 924	1	0 109, 082	198	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 58, 691	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 3, 110	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 252, 896	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0		0 862, 231	0	73. 01
76.00	03160 CARDI OPULMONARY	3, 016	675, 524		0 1, 176, 836	3, 016	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	O		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			•			
90.00	09000 CLI NI C	0	C		0 0	0	90.00
91.00	09100 EMERGENCY	7, 702	1, 255, 500		0 3, 789, 632	7, 702	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		1			
101.00	10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
	10200 OPI OI D TREATMENT PROGRAM	o	0		0		102.00
	SPECIAL PURPOSE COST CENTERS	-1	<del>-</del>		<u>-,                                    </u>		
118.00		57, 744	6, 532, 128	-6, 748, 06	3 20, 942, 693	42 320	118. 00
	NONREI MBURSABLE COST CENTERS	3.77.11	0,002,120	, 0,,,0,00	2011121010	12,020	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
	19100 RESEARCH	o	0	1	o o		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES		0	1	o o		192. 00
	19202 MOB	0	0		0		192. 02
	19300 NONPALD WORKERS	0	0			0	193. 00
	07950 LEASED SPACE	0	0		0		194. 00
		۷	U	ή '	U U	0	
200.00							200.00
201.00		2 027 102	1 100 0/7	,	/ 740 0/2	2 077 /0/	201. 00
202.00	71	2, 837, 192	1, 183, 367		6, 748, 063	2, 877, 696	202.00
000 00	Part I)	40. 400074	0 4044/4		0.000047	/7 000 400	000 00
203.00		49. 133971	0. 181161	1	0. 322216		
204.00			5, 552	2	447, 770	351, 567	204.00
	Part II)						
205.00			0. 000850	ין	0. 021381	8. 307349	205. 00
001 5							00/ 05
206. 00							206. 00
207.00	(per Wkst. B-2)						207.00
207. 00							207. 00
	Parts III and IV)	1		1		I	I

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 11:32 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (SQUARE FEET) (PATIENT DAYS) ADMI NI STRATI ON (FTE'S) (PATIENT DAYS) (DI RECT NURSING HOURS) 8.00 9.00 10.00 11.00 13.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 1,087 8.00 8.00 00900 HOUSEKEEPI NG 9.00 41, 455 9 00 10.00 01000 DI ETARY 0 1, 234 1,087 10.00 11.00 01100 CAFETERI A 0 939 7,723 11.00 0 01300 NURSING ADMINISTRATION 0 66, 209 13 00 801 792 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 944 0 0 0 14.00 15.00 01500 PHARMACY 0 1, 427 0 286 0 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 0 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 1,087 8, 203 1,087 1, 365 27, 316 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 447 0 0 382 4,056 50 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3, 875 1,013 0 54.00 06000 LABORATORY 0 0 60.00 60.00 1, 563 1, 165 0 66.00 06600 PHYSI CAL THERAPY 0000000000 0 66.00 3, 633 0 06700 OCCUPATIONAL THERAPY 0 0 67 00 226 0 67 00 0 68.00 06800 SPEECH PATHOLOGY 247 100 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 198 79 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C o 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 72 00 Ω 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 07301 ONCOLOGY DRUGS 0 0 0 73.01 73.01 03160 CARDI OPULMONARY 0 76.00 3.016 813 12 76, 00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 0 0 0 09100 EMERGENCY 0 91.00 0 7, 702 1, 728 34, 825 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 0 101, 00 0 0 102.00 10200 OPI OI D TREATMENT PROGRAM O 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 087 41, 455 1, 087 7, 723 66, 209 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 0 192. 02 19202 MOB 0 C 0 0 0 192. 02 193.00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 LEASED SPACE 0 0 0 0 194.00 C 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 414, 488 202.00 Cost to be allocated (per Wkst. B, 64,642 884, 788 487, 578 2, 027, 056 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 448. 553818 53. 669299 30. 616019 203. 00 59. 468261 21. 343336 85, 134 204. 00 204.00 Cost to be allocated (per Wkst. B, 1,045 63, 280 78.967 60.803 Part II) Unit cost multiplier (Wkst. B, Part 7.872977 1. 285837 205. 00 205.00 0.961362 1.526474 72.646734 H)

206 00

207 00

206 00

207 00

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

(per Wkst. B-2)

Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1316 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 11:32 am Cost Center Description CENTRAL PHARMACY MEDI CAL SERVICES & RECORDS & (COSTED SUPPLY REQUIS.) LI BRARY (TIME SPENT) (COSTED REQUIS.) 15.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 214, 741 14.00 15.00 01500 PHARMACY 5, 983 1, 196, 398 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 29, 394 13, 084 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 35, 131 9 750 0 50 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 5, 123 4, 265 54.00 60.00 06000 LABORATORY 5,001 0 60.00 C 0 66.00 06600 PHYSI CAL THERAPY 823 66.00 0 06700 OCCUPATIONAL THERAPY 0 67 00 Ω 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 5, 595 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 58, 691 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 72 00 3.110 C 73.00 07300 DRUGS CHARGED TO PATIENTS 252, 896 73.00 0 07301 ONCOLOGY DRUGS 862, 230 0 73.01 73.01 03160 CARDI OPULMONARY 0 76.00 10.817 856 76, 00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 C 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 90.00 09100 EMERGENCY 55,073 0 91.00 53, 317 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 101.00 10100 HOME HEALTH AGENCY 101.00 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 214, 741 1, 196, 398 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 191. 00 19100 RESEARCH 0 0 191. 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 0 0 192. 02 19202 MOB 0 0 192. 02 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 LEASED SPACE 0 C 0 194.00 Cross Foot Adjustments 200. 00 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 952, 526 1, 514, 929 0 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 4. 435697 0.000000 203.00 1. 266242 204.00 Cost to be allocated (per Wkst. B, 127, 226 111, 954 204.00 Part II) Unit cost multiplier (Wkst. B, Part 0.592463 0.093576 0.000000 205.00 205.00 H) 206 00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207 00 NAHE unit cost multiplier (Wkst. D, 207 00 Parts III and IV)

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316	Period: Worksheet C From 01/01/2023 Part I
		To 12/31/2023 Part I me Prenared

				From 01/01/2023 Fo 12/31/2023	Date/Time Pre	
		T: +1 -	WILL	11	5/29/2024 11:	32 am_
		IIIIE	XVIII	Hospi tal Costs	Cost	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
	Part I, col.	Auj .		Di Sai i Owance		
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDI ATRI CS	5, 156, 867		5, 156, 867	7 0	0	30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 387, 707		2, 387, 707	7 0	0	50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 401, 183		2, 401, 183		0	54. 00
60. 00   06000   LABORATORY	3, 257, 303		3, 257, 303	3 0	0	60.00
66. 00  06600  PHYSI CAL THERAPY	1, 455, 886	l e	1, 455, 886		0	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	295, 304		295, 304		0	67. 00
68. 00   06800   SPEECH PATHOLOGY	215, 118		215, 118		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	190, 978	l e	190, 978		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	337, 937		337, 937		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 907		17, 907		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	654, 611		654, 611		0	73. 00
73. 01 07301 ONCOLOGY DRUGS	2, 231, 846		2, 231, 846		0	73. 01
76. 00   03160   CARDI OPULMONARY	1, 918, 551		1, 918, 551	0	0	76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0		(	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						00.00
90. 00   09000   CLI NI C	7 1/0 550	l	7 1/0 55	-	0	70.00
91. 00 09100 EMERGENCY	7, 169, 558	l .	7, 169, 558		0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1, 671, 309		1, 671, 309	7	0	92.00
101.00 10100 HOME HEALTH AGENCY	1 0		1		0	101.00
102. 00 10200 OPLOLD TREATMENT PROGRAM	0					102.00
200.00 Subtotal (see instructions)	29, 362, 065	0	29, 362, 065	5		200.00
201.00 Less Observation Beds	1, 671, 309	l e	1, 671, 309			201.00
202.00 Total (see instructions)	27, 690, 756	l e				202. 00
232.33	2.,0,0,,00	١ ٠	2.,070,700	٥,		1202.00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316		Worksheet C Part I Date/Time Prepared: 5/29/2024 11:32 am

					rom 01/01/2023 To 12/31/2023	Part     Date/Time Pre	nared·
				'	12/01/2020	5/29/2024 11:	
			Title	xVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	1, 989, 795		1, 989, 795	5		30. 00
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	5, 595, 755			0.000000	
	RADI OLOGY-DI AGNOSTI C	310, 439	12, 544, 074	12, 854, 513	0. 186797	0.000000	54.00
	LABORATORY	508, 723	5, 728, 138	6, 236, 861		0.000000	60.00
	PHYSI CAL THERAPY	385, 053	2, 940, 036	3, 325, 089	0. 437849	0.000000	
	OCCUPATIONAL THERAPY	196, 942	1, 024, 426	1, 221, 368		0.000000	
68.00 06800	SPEECH PATHOLOGY	57, 112	530, 764	587, 87 <i>6</i>	0. 365924	0.000000	68. 00
69.00 06900	ELECTROCARDI OLOGY	0	1, 139, 007	1, 139, 007	0. 167671	0.000000	69. 00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69, 399	69, 399	4. 869479	0.000000	71. 00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	121, 152	121, 152	0. 147806	0.000000	72. 00
73.00 07300	DRUGS CHARGED TO PATIENTS	758, 442	2, 072, 387	2, 830, 829	0. 231244	0.000000	73. 00
73. 01 07301	ONCOLOGY DRUGS	0	5, 457, 748	5, 457, 748	0. 408932	0.000000	73. 01
76. 00 03160	CARDI OPULMONARY	537, 381	3, 810, 181	4, 347, 562	0. 441294	0.000000	76. 00
77. 00 07700	ALLOGENEIC HSCT ACQUISITION	0	0	(	0.000000	0.000000	77. 00
78.00 07800	CAR T-CELL IMMUNOTHERAPY	0	0	(	0.000000	0.000000	78. 00
	ATIENT SERVICE COST CENTERS						
	CLINIC	0	0	(	0.000000	0.000000	
	EMERGENCY	287, 017	26, 458, 127	26, 745, 144		0.000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	6, 351	2, 513, 674	2, 520, 025	0. 663211	0. 000000	92.00
	R REIMBURSABLE COST CENTERS						
	HOME HEALTH AGENCY	0	0	(			101. 00
	OPIOID TREATMENT PROGRAM	0	0	(			102. 00
200. 00	Subtotal (see instructions)	5, 037, 255	70, 004, 868	75, 042, 123	3		200. 00
201. 00	Less Observation Beds						201. 00
202.00	Total (see instructions)	5, 037, 255	70, 004, 868	75, 042, 123	3		202. 00

Health Financial Systems	IU HEALTH FRANKF	ORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 11:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				

				5/29/2024 11:32 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATING ROOM	0. 000000			50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00   06000   LABORATORY	0. 000000			60. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01   07301   0NCOLOGY DRUGS	0. 000000			73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
102.00 10200 OPIOID TREATMENT PROGRAM				102. 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 FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316	From 01/01/2023 F To 12/31/2023 D	Worksheet C Part I Date/Time Prepared: 5/29/2024 11:32 am		

				j	To 12/31/2023	Date/Time Pre 5/29/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		l				
	03000 ADULTS & PEDIATRICS	5, 156, 867		5, 156, 867	7 0	5, 156, 867	30.00
	ANCILLARY SERVICE COST CENTERS	0.007.707	1				
	05000 OPERATING ROOM	2, 387, 707	l e	2, 387, 707		2, 387, 707	
	05400 RADI OLOGY-DI AGNOSTI C	2, 401, 183	l e	2, 401, 183		2, 401, 183	
	06000 LABORATORY	3, 257, 303		3, 257, 303		3, 257, 303	
	06600 PHYSI CAL THERAPY	1, 455, 886	l e	1, 455, 886		1, 455, 886	
	06700 OCCUPATI ONAL THERAPY	295, 304	l e	295, 304		295, 304	
	06800 SPEECH PATHOLOGY	215, 118		215, 118		215, 118	
	06900 ELECTROCARDI OLOGY	190, 978		190, 978		190, 978	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	337, 937	l e	337, 937		337, 937	
	07200 I MPL. DEV. CHARGED TO PATIENTS	17, 907		17, 907		17, 907	
	07300 DRUGS CHARGED TO PATIENTS	654, 611		654, 611		654, 611	
	07301 ONCOLOGY DRUGS	2, 231, 846		2, 231, 846		2, 231, 846	
	03160 CARDI OPULMONARY	1, 918, 551		1, 918, 551	0	1, 918, 551	
	07700 ALLOGENEIC HSCT ACQUISITION	0			0	0	1
	07800 CAR T-CELL IMMUNOTHERAPY	1 0		(	)  0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	1 0					90.00
				1	· · · · · · · ·	7 1/0 550	
	09100 EMERGENCY	7, 169, 558		7, 169, 558		7, 169, 558	
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	1, 671, 309		1, 671, 309	<del>/</del>	1, 671, 309	92. 00
	OTHER REIMBURSABLE COST CENTERS  10100 HOME HEALTH AGENCY			1	1		101. 00
	10200 OPI OLD TREATMENT PROGRAM	0					101.00
200. 00		20 242 045	,	20 242 04		29, 362, 065	
		29, 362, 065	ł	29, 362, 065			
201. 00	l	1, 671, 309	l e	1, 671, 309		1, 671, 309	
202. 00	Total (see instructions)	27, 690, 756	0	27, 690, 756	6 0	27, 690, 756	1202. UU

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 11:	
	Title XIX	Hospi tal	PPS	

				Т	o 12/31/2023	Date/Time Pre 5/29/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
			Charges		·		
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS	1, 989, 795		1, 989, 795			30. 00
	LARY SERVICE COST CENTERS						1
	OPERATING ROOM	0	5, 595, 755			0. 000000	
	RADI OLOGY-DI AGNOSTI C	310, 439	12, 544, 074			0. 000000	
	LABORATORY	508, 723	5, 728, 138			0. 000000	1
	PHYSI CAL THERAPY	385, 053	2, 940, 036			0. 000000	1
	OCCUPATI ONAL THERAPY	196, 942	1, 024, 426			0. 000000	1
	SPEECH PATHOLOGY	57, 112	530, 764			0. 000000	
•	ELECTROCARDI OLOGY	0	1, 139, 007			0. 000000	1
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69, 399			0. 000000	1
	IMPL. DEV. CHARGED TO PATIENTS	0	121, 152			0. 000000	1
	DRUGS CHARGED TO PATIENTS	758, 442	2, 072, 387			0. 000000	1
	ONCOLOGY DRUGS	0	5, 457, 748	5, 457, 748		0. 000000	1
	CARDI OPULMONARY	537, 381	3, 810, 181	4, 347, 562		0. 000000	
	ALLOGENEIC HSCT ACQUISITION	0	0	0	0. 000000	0. 000000	1
	CAR T-CELL IMMUNOTHERAPY	0	0	C	0.000000	0. 000000	78. 00
	TIENT SERVICE COST CENTERS						
	CLINIC	0	0			0. 000000	1
	EMERGENCY	287, 017	26, 458, 127			0. 000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	6, 351	2, 513, 674	2, 520, 025	0. 663211	0. 000000	92. 00
	REIMBURSABLE COST CENTERS						
	HOME HEALTH AGENCY	0	0	0			101. 00
	OPIOID TREATMENT PROGRAM	0	0	0			102. 00
200. 00	Subtotal (see instructions)	5, 037, 255	70, 004, 868	75, 042, 123			200. 00
201. 00	Less Observation Beds						201. 00
202.00	Total (see instructions)	5, 037, 255	70, 004, 868	75, 042, 123			202. 00

Health Financial Systems	IU HEALTH FRANKFO	ORT HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prep 5/29/2024 11:3	
		Title XIX	Hospi tal	PPS	
Cost Contor Description	DDS Innationt		· · · · · · · · · · · · · · · · · · ·		

				5/29/2024 II: 32 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATI NG ROOM	0. 426700			50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 186797			54.00
60. 00   06000   LABORATORY	0. 522266			60.00
66. 00   06600 PHYSI CAL THERAPY	0. 437849			66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0. 241781			67. 00
68. 00   06800   SPEECH PATHOLOGY	0. 365924			68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 167671			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4. 869479			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 147806			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 231244			73. 00
73. 01   07301   0NCOLOGY DRUGS	0. 408932			73. 01
76. 00 03160 CARDI OPULMONARY	0. 441294			76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00   09100   EMERGENCY	0. 268070			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 663211			92. 00
OTHER REIMBURSABLE COST CENTERS				
101.00 10100 HOME HEALTH AGENCY				101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
				•

				10 12/31/2023	5/29/2024 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cos		Operating Cost	
	(Wkst. B, Part	•			Reduction	
	I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
			col . 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				_1		
50. 00   05000   OPERATI NG ROOM	2, 387, 707	434, 619			0	00.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	2, 401, 183	272, 533			0	1 0 00
60. 00   06000   LABORATORY	3, 257, 303	153, 346			0	60.00
66. 00 06600 PHYSI CAL THERAPY	1, 455, 886	232, 954			0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	295, 304	17, 775			0	67. 00
68.00 06800 SPEECH PATHOLOGY	215, 118	18, 475			0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	190, 978				0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	337, 937	36, 025			0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 907	1, 909			0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	654, 611	29, 072			0	73. 00
73. 01   07301   0NCOLOGY DRUGS	2, 231, 846	99, 120			0	73. 01
76. 00 03160 CARDI OPULMONARY	1, 918, 551	216, 488	1, 702, 06	3 0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0		0	0	, 0. 00
91. 00   09100   EMERGENCY	7, 169, 558	632, 261			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 671, 309	218, 637	1, 452, 67	2 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS				_		
101.00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		0	-	102. 00
200.00 Subtotal (sum of lines 50 thru 199)	24, 205, 198	2, 381, 218				200. 00
201.00 Less Observation Beds	1, 671, 309	218, 637				201. 00
202.00   Total (line 200 minus line 201)	22, 533, 889	2, 162, 581	20, 371, 30	8 0	0	202. 00

Health Financial Systems IU HEALTH FRANKFORT HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Provider CCN: 15-1316 | Period: From 01/01/2023 | Part II Date/Time Prepared: 5/29/2024 11: 32 am

Title XIX						5/29/2024 11: 32	am
Capital and Operating Cost Part I, column Ratio (col. 6 Reduction 8)			Ti tl	e XIX	Hospi tal	PPS	
ANCI LLARY SERVICE COST CENTERS   6.00   7.00   8.00	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
Reduction   8)							
ANCI LLARY SERVI CE COST CENTERS   5.00   05000   0PERATI NG ROOM   2,387,707   5,595,755   0.426700   55.00   05400   RADI OLOGY - DI AGNOSTI C   2,401,183   12,854,513   0.186797   54.00   06000   LABORATORY   3,257,303   6,236,861   0.522266   66.00   06000   LABORATORY   1,455,886   3,325,089   0.437849   66.00   06700   0CCUPATI ONAL THERAPY   1,455,886   3,325,089   0.437849   66.00   06700   0CCUPATI ONAL THERAPY   295,304   1,221,368   0.241781   67.00   68.00   06800   SPEECH PATHOLOGY   215,118   587,876   0.365924   68.00   69.00   06900   ELECTROCARDI OLOGY   190,978   1,139,007   0.167671   69.00   07100   MeDI CAL SUPPLI ES CHARGED TO PATI ENTS   337,937   69,399   4.869479   71.00   07100   MeDI CAL SUPPLI ES CHARGED TO PATI ENTS   17,907   121,152   0.147806   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   654,611   2,830,829   0.231244   73.00   07301   0NCOLOGY DRUGS   2,231,846   5,457,748   0.408932   73.01   76.00   03160   CARDI OPULMONARY   1,918,551   4,347,562   0.441294   76.00   0.07700   ALLOGENEI C HSCT ACQUI SI TI ON   0   0   0.000000   77.00   00TPATI ENT SERVI CE COST CENTERS   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.							
ANCILLARY SERVICE COST CENTERS							
50.00   05000   0PERATI NG ROOM   2,387,707   5,595,755   0.426700   50.00   54.00   64.00   64.00   64.00   64.00   64.00   64.00   66.00		6. 00	7. 00	8. 00			
54. 00							
60. 00							
66. 00	· · · · · · · · · · · · · · · · · · ·					•	
67. 00						·	
68. 00						·	
69. 00						·	
71. 00	68. 00   06800   SPEECH PATHOLOGY	215, 118	587, 876	0. 365924			
72. 00	69. 00   06900   ELECTROCARDI OLOGY	190, 978	1, 139, 007	0. 167671			
73. 00   07300   DRUGS CHARGED TO PATIENTS   654, 611   2,830,829   0.231244   73. 00   73. 01   07301   0NCOLOGY DRUGS   2,231,846   5,457,748   0.408932   73. 01   07301   0NCOLOGY DRUGS   1,918,551   4,347,562   0.441294   76. 00   0.70000   0.70000   0.70000   0.70000   0.700000   0.70000   0.700000   0.700000   0.700000   0.700000   0.700000   0.700000   0.7000000   0.7000000   0.7000000   0.7000000   0.7000000   0.70000000   0.70000000   0.70000000   0.70000000   0.70000000   0.700000000   0.700000000   0.70000000000		337, 937	69, 399	4. 869479			
73. 01   07301   0NCOLOGY DRUGS   2, 231, 846   5, 457, 748   0. 408932   73. 01   76. 00   03160   CARDI OPULMONARY   1, 918, 551   4, 347, 562   0. 441294   76. 00   07700   ALLOGENEI C HSCT ACQUISITION   0   0   0. 000000   0. 000000   77. 00   07800   CAR T - CELL IMMUNOTHERAPY   0   0   0. 000000   0. 000000   78. 00   000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	17, 907				72	2.00
76. 00		654, 611	2, 830, 829	0. 231244		7:	3.00
77. 00	73. 01   07301   0NCOLOGY DRUGS	2, 231, 846	5, 457, 748	0. 408932		7;	3. 01
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0.0000000 78. 00 00 0.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.0000000 90.00000000	76. 00   03160   CARDI OPULMONARY	1, 918, 551	4, 347, 562	0. 441294		70	6.00
OUTPATIENT SERVICE COST CENTERS           90. 00         09000 CLINIC         0         0.000000         90.00           91. 00         09100 EMERGENCY         7, 169, 558         26, 745, 144         0. 268070         91. 00           92. 00         09200 OBSERVATION BEDS (NON-DISTINCT PART)         1, 671, 309         2, 520, 025         0. 663211         92. 00           OTHER REIMBURSABLE COST CENTERS	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000		7	7. 00
90. 00		0	0	0.000000		78	8.00
91. 00   09100   EMERGENCY   7, 169, 558   26, 745, 144   0. 268070   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   1, 671, 309   2, 520, 025   0. 663211   92. 00   00	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1, 671, 309 2, 520, 025 0. 663211 92. 00 OTHER REIMBURSABLE COST CENTERS		0	0	0.000000		90	0.00
OTHER REIMBURSABLE COST CENTERS	91. 00   09100   EMERGENCY	7, 169, 558	26, 745, 144	0. 268070		9.	1. 00
	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 671, 309	2, 520, 025	0. 663211		92	2.00
101 00 10100 HOME HEALTH ACENCY 0 0 0 0000000	OTHER REIMBURSABLE COST CENTERS						
101. 00 10100 10WE 11EAE111 AGENCT 0  0. 000000	101.00 10100 HOME HEALTH AGENCY	0	0	0.000000		10	1. 00
102. 00   10200   OPI OI D TREATMENT PROGRAM 0 0 0. 000000 102. 00	102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0.000000		102	2.00
200.00   Subtotal (sum of lines 50 thru 199)   24,205,198   73,052,328   200.00	200.00 Subtotal (sum of lines 50 thru 199)	24, 205, 198	73, 052, 328			200	0.00
201.00 Less Observation Beds 1,671,309 0 201.00	201.00 Less Observation Beds	1, 671, 309	0			20°	1.00
202.00 Total (line 200 minus line 201) 22,533,889 73,052,328 202.00	202.00 Total (line 200 minus line 201)	22, 533, 889	73, 052, 328			202	2. 00

	IU HEALTH FRANK				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023 To 12/31/2023		nared:
				10 12/31/2023	5/29/2024 11:	32 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
· ·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	434, 619	5, 595, 755	1		0	50. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	272, 533		1			54. 00
60. 00   06000   LABORATORY	153, 346					
66. 00  06600 PHYSI CAL THERAPY	232, 954					66. 00
67. 00  06700 0CCUPATI ONAL THERAPY	17, 775					67. 00
68.00   06800   SPEECH PATHOLOGY	18, 475	587, 876	0. 03142	5, 719	180	68. 00
69. 00  06900  ELECTROCARDI OLOGY	18, 004	1, 139, 007	0. 01580	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	36, 025	69, 399	0. 51910	0 0	0	71. 00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	1, 909	121, 152	0. 01575	7 0	0	72. 00
73.00   07300   DRUGS CHARGED TO PATIENTS	29, 072	2, 830, 829	0. 01027	0 186, 590	1, 916	73. 00
73. 01   07301   0NCOLOGY DRUGS	99, 120	5, 457, 748	0. 01816	1 0	0	73. 01
76. 00   03160   CARDI OPULMONARY	216, 488	4, 347, 562	0. 04979	5 170, 602	8, 495	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
		l	0 00000	0	l 0	an nn

632, 261

218, 637 2, 381, 218

0.000000

0.023640

0.086760

11, 185

3, 915 651, 840

26, 745, 144 2, 520, 025 73, 052, 328

91.00

340 92.00

19, 447 200. 00

0 90.00

264

90. 00 09000 CLINIC

91.00 | 09100| EMERGENCY 92.00 | 09200| OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-131	
THROUGH COSTS		From 01/01/2023   Part IV

				To 12/31/2023	Date/Time Prep 5/29/2024 11:	pared: 32 am
		Title	xVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist Cost	Program Post-Stepdown Adjustments	Nursi ng Program	Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0		0	0	50.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0		0	0	54.00
60. 00   06000   LABORATORY	0	0		0	01	60.00
66. 00   06600   PHYSI CAL THERAPY	0	0		0	01	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	01	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0		0	01	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	01	69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0	0	72.00
73.00   07300   DRUGS CHARGED TO PATIENTS 73.01   07301   ONCOLOGY DRUGS	0	0		0	0	73. 00 73. 01
73. 01   07301  ONCOLOGY   DRUGS 76. 00   03160  CARDI OPULMONARY	0	0		0	0	76.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0			0	1
OUTPATIENT SERVICE COST CENTERS	1 0			0 0	0	78.00
90. 00 09000 CLINIC	0	1		n n	0	90.00
91. 00   09100   EMERGENCY					0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
200.00 Total (lines 50 through 199)		1		n n	1	200. 00
200.00   10tal (111100 00 till oagh 177)	1	1	ı	91	,	1-30.00

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APP0RT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUG	SH COSTS				From 01/01/2023		
					To 12/31/2023	Date/Time Prep 5/29/2024 11:	parea:
			Title	xVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	cost center bescription	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost				(col . 5 ÷ col .	
			4)	col s. 2, 3,	8)	7)	
			· /	and 4)		(see	
						instructions)	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				·		
50.00	05000 OPERATING ROOM	0	0		0 5, 595, 755	0.000000	50. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 12, 854, 513	0.000000	54.00
60.00	06000 LABORATORY	0	0		0 6, 236, 861	0.000000	60.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 3, 325, 089	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 1, 221, 368	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		0 587, 876	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 1, 139, 007	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 69, 399	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 121, 152	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 2, 830, 829	0.000000	73. 00
73. 01	07301 ONCOLOGY DRUGS	0	0		0 5, 457, 748	0.000000	73. 01
76.00	03160 CARDI OPULMONARY	0	0		0 4, 347, 562	0.000000	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0.000000	78. 00
	OUTPATIENT SERVICE COST CENTERS						
00 00	00000 CLINIC	0	0		0 0	0 000000	1 00 00

0 0 0

0 0 0

0 0 0

26, 745, 144 2, 520, 025 73, 052, 328

90.00

91.00

92. 00 200. 00

0.000000

0.000000

0.000000

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200. 00 Total (lines 50 through 199)

Health Financial Systems	U HEALTH FRANKF	ORT HOSPITAL		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS				Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	0		0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	90, 619		0	0	54.00
60. 00   06000   LABORATORY	0. 000000	132, 957		0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	41, 993		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	8, 260		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	5, 719		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	186, 590		0 0	0	73. 00
73. 01 07301 ONCOLOGY DRUGS	0. 000000	0		0 0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000	170, 602		0 0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	l 0 <sup>1</sup>	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	o	78. 00
OUTPATIENT SERVICE COST CENTERS				•		
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
01 00 00100 EMERCENCY	0.000000	11 105	l		ا م	

0. 000000 0. 000000

0.000000

11, 185 3, 915 651, 840

0 0 0

0 0 0

0 91.00 0 92.00 0 200.00

91.00 | 09100| EMERGENCY 92.00 | 09200| OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider Co			Date/Time Pre 5/29/2024 11:	
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 426700		1, 080, 22		0	00.00
	05400  RADI OLOGY-DI AGNOSTI C	0. 186797		1, 789, 58		0	54. 00
60.00	06000 LABORATORY	0. 522266		741, 42		0	60.00
66.00	06600 PHYSI CAL THERAPY	0. 437849		581, 52		0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 241781		224, 58		0	07.00
68.00	06800 SPEECH PATHOLOGY	0. 365924	0	33, 25	2 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 167671	0	197, 93	6 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4. 869479	0	15, 05	6 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 147806	0	10, 94	0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 231244	0	171, 67	8 138	0	73.00
73. 01	07301 ONCOLOGY DRUGS	0. 408932	0	1, 468, 93	1 0	0	73. 01
76.00	03160 CARDI OPULMONARY	0. 441294	0	790, 38	1 0	0	76.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	·			<del>'</del>		
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	0. 268070	0	3, 112, 32	7 1, 339	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 663211	l o	544, 50		0	92.00
200.00			0	10, 762, 35		0	200.00
201.00					0 0		201.00
	Only Charges						
202.00			0	10, 762, 35	1, 477	0	202. 00

					10 12/31/2023	5/29/2024 11:	pareu: 32 am
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
ANCLI	LADV CEDVICE COST CENTEDS	6. 00	7. 00				
	LLARY SERVICE COST CENTERS OF OPERATING ROOM	460, 933	0	I			50. 00
	D RADI OLOGY-DI AGNOSTI C	334, 289	0				54. 00
	D LABORATORY	387, 219	0				60.00
	DI PHYSI CAL THERAPY	254, 621	0				66.00
	O OCCUPATIONAL THERAPY	54, 301	0				67.00
	O SPEECH PATHOLOGY	12, 168	0				68. 00
	O ELECTROCARDI OLOGY	33, 188	0				69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	73, 315	0				71.00
	DIMPL. DEV. CHARGED TO PATIENTS	1, 617	0				72.00
	D DRUGS CHARGED TO PATIENTS	39, 700	32				73. 00
	1 ONCOLOGY DRUGS	600, 693	0				73. 01
•	CARDI OPULMONARY	348, 790	0				76. 00
•	ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78. 00 07800	CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPA	ATIENT SERVICE COST CENTERS						
90.00 09000	D CLI NI C	0	0				90. 00
91.00 09100	DEMERGENCY	834, 321	359				91. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	361, 120	0				92. 00
200.00	Subtotal (see instructions)	3, 796, 275	391				200. 00
201. 00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202. 00	Net Charges (line 200 - line 201)	3, 796, 275	391				202. 00

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	
		T:	VIV		5/29/2024 11:	32 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	674, 611	93, 855	580, 75	6 1, 105	525. 57	30.00
200.00 Total (lines 30 through 199)	674, 611		580, 75	1, 105		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6.00	7. 00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	•		•			
30. 00 ADULTS & PEDIATRICS	67	35, 213	3			30.00
200.00 Total (lines 30 through 199)	67	35, 213	8			200. 00

Health Financial Systems	IU HEALTH FRANK	(FORT HOSPITAL		In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAN				Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part II	pared:
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	434, 619	5, 595, 755	0. 07766	9 0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	272, 533	12, 854, 513	0. 02120	3, 499	74	54.00
60. 00   06000   LABORATORY	153, 346	6, 236, 861	0. 02458	9, 196	226	60.00
66. 00  06600 PHYSI CAL THERAPY	232, 954	3, 325, 089	0. 07005	9 40, 465	2, 835	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	17, 775	1, 221, 368	0. 01455	34, 033	495	67. 00
68.00 06800 SPEECH PATHOLOGY	18, 475	587, 876	0. 03142	7 11, 257	354	68. 00
69. 00 06900 ELECTROCARDI OLOGY	18, 004	1, 139, 007	0. 01580	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	36, 025	69, 399	0. 51910	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 909	121, 152	0. 01575	7 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	29, 072	2, 830, 829	0. 01027	0 11, 281	116	73. 00

99, 120

0

216, 488

632, 261

218, 637

2, 381, 218

5, 457, 748 4, 347, 562

26, 745, 144

2, 520, 025 73, 052, 328 0.018161

0.049795

0.000000

0.000000

0.000000

0.023640

0.086760

8, 972

103

118, 806

0

0 77.00

0 78.00

0 90.00

2 91.00

4, 549 200. 00

447

73. 01

76. 00

92.00

73. 01 07301 ONCOLOGY DRUGS

76. 00 | 03160 | CARDI OPULMONARY

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

78.00

200.00

77.00 07700 ALLOGENEIC HSCT ACQUISITION

07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2023 To 12/31/2023		
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments		All Other Medical Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDIATRICS 200.00   Total (Lines 30 through 199)	0	0		0 0	0	30. 00 200. 00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00   03000   ADULTS & PEDLATRICS 200.00   Total (lines 30 through 199)	0	0	1, 10 1, 10			30. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	0					30. 00 200. 00

Health Financial Systems	IU HEALTH FRANKFOR	RT HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

				'	12/31/2023	5/29/2024 11:3	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
-	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(	0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54. 00
	06000 LABORATORY	0	0	(	0	0	60.00
	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
	07301 ONCOLOGY DRUGS	0	0	(	0	0	73. 01
	03160 CARDI OPULMONARY	0	0	(	0	0	76. 00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(	0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(	0	0	90.00
91.00	09100 EMERGENCY	0	0	(	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(		0	92. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00

Heal th Financial Systems
THROUGH COSTS   From 01/01/2023   To 12/31/2023   Date/Time Prepared: 5/29/2024 11: 32 am   PPS
Title XIX   Hospital   PPS
Title XIX   Hospital   PPS
Title XIX
Cost Center Description
Medical   (sum of cols.   Outpatient   (from Wkst. C,   to Charges   (col. 5 ÷ col.   cols. 2, 3,   and 4)   (see   instructions)
Education Cost   1, 2, 3, and   Cost (sum of cols. 2, 3, and 4)   Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   4, 00   5.00   6.00   7.00   8.00   Service Cost Centers   Solution Cost   1, 2, 3, and 4, and 4   Service Cost Centers   Cost Centers   Solution Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   Solution Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   Solution Cost   Service Cost Centers   Solution Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   Solution Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   Solution Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   Solution Cost (sum of cols. 2, 3, and 4)   Service Cost (sum of cols. 2, 3, and 4)   Service Cost Centers   Service Centers   Service Cost Centers   Service C
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 5, 595, 755 0. 000000 50. 00
ANCI LLARY SERVI CE COST CENTERS  50. 00   05000   0PERATI NG ROOM   0   0   5,595,755   0.000000   50.00
50. 00 05000 OPERATI NG ROOM 0 5, 595, 755 0. 000000 50. 00
54. 00   05400  RADI OLOGY-DI AGNOSTI C   O  O  12. 854. 513  0. 000000  54. 00
60. 00   06000   LABORATORY   0   0   6, 236, 861   0. 000000   60. 00
66. 00   06600  PHYSI CAL THERAPY   0   0   3, 325, 089   0. 000000   66. 00
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   1, 221, 368   0. 000000   67. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   587, 876   0. 000000   68. 00
69. 00   06900  ELECTROCARDI OLOGY   0   0   1, 139, 007   0. 000000   69. 00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   69,399   0.000000   71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   121,152   0.000000   72.00
73.00   07300   DRUGS CHARGED TO PATIENTS   0   0   2,830,829   0.000000   73.00
73. 01   07301   0NCOLOGY DRUGS   0   0   5, 457, 748   0. 000000   73. 01
76. 00   03160   CARDI OPULMONARY   0   0   4, 347, 562   0. 000000   76. 00
77.00   07700   ALLOGENEIC HSCT ACQUISITION   0 0 0 0 0 0.000000   77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0. 000000 78. 00

0 0 0

0 0 0

26, 745, 144 2, 520, 025 73, 052, 328

0 0 0

0.000000

0.000000

0.000000

90.00

91.00

92.00 200. 00

OUTPATIENT SERVICE COST CENTERS

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

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

Health Financial Systems	IU HEALTH FRANKF	TAT HASAL TAN		In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷ col.	•	Costs (col. 8	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 000000	0		0 0	0	50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000	3, 499		0 0	0	54.00
60. 00   06000   LABORATORY	0. 000000	9, 196		0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	40, 465		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	34, 033		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	11, 257		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 281		0 0	0	73. 00
73. 01 07301 ONCOLOGY DRUGS	0. 000000	0		0 0	0	73. 01
76. 00 03160 CARDI OPULMONARY	0. 000000	8, 972		0 0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	l 0	78. 00
OUTPATIENT SERVICE COST CENTERS	,			•		
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
01 00 00100 EMEDGENCY	0 000000	102	I		1	01 00

0. 000000 0. 000000 0. 000000

0 0 0

103 118, 806 0 0 0

0 91.00 0 92.00 0 200.00

91.00 | 09100 | EMERGENCY 92.00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART) 200.00 | Total (lines 50 through 199)

Heal th	Financial Systems	IU HEALTH FRANK	FORT HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der Co		Peri od: From 01/01/2023 To 12/31/2023 Worksheet D Part V Date/Time Pro 5/29/2024 11:		
			Ti tl	e XIX	Hospi tal	PPS	
				Charges	_	Costs	
	Cost Center Description	9	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Servi ces Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				_		1
50.00	05000 OPERATING ROOM	0. 426700		32, 25		0	00.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 186797		105, 04		0	54.00
60.00	06000 LABORATORY	0. 522266		87, 96		0	60.00
66.00	06600 PHYSI CAL THERAPY	0. 437849	l .	22, 85		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 241781	l .	2, 57		0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 365924	0	52, 10	4 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 167671	0	19, 48	3 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4. 869479	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 147806	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 231244	0	29, 61	4 0	0	73. 00
73. 01	07301 ONCOLOGY DRUGS	0. 408932	0	11, 60	4 0	0	73. 01
76.00	03160 CARDI OPULMONARY	0. 441294	0	25, 75	6 0	0	76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91.00	09100 EMERGENCY	0. 268070	0	434, 76	8 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 663211	0	55, 26	7 0	0	92.00
200.00	Subtotal (see instructions)		0	879, 28	8 0	0	200.00
201.00					0 0		201.00
	Only Charges						
202.00			0	879, 28	8 0	0	202. 00

| Period: | Worksheet D | From 01/01/2023 | Part V | Date/Time Prepared: | 5/29/2024 | 11: 32 am

					5/29/2024 11:32 am
		Ti tl	e XIX	Hospi tal	PPS
	Cos	sts			
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subject To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	13, 764	0			50.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	19, 621	0			54. 00
60. 00   06000   LABORATORY	45, 943	0			60.00
66. 00   06600 PHYSI CAL THERAPY	10, 007	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	622	0			67. 00
68.00 06800 SPEECH PATHOLOGY	19, 066	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	3, 267	0			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 848	0			73.00
73. 01   07301   ONCOLOGY DRUGS	4, 745	0			73. 01
76. 00 03160 CARDI OPULMONARY	11, 366	0			76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0			78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0			90.00
91. 00 09100 EMERGENCY	116, 548	0			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	36, 654	0			92.00
200.00 Subtotal (see instructions)	288, 451	0			200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				201. 00
Only Charges					
202.00 Net Charges (line 200 - line 201)	288, 451	0			202. 00
	•	•	•		•

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1316	Peri od: From 01/01/2023	Worksheet D-1	
		To 12/31/2023	Date/Time Prepared: 5/29/2024 11:32 am	
	Title XVIII	Hospi tal	Cost	

Mark   - ALL PROFILE COBROWNIS   1.00   1.					5/29/2024 11:	32 am
PART   1 - ALL PROVIDER COMPRENIS			Title XVIII	Hospi tal	Cost	
NAME   MAYS		Cost Center Description				
PARTIENT DAYS					1.00	
1.00   Inpatient days (including private room days, and seing-bed days, excluding newborn)   1.503   1.00		PART I - ALL PROVIDER COMPONENTS				
1,105   2,00						
20.00   20.0	1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)			
do not complete this line.  4. 00 Sele-private room days (excluding swing-bed and observation bed days) through Becember 31 of the cost 1074 is swing-bed SW type Inpatient days (including private room days) after December 31 of the cost 1074 is swing-bed SW type Inpatient days (including private room days) after December 31 of the cost 1074 is swing-bed SW type Inpatient days (including private room days) through Becember 31 of the cost 1074 is swing-bed SW type Inpatient days (including private room days) through Becember 31 of the cost 1074 is swing-bed SW type Inpatient days (including private room days) after December 31 of the cost 1074 is swing-bed SW type Inpatient days (including private room days) after December 31 of the cost 1074 is swing-bed SW type Inpatient days applicable to the Program (excluding swing-bed and nesborn days) (see Instructions)  10.00 Saling-bed SW type Inpatient days applicable to this SW type Inpatient days applicable to SW type Inpatient Appl	2.00				1, 105	2. 00
Semi-private room days (excluding swing-bed and observation bed days)   1	3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost   0.6.00		do not complete this line.		-		
reporting period (if calendar year, enter 0 on this line) 7.00 Total saming-bed NF type inpatient days (including private room days) after December 31 of the cost 235 7.00 reporting period (if calendar year, enter 0 on this line) 8.00 Total saming-bed NF type inpatient days (including private room days) after December 31 of the cost 236 7.00 reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days apriced (see instructions) 10.00 Saing-bed SNF type inpatient days (and in this line) 10.00 Saing-bed SNF type inpatient days (and in this line) 10.00 Saing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newtorn days) (see instructions) 11.00 Saing-bed SNF type inpatient days applicable to the Program (excluding private room days) after 11.00 Sing-bed SNF type inpatient days applicable to the Program (see instructions) 11.00 Saing-bed SNF type inpatient days applicable to the Program (excluding private room days) after 11.00 Sing-bed SNF type inpatient days applicable to tritle SNF in XIX only (including private room days) after 11.00 SNF intrough December 31 of the cost reporting period (see instructions) 12.00 SNF intrough December 31 of the cost reporting period (see instructions) 13.00 SNF intrough December 31 of the cost reporting period (see instructions) 14.00 Weld call y necessary private room days applicable to tritles V or XIX only (including private room days) 15.00 NF intrough December 31 of the cost reporting period (if calendar year, enter 0 on this line) 16.00 Weld care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (see instructions) 17.00 Weld care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 see instructions) 18.00 Weld call draft for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 see instructions) 18.00 Ning-bed cost applicable to SNF type s	4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		689	4. 00
10   10   10   10   10   10   10   10	5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	r 31 of the cost	163	5. 00
reporting period (if calendar year, enter 0 on this line)		reporting period				
1.00   10tal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   10tal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   248	6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6. 00
Perporting period   Perporting period   Perporting period   Perporting period   Perporting period   Perporting period   Period   Perporting period   Perporting period   Perporting period   Period   Perporting   Period   Perporting   Period   Perporting   Period   Perporting   Period   Perporting   Period		reporting period (if calendar year, enter 0 on this line)				
10	7.00		n days) through December	31 of the cost	235	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed NF type Inpatient days applicable to title 8V or XIX only (including private room days) through December 31 of the cost reporting period (see instructions) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Swing-bed SNF services applicable to services through December 31 of the cost reporting period (see Dead) 17.00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of swing-bed cost applicable to SNF type						
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)   10.00	8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8. 00
newborn days) (see Instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 14.00 Swing-bed NF type inpatient days applicable to title XV or XIX only (including private room days) 15.00 Total unresery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 visual period visua						
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 163 10.00 through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0 December 31 of the cost reporting period (incleandar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Amount of through December 31 of the cost reporting period (incleandar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 10.00 New York (see Instructions) 15.00 Total nursery days (title V or XIX only) 10.00 New York (see Instructions) 16.00 Nursery days (title V or XIX only) 10.00 New York (see Instructions) 17.00 New York (see Instructions)	9.00		o the Program (excluding	swi ng-bed and	248	9. 00
through December 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed Cost applicable to SNF type services through December 31 of the cost reporting period (line 2 2 2 0 2 2 2 0 2 2 2 0 2 2 2 0 2						
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x 11 in 19)  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x 11 in 19)  23.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x 11 in 19)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x 11 in 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x 11 in 19)  26.00 Total swing-bed cost (see instructions)  27.00 Central Inpatient routine service cost (excluding swing-bed and observation bed charges)  28.00 Central Inp	10. 00			oom days)	163	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00						
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 19.00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x 10 x	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical gly necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical dar for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medical dar for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 12)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  27.00 Cereal inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed cost Applicable in toutine service cost net of swing-bed cost applicable in private room cost differential (line 27 + line 23)  30.00 Average per diem privat					_	
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if cale all and any services after December 31 of the cost reporting period (if cale and any services after December 31 of the cost reporting period (if cale and any services after December 31 of the cost reporting period (if cale any services after December 31 of the cost reporting period (if cale any services after December 31 of the cost reporting period (if cale any services applicable to services after December 31 of the cost reporting period (if cale any services applicable to services after December 31 of the cost reporting period (if cale any services applicable to services after December 31 of the cost reporting period (if cale and any services applicable to services after December 31 of the cost reporting period (if cale and any services applicable to services after December 31 of the cost reporting period (if cale and any service) (if cale any services applicable to services after December 31 of the cost (see instructions) (if cale any service)	12. 00		( only (including private	e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00  16.00 Norsery days (title V or XIX only)  16.00  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (lacer erate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (lacer erate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (lacer erate for swing-bed NF services applicable to services through December 31 of the cost reporting period (laced a rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (laced a rate for swing-bed NF services applicable to services after December 31 of the cost (see instructions)  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line S X line 17)  21.00 Total general inpatient routine services through December 31 of the cost reporting period (line S X line 18)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 X line 18)  23.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 X line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 X line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 X line 19)  26.00 Total swing-bed cost (see instructions)  27.10 (acer a linpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room period em charge (line 29 + line 3)  30.00 Aver						
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   0   16.00   Nursery days (title V or XIX only)   0   15.00   15.00   0	13. 00				0	13. 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)  With BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period medical directory and the cost services after December 31 of the cost reporting period (line period medical general inpatient routine service cost (see instructions)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line period period medical period medica			am (excluding swing-bed o	days)		
SWING BED ADJUSTMENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting r						
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   18. 00   Medicare rate for swing-bed NF services applicable to services through December 31 of the cost   266. 32   19. 00   Medicare rate for swing-bed NF services applicable to services after December 31 of the cost   266. 32   19. 00   Medicare rate for swing-bed NF services applicable to services after December 31 of the cost   20. 00   Medicare for swing-bed NF services applicable to services after December 31 of the cost   20. 00   20. 00   Medicare for swing-bed NF services applicable to services after December 31 of the cost reporting period (line   5   156, 867   21. 00   22. 00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   5   11 ine 18)   23. 00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line   6   2   23. 00   25. 00	16. 00				0	16. 00
reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 266.32 19.00 reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 5.156.87 21.00 21.00 Total general inpatient routine service cost (see instructions)  23.00 Total general inpatient routine service cost (see instructions)  24.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5.156.87 21.00 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6.2.585 24.00 X ine 18)  25.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6.2.585 24.00 X ine 18)  26.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6.2.585 24.00 X ine 18)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8.2.585 24.00 X ine 18)  28.00 Total swing-bed cost (see instructions)  29.00 Total swing-bed cost (see instructions)  20.00 Semi-private room charges (excluding swing-bed charges)  20.00 Average peri private room per diem charge (line 30 s + line 4)  20.00 Average peri private room per diem charge (line 30 s + line 4)  20.00 Average peri dem private room charge differential (line 32 minus line 33)(see instructions)  20.00 Average peri dem private room cost differential (li						
18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 2 19. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 2 20. 00 Medicald rate for swing-bed NF services applicable to services after December 31 of the cost 20. 00 20. 00 reporting period 3 21. 00 Total general inpatient routine service cost (see instructions) 5, 156, 867 21. 00 22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 2 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 2 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 2 25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 2 26. 00 Total swing-bed cost (see instructions) 717, 449 26. 00 4, 439, 418 2 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 4, 439, 418 2 28. 00 General inpatient routine service cost net of swing-bed and observation bed charges) 0 29. 00 90 00 Protate room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 Semi-private room charges (excluding swing-bed charges) 0 30. 00 Average peri diem private room charge (line 29 + line 3) 0. 00 Average peri diem private room cost differential (line 3 x line 35) 0 0 Average peri diem private room cost differential (line 3 x line 35) 0 0 Average peri diem private room cost differential (line 3 x line 35) 0 0 Average peri diem private room cost differential (line 3 x line 35) 9 0 0 Program general inpatient routine service cost periodes (see instructions) 9 0 0 Program general inpatient routine service cost periodes (see instructions) 9 0 0 0 Program genera	17. 00		es through December 31 o	f the cost		17. 00
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5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 62,585)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Deferred inpatient routine service charges (excluding swing-bed charges)  Deferred inpatient routine service cost/charge ratio (line 27 * line 28)  Average private room charges (excluding swing-bed charges)  Average per diem private room per diem charge (line 30 * line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)  Average per diem private room cost differential (line 3 x line 35)						
23. 00	22.00		er 31 of the cost report	ng period (iine	١	22.00
x line 18)  24. 00  25. 00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00  Total swing-bed cost (see instructions)  717, 449  26. 00  Total swing-bed cost (see instructions)  717, 449  27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00  9. 00  Private room charges (excluding swing-bed charges)  9. 00	22.00		21 of the cost momenting	noried (line (	ا	22.00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Seneral inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Average private room per diem charge (line 29 + line 3)  Average private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Q 40.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  Q 50.00  A 4, 439, 418  A, 419, 418  A, 439, 418  A, 419, 418  A, 439, 418  A, 410  A, 439, 418  A, 410  A, 439, 418  A, 410  A, 439, 418  A, 439, 418  A, 410  A, 439, 418  A, 410  A, 439, 418  A, 41	26 00				717 //0	26 00
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  32.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  33.00 Average per diem pri vate room cost differential (line 34 x line 31)  35.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  996, 357 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 20.00  28.00 29.00  29.00 29.00  29.00  20.00 29.00  20.00			(line 21 minus line 26)			1
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32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 and 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 0.00 34.00 0.00 34.00 0.00 35.00 0.00 36.00 0.00						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 and substance)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 and 50)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						1
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						1
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00  4, 439, 418  4, 439, 418  37.00  4, 017.57  38.00  996, 357  996, 357  90 40.00						1
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 439, 418 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 4,017.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 996,357 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ic 31)			•
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 4,017.57 38.00 Program general inpatient routine service cost (line 9 x line 38) 996,357 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						•
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  996,357 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37.00		and brivate room cost dr	irerential (IINe	4, 439, 418	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  996,357 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 4,017.57 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 996,357 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS			-
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 996, 357 39.00 40.00	20.00				4 017 57	20.00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			•			1
			•			1
41.00   Total Program general impatient routine service cost (line 39 + 11ne 40)			,			1
	41.00	Trotal Program general impatrent routine service cost (Tine 39	+ ITTIE 40)		996, 35/	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH FRANK	Provider CO	CN: 15-1316	Period: From 01/01/2023 To 12/31/2023	u of Form CMS-2 Worksheet D-1 Date/Time Pre	
						5/29/2024 11:	
	Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
	Social Control Control Per on		Inpatient Days	Diem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	· 					43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			232, 871	48. 00
48. 01	Program inpatient cellular therapy acquisiti Total Program inpatient costs (sum of lines				column 1)	1 220 220	
49. 00	PASS THROUGH COST ADJUSTMENTS	41 through 48.0	T) (See Thistruc	ti ons)		1, 229, 228	] 49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D, sur	n of Parts I and	0	50.00
51. 00	  Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
E2 00	and IV)		•			_	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and	0	
	medical education costs (line 49 minus line						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
55. 01 55. 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
56.00	Target amount (line 54 x sum of lines 55, 55	5. 01, and 55. 02)				0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,		the cost repo	rting period	endi ng 1996,	0.00	
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		m prior vear c	ost report. u	updated by the	0. 00	60.00
	market basket)			•			
61. 00	Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by w	hich operatir	ng costs (line	0	61. 00
62. 00							62. 00
63. 00							63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of the	cost reporti	ng period (See	654, 864	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost renortino	n neriod (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVII	ll only); for	654, 864	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19)  Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
	(line 13 x line 20)			•		2	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	,		,	)	-	70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	71)		,			71. 00 72. 00
73. 00 74. 00	Medically necessary private room cost applic			ne 35)			73. 00 74. 00
75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orksheet B, F	Part II, column		75. 00
7/ 00	26, line 45)	ma 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	,	mand dam magand	a)			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*	nus line 79)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi		`				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	nstructions)	,				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				44.	1
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			416 4, 017. 57	1
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 671, 309	89.00

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 11:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	674, 611	5, 156, 867	0. 13081	1, 671, 309	218, 637	90.00
91.00 Nursing Program cost	0	5, 156, 867	0.00000	1, 671, 309	0	91.00
92.00 Allied health cost	0	5, 156, 867	0.00000	1, 671, 309	0	92.00
93.00 All other Medical Education	0	5, 156, 867	0. 00000	1, 671, 309	0	93. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1316	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/29/2024 11:	pared:
	Title XIX	Hospi tal	PPS	

Cost Center Description  PART 1 - ALL PROFUBER COMPONENTS  1.00  PART 1 - ALL PROFUBER COMPONENTS  1.00  1.0	-		Title XIX	Hospi tal	5/29/2024 11:	32 am
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description	TI LIE XIX	nospi tai	113	
INPARTENT MAYS						
Impatient days (including private room days and swing-bed days, excluding newborn)   1,503   1,00   2,00   Private room days (excluding sprivate room days)   1,503   1,00   3,00   5,00   7 rivate room days (excluding swing-bed and observation bed days)   1,500   3,00   7 rivate room days (excluding swing-bed and observation bed days)   6,89   4,00   7,00						
1,105   2,00	1 00		s excluding newborn)		1 503	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do 0 a.0.0 do not complete this line.  4.00 Somi-private room days (excluding swing-bed and observation bed days).  5.01 Total swing-bed SW type inpatient days (including private room days) through Becember 31 of the cost reporting period (if callendary year, enter 0 on this line).  7.00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line).  8.00 Into the swing-bed N type inpatient days (including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line).  9.00 Total lineatient days including private room days) after December 31 of the cost reporting period (if callendary year, enter 0 on this line).  10.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  11.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  11.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  12.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  13.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  14.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  15.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  16.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  17.00 Swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  18.00 Swing-bed XW type inpatient days applicable to title XVIII only (including private room days).  18.00 Total swing-bed SW type inpatient days applicable to title XVIII only (including private room days).  18.00 Swing-bed XW type inpatient days applicable						
Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed Str type inpatient days (including private room days) through December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and private proom days) Total inpatient days applicable to this WINI on Intly (including private room days) Total inpatient days applicable to title XVII only (including private room days) Total inpatient days applicable to title XVII only (including private room days) Total inpatient days applicable to title XVII only (including private room days) Total period (including				vate room days,		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		do not complete this line.				
reporting period (1° calendar year, enter 0 on this line) 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (1° calendar year, enter 0 on this line) 8.00 Total swing-bed MF type inpatient days (including private room days) through December 31 of the cost reporting period (1° calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days after December 31 of the cost reporting period (1° calendar year, enter 0 on this line) 10.00 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11.00 Swing-bed SWF type inpatient days applicable to trill exivilion of the cost reporting period (1° calendar year) 11.00 Swing-bed SWF type inpatient days applicable to trill exivilion of this line) 11.00 Swing-bed SWF type inpatient days applicable to trill exivilion of this line) 11.00 Swing-bed SWF type inpatient days applicable to trill exivilion of this line) 12.00 Swing-bed SWF type inpatient days applicable to trill exivilion of this line) 13.00 Swing-bed SWF type inpatient days applicable to trill exivilion of this line) 14.00 Swing-bed WF type inpatient days applicable to trilles V or XIX only (including private room days) 15.00 Swing-bed WF type inpatient days applicable to trilles V or XIX only (including private room days) 16.00 Swing-bed WF type inpatient days applicable to trilles V or XIX only (including private room days) 17.00 Swing-bed WF type inpatient days applicable to trilles V or XIX only (including private room days) 18.00 Swing-bed WF type inpatient days applicable to trilles V or XIX only (including private room days) 18.00 Swing-bed WF type inpatient days applicable to trilles V or XIX only (including private room days) 18.00 Swing-bed WF type inpatient days applicable to services through December 31 of the cost reporting period (including trilles V or XIX only) 18.00 Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-bed Swing-						
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	5.00		om days) through December	31 of the cost	163	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and nebtorn days) (if calendar year, enter 0 on this line) 10.00 Swing-bed SRF type inpatient days applicable to the Program (excluding swing-bed and nebtorn days) (see instructions) 11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after 0 income the program (excluding swing-bed and nebtorn days) (see instructions) 11.00 Swing-bed SRF type inpatient days applicable to title XVIII only (including private room days) after 0 income through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title V or XX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 12.01 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XX only (including private room days) 15.00 Total nursery days (title V or XX only) 16.00 Nursery days (title V or XX only) 17.00 Total nursery days (title V or XX only) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private	6 00		om davs) after December (	21 of the cost	0	6 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (ir calendar year, enter 0 on this line)	0.00		on days) arter becember .	or or the cost	O	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   10   10   10   10   10   10   10   1	7.00		n days) through December	31 of the cost	235	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after supplied (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (on this line) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (on this line) 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nedically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Nedically necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Nedical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 18.00 Nedical care rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 Supplicable to SNF type services through December 31 of the cost reporting period (line 6 Supplicable to SNF type services through December 31 of the cost reporting period (line 6 Supplicable to SNF type services through December 31 of the cost reporting period (line 6 Supplicable to SNF type services through						
Total inpatient days including private room days applicable to title XVIII only (Including private room days)   0.00	8. 00		n days) after December 3°	of the cost	0	8. 00
newborn days) (see instructions)  10.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) at 10.00 through December 31 of the cost reporting period (see instructions)  11.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NE type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NE type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Swing-bed NE type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 Nursery days (title V or XIX only)  19.00 Nedicare rate for swing-bed SWF services applicable to services after December 31 of the cost reporting period  19.00 Nedicare rate for swing-bed SWF services applicable to services through December 31 of the cost reporting period  19.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line or period period period period period period period period (line or period period or period period or period period (line or period period or period period (line or period period or period period or period period (line or period period or period period (line or period period or period period (line or period period or period period or period period (line or period line or period (line or period line or period line or period line or period (line or period line or pe	9 00		the Program (evoluding	swing-had and	67	9 00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Necessary private room days applicable to services through December 31 of the cost 18.00 Necessary (title V or XIX only) 18.00 Necessary (title V or XIX on	7. 00		The Frogram (excluding	swifig-bed and	07	7. 00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15.00 IoTal nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Nursery days (title V or XIX only)  18.00 SWING BED ADJUSTMENT  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of Nursery days (title V or XIX only)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of Nursery days (title V or XIX only)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period of Nursery days (title V or XIX only)  20.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (tide did rate for swing-bed NF services applicable to services after December 31 of the cost of the cost reporting period (tide of the cost in the cost of the cost in the cost	10.00		nly (including private ro	oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   0   12.00						
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 19.00 More BED ADJUSTMENT 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line of reporting period) 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line of reporting period) 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of reporting period) 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of reporting period) 19.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line of reporting period) 19.00 Total general inpatient routine service cost (see instructions) 19.10 Total general inpatient routine service safter December 31 of the cost reporting period (line of x line 19) 20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line of x line 19) 21.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line of x line 29) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 29) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line of x line 29) 24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting per	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00  16.00 Total nursery days (title V or XIX only)  16.00  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line days reporting period (line days)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line days reporting period (line days)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line days line line line days line line line line line line line line	12 00			room days)	0	12 00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   0   13.00     14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00     15.00   Total nursery days (title V or XIX only)   0   15.00     15.00   SWING BED ADJISHENT	12.00		Comy (Therearing private	, room days)	O	12.00
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   16.00	13.00		only (including private	e room days)	0	13.00
15.00   Total nursery days (title V or XIX only)	44.00					44.00
16. 00   Nursery days (title V or XIX only)   16. 00   18. 00			am (excluding swing-bed o	days)		
SWING BED ADJUSTNENT  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19. 00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost 266. 32 19. 00 reporting period  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 cost x line 19)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 cost x line 19)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost for post of the cost reporting period (line 8 cost cost net of swing-bed cost (line 27 * line 28)  32. 00 Provate room charges (excluding swing-bed charges)  33. 00 Average period end private room charges (excluding swing-bed charges)  34. 00 Average period end private room cost differential (line 3 × line 31)  35. 00 Average period end private room cost differential (line 3 × line 31)  38. 00 Average period end private room cost di						
17. 00   Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period   18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   18. 00   19. 00   Medicald rate for swing-bed NF services applicable to services through December 31 of the cost   266. 32   19. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   266. 32   19. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost   266. 32   19. 00   20. 00   Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line   5   156. 867   21. 00   22. 00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line   6   20. 20. 00   20. 0	10.00					10.00
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   266.32   19.00	17. 00		es through December 31 of	the cost		17. 00
reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 c. 585 z line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 c. 585 z line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTNENT  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  31.00 Average per juvate room per diem charge (line 29 + line 3)  32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Average per diem private room cost differential (line 3 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Proyram general inpatient routine service cost (line 9 x line 38)  39.00 Proyram general inpatient routine service cost (line 9 x line 38)  39.00 Proyram general						
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   Total general inpatient routine service cost (see instructions)   5, 156, 867   21.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   26.00   Total swing-bed cost (see instructions)   717, 449   26.00   27.00   28.00   27.00   28.00   28.00   27.00   28.	18. 00		es after December 31 of 1	the cost		18. 00
reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room Charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average per livate room per diem charge (line 29 + line 3)  33.00 Average per livate room per diem charge (line 29 + line 3)  33.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 32 minus line 33)  35.00 Average per diem private room cost differential (line 32 minus line 33)  36.00 Average per diem private room cost differential (line 34 minus line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general	19 00		s through December 31 of	the cost	266 32	19 00
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22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Private room charges (excluding swing-bed charges)  29. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average perivate room per diem charge (line 29 ÷ line 3)  30. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Private room cost differential dijustment (line 34 x line 31)  30. 00 Private room cost differential dijustment (line 34 x line 31)  30. 00 Private room cost differential dijustment (line 34 x line 31)  30. 00 Private room cost differential dijustment (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 30 x line 31)  30. 00 Private room cost differential dijustment (line 34 x line 35)  30. 00 Private room cost differential dijustment (line 30 x line 31)  30. 00 Average per diem private room cost differential (line 30 x line 31)  30. 00 Average per diem private room cost differential (line 30 x line 31)  30. 00 Average per diem private room cost differential (line 30 x line 31)  30. 00 Average per diem private room cost differential (line 30 x line 31)  30. 00 Average per diem private room cost differential (line 30 x line 31)  30. 00 Average per diem private room cost differential (line 30 x	21 00		-)		E 1E/ 0/7	21 00
5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 c. 5.85)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 * line 28)  32.00 Average private room per diem charge (line 29 * line 3)  33.00 Average semi-private room per diem charge (line 30 * line 30 * line 31)  35.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  36.00 Average per diem private room cost differential (line 32 minus line 33)  37.00 General inpatient routine service cost reporting period (line 4, 439, 418)  37.00 General inpatient routine service cost net of Swing-bed cost (line 21 minus line 36)  37.00 General inpatient routine service cost net of Swing-bed cost and private room cost differential (line 4, 439, 418)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4.017.57  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  4.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)				ng period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 62, 585 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 3 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  PRATI II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,000 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22.00		or or the cost reporti	ng perrou (rine	O	22.00
24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 v line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average perivate room per diem charge (line 29 + line 3)  33. 00 Average semi-private room per diem charge (line 30 + line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  27. 00 Program general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40. 00 Value (line 34 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00		31 of the cost reporting	g period (line 6	0	23. 00
7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average private room per diem charge (line 29 + line 3)  33. 00 Average semi-private room per diem charge (line 29 + line 3)  34. 00 Average semi-private room cost differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost per diem (see instructions)  4, 017. 57  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00  40. 00  40. 00						
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x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32. 00 Average private room per diem charge (line 29 ± line 3)  33. 00 Average semi-private room per diem charge (line 30 ± line 4)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017. 57  38. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 do 0. 00  40. 00  40. 00  40. 00	25. 00		31 of the cost reporting	period (line 8	0	25. 00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average per diem private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 439, 418)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)			3			
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 29. 00 30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charges ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 ÷ line 3)  30. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  30. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  31. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  32. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  33. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  34. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  35. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  36. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  37. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  38. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  39. 00 Average per diem private room cost net of swing-bed cost and private room cost differential (l		, ,				
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  31.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  32.00 Average per diem private room cost differential (line 34 x line 31)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Private room cost differential adjustment (line 3 x line 35)  35.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 29.00  29.00 29.00  0 29.00  0 30.00  0 0.000000  31.00  0 0.000003  32.00 32.00  32.00 32.00  32.00 32.00  32.00 33.00  4.000 32.00  32.00 32.00  32.00 33.00  4.000 32.00  32.00 33.00  4.000 32.00  32.00 32.00  32.00 32.00  32.00 33.00  4.000 32.00  32.00 3	27. 00		(line 21 minus line 26)		4, 439, 418	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	28 00		d and observation hed cha	arnes)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			a and observation bed en	11 903)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  36.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 000 32.00  0.00 33.00  0.00 35.00  37.00 40.00						
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 32.00 0 0.00 33.00 0 0.00 34.00 35.00 40.00	31.00		: line 28)		0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32.00
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 439, 418 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 37.00 4,439,418 4,439,	34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0.00	34.00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		, ,	ne 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		and private room cost dit	terential (line	4, 439, 418	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  4,017.57 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 4,017.57 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 4,017.57 38.00 269,177 39.00			ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 269,177 39.00 40.00	38. 00				4, 017. 57	38. 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   269,177   41.00						
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		269, 177	41. 00

COMI OT	ATION OF INPATIENT OPERATING COST		Trovider		Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre	
					10 12/31/2023	5/29/2024 11:	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent cost	l lipati ent bay	col. 2)		4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)						42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
44. 00	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
	<u> </u>					1. 00	
	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III lino 10	column 1)	42, 119	48. 00 48. 01
	Total Program inpatient costs (sum of lines				corumir 1)	311, 296	
	PASS THROUGH COST ADJUSTMENTS	J	, ,	ĺ			
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	om Wkst. D, sum	of Parts I and	35, 213	50.00
51. 00	III) Pass through costs applicable to Program inp	atient ancillar	ry services (f	rom Wkst. D. s	um of Parts II	4, 549	51.00
	and IV)		,	, -, -,			
52.00	Total Program excludable cost (sum of lines	,	Natad === '	wel olen anna	otict and	39, 762	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		erateu, non-pr	iysician anesth	eust, and	271, 534	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					1
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
	Adjustment amount per discharge (contractor	use only)				0.00	
	Target amount (line 54 x sum of lines 55, 55					0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	line 56 minus	line 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	n the cost rep	orting period	endi ng 1996,	0.00	1
	updated and compounded by the market basket)			0 .			
60. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	om prior year	cost report, u	pdated by the	0.00	60.00
61. 00	Continuous improvement bonus payment (if line					0	61. 00
	55.01, or line 59, or line 60, enter the less						
	53) are less than expected costs (lines $54 \times 10^{-2}$ enter zero. (see instructions)	60), or 1 % of	the target a	amount (line 56	), otherwise		
62. 00	Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	ne cost reporti	na period (See	0	64. 00
	instructions)(title XVIII only)	Ü		·			
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVII	l only); for	0	66. 00
	CAH, see instructions						
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	ı December 31	or the cost re	porting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31 of	the cost repo	rting period	0	68. 00
40.00	(line 13 x line 20)	coutino costo (	lino 47 : lin	20 49)		0	40.00
69. 00	Total title V or XIX swing-bed NF inpatient   PART III - SKILLED NURSING FACILITY, OTHER NU		•			<u> </u>	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
	Medically necessary private room cost applications		n (line 14 x l	ine 35)			73.00
74. 00	Total Program general inpatient routine serv	ce costs (line	e 72 + line 73	3)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	Worksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der recor	rds)			78. 00 79. 00
	Total Program routine service costs for compa				us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on		•	,		81.00
	Inpatient routine service cost limitation (I		*				82.00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		13)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ons)				85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						4
87. 00	Total observation bed days (see instructions)	)				416	87.00

416 87.00 4,017.57 88.00 1,671,309 89.00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems	U HEALTH FRANK	FORT HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/29/2024 11:3	oared: 32 am_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	674, 611	5, 156, 867	0. 13081	8 1, 671, 309	218, 637	90.00
91.00 Nursing Program cost	0	5, 156, 867	0.00000	0 1, 671, 309	0	91.00
92.00 Allied health cost	0	5, 156, 867	0.00000	0 1, 671, 309	0	92.00
93.00 All other Medical Education	0	5, 156, 867	0. 00000	0 1, 671, 309	0	93. 00

	Financial Systems IU HEALTH FRANKFORENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-1316	Peri od:	wof Form CMS-3 Worksheet D-3	
1 101 7411	ENT ANOTEEART SERVICE GOST ALTORITONIMENT	Trovider o	CIV. 13 1310	From 01/01/2023		
				To 12/31/2023		
					5/29/2024 11:	32 am_
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos	10.00	Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	_
	03000 ADULTS & PEDIATRICS			546, 062		30.00
	ANCI LLARY SERVI CE COST CENTERS			340,002		30.00
	05000 OPERATING ROOM		0. 42670	00 0	0	50.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 18679		1	
	06000 LABORATORY		0. 52226	· ·		
	06600 PHYSI CAL THERAPY		0. 43784	· ·		
	06700 OCCUPATI ONAL THERAPY		0. 24178			
	06800 SPEECH PATHOLOGY		0. 36592			
	06900 ELECTROCARDI OLOGY		0. 16767		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		4. 86947		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14780		0	•
	07300 DRUGS CHARGED TO PATLENTS		0. 23124		43, 148	73.00
	07301 ONCOLOGY DRUGS		0. 40893	· ·	0	1
76.00	03160 CARDI OPULMONARY		0. 44129	170, 602	75, 286	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0.00000	00	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00	0	78. 00
	OUTPATIENT SERVICE COST CENTERS					1
90.00	09000 CLI NI C		0.00000	00	0	90.00
91.00	09100 EMERGENCY		0. 26807	70 11, 185	2, 998	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6632	3, 915	2, 596	92.00
200.00				651, 840	232, 871	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201. 00
202.00	Net charges (line 200 minus line 201)			651, 840		202.00

Health Financial Systems IU HEALTH FRANK				u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1316	Peri od: From 01/01/2023	Worksheet D-3	1
	Component	CCN: 15-Z316	To 12/31/2023	Date/Time Pre	nared.
	Component	00N. 10 2010	10 12/01/2020	5/29/2024 11:	
	Titl∈	XVIII	Swing Beds - SNF	Cost	
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	
INPATIENT ROUTINE SERVICE COST CENTERS					4
30. 00 03000 ADULTS & PEDI ATRI CS					30. 00
ANCILLARY SERVICE COST CENTERS		0.4077	20		
50. 00   05000   0PERATI NG ROOM		0. 42670			
54. 00   05400   RADI OLOGY - DI AGNOSTI C		0. 18679			
60. 00   06000   LABORATORY		0. 52226			
66. 00   06600   PHYSI CAL THERAPY		0. 43784	·		
67. 00 06700 OCCUPATI ONAL THERAPY		0. 24178			
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY		0. 36592 0. 1676		1, 747 0	1
		1		0	
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   MPL. DEV. CHARGED TO PATIENTS		4. 8694 0. 14780		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 14780		1	
73. 01   07301   0NCOLOGY   DRUGS		0. 23124		23, 000	
76. 00   03160  CARDI OPULMONARY		0. 44129		1	
77. 00   07700   ALLOGENEI C HSCT ACQUI SI TI ON		0. 00000		0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000		0	
OUTPATIENT SERVICE COST CENTERS		0.0000	0		70.00
90. 00   09000   CLI NI C		0.00000	00	0	90.00
91. 00   09100   EMERGENCY		0. 2680		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 6632		Ö	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0002	349, 683	115, 592	
201.00 Less PBP Clinic Laboratory Services-Program only charce	es (line 61)		0177000	1.10,072	201. 00
202.00 Net charges (line 200 minus line 201)	, (	1	349, 683		202. 00

Heal th Financial Systems IU HEALTH FRANKE	_	011 45 4044		eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1316	Peri od: From 01/01/2023	Worksheet D-3	
			To 12/31/2023	Date/Time Pre	pared:
				5/29/2024 11:	
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LANDATI ENT. DOUTLING OFFINIOS COOT OFFITEDO		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			70.070		
30. 00 03000 ADULTS & PEDI ATRI CS			79, 072		30.00
ANCILLARY SERVICE COST CENTERS  50, 00 OPERATING ROOM		0.42470	00	0	50.00
		0. 42670 0. 18679		0	
54. 00   05400  RADI OLOGY-DI AGNOSTI C 60. 00   06000  LABORATORY		0. 18679			
66. 00   06600  PHYSI CAL THERAPY		0. 52226			
67. 00   06700   OCCUPATI ONAL THERAPY		0. 43764			
68. 00   06800   SPEECH PATHOLOGY		0. 36592			
69. 00   06900   ELECTROCARDI OLOGY		0. 36342		4, 117	
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		4. 86947		0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14780		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 23124		2, 609	
73. 01 07301 0NCOLOGY DRUGS		0. 40893		2,007	73. 01
76. 00   03160   CARDI OPULMONARY		0. 44129			76. 00
77. 00 07700 ALLOGENEI C HSCT ACQUISITION		0.00000		0,707	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000		0	1
OUTPATIENT SERVICE COST CENTERS			-		
90. 00 09000 CLI NI C		0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY		0. 26807	0 103	28	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 66321	1 0	0	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			118, 806	42, 119	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charg	es (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)			118, 806		202. 00

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1316	Peri od: Worksheet E From 01/01/2023 Part B To 12/31/2023 Date/Time Prepared: 5/29/2024 11:32 am

0.01   continued				10 12/01/2020	5/29/2024 11:	
Merical and other services (see instructions)		<u> </u>	Title XVIII	Hospi tal	Cost	
Merical and other services (see instructions)					1 00	
		DADT D. MEDICAL AND OTHER HEALTH SERVICES			1.00	
	1 00				3 796 666	1 00
3.00   OPPS or RPH payment (see instructions)   3.00   4.01   Outline reconciliation amount (see instructions)   0.00			tions)			•
0.01   Inter-Feboral Listion amount (see Instructions)   0.000   5.00   1.00		· · · · · · · · · · · · · · · · · · ·				3.00
Infance the hospit fall specific payment to cost rartio (see Instructions)	4.00					4. 00
1.1 no. 2   Tienes 1 in e. 5   0   0.00   7.00	4. 01	1 Outlier reconciliation amount (see instructions)				4. 01
		, , , , , , , , , , , , , , , , , , , ,	ctions)			5. 00
Transit torust corridor payment (see instructions)						ł
Ancil lary service other pass through costs including REH direct graduate medical education costs from   0		1				ł
West, D., Pt. IV, col. 13, line 200		, , , , , , , , , , , , , , , , , , , ,	ct araduate medical educ	ation costs from		ł
10.00   Grgam acquist irlons   3,796,666   11.00   Total cost (sum of lines 1 and 10) (see instructions)   3,796,666   11.00   Total cost (sum of lines 1 and 10) (see instructions)   12.00   12.00   13.00	7. 00		et gradate medicar edde	atron costs 110m	O	7.00
COMPUTATION OF LESSER OF COST OR CHARGES   Neasonable Celturges	10.00				0	10.00
Reasonable charges	11. 00				3, 796, 666	11. 00
12.00   Ancillary service charges   0   12.00   13.00   Organ acquist tion charges (from Wist. D.4, Pt. III, col. 4, Iline 69)   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   13.00   0   14.						
13.00   Organ acquist it on charges (From Wisst. D-4, Pt. III. col. 4, line 69)	40.00					10.00
14.00   Total reasonable charges (sum of lines 12 and 13)   14.00   14.00   20.00			ino (0)			
Discount   Construction   Construc			THE 69)			1
15.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   15.00	14.00					14.00
16.00   Amounts that would have been realized from patients liable for payment for services on a chargebasis   0   16.00   had such payment been made in accordance with 42 CFR \$413.13(e)   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.000000   17.00   0.0000000   0.00000000	15. 00		payment for services on	a charge basis	0	15. 00
17.00	16.00				0	16. 00
Total customary charges (see instructions)   0   18.00   18.			e)			
19.00   Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see   0   19.00		,				ı
instructions			l ! & l 10	11) (		1
20.00   Excess of reasonable cost over customery charges (complete only if line 11 exceeds line 18) (see instructions)   3.834, 633   21.00	19.00		ry ii iine 18 exceeds ii	ne II) (See	U	19.00
Instructions	20. 00		lv if line 11 exceeds li	ne 18) (see	0	20.00
22.00   Interns and residents (see instructions)   0.22.00			,	, (,,		
23.00   Cost of physicians' services in a teaching hospital (see instructions)   0.24.00   0.24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   0.24.00   0.24.00   COMPUTATION OF REIMBURSMENT SETTLEMENT   25.00   Deductible sand color insurance amounts (for CAH, see instructions)   25.351   25.00   25.0	21. 00	Lesser of cost or charges (see instructions)			3, 834, 633	21. 00
24.00   Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)   24.00   26.00						22. 00
COMPUTATION OF RELIMBURSEMENT SETTLEMENT   2.5			ructions)			
25. 00   Deductibles and coinsurance amounts (for CAH, see instructions)   25, 351   25. 00	24.00				0	24.00
26.00   Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see Instructions)   1,944,842   26.00   28.00   29.00   28.00   29.00	25 00		e)		25 351	25 00
27. 00   Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see   1,864,440   27. 00   1,864,440   27. 00   1,864,440   27. 00   1,864,440   27. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   28. 00   29. 0		1	•	uctions)		1
28. 00       Direct graduate medical education payments (from Wkst. E-4, line 50)       28. 00         28. 50       RFH réallity payment amount (see instructions)       28. 50         29. 00       ESRD direct medical education costs (from Wkst. E-4, line 36)       0. 29. 00         30. 00       Subtotal (sum of lines 27, 28, 28. 50 and 29)       1, 864, 440       30. 00         31. 00       Inarry payer payments       2,558       31. 00         32. 00       Subtotal (line 30 minus line 31)       1, 861,882       32. 00         33. 00       Composite rate ESRD (from Wkst. I-5, line 11)       0       33. 00         34. 00       Allowable bad debts (see instructions)       435, 604       34. 00         35. 00       Allowable bad debts (see instructions)       283, 143       35. 00         36. 00       Allowable bad debts (see instructions)       283, 143       35. 00         37. 00       Subtotal (see instructions)       2,145, 025       37. 00         38. 00       MSP-LCC reconcilitation amount from PS&R       2,145, 025       37. 00         39. 00       OTHER ADJUSTMENTS (SEE InSTRUCTIONS) (SPECIFY)       39. 00         39. 75       NS respirator payment adjustment amount (see instructions)       39. 00         39. 78       Partial or full credits received from manufacturers for replaced d		l e	•	'		ł
28.50   REH facility payment amount (see instructions)   28.50   SRD direct medical education costs (from Wkst. E-4, line 36)   0   09.00   03.00   Subtotal (sum of lines 27, 28, 28.50 and 29)   1,864,440   31.00   Primary payer payments   2,558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   31.00   25.558   25.00   25.558   25.00						
29.00   ESRD direct medical education costs (From Wkst. E-4, line 36)   29.00   30.00   Subtotal (sum of lines 27, 28, 28.50 and 29)   1,864.440   30.00   20.00   31.00   20.00   31.00   20.00   31.00   20.00   31.00   31.00   20.00   31.00   3			ine 50)		0	•
30. 00   Subtotal (sum of lines 27, 28, 28.50 and 29)   1, 864, 440   30. 00   Primary payer payments   2, 558   31. 00   32. 00   Subtotal (line 30 minus line 31)   1, 861, 882   32. 00   33. 00   Composite rate ESRD (from West. I -5, line 11)   0   33. 00   34. 00   Allowable bad debts (see instructions)   283, 143   35. 00   35. 00   Allowable bad debts (see instructions)   283, 143   35. 00   37. 00   38. 00   Allowable bad debts for dual eligible beneficiaries (see instructions)   332, 511   36. 00   37. 00   38.		,			0	1
31.00   Subtotal (line 30 minus line 31)   1,861,882   32.00   ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. 1-5, line 11)   0   33.00   Adjusted reimbursable bad debts (see instructions)   435,604   34.00   Allowable bad debts (see instructions)   332,511   36.00   37.00   38.00   Allowable bad debts (see instructions)   332,511   36.00   38.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   332,511   36.00   37.00   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   70   Foreign (line and allowable bad debts (see instructions)   39.50   70   Foreign (line and allowable bad debts (see instructions)   39.50   70   Foreign (line and allowable bad debts (see instructions)   39.50   70   70   70   70   70   70   70						•
Subtotal (line 30 minus line 31)		, , , , , , , , , , , , , , , , , , , ,				•
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)   33.00   Composite rate ESRD (from Wkst. I -5, line 11)   0   33.00   34.00   All owable bad debts (see instructions)   435,664   34.00   35.00   Adjusted reimbursable bad debts (see instructions)   283, 143   35.00   36.00   All lowable bad debts for dual eligible beneficiaries (see instructions)   283, 143   35.00   37.00   Subtotal (see instructions)   2, 145,025   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   39.00   39.00   THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.50   99.00   79.00						•
34.00			CES)		·	
35.00						33. 00
33. 00						
37.00   Subtotal (see instructions)   2,145,025   37.00   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   3		·	musti ana)			1
38.00   MSP-LCC reconciliation amount from PS&R   0   38.00   39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   39.00   39.00   39.50   39.50   39.50   39.57   39.97   50   50   50   50   50   50   50   5		1	ructions)			ı
39.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   39.50   39.00   39.00   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.50   39.75   39.50   39.97   Demonstration payment adjustment amount (see instructions)   0.39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0.39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0.39.99   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   39.90   40.00   40.						
39.50   Pioneer ACO demonstration payment adjustment (see instructions)   39.50   39.75   NSF respirator payment adjustment amount (see instructions)   0 39.75   39.97   Demonstration payment adjustment amount before sequestration   0 39.97   39.98   Partial or full credits received from manufacturers for replaced devices (see instructions)   0 39.98   39.99   RECOVERY OF ACCELERATED DEPRECIATION   0 39.99   40.00   Subtotal (see instructions)   2,145,025   40.00   40.01   Sequestration adjustment (see instructions)   42.901   40.01   40.02   Demonstration payment adjustment amount after sequestration   0 40.02   40.03   Sequestration adjustment amount after sequestration   0 40.02   40.03   40.01						39.00
39. 97 Demonstration payment adjustment amount before sequestration 39. 97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 SECOVERY OF ACCELERATED DEPRECIATION 39. 99 SECOVERY OF ACCELERATED DEPRECIATION 39. 99 COUNTY OF ACCELERATED DEPRECIATION 39. 99 SECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Sequestration adjustment amount after sequestration 40. 02 Sequestration adjustment amount after sequestration 40. 03 Sequestration adjustment amount (see instructions) 41. 01 Interim payments 41. 01 Interim payments 41. 01 Interim payments 41. 01 Interim payments 42. 00 Sequestration adjustment amount (see instructions) 42. 01 Tentative settlement (for contractor use only) 42. 01 Tentative settlement (for contractor use only) 42. 01 Tentative settlement (for contractor use only) 43. 01 Sequestration adjustment amount (see instructions) 43. 01 Sequestration adjustment amount (see instructions) 43. 01 Sequestration adjustment amount (see instructions) 44. 00 Sequestration adjustment amount (see instructions) 45. 00 Sequestration adjustment amount (see instructions) 46. 00 Sequestration adjustment amount (see instructions) 47. 00 Sequestration adjustment amount (see	39. 50	, , , , ,	s)			39. 50
39. 98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39. 98         39. 99       RECOVERY OF ACCELERATED DEPRECIATION       0       39. 99         40. 00       Subtotal (see instructions)       2, 145, 025       40. 00         40. 01       Sequestration adjustment (see instructions)       42, 901       40. 01         40. 02       Demonstration payment adjustment amount after sequestration       0       40. 02         40. 03       Sequestration adjustment-PARHM pass-throughs       1, 748, 432       41. 00         41. 01       Interim payments       1, 748, 432       41. 00         41. 01       Interim payments-PARHM       1, 748, 432       41. 00         42. 01       Tentative settlement (for contractors use only)       0       42. 01         43. 01       Bal ance due provider/program (see instructions)       353, 692       43. 00         43. 01       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       303, 748       44. 00         90. 00       Original outlier amount (see instructions)       0       90. 00         91. 00       Outlier reconciliation adjustment amount (see instructions)       0       90. 00         92. 00       The rate used to calculate the Time Value of Money						39. 75
39. 99 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 02 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 41. 01 Interim payments-PARHM 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement-PARHM (for contractor use only) 43. 00 Bal ance due provider/program (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Bal ance due provider/program-PARHM (see instructions) 43. 01 Original outlier amount (see instructions) 44. 00 Original outlier amount (see instructions) 45. 01 Original outlier amount (see instructions) 46. 00 Outlier reconciliation adjustment amount (see instructions) 47. 00 Outlier reconciliation adjustment amount (see instructions) 48. 00 Outlier reconciliation adjustment amount (see instructions) 49. 00 Outlier amount (see instructions) 49. 00 Outlier reconciliation adjustment amount (see instructions)						39. 97
40.00       Subtotal (see instructions)       2, 145, 025       40.00         40.01       Sequestration adjustment (see instructions)       42, 901       40.01         40.02       Demonstration payment adjustment amount after sequestration       0 40.02         40.03       Sequestration adjustment-PARHM pass-throughs       1, 748, 432       41.00         41.00       Interim payments       1, 748, 432       41.00         41.01       Interim payments-PARHM       1       41.00         42.01       Tentative settlement (for contractors use only)       0 42.00         42.01       Tentative settlement-PARHM (for contractor use only)       353,692       43.00         43.01       Balance due provider/program (see instructions)       353,692       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303,748       44.00         90.00       Original outlier amount (see instructions)       0 90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0 90.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00		·	ced devices (see instruc	tions)		ı
40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 40. 03 Sequestration adjustment-PARHM pass-throughs 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 42. 01 Tentative settlement -PARHM (for contractor use only) 43. 00 Balance due provider/program (see instructions) 43. 01 Balance due provider/program-PARHM (see instructions) 43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303, 748 44. 00 Original outlier amount (see instructions)  90. 00 Outlier reconciliation adjustment amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 92. 00 The rate used to calculate the Time Value of Money 94. 0. 01 Outlier amount (see instructions) 95. 02 Outlier amount (see instructions) 96. 00 Outlier amount (see instructions) 97. 00 Outlier amount (see instructions) 98. 00 Outlier amount (see instructions) 99. 00 Outlier amount (see instructions)						ı
40. 02 Demonstration payment adjustment amount after sequestration  40. 03 Sequestration adjustment-PARHM pass-throughs  41. 00 Interim payments  41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Balance due provider/program (see instructions)  43. 01 Balance due provider/program-PARHM (see instructions)  43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303, 748 due to a single complete by CONTRACTOR  90. 00 Original outlier amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  9 O O O Outlier reconciliation adjustment amount (see instructions)  9 O O O Outlier reconciliation adjustment amount (see instructions)  9 O O O Outlier reconciliation adjustment amount (see instructions)  9 O O Outlier reconciliation adjustment amount (see instructions)  9 O OO Outlier reconciliation adjustment amount (see instructions)  9 O OO Outlier reconciliation adjustment amount (see instructions)						•
40. 03   Sequestration adjustment-PARHM pass-throughs   40. 03   1   1   1   1   1   1   1   1   1						
41. 01 Interim payments-PARHM  42. 00 Tentative settlement (for contractors use only)  42. 01 Tentative settlement-PARHM (for contractor use only)  43. 00 Bal ance due provider/program (see instructions)  43. 01 Bal ance due provider/program-PARHM (see instructions)  43. 01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303,748 44.00  90. 00 Original outlier amount (see instructions)  90. 00 Outlier reconciliation adjustment amount (see instructions)  91. 00 Outlier reconciliation adjustment amount (see instructions)  92. 00 The rate used to calculate the Time Value of Money  41. 01  42. 00  42. 01  42. 01  43. 00  42. 01  43. 00  43. 01  44. 00  90. 00  90. 00  91. 00  91. 00  92. 00						40. 03
42.00 Tentative settlement (for contractors use only) 42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303,748 44.00  Solve To BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 Tentative settlement (for contractors use only) 42.01 42.00 42.01 42.00 42.01 42.00 42.01 42.00	41. 00	, ,			1, 748, 432	41.00
42.01 Tentative settlement-PARHM (for contractor use only) 43.00 Balance due provider/program (see instructions) 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303,748 44.00  Solve To Be Completed By Contractor  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 92.00 Tentative settlement-PARHM (for contractor use only) 42.01 43.00 43.00 43.00 43.01 90.00 90.00 90.00 90.00 91.00 92.00		l · · · · · · · · · · · · · · · · · · ·				41. 01
43.00 Balance due provider/program (see instructions)  43.01 Balance due provider/program-PARHM (see instructions)  43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303,748 44.00 Si15.2  TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  43.00 Ago 90.00 90.00		1			0	42.00
43. 01 Balance due provider/program-PARHM (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 303, 748 44. 00 Sils. 2  90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money  43. 01 44. 00 90. 00 90. 00 90. 00 91. 00 92. 00		,			252 (02	•
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$303,748 44.00 \frac{\text{\$\frac{\text{\$\frac{\text{9115.2}{\text{\$\frac{\text{\$\finte}}{2}}\text{\$\frac{\text{\$\fintert{\$\frac{\text{\$\frac{\exitex{\$\}\$\frac{\text{\$\frac{\til\exitit{\$\frac{\					353, 692	1
\$115.2 TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money  93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 96.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions) 98.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions) 99.00 Outlier reconciliation adjustment amount (see instructions)			nce with CMS Pub 15-2	chapter 1	303 748	•
TO BE COMPLETED BY CONTRACTOR  90.00 Original outlier amount (see instructions)  91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  93.00 Outlier reconciliation adjustment amount (see instructions)  94.00 Outlier reconciliation adjustment amount (see instructions)  95.00 Outlier reconciliation adjustment amount (see instructions)  96.00 Outlier reconciliation adjustment amount (see instructions)  97.00 Outlier reconciliation adjustment amount (see instructions)	<del>-</del> 00		nee with owe rub. 15-2,	chapter I,	303, 740	00
91.00 Outlier reconciliation adjustment amount (see instructions)  92.00 The rate used to calculate the Time Value of Money  0 91.00  0 91.00						1
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		, ,				ı
		,				91.00
73. 00   This value of Mothey (See This fructions)   0  93. 00						ı
	93.00	Time value of woney (see firstructions)			0	73.00

Health Financial Systems	IU HEALTH FRANKFOR	T HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1316	Peri od: From 01/01/2023 To 12/31/2023		narodi
			10 12/31/2023	5/29/2024 11:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

| Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/29/2024 | 11: 32 am Health Financial Systems I U HEALTH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1316

Interfim payments payable on individual bills, either submitted or to be submitted for the cost reporting period. If none, write "NONE" or enter a zero.    2.00						5/29/2024 11: 3	32 am
1.00							
1.00   7   Total interim payments paid to provider   1.00   2.00   3.00   4.00   1.748, 432   1.00   1.101   1.00   1.0			Inpatier	nt Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
InterIm payments payable on individual bills, either submitted or to be submitted or to here a zero or the cost reporting period. Also show date of each payment. If none, write "NME" or enter a zero. (1)   Program to Provider				2.00		4. 00	
InterIm payments payable on individual bills, either submitted or to be submitted or to here a zero or the cost reporting period. Also show date of each payment. If none, write "NME" or enter a zero. (1)   Program to Provider	1.00	Total interim payments paid to provider		821, 538	3	1, 748, 432	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero write "NONE" or enter a zero the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2.00				)	0	2.00
write "NONE" or enter a zero . 0. 0. List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider . 0		submitted or to be submitted to the contractor for					
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05 3.05 3.07 3.08 3.09 3.09 3.09 3.00 3.00 3.00 3.00 3.00							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   NONE" or enter a zero. (1)   Program to Provider   NONE" or enter a zero. (1)   NONE   NONE	3.00						3. 00
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Program to Provider   ADJUSTMENTS TO PROVIDER   09/26/2023   120,600   0   0   3.0							
ADJUSTMENTS TO PROVIDER							
3.03   0				100 (0)	~I		
3.04 3.05 Provider to Program  3.50 3.51 3.51 3.52 3.53 3.54 4.00 Total interim payments (sum of lines 1, 2, and 3.99) To BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR TO BE COMPLETED BY CONTRACTOR TENTATI VE TO PROGRAM  TENTATI VE TO PROGRAM  O DO DEET DEED CONTRACTOR TENTATI VE TO PROGRAM  O DO DEET DEET DEET DEET DEET DEET DEET		ADJUSTMENTS TO PROVIDER	09/26/2023				
3.05   Provider to Program				1			
3. 50   ADJUSTMENTS TO PROGRAM				l .			
Provider to Program   ADJUSTMENTS TO PROGRAM   0						1	
ADJUSTMENTS TO PROGRAM	3.05				)	0	3. 05
3.52   3.52   3.53   0   0   0   3.55     3.53   0   0   0   0     3.53   3.53   0   0   0     3.53   3.54   0   0   0     3.55   3.54   0   0   0     3.55   3.54   0   0   0     3.55   3.59   0   0   0     3.50   3.99   3.50   3.98   120,600   3.55     3.50   3.98   120,600   3.55     3.50   10   10   10   10     3.50   10   10   10     4.00   10   10   10     5.00   10   10   10     5.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10   10     6.00   10     6.00   10   10     7.00   10     7.00   10   10     7.00   10   10     8.00   10	2 50			1 ,			2 50
3.52   3.53   3.54   3.50		ADJUSTMENTS TO PROGRAM		l .			
3.53   0				1		1	
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   120,600   0   3.59   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR				l .			
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   120,600   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   942,138   1,748,432   4.00   5.0				1		1 -1	
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)		Subtotal (sum of lines 3 01-3 40 minus sum of lines		1			
4.00   Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	J. 77			120, 000			3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	4 00			942 138	3	1 748 432	4. 00
appropriate   TO BE COMPLETED BY CONTRACTOR						., ,	
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		TO BE COMPLETED BY CONTRACTOR					
Write "NONE" or enter a zero. (1)   Program to Provider	5.00	List separately each tentative settlement payment after					5. 00
Program to Provider		desk review. Also show date of each payment. If none,					
TENTATI VE TO PROVI DER							
5.02   0					1		
5.03   Provider to Program   5.50   TENTATIVE TO PROGRAM   0   0   5.50     5.51   0   0   0   5.55     5.52   0   0   0   5.55     5.52   5.50-5.98   0   0   0   5.55     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROGRAM   0   0   6.00     6.02   SETTLEMENT TO PROGRAM   0   0   6.00     7.00   Total Medicare program liability (see instructions)   1,124,377   2,102,124   7.00     Contractor Number (Mo/Day/Yr)   0   1.00   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00     7.00   Total Medicare program liability (see instructions)   1,100   2.00		TENTATI VE TO PROVI DER		1			
Provider to Program							
TENTATI VE TO PROGRAM	5.03				)	0	5. 03
5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  182,239 353,692 6.02 7.00 Total Medicare program liability (see instructions)  1,124,377  Contractor NPR Date (Mo/Day/Yr)  Number (Mo/Day/Yr)  0 1.00 2.00	F F0		I	1	-l		F F0
5.52   0 0 5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   182,239   353,692   6.02   SETTLEMENT TO PROGRAM   0   0   6.02   7.00   Total Medicare program liability (see instructions)   1,124,377   2,102,124   7.00   7.00   Contractor Number (Mo/Day/Yr)   0   1.00   2.00   1.00   2.00   1.00		TENTATIVE TO PROGRAM		1			
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions)   Contractor NPR Date (Mo/Day/Yr)  0 1. 00 2. 00				1		1 -1	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		Subtatal (sum of lines E O1 E 40 minus sum of lines		1		1 -1	
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	5. 99	· ·			ا	ا	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  182,239  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6 00						6 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  182, 239 0 6.00 1, 124, 377 0 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	0.00	` ,					0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  0 0 6.00 2, 102, 124 7.00  Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6. 01			182 239	9	353 692	6. 01
7.00 Total Medicare program liability (see instructions)  1,124,377  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00				1 .52, 25	)		6. 02
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00				1, 124 37	7	1 °1	7. 00
Number         (Mo/Day/Yr)           0         1.00         2.00	00			., 121, 37			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00				0			
	8.00	Name of Contractor					8. 00

Health Financial Systems 1 U HEALT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/29/2024 11:	32 am
				wing Beds - SNF		
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		554, 346		0	1. 00
2.00	Interim payments payable on individual bills, either		C	)	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	09/26/2023	57, 200		0	3. 01
3. 02			C		0	3. 02
3. 03			C		0	3. 03
3. 04			C		0	3. 04
3. 05			C		0	3. 05
	Provi der to Program	ı				
3.50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3.51			C		0	3. 51
3.52			C		0	3. 52
3.53			C		0	3. 53
3.54	Cultural ( 1 in 2 01 2 40 minus 1 in		[ C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		57, 200		0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		611, 546		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		011, 540	,	U	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	L	l .	l		
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		C	)	0	5. 01
5.02			C	)	0	5. 02
5.03			C		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52			C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		440.000			, 61
6. 01	SETTLEMENT TO PROVIDER		149, 092		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		7,0,00		0	6. 02
7. 00	Total Medicare program liability (see instructions)		760, 638		0	7. 00
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
0.00	Thame of Softi dotor	I		I		0.00

Heal th	Financial Systems IU HEALTH FRANKFO	RT HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL					epared: 32 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	2.00 Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00					
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	1.00 Other Adjustment (specify)				
	1.00 Other Adjustment (specify)				

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

30. 00 31. 00 32. 00

		Component CCN: 15-Z316	To 12/31/2023	Date/Time Pre 5/29/2024 11:	
		Title XVIII	Swing Beds - SNF		<u> </u>
			Part A	Part B	
	[		1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES  Inpatient routine services - swing bed-SNF (see instructions)		441 412	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-NF (see instructions)		661, 413	Ü	1. 00 2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	116, 748	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see			Ŭ	0.00
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4. 00
E 00	instructions)		142	0	E 00
5. 00 6. 00	Program days Interns and residents not in approved teaching program (see in	netructions)	163	0	5. 00 6. 00
7. 00	Utilization review - physician compensation - SNF optional met		0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		778, 161	0	1
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		778, 161	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11. 00
12 00	professional services)		770 1/1	,	12 00
12. 00 13. 00	Subtotal (line 10 minus line 11) Coinsurance billed to program patients (from provider records)	(aveluda coi nsuranca	778, 161 2, 000	0 0	12. 00 13. 00
13.00	for physician professional services)	(exclude collisulance	2,000		13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14. 00
15. 00	Subtotal (see instructions)		776, 161	0	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	· ·			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
16. 99	adjustment (see instructions)  Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	Ö	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19. 00	Total (see instructions)		776, 161	0	
19. 01	Sequestration adjustment (see instructions)		15, 523	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs		0	0	19. 03 19. 25
20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		611, 546		20.00
20. 01	Interim payments-PARHM		011, 540		20. 01
21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	149, 092	0	
22. 01	Balance due provider/program-PARHM (see instructions)		E		22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	56, 651	0	23. 00
	<pre>chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr</pre>	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration per				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201. 00
202.00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	West D 2 col 2 lin			202. 00
202.00	200 (title XVIII swing-bed SNF))	I WKSt. D-3, COI. 3, IIII	е		202.00
203.00	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	trati on	
	peri od)				
	Medicare swing-bed SNF target amount	maa lina 204)			205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				206. 00
207 00					207. 00
	7.00 Program reimbursement under the §410A Demonstration (see instructions) 8.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1		1		208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210.00	Reserved for future use				210. 00
245 62	Comparision of PPS versus Cost Reimbursement	000 -1 1:- 010) (			015 00
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2 instructions)	209 plus line 270) (see			215. 00
	Thisti deti ons)		I	ı	I

Health Financial Systems	IU HEALTH FRANKFORT HOSPITAL	In Lieu of Form	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1316	Peri od: Workshee From 01/01/2023 Part V To 12/31/2023 Date/Tim 5/29/202	
	T		

				5/29/2024 11:3	32 am_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULATION OF REIMBU	ART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			1, 229, 228	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions	s)		0	2. 00
3.00	Organ acqui si ti on			0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 229, 228	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 241, 520	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10. 00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for page 1	,	9	0	11. 00
12. 00	Amounts that would have been realized from patients liable for	payment for services or	n a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds lir	ne 6) (see	0	15. 00
47.00	instructions)		44) (	0	47.00
16. 00	Excess of reasonable cost over customary charges (complete only	IT line 6 exceeds line	e 14) (see	0	16. 00
17. 00	instructions)	ationa)		0	17. 00
17.00	Cost of physicians' services in a teaching hospital (see instru- COMPUTATION OF REIMBURSEMENT SETTLEMENT	ctrons)		U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	Line 40)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	11116 49)		1, 241, 520	
20. 00	Deductibles (exclude professional component)			103, 912	
21. 00	Excess reasonable cost (from line 16)			103, 912	21. 00
21.00	Subtotal (line 19 minus line 20 and 21)			1, 137, 608	
23. 00	Coi nsurance			1, 137, 606	23. 00
24. 00	Subtotal (line 22 minus line 23)			1, 137, 608	
25. 00	Allowable bad debts (exclude bad debts for professional services	c) (see instructions)		1, 137, 008	
26. 00	Adjusted reimbursable bad debts (see instructions)	s) (see mistructions)		9, 715	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		7, 868	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ctrons)		1, 147, 323	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 147, 323	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 30	Recovery of accelerated depreciation.			0	29. 50
29. 98 29. 99				0	29. 98
29. 99 30. 00	Demonstration payment adjustment amount before sequestration			-	
	Subtotal (see instructions)			1, 147, 323	
30. 01 30. 02	Sequestration adjustment (see instructions)			22, 946	30. 01 30. 02
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM			042 120	
	Interim payments			942, 138	31.00
31.01	Interim payments-PARHM			0	31.01
32. 00 32. 01	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)			U	32.00
32.01	Balance due provider/program (line 30 minus lines 30.01, 30.02,	21 and 22)		182, 239	32.01
33. 00	Balance due provider/program (Tine 30 minus Tines 30.01, 30.02, Balance due provider/program-PARHM (Lines 2, 3, 18, and 26, minus		and 22 01)	182, 239	33.00
34. 00	Protested amounts (nonallowable cost report items) in accordance		,	90, 348	34. 00
34.00	§115. 2	e with two Pub. 15-2, (	Jiaptei I,	90, 348	34.00
	3110.2		ļ		l

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

Provider CCN: 15-1316

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 11: 32 am

Offi y)					5/29/2024 11:	32 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1. 00	2.00	3. 00	4.00	
	CURRENT ASSETS	1, 177 051	1		1	
1. 00 2. 00	Cash on hand in banks Temporary investments	-16, 477, 954	0	_	_	
3. 00	Notes receivable			_	0	3.00
4. 00	Accounts receivable	3, 247, 053	1	0	o o	
5. 00	Other recei vabl e	2, 309, 455		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	293, 819		0	0	
8.00	Prepai d expenses	43, 749	1	0	0	
9.00	Other current assets	0	0	_	0	1
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	-10, 583, 878	0	_		10.00
11.00	FIXED ASSETS	-10, 303, 070	,		0	11.00
12. 00	Land	1, 030, 133	0	0	0	12. 00
13.00	Land improvements	23, 434	0	0	0	13. 00
14. 00	Accumul ated depreciation	-11, 326	1	_	_	14. 00
15. 00	Bui I di ngs	27, 513, 288	1	0	0	15. 00
16.00	Accumulated depreciation	-2, 338, 385	1	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	927, 373 -581, 968		_	0	17. 00 18. 00
19. 00	Fi xed equi pment	-381, 900		_	0	19.00
20. 00	Accumulated depreciation	0	Ö	o o	ő	20.00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	9, 582, 732		0	0	23. 00
24. 00	Accumulated depreciation	-7, 438, 817	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation			0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e		o o	_	ő	29. 00
30.00	Total fixed assets (sum of lines 12-29)	28, 706, 464	0	0	0	30.00
	OTHER ASSETS					
31. 00	Investments	0	0	_	_	
32. 00	Deposits on Leases	0	0	_	_	32.00
33.00	Due from owners/officers	0	0	_	0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)		0		0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	18, 122, 586	1	_	Ö	36.00
00.00	CURRENT LIABILITIES	10/122/000	,			00.00
37.00	Accounts payable	3, 186, 556	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	375, 745	1	0		38. 00
39. 00	Payroll taxes payable	28, 619	1	0	0	
40.00	Notes and Loans payable (short term)	0	0	0	0	1
41. 00 42. 00	Deferred income Accelerated payments	0	) U	0	0	41. 00 42. 00
43.00	Due to other funds	618, 004	ĺ	0	0	43.00
44. 00	Other current liabilities	010,001	1	0	ő	
45.00	Total current liabilities (sum of lines 37 thru 44)	4, 208, 924	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	_	_	
47. 00	Notes payable	23, 373, 443		_	_	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	0	0	_		48. 00 49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	23, 373, 443		_		
51. 00	Total liabilities (sum of lines 45 and 50)	27, 582, 367	1	_		51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	-9, 459, 781				52. 00
53.00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0	0	56.00
57. 00 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,		1		0	57. 00 58. 00
55. 55	replacement, and expansion					55. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	-9, 459, 781	0	0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	18, 122, 586	0	0	0	60. 00
	[59]	I	1		l	l

Provider CCN: 15-1316

Peri od: Worksheet G-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					To 12/31/2023	Date/Time Prep 5/29/2024 11:3	oared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	52 aiii
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	-5, 326, 421	3.00	4.00	5.00	1. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-4, 133, 359 -9, 459, 780		0		2. 00 3. 00
4. 00 5. 00	Additions (credit adjustments) (specify)	0			0	0	4. 00 5. 00
6. 00		0			0	Ö	6. 00
7. 00 8. 00		0			0	0	7. 00 8. 00
9.00		o o			Ö	ő	9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 -9, 459, 780		0		10. 00 11. 00
12. 00	ROUNDI NG	1	7, 107, 700		0	0	12.00
13. 00 14. 00		0			0	0	13. 00 14. 00
15. 00 16. 00		0			0	0	15. 00 16. 00
17. 00		o o			Ö	Ö	17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance		1 -9, 459, 781		0		18. 00 19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1. 00	Fund balances at beginning of period	6.00	7. 00	8. 00	0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3. 00 4. 00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		3. 00 4. 00
5.00	(		0				5. 00
6. 00 7. 00			0				6. 00 7. 00
8. 00 9. 00			0				8. 00 9. 00
10.00	Total additions (sum of line 4-9)	O	J		0		10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) ROUNDING	0	0		0		11. 00 12. 00
13. 00 14. 00		İ	0				13. 00 14. 00
15. 00			0				15. 00
16. 00 17. 00			0				16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	0	Ĭ		0		18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		19. 00

Health Financial Systems IU STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1316

			To	12/31/2023	Date/Time Prep 5/29/2024 11:3	
	Cost Center Description	Inpati	ent	Outpati ent	Total	<u></u>
		1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal	1, 60	5, 047		1, 605, 047	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	38	34, 748		384, 748	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)	1.98	39, 795		1, 989, 795	10. 00
	Intensive Care Type Inpatient Hospital Services	<u>'</u>			, , ,	
11. 00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12. 00
13.00	BURN INTENSIVE CARE UNIT					13. 00
14.00	SURGICAL INTENSIVE CARE UNIT					14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16.00	Total intensive care type inpatient hospital services (sum of	i nes	0		0	16. 00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)	1, 98	39, 795		1, 989, 795	17. 00
18.00	Ancillary services	2, 7!	4, 092	41, 033, 067	43, 787, 159	18. 00
19.00	Outpati ent servi ces	29	3, 368	28, 971, 801	29, 265, 169	19. 00
20.00	RURAL HEALTH CLINIC		0	o	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	0	21. 00
22.00	HOME HEALTH AGENCY			0	0	22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPI CE					26.00
27. 00	OTHER (SPECIFY)		0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 5,03	37, 255	70, 004, 868	75, 042, 123	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			28, 585, 743		29. 00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31. 00
32. 00			0			32. 00
33. 00			0			33. 00
34. 00			0			34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40. 00
41.00			0	_		41.00
42. 00	Total deductions (sum of lines 37-41)			0 505 7.0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		28, 585, 743		43. 00
	to Wkst. G-3, line 4)	l		ļ		

	Financial Systems IU HEALTH FRAN ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1316	Peri od:	u of Form CMS-2 Worksheet G-3	
O I / ( I E I	ENT OF REVENUES 7110 ENTENUES	11001461 0011. 10 1010	From 01/01/2023	WOT ROTICET & &	
			To 12/31/2023		
				5/29/2024 11:3	32 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3,	line 28)		75, 042, 123	1. 00
2.00	Less contractual allowances and discounts on patients' acc			49, 851, 877	2. 00
3.00	Net patient revenues (line 1 minus line 2)			25, 190, 246	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, Ii	ne 43)		28, 585, 743	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			-3, 395, 497	5. 00
	OTHER INCOME				l
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8.00	Revenues from telephone and other miscellaneous communicat	ion services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	1
13.00	Revenue from Laundry and Linen service			0	
14. 00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	
16. 00	Revenue from sale of medical and surgical supplies to othe	r than patients		0	
17. 00	Revenue from sale of drugs to other than patients				17. 00
18. 00	Revenue from sale of medical records and abstracts				18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			-	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	
21.00	Rental of vending machines			0	
22. 00	Rental of hospital space			0	
23. 00	Governmental appropriations			0	
24. 00	MI SCELLANEOUS I NCOME			-737, 862	
24. 50	COVI D-19 PHE Fundi ng			0	
25. 00	Total other income (sum of lines 6-24)			-737, 862	
26. 00	Total (line 5 plus line 25)			-4, 133, 359	
27. 00	OTHER EXPENSES (SPECIFY)			0	
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28	5)	ļ	-4, 133, 359	, 29. 00