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: 15-1311 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/29/2024 2: 28 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/29/2024 2:28 pm 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] Initial 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 Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH TIPTON HOSPITAL (15-1311) for the cost reporting period beginning 01/01/2023 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		
		1	2	SI GNATURE STATEMENT	
1	Cara	a Breidster	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Cara Breidster			2
3	Signatory Title	CF0			3
4	Date	(Dated when report is electronica			4

			Title	XVIII			
		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	8, 121	85, 720	0	0	1. 00
2.00	SUBPROVI DER - I PF	0	0	0		0	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	64, 126	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
200.00	TOTAL	0	72, 247	85, 720	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.

	TAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		er CCN: 1		Peri od:		Workshe		
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	pared:
	1.00	2.00		3. 00			4. 00	5/29/20	24 2: 2	8 pm
	Hospital and Hospital Health Care Co			3.00			+. 00			
1.00	Street: 1000 SOUTH MAIN STREET	P0 Box:								1. 00
2.00	City: TIPTON	State: IN	Zi p Code			y: TIPTON	Б	1.6.1	(D	2. 00
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		nt Systo O, or		
			- Namber	ramber	1,700	oci ti i i cu	V ,	XVIII	XIX	
		1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
2 00	Hospital and Hospital-Based Componen		151011	00015	1 1	11 /12 /2005	N.		_	2.00
3. 00	Hospi tal	IU HEALTH TIPTON HOSPITAL	151311	99915	1	11/12/2005	N	0	Р	3. 00
4.00	Subprovi der - IPF									4. 00
5. 00	Subprovi der - IRF									5. 00
6. 00 7. 00	Subprovi der - (Other) Swing Beds - SNF	IU HEALTH TIPTON	15Z311	29020		11/12/2005	l N	0	N	6. 00 7. 00
7.00	SWITIG BEUS - SIVE	HOSPITAL	132311	29020		1171272005	IN		IN	7.00
8.00	Swing Beds - NF									8. 00
9.00	Hospi tal -Based SNF									9. 00
10. 00 11. 00	Hospi tal -Based NF Hospi tal -Based OLTC									10.00
	Hospi tal -Based HHA									12.00
13. 00	·									13. 00
	Hospi tal -Based Hospi ce									14. 00
	Hospital Based Health Clinic - RHC									15.00
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16. 00 17. 00
18. 00	Renal Dialysis									18.00
19. 00	Other						L,			19. 00
						1.00		2. C		
20. 00	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20. 00
	Type of Control (see instructions)					2	020		2020	21. 00
	Inpatient PPS Information				1. 00	2. 00		3.0	00	
22. 00	Does this facility qualify and is it	currently receiving pay	vments for		N	N				22. 00
	disproportionate share hospital adju	stment, in accordance wi	ith 42 CFR							
	§412. 106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo		enament							
22. 01	Did this hospital receive interim UC		tal UCPs,	for	N	N				22. 01
	this cost reporting period? Enter in									
	for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on o		tron or th							
	instructions)									
22. 02	Is this a newly merged hospital that				N	N				22. 02
	determined at cost report settlement 1, "Y" for yes or "N" for no, for th			umn						
	period prior to October 1. Enter in			no,						
	for the portion of the cost reportin	5 1								
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar				N	N		N		22. 03
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin	g period prior to Octobe	er 1. Ente							
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or aft Does this hospital contain at least			s						
	counted in accordance with 42 CFR 41									
	yes or "N" for no.									
22. 04	Did this hospital receive a geograph rural as a result of the revised OMB									22. 04
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin	3 1		r						
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft									
	Does this hospital contain at least			s						
	counted in accordance with 42 CFR 41									
22.00	yes or "N" for no.	disald days !! 04	and/ 25			2				22.00
23.00	Which method is used to determine Me below? In column 1, enter 1 if date					3 N				23. 00
	if date of discharge. Is the method									
	reporting period different from the									
	reporting period? In column 2, ente	r "Y" tor yes or "N" fo	r no.			1				

				<u> </u>	<u> 124 2.2</u>	28 pm
	Medicaid Medicaid State S paid days eligible Medicaid Me unpaid paid days el	State di cai d i gi bl e	Medicai HMO day	/s Med	ther di cai d days	
	3	npai d	F 00			4
24. 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.	4.00	5. 00	0	5. 00 C	24.00
25. 00	Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0 Urban/Ru	ral S I	O Date of	Geogr	25. 00
		1. 00		2. (
26. 00	Enter your standard geographic classification (not wage) status at the beginning of the		2			26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.		2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.		0			35. 00
	periods in the door reporting period.	Begi nni		Endi 2. (
36. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number	1.00)	2. (JU	36. 00
37. 00	of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status		0			37. 00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					37. 01
38. 00	Iffline 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.					38. 00
	price cascoquent datos.	Y/N		Υ/		
39. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume	1. 00 N)	2. (N		39. 00
37.00	hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N		IV.		37.00
40. 00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	V	N		40. 00
				V////	VIV	
			1.00	2. 00	XI X 3. 00	
45	Prospective Payment System (PPS)-Capital		1.00	2. 00	3.00	45
	Does this facility qualify and receive Capital payment for disproportionate share in acc with 42 CFR Section §412.320? (see instructions)		1. 00	2. 00 N	3. 00 N	45. 00
	Does this facility qualify and receive Capital payment for disproportionate share in acc	es	1.00	2. 00	3.00	45. 00 46. 00
46. 00	Does this facility qualify and receive Capital payment for disproportionate share in acc with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstanc pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t	es hrough	1. 00	2. 00 N	3. 00 N	
46. 00 47. 00	Does this facility qualify and receive Capital payment for disproportionate share in account 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstance pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. II Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for 1s the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost rep	es hrough or no.	N N N	2.00 N N	3.00 N N	46. 00 47. 00
46. 00 47. 00 48. 00	Does this facility qualify and receive Capital payment for disproportionate share in acceive this facility eligible for additional payment exception for extraordinary circumstance pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t. Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for ls the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reperiods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2 the instructions. For column 2, if the response to column 1 is "Y", or if this hospital involved in training residents in approved GME programs in the prior year or penultimate and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction	orting 1. For 1. see was 2. year,	N N N N N	2.00 N N	3.00 N N	46. 00 47. 00 48. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital payment for disproportionate share in account 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstance pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t. Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for 1s the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reperiods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2 the instructions. For column 2, if the response to column 1 is "Y", or if this hospital involved in training residents in approved GME programs in the prior year or penultimate	porting 1. For 1. For 1. For 2. See 2. Year 2. Enter 3. Yes, 4. Trained 4. Trained 4. Trained 5. Trained 6. Tr	N N N N N	2.00 N N	3.00 N N	46. 00 47. 00 48. 00
46. 00 47. 00 48. 00 56. 00	Does this facility qualify and receive Capital payment for disproportionate share in account 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstance pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t. Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? For cost reperiods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2 the instructions. For column 2, if the response to column 1 is "Y", or if this hospital involved in training residents in approved GME programs in the prior year or penultimate and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction "Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is this the first cost reporting period during which residents in approved GME programs at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for "N" for no in column 2. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting period beginning on or after December 27, 2020, under 42 CFR 413.77(e) (1) (iv) and (v), regardly which month(s) of the cost report the residents were on duty, if the response to line 56	orting 1. For 1), see was 2 year, 2 Enter 5 yes, trained 1 yes or 1 ods 1 ess of 1 is "Y" 1 E-4.	N N N N N	2.00 N N	3.00 N N	46. 00 47. 00 48. 00 56. 00

Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1311 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 2: 28 pm XVIII XIX 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 1.00 2.00 3.00 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 IMF Direct GME IME Direct GME 2. 00 3. 00 4.00 5.00 1 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). Enter the difference between the baseline primary 61.05 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) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01

during in this cost reporting period of HRSA THC program. (see instructions)

Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

Teaching Hospitals that Claim Residents in Nonprovider Settings

III HEAI	TH TIPTON HOSPITAL		Inlie	u of Form CMS-2	9552-10
			eri od:	Worksheet S-2	1002 10
				Date/Time Pre	
		Nonprovi der	Hospi tal	2))	
			2 00	3 00	
esidents in No	onprovider Settings1				
r your facilit unweighted nor occurring in of unweighted	ty trained residents n-primary care all nonprovider d non-primary care	0.00	0.00	0. 000000	64. 00
gram Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
		FTÉs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
1.00	2.00	3. 00	4.00	5. 00	
					05.00
		FTĔs	FTEsin	(col. 1 + col.	
			ноѕрі таі	2))	
		1, 00	2.00	3.00	
E Residents in	n Nonprovider Settings	sEffective fo			
g in all nonpr ted non-primar er in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66.00
gram Name	Program Code	Unwei ghted			
		Si te		.,,	
1.00	2.00	3. 00	4.00	5.00	
		0.00	0.00	0.000000	67.00
	esidents in No 2009 and befor your facilitunweighted nor occurring in of unweighter ital. Enter ir umn 2)). (see gram Name 1.00 E Residents in ted non-primare in column 3 2)). (see insert gram Name	esidents in Nonprovider Settings 2009 and before June 30, 2010. r your facility trained residents unweighted non-primary care occurring in all nonprovider of unweighted non-primary care ital. Enter in column 3 the ratio umn 2)). (see instructions) gram Name	Unweighted FTEs Nonprovider SettingsThis base year 2009 and before June 30, 2010. r your facility trained residents unweighted non-primary care occurring in all nonprovider of unmousighted non-primary care ital. Enter in column 3 the ratio unm 2)). (see instructions) gram Name Program Code Press Nonprovider Site 1.00 2.00 3.00 0.00 E Residents in Nonprovider SettingsEffective for ted non-primary care resident gin all nonprovider settings. ted non-primary care resident er in column 3 the ratio of the following settings and the following settings are resident er in column 3 the ratio of 2)). (see instructions) gram Name Program Code Unweighted FTEs Nonprovider Site 2)). (see instructions) gram Name Program Code Unweighted FTEs Nonprovider Settings. ted non-primary care resident er in column 3 the ratio of 2)). (see instructions) gram Name Program Code Unweighted FTES Nonprovider Site	Unweighted FTEs in Hospital Incomprovider Settings-Tes in Hospital Site Unweighted FTEs in Hospital Incomprovider Settings-This base year is your cost reporting in all nonprovider Settings-Effective for cost reporting in all nonprovider settings. The set of the	Unweighted FTEs Unweighted PTEs Unweighted PTEs Unweighted Unweighted PTEs Unweighted Unw

116. 00

117. 00

118. 00

Ν

N

"N" for no.

the definition in CMS Pub. 15-1, chapter 22, §2208.1.

116.00 Is this facility classified as a referral center? Enter "Y" for yes or

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

Health Financial Systems	IU HEALTH TIPTON				u of Form CM	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE	NTIFICATION DATA	Provider CC	CN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part I Date/Time P 5/29/2024 2	repared:
			Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums ar	nd paid Losses:		1. 00 34, 1	2. 00 62	3. 00	0 118. 01
- 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	· ·· -· · · · · · · · · · · · · · · · · 					
118.02 Are mal practice premiums and paid losse	es reported in a cost ce	enter other t	han the	1. 00 N	2. 00	118. 02
Administrative and General? If yes, su and amounts contained therein.	ıbmi t supporting schedul	e listing co	ost centers			
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for \$3121 and applicable amendments? (see in "N" for no. Is this a rural hospital with Hold Harmless provision in ACA \$3121 and 100 and 100 are supported by the second	nstructions) Enter in o th < 100 beds that qual nd applicable amendments	column 1, "Y" ifies for th	for yes or ne Outpatient		N	119. 00 120. 00
Enter in column 2, "Y" for yes or "N" 1 121.00 Did this facility incur and report cost	s for high cost implant	table devices	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for 122.00 Does the cost report contain healthcare Act?Enter "Y" for yes or "N" for no in	e related taxes as defir				5. 00	122. 00
the Worksheet A line number where these 123.00 Did the facility and/or its subprovider services, e.g., legal, accounting, tax management/consulting services, from an	rs (if applicable) purch preparation, bookkeepir	ng, payroll,	and/or	Y	N	123. 00
for yes or "N" for no. If column 1 is "Y", were the majority of professional services expenses, for ser located in a CBSA outside of the main he "N" for no.	rvices purchased from ur	nrelated orga	ani zati ons			
Certified Transplant Center Information 125.00 Does this facility operate a Medicare-o		nter2 Enter "	V" for yes	N		125. 00
and "N" for no. If yes, enter certifica	ation date(s) (mm/dd/yyy	yy) below.	,			
126.00 If this is a Medicare-certified kidney in column 1 and termination date, if a		ter the certi	fication dat	e		126. 00
127.00 If this is a Medicare-certified heart	ransplant program, ente	er the certif	ication date	•		127. 00
in column 1 and termination date, if ap 128.00 If this is a Medicare-certified liver 1		er the certif	ication date	•		128. 00
in column 1 and termination date, if a 129.00 If this is a Medicare-certified lung to		the certifi	cation date			129. 00
in column 1 and termination date, if a 130.00 If this is a Medicare-certified pancrea		enter the cer	ti fi cati on			130. 00
date in column 1 and termination date, 131.00 of this is a Medicare-certified intesti	nal transplant program,	enter the c	certi fi cati or	1		131. 00
date in column 1 and termination date, 132.00 If this is a Medicare-certified islet in column 1 and termination date, if a	ransplant program, ente		ication date			132. 00
133.00 Removed and reserved	•	20)	- 000			133.00
134.00 f this is a hospital-based organ procuin column 1 and termination date, if ap		o), enter tr	ne opo number			134. 00
All Providers 140.00 Are there any related organization or h chapter 10? Enter "Y" for yes or "N" for are claimed, enter in column 2 the home	or no in column 1. If ye	es, and home	office costs	, Y	15H059	140. 00
1.00 If this facility is part of a chain ord	2.00	nos 1/1 thro	igh 1/2 the	3.00	of the	
home office and enter the home office	contractor name and con-		er.			
141.00 Name: INDIANA UNIVERSITY HEALTH 142.00 Street: 340 WEST 10TH STREET	Contractor's Name: WPS PO Box:		Contract	or's Number: 0810)1	141. 00 142. 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 in	ncluded in Worksheet A?				Y	144. 00
				1. 00	2. 00	
145.00 If costs for renal services are claimed inpatient services only? Enter "Y" for no, does the dialysis facility include	yes or "N" for no in co Medicare utilization fo	olumn 1. If o	column 1 is		2.00	145. 00
period? Enter "Y" for yes or "N" for r 146.00 Has the cost allocation methodology cha Enter "Y" for yes or "N" for no in colu yes, enter the approval date (mm/dd/yyy	anged from the previousl umn 1. (See CMS Pub. 15-			N		146. 00
				1		

Health Financial Systems	IU HEALTI	H TIPTOI	N HOSPITAL			In Lie	eu of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	A	Provi der CC	N: 15-1311		riod: om 01/01/2023 12/31/2023		epared:
							1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y"	for ve	s or "N" for	no.			1.00 N	147. 00
148.00 Was there a change in the order of							N	148. 00
149.00 Was there a change to the simplifi	ed cost finding meth	od? Ent	er "Y" for ye	s or "N"	for no		N	149. 00
			Part A	Part		Title V	Title XIX	
D 11: 6 :1:1	1 11 1 11 61 6		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or '								
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der – IPF			N	N		N	N	156. 00
157. 00 Subprovi der - I RF			N	N		N	N	157. 00
158. 00 SUBPROVI DER								158. 00
159. 00 SNF			N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY			N	N		N	N N	160.00
161. 00 CMHC				N		N	N	161. 00
							1.00	
Mul ti campus								
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that h	as one	or more campu	ses in di	fferer	nt CBSAs?	N	165. 00
Effect 1 for yes of 14 for no.	Name		County	State	Zip (Code CBSA	FTE/Campus	
	0		1. 00	2. 00	3. 0	00 4.00	5.00	1
166.00 If line 165 is yes, for each							0.0	0 166. 00
campus enter the name in column								
0, county in column 1, state in								
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in								
column 5 (see instructions)								
cordiiir 5 (see Fristructrons)								
							1.00	
Heal th Information Technology (HI						Act	Υ	1/7 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10						ntor tho	Y	167. 00 168. 00
reasonable cost incurred for the				107 13	1), 6	inter the		100.00
168.01 If this provider is a CAH and is r				gual i fv	for a	hardshi p	N	168. 01
exception under §413.70(a)(6)(ii)						nar aom p		1.00.01
169.00 If this provider is a meaningful u) and i	s not a CAH (line 105	is "N"), enter the	0.0	0169. 00
transition factor. (see instruction	ons)							
						Begi nni ng	Endi ng	4
170 00 5 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2 2 1 2		-11 1	+- 6 +			1. 00	2.00	170.00
170.00 Enter in columns 1 and 2 the EHR liperiod respectively (mm/dd/yyyy)	beginning date and en	iai ng aa	ite for the re	porting				170. 00
						1 00	2.00	
171.00 If line 167 is "Y", does this prov	vider have any days f	or indi	viduals encol	led in		1. 00 Y	2.00	1171.00
section 1876 Medicare cost plans m "Y" for yes and "N" for no in colu	reported on Wkst. S-3 umn 1. If column 1 is	B, Pt. I	, line 2, col	. 6? Ente		Y	2	1171.00
1876 Medicare days in column 2. (s	see instructions)						1	1

	Financial Systems IU HEALTH TIP				u of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/29/2024 2:2	epared:
				Y/N	Date	20 Pill
				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 Provider Organization and Operation			r all dates in [.]	the	
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a			N		1.00
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare F	Program? If	1.00 N	2.00	3. 00	2.00
. 00	yes, enter in column 2 the date of termination and in colur voluntary or "I" for involuntary. Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of	nn 3, "V" for ng management offices, drug	Y			3.00
	or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	of the board	V/N	Type	Data	
			1. 00	7ype 2. 00	Date 3.00	
	Financial Data and Reports					
1. 00 5. 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. Are the cost report total expenses and total revenues difference.	for Compiled, ailable in	Y	A		4. 00 5. 00
0.00	those on the filed financial statements? If yes, submit receives		"			3.00
				Y/N	Legal Oper.	
	A			1. 00	2. 00	
. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the Legal operator of the program?	2: If yes, is	s 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.		wed during the	N N		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.		N		9. 00
1. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N N		10.00
1.00	Teaching Program on Worksheet A? If yes, see instructions.	ακιιι αιι Αρμ	or oved	IN		11.00
					Y/N	
	Ded Dakte				1. 00	
2 00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s see instruct	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N	13. 00
4. 00	If line 12 is yes, were patient deductibles and/or coinsural instructions.	ance amounts wa	nived? If yes,	see	N	14. 00
5. 00	Bed Complement Did total beds available change from the prior cost reporti	na period? If	ves. see inst	ructions.	N	15. 00
	<u> </u>		rt A		t B	
		Y/N	Date	Y/N	Date	
	PS&R Data	1.00	2. 00	3. 00	4. 00	
6. 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
7. 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 in columns 2 and 4. (see instructions)	Y	04/02/2024	Y	04/02/2024	17. 00
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19. 00

Heal th	Financial Systems IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CM	S-2552-10	
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time P 5/29/2024 2	repared:	
			iption	Y/N	Y/N		
20.00	16 1: 1/ 17 :		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	EPT CHILDRENS I	HOSPI TALS)				
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made dur	ing the cost	N	23. 00	
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into durina	this cost re	porting period?	N	24. 00	
21.00	If yes, see instructions		200				
25. 00	Have there been new capitalized leases entered into during	If yes, see	N	25. 00			
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	no cost roport	ing poriod2 L	f vos soo	N	26. 00	
20.00	instructions.	ie cost report	ing perrous r	i yes, see	IN	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.						
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cost	reporting	N	28. 00	
20.00	period? If yes, see instructions.		g : 0001	. opo. cr.ng		20.00	
29. 00	Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	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		dobt2 Lf vos	500	N	30.00	
30.00	instructions.	urity wrth new	debt: IT yes	, see	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.						
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	rvices furnish	ed through co	ntractual	N	32.00	
02.00	arrangements with suppliers of services? If yes, see instru		ou in ough oc	ao caar		02.00	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 app	plied pertaini	ng to competi	tive bidding? If		33. 00	
	no, see instructions. Provider-Based Physicians						
34. 00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	Y	34.00	
	If yes, see instructions.	3		, , , , , , , , , , , , , , , , , , , ,			
35. 00	If line 34 is yes, were there new agreements or amended exi		nts with the	provi der-based	N	35. 00	
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date		
				1. 00	2. 00		
	Home Office Costs						
36.00	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 proof of the liftyes, see instructions.	repared by the	nome office?	Υ		37. 00	
38. 00	If line 36 is yes, was the fiscal year end of the home off	fice different	from that of	· N		38. 00	
	the provider? If yes, enter in column 2 the fiscal year end	d of the home	offi ce.				
39. 00	If line 36 is yes, did the provider render services to other	er chain compo	nents? If yes	Υ Υ		39. 00	
40. 00	see instructions. If line 36 is yes, did the provider render services to the		40. 00				
	00 If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.						
				_			
	Cost Panort Prenarer Contact Information	1	. 00	2.	00		
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	RHONDA		41.00			
	held by the cost report preparer in columns 1, 2, and 3,			UTTER		55	
	respecti vel y.						
42. 00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVE	RSITY HEALTH			42. 00	
43. 00	1! !	317. 556. 3910		RUTTER@I UHEALT	H. ORG	43. 00	
	report preparer in columns 1 and 2, respectively.						

Heal th	Financial Systems	IU HEALTH 1	TI PTON	HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi der	CCN: 15-1311	eri od:	Worksheet S-2	
						rom 01/01/2023 o 12/31/2023	Part II Date/Time Pre	nared·
							5/29/2024 2: 2	8 pm
					3. 00			
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the			RECTOR OF	GOVERNMENT			41. 00
	held by the cost report preparer in colu	mns 1, 2, and 3,	PRO	OGRAMS				
	respecti vel y.							
42.00	Enter the employer/company name of the c	ost report						42. 00
	preparer.							
43.00	Enter the telephone number and email add	ress of the cost	:					43.00
	report preparer in columns 1 and 2, resp	ecti vel y.						

Health Financial Systems IU HEAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1311

PART - STATISTICAL DATA					T	o 12/31/2023	Date/Time Prep 5/29/2024 2:28	
No. of Beds Bed Days CAH/REH Hours Title V No. of Beds Bed Days CAH/REH Hours Title V No. of Beds Color No. of Beds No. of Beds Color No. of Beds								5 PIII
Component								
Line No. Available No. Available No. Available No. No. Available No.		Component	Worksheet A	No. of Beds	Bed Days			
PART I - STATISTICAL DATA								
1.00 Hospi tall Adult s & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LIDP room available beds) 2.00 Hospi ced ays) (see instructions) 2.00 Hospi ced ays) (see instructions) 2.00 Hospi tall Adult s & Peds. Swing Bed SNF 3.00 4.00 Hospi tall Adult s & Peds. Swing Bed SNF 3.50 5.00 4.00 Hospi tall Adult s & Peds. Swing Bed SNF 3.50 5.00 6.00				2.00		4. 00	5. 00	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		PART I - STATISTICAL DATA						
Hospice days) (See instructions for col. 2 for the portion of LDP room available beds) 2.00 HM0 and other (See instructions) 2.00 3.00 HM0 IPF Subprovi der 4.00 5.00 HM0 IPF Subprovi der 4.00 5.00 HM0 IPF Subprovi der 4.00 6.00 HM0 IPF Subprovi der 4.00 6.00 HM0 IPF Subprovi der 4.00 6.00 HM0 IPF Subprovi der 4.00 FM0 IMF Subprovi der 4.00 FM	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	25	9, 125	38, 136. 00	0	1.00
For the portion of LDP room available beds 2.00 MMO and other (see instructions) 3.00 MMO IRF Subprovider 4.00 4.00 MMO IRF Subprovider 4.00 4.00 MMO IRF Subprovider 4.00 6.00 Mospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 hospital Adults & Peds. Swing Bed NF 0 6.00 7.00 hospital Adults & Peds. Swing Bed NF 0 6.00 7.00 hospital Adults & Peds. Swing Bed NF 0 6.00 7.00 10.00 1		8 exclude Swing Bed, Observation Bed and						
2.00 HM0 and other (see instructions) 3.00 HM0 IPF Subprovider 4.00 HM0 IRF Subprovider 4.00 HM0 IRF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORNARY CARE UNIT 11.00 SURN INTENSIVE CARE UNIT 12.00 INTERSIVE CARE UNIT 13.00 HACS SURSICAL INTENSIVE CARE UNIT 14.00 Total (see instructions) 15.00 CAH visits 15.10 REH hours and visits 15.10 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 19.00 SUBPROVIDER								
3.00 HMO IPF Subprovider 4.00 HMO IPF Subprovider 5.00 Hospital Adults & Peds. Swing Bed SNF 6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTRESIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURRI INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 INURSERY 10.10 OTHER SPECIAL CARE (SPECIFY) 13.00 INURSERY 10.10 OSUBPROVIDER - IPF 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IPF 18.00 SUBPROVIDER - IRF 19.00 OTHER LITTY 19.00 OTHER LONG TERM CARE 22.00 OTHER LONG TERM CARE 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.00 HOSPICE 25.00 CMC - CMHC 25.00 CMC - CMHC 25.00 CMRC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 TOTAL (Sum of lines 14-26) 27.00 Total (Sum of lines 14-26) 28.00 OSES-VATION BE OBLIT EN BE OBLIT SURGING BE OBLIT SURGIN								
4.00								
5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 9.00 CORONARY CARE UNIT 10.00 10.00 BURNI INTENSIVE CARE UNIT 11.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 15.00 CAH visits 5 0.00 0 15.00 15.10 REH hours and visits 5 0.00 0 15.10 15.00 SUBPROVI DER - IPF 16.00 17.00 SUBPROVI DER - IRF 18.00 18.00 SUBPROVI DER - IRF 19.00 19.00 SKILLED NURSING FACILITY 20.00 10.00 NURSING FACILITY 20.00 10.00 AMBULATORY SURGICAL CENTER (D. P.) 10.00 CAHC - CMHC 22.00 24.10 HOSPICE (non-distinct part) 30.00 25 25.00 CMRC - CMHC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 25 10.00 Observation Bed Days 0 28.00 10.00 Observation Bed		•						
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.10 REH hours and visits 15.10 REH hours and visits 16.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER SECILITY 19.00 SUBPROVIDER SECILITY 19.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE (non-distinct part) 25.00 CMC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 38, 136.00 38, 13		•						
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) (surgical intensive Care unit 10.00 Burn Intensive Care unit 11.00 Surgical Intensive Care unit 11.00 Surgical Intensive Care unit 11.00 Total (see instructions) (see								
beds) (see instructions)				0.5	0.405	00 404 00		
8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 NURSERY 14.00 Total (see instructions) 15.00 CAH visits 10.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 18.00 SUBPROVIDER - IRF 19.00 SKILLED NURSING FACILITY 20.00 NURSING FACILITY 21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 24.10 HOSPICE 25.00 CMICA - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 8.00 9.00 9.00 9.00 11.00 9.00 11.00 9.00 11.00 9.00 11.00 9.00 9	7.00			25	9, 125	38, 136. 00	U	7.00
9. 00 CORONARY CARE UNIT	9 00	, ,						0 00
10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH vi sits 15. 10 REH hours and visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SKILLED NURSING FACILITY 19. 00 ONURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 10 HOSPICE 24. 10 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 Observation Bed Days 25. 00 Observation Bed Days 27. 00 28. 00 Observation Bed Days 25. 00 Intensive Care Unit 10. 00 11. 00								
11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 THER SPECIAL CARE (SPECIFY) 12. 00 13. 00 NURSERY 13. 30 14. 00 15. 00 CAH visits 0 15. 00 CAH v								
12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 14.00 Total (see instructions) 25 9,125 38,136.00 0 14.00 15.00 CAH visits 0 0 15.00 CAH visits 0 0 15.00 15.00 15.10 16.00 SUBPROVI DER - I PF 16.00 17.00 SUBPROVI DER - I RF 17.00 SUBPROVI DER - I RF 17.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 1								
13.00 NURSERY 13.00 14.00 15.00 16.00 15.00 16.00 16.00 16.00 16.00 16.00 17.00 17.00 18		1						
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15. 10 REH hours and visits 16. 00 SUBPROVIDER - I PF 18. 00 SUBPROVIDER - I RF 18. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOSPICE 24. 00 HOSPICE 24. 00 HOSPICE (non-distinct part) 25. 00 CMRC - CMHC 26. 05 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 0 .00 0 0 15. 10 16. 00 1 15. 10 16. 00 1 15. 10 1 16. 00 1 15. 10 1 16. 00 1 15. 10 1 16. 00 1 15. 10 1 16. 00 1 17. 00 1 18. 00 1 19. 00 2 20. 00 2 20. 00 2 20. 00 2 20. 00 2 21. 00 2 22. 00 2 24. 00 2 24. 00 2 25. 00 2 26. 05 2 27. 00 2 28. 00 2 28. 00 2 28. 00		,			.,			
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18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 19. 00 20. 00 NURSI NG FACI LI TY 20. 00 OTHER LONG TERM CARE 21. 00 21. 00 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 22. 00 HOSPI CE 24. 00 24. 10 HOSPI CE (non-distinct part) 30. 00 24. 10 Example 10 25. 00 25. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 28. 00 Observation Bed Days 0 28. 00 28. 00								16. 00
19. 00	17.00	SUBPROVIDER - IRF						17.00
20. 00 NURSING FACILITY 20. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 22. 00 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 23. 00 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 30. 00 25. 00 CMHC - CMHC 25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 27. 00 Observation Bed Days 25 0 28. 00	18.00	SUBPROVI DER						18.00
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D. P.) 24.00 HOSPICE 24.10 HOSPICE (non-distinct part) 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 RURAL HEALTH CLINIC 26.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 21.00 22.00 23.00 24.10 25.00 26.25 27.00 28.00	19.00	SKILLED NURSING FACILITY						19.00
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 22. 00 23. 00 24. 20 25. 00 26. 25 27. 00 28. 00 Observation Bed Days	20.00	NURSING FACILITY						20.00
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24. 10 HOSPICE (non-distinct part) 30.00 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 27.00 Total (sum of lines 14-26) 25 28.00 Observation Bed Days 20.00		, ,						
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27. 00 Total (sum of lines 14-26) 25 27. 00 28. 00 Observation Bed Days 0 28. 00								
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outpatient days (see instructions)	JZ. U1							JZ. U1
33. 00 LTCH non-covered days 33. 00	33. 00							33. 00
33. 01 LTCH site neutral days and discharges 33. 01		,						
34.00 Temporary Expansi on COVI D-19 PHE Acute Care 30.00 0 0 34.00		3	30. 00	0	[c		0	

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

Component					'	0 12/31/2023	5/29/2024 2: 2	
PART I - STATISTICAL DATA 6.00 7.00 8.00 9.00 10.00			I/P Days	/ O/P Visits	/ Trips	Full Time		
PART I - STATISTICAL DATA		Component	Title XVIII	Title XIX				
PART I - STATISTICAL DATA 1.00			6, 00	7. 00				
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 850 8 1,589 1,000		PART I - STATISTICAL DATA		,				
Hospice days) (see instructions for col. 2 7	1.00		850	8	1, 589			1.00
For the portion of LDP room available beds) 2.00 HMO and other (see instructions) 3.00 0 0 0 0 0 0 0 0 0		8 exclude Swing Bed, Observation Bed and						
2.00 HM0 and other (see instructions)								
3.00 HMO IPF Subprovider								
4. 00 HMO I RF Subprovi der 0 0 11 5. 00 6. 00 Hospital Adult is & Peds. Swing Bed SNF 111 0 111 5. 00 6. 00 Hospital Adult is & Peds. Swing Bed NF 1 0 29 7. 00 6. 00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 8. 00 1,729 7. 00 10.		,						
5.00		1		-				
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 ONNANY CARE UNIT 9.00 ONNANY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 14.00 Total (see instructions) 961 8 1,729 0.00 149.00 149.00 15.00 15.00 CAH visits 0 0 0 0 0 149.00 149.00 15.10 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IFF 17.00 SUBPROVIDER - IFF 18.00 ONNESTORY 18.00 ONNEST		1 ·		-				
7.00 Total Adults and Peds. (exclude observation book beds) (see instructions) 8.00 NITENSIVE CARE UNIT		, ,	111	-				
DedS) (see instructions) R. 00			0.4	ΨĮ.				
8. 00 INTENSIVE CARE UNIT	7.00		961	8	1, 729			7.00
9. 00 CORONARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 THER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 15. 00 Total (see instructions) 16. 00 CAH visits 17. 00 UNSPROVIDER - IPF 18. 00 UNSPROVIDER - IPF 19. 00 SUBPROVIDER - IPF 19. 00 SUBPROVIDER - IRF 19. 00 OND SKILLED NURSING FACILITY 20. 00 HORSING FACILITY 20. 00 HORSING FACILITY 20. 00 OND MINESING FACILITY	9 00							0 00
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11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 NURSERY 13.00 NURSERY 15.00 149.00 149.00 149.00 149.00 15.00 149.00 149.00 15.00 149.00 15.00 149.00 15.00								1
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19. 00	17.00	SUBPROVI DER - I RF						17. 00
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21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 33. 00 LTCH non-covered days 33. 00 LTCH site neutral days and discharges 21. 00 22. 00 22. 00 22. 00 22. 00 23. 00 24. 10 25. 00 0 0 0 0 0. 00 0 0. 0	19. 00	SKILLED NURSING FACILITY						
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26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0.00 0.00 26. 25 27. 00 Total (sum of lines 14-26) 0.00 149. 00 27. 00 28. 00 Observation Bed Days 0 28. 00 284 29. 00 Ambulance Trips 0 29. 00 Employee discount days (see instruction) Employee discount days - IRF 0 31. 00 29.								
27. 00 Total (sum of lines 14-26) 0.00 149. 00 27. 00 28. 00 0 284 0 28. 00 28. 00 29. 00 284 0 29. 00 29. 00 30. 00 Employee discount days (see instruction) Employee discount days - IRF 0 31. 00 29. 00 32. 00 29. 00 32. 00 29. 00 32. 00 29. 00 32. 00 32. 00 32. 00 33. 00 29. 00 33. 00 29. 00			0	0	Ō	0.00	0.00	
28. 00 Observation Bed Days 28. 00 29. 00 30. 00 Employee discount days (see instruction) 30. 00 Employee discount days - IRF 0 31. 00 32. 00 Labor & delivery days (see instructions) 0 0 0 0 32. 00 33. 01 LTCH non-covered days 0 LTCH site neutral days and discharges 0 284 28. 00 29. 00 29. 00 30. 00 30. 00 31. 00 31. 00 32. 00 0 0 0 0 0 0 0 0 0				J				1
29.00 Ambulance Trips		,		0	284		147.00	
30.00 Employee discount days (see instruction) 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 33.00 LTCH non-covered days 0 LTCH site neutral days and discharges 0 33.01 33.01 See instruction 0 0 0 0 0 0 0 0 0			0	J	201			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 31.00 O O O O O O O O O O O O O O O O O O		!			0			1
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outpatient days (see instructions) 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 0 33.01	32. 01				C			32. 01
33.01 LTCH site neutral days and discharges 0 33.01		outpatient days (see instructions)						
			0					
34.00 Temporary Expansion COVID-19 PHE Acute Care 0 0 0 34.00								1
	34. 00	Temporary Expansion COVID-19 PHE Acute Care	0	이	C			34.00

Health Financial Systems IU HEAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1311

				T	o 12/31/2023	Date/Time Prep 5/29/2024 2:28	
		Full Time Equivalents	<u> </u>	Di sch	arges	0,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	<u>Б</u>
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA				. 1		
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2		0	239	2	436	1. 00
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			133	12		2.00
3.00	HMO IPF Subprovider			100	0		3. 00
4. 00	HMO IRF Subprovider				0		4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ü		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	0	239	2	436	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						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 20. 00	SKILLED NURSING FACILITY NURSING FACILITY						19. 00 20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance 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
22.00	outpatient days (see instructions)						22.00
33. 00 33. 01	LTCH non-covered days			0 0			33. 00 33. 01
	LTCH site neutral days and discharges						34. 00
34.00	Temporary Expansion COVID-19 PHE Acute Care						34.00

	Financial Systems IU HEALTH TIPTON				eu of Form CMS-2			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1311	Period: From 01/01/2023 To 12/31/2023		pared:		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA							
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 287522	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid				4, 737, 285	2.00		
3.00								
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen If line 4 is no, then enter DSH and/or supplemental payments f			ai d?	0	4. 00 5. 00		
6.00	Medicaid charges	rom wearcard	u		26, 506, 781	6.00		
7. 00	Medicaid cost (line 1 times line 6)				7, 621, 283	7. 00		
8. 00	Difference between net revenue and costs for Medicaid program	(see instru	ctions)		2, 883, 998	8.00		
0.00	Children's Health Insurance Program (CHIP) (see instructions for				2,000,770	0.00		
9.00	Net revenue from stand-alone CHIP		- /		0	9.00		
10.00	Stand-alone CHIP charges				0	10.00		
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00		
12. 00	Difference between net revenue and costs for stand-alone CHIP				0	12. 00		
	Other state or local government indigent care program (see ins							
13.00	Net revenue from state or local indigent care program (Not inc				38, 512	13.00		
14. 00	Charges for patients covered under state or local indigent cardion	e program (Not included	in lines 6 or	173, 713	14. 00		
15. 00	State or local indigent care program cost (line 1 times line 1	4)			49, 946	15. 00		
16. 00	Difference between net revenue and costs for state or local in		program (se	e instructions)	11, 434			
	Grants, donations and total unreimbursed cost for Medicaid, CH							
	instructions for each line)							
17. 00	Private grants, donations, or endowment income restricted to f	0	,		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of				0	18. 00		
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and loca 8, 12 and 16)	l indigent (care program	s (sum of lines	2, 895, 432	19. 00		
			Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
20.00	Uncompensated care cost (see instructions for each line)	, 1	1 004 7	2/ 470 050	1 0/5 005	20.00		
20.00	Charity care charges and uninsured discounts (see instructions		1, 094, 7					
21.00	Cost of patients approved for charity care and uninsured discoinstructions)	unts (see	314, 7	58 117, 292	432, 050	21.00		
22. 00	Payments received from patients for amounts previously written	off as	5, 7	64 0	5, 764	22. 00		
22 00	charity care		200 0	04 117 202	424 204	22 00		
23. 00	Cost of charity care (see instructions)		308, 9	94 117, 292	426, 286	23. 00		
					1. 00			
24. 00	Does the amount on line 20 col. 2, include charges for patient	days beyon	d a length o	f stay limit	N	24. 00		
	imposed on patients covered by Medicaid or other indigent care		-					
25. 00	If line 24 is yes, enter the charges for patient days beyond t	he indigent	care progra	m's length of	0	25. 00		

25.01

26.00

27.01

28.00

29.00

74, 483

2, 417, 170 546, 322 840, 496

1, 576, 674

747, 502

1, 173, 788 30. 00 4, 069, 220 31. 00

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)

Charges for insured patients' liability (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

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

25. 01

	Financial Systems IU HEALTH TIPTON HO	OSPI TAL	In Lie	eu of Form CMS-2	2552-1
OSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/29/2024 2:2	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.
	Medicaid (see instructions for each line)				1
. 00	Net revenue from Medicaid				2.
.00	Did you receive DSH or supplemental payments from Medicaid?				3.
.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al pavments from Medi	cai d?		4.
00	If line 4 is no, then enter DSH and/or supplemental payments fro				5.
00	Medi cai d charges				6.
00	Medicaid cost (line 1 times line 6)				7.
00	Difference between net revenue and costs for Medicaid program (s	see instructions)			8.
	Children's Health Insurance Program (CHIP) (see instructions for				1
00	Net revenue from stand-alone CHIP				9.
. 00	Stand-alone CHIP charges				10.
. 00	Stand-alone CHIP cost (line 1 times line 10)				11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (s				12.
	Other state or local government indigent care program (see instr				
3. 00	Net revenue from state or local indigent care program (Not inclu				13.
. 00	Charges for patients covered under state or local indigent care	program (Not include	d in lines 6 or		14.
- 00	10)				4.5
5. 00	State or local indigent care program cost (line 1 times line 14)		oo i notrusti sno)		15.
5. 00	Difference between net revenue and costs for state or Local indi Grants, donations and total unreimbursed cost for Medicaid, CHLP			mc (coo	16.
	instructions for each line)	and State/Tocal Thu	igent care program	IIS (See	
7. 00	Private grants, donations, or endowment income restricted to fun	nding charity care			17.
3. 00	Government grants, appropriations or transfers for support of ho	9			18.
9. 00	Total unreimbursed cost for Medicaid , CHIP and state and Local		ms (sum of lines		19.
	8, 12 and 16)	a. go oa. o p. og. a	(54 51 111155		. , .
		Uni nsure	d Insured	Total (col. 1	
		pati ents	pati ents	+ col. 2)	
		1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)				
. 00	Charity care charges and uninsured discounts (see instructions)				20.
. 00	Cost of patients approved for charity care and uninsured discoun	nts (see			21.
	instructions)				
. 00	Payments received from patients for amounts previously written o	off as			22.
00	charity care				
. 00	Cost of charity care (see instructions)				23.
				1.00	
00	Does the amount on line 20 col. 2, include charges for patient d	lays heyond a Length	of stay limit	1.00	24
50	imposed on patients covered by Medicaid or other indigent care p		or stay irmit		-4
00	If line 24 is was anter the charges for nations days beyond the			1	25

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

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

26.00

27. 00 27. 01

28.00

29.00

30.00

31.00

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	IU HEALTH TIPTON	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		Peri od:	Worksheet A	
					rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/29/2024 2:2	
	Cost Center Description	Sal ari es	0ther	,	Recl assi fi cati	Reclassi fied	
				+ 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	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		0	(795, 248	795, 248	1. 00
1.01	00101 CAP REL COSTS-BLDG & FIXT - INTERES		0	d		513, 352	1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		1, 062, 695	1, 062, 695	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 933	12, 933	2, 012, 339	2, 025, 272	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	421, 211	10, 495, 013	10, 916, 224	-1, 118, 709	9, 797, 515	5. 00
7.00	00700 OPERATION OF PLANT	782, 942	3, 055, 267	3, 838, 209	-172, 357	3, 665, 852	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	C	0	0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	74, 169	74, 169	0	74, 169	8. 00
9.00	00900 HOUSEKEEPI NG	504, 541	401, 272		·	771, 758	9. 00
10.00	01000 DI ETARY	361, 887	378, 923			205, 741	10. 00
11. 00	01100 CAFETERI A	0	0	1	1,	434, 485	11. 00
13. 00	01300 NURSING ADMINISTRATION	641, 337	560, 007			831, 060	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	10, 776			342, 505	14. 00
15. 00	01500 PHARMACY	765, 171	5, 686, 090	6, 451, 261	-5, 183, 623	1, 267, 638	15. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	4 0/0 5/4	4 007 455	0.050.74	000 447	0.004.070	00.00
30. 00	03000 ADULTS & PEDI ATRI CS	1, 263, 561	1, 087, 155	2, 350, 716	-329, 447	2, 021, 269	30. 00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1 041 7/2	2 1/2 702	4 204 445	1 (25 072	2 5/0 202	50. 00
53. 00	05300 ANESTHESI OLOGY	1, 041, 763	3, 162, 702 643, 505			2, 569, 393 634, 517	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 145, 056	718, 478			1, 309, 654	
60.00	06000 LABORATORY	1, 145, 050	1, 814, 190			1, 783, 534	60.00
65. 00	06500 RESPIRATORY THERAPY	685, 946	227, 841	913, 787		758, 235	65.00
66. 00	06600 PHYSI CAL THERAPY	803, 034	486, 040		·	848, 322	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	203, 953	40, 238			261, 577	67. 00
68. 00	06800 SPEECH PATHOLOGY	42, 004	5, 148			47, 706	68. 00
69. 00	06900 ELECTROCARDI OLOGY	551, 590	285, 933			675, 664	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1		251, 455	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0			646, 073	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0		4, 169, 102	4, 169, 102	73. 00
73. 01	03480 ONCOLOGY	160, 759	76, 123	236, 882		187, 420	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	0		1, 091, 193	1, 091, 193	73. 02
76.00	03160 CARDI OPULMONARY	О	0		o	0	76. 00
76. 97	07697 CARDIAC REHABILITATION	145, 512	88, 687	234, 199	-65, 513	168, 686	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(o	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	1, 151, 243	2, 116, 448	3, 267, 691	-303, 687	2, 964, 004	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	40.4=					
118.00		10, 671, 510	31, 426, 938	42, 098, 448	76, 646	42, 175, 094	118. 00
400.01	NONREI MBURSABLE COST CENTERS	(4.00)	FF 222	440.01		70.001	100.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	64, 036	55, 009			73, 801	
	19201 OCCUPATI ONAL MEDI CI NE	67, 738	83, 805			120, 141	
	19202 VACANT SPACE	10, 002, 204	0		´1		192. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	10, 803, 284	31, 565, 752	42, 369, 036	기 이	42, 369, 036	200.00

Peri od: From 01/01/2023 To 12/31/2023

Worksheet A Date/Time Prepared: 5/29/2024 2:28 pm

				5/29/2024 2: 28 [piii
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7.00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	609, 770			1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	172, 355			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	171, 579			2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-129, 051	1, 896, 221		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 102, 953	6, 694, 562		5.00
7.00	00700 OPERATION OF PLANT	492, 176	4, 158, 028		7.00
7.01	00701 OPERATION OF PLANT - OFFSITE	0	0		7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	74, 169		8.00
9.00	00900 HOUSEKEEPI NG	-47, 280	724, 478		9.00
10.00	01000 DI ETARY	-541	205, 200	11	0.00
11. 00	01100 CAFETERI A	0	434, 485	1	1.00
13.00	01300 NURSING ADMINISTRATION	-5, 260	825, 800	1.	3.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1	1.1	4.00
15. 00	01500 PHARMACY	14, 384		1.1	5.00
	INPATIENT ROUTINE SERVICE COST CENTERS	,	.,		
30. 00		-536, 952	1, 484, 317	30	80. 00
	ANCILLARY SERVICE COST CENTERS		.,,		
50.00	05000 OPERATI NG ROOM	-463, 250	2, 106, 143	5	0.00
53. 00	05300 ANESTHESI OLOGY	-583, 657	50, 860		3. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	115, 477	1, 425, 131		4. 00
60.00	06000 LABORATORY	0			0.00
65. 00	06500 RESPI RATORY THERAPY	0	758, 235		5. 00
66. 00	06600 PHYSI CAL THERAPY	0	848, 322		6. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	261, 577		7. 00
68. 00	06800 SPEECH PATHOLOGY	0	47, 706		8. 00
69. 00	06900 ELECTROCARDI OLOGY	-87, 045			9. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	•			11.00
71.00		0			
73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	_	646, 073		72. 00 73. 00
		0	4, 169, 102		
73. 01	03480 ONCOLOGY	_	187, 420		3. 01
73. 02	1	0	1, 091, 193		3. 02
76.00	03160 CARDI OPULMONARY	0	0		6.00
76. 97	07697 CARDI AC REHABI LI TATI ON	-101	168, 585		6. 97
77. 00		0	1		7.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	7	8. 00
	OUTPATIENT SERVICE COST CENTERS				
91. 00		-22, 633	2, 941, 371		91. 00
92. 00				9.	2. 00
	OTHER REIMBURSABLE COST CENTERS				
102. 00	10200 OPIOID TREATMENT PROGRAM	0	0	10.	2. 00
	SPECIAL PURPOSE COST CENTERS				
118. 00		-3, 402, 982	38, 772, 112	11/2	8.00
	NONRE MBURSABLE COST CENTERS				
	19200 PHYSICIANS' PRIVATE OFFICES	0			2. 00
	1 19201 OCCUPATIONAL MEDICINE	0	120, 141		2. 01
192. 02	2 19202 VACANT SPACE	0	0	19.	2. 02
200.00	TOTAL (SUM OF LINES 118 through 199)	-3, 402, 982	38, 966, 054	20	00.00

	Financial Systems		IU HEALTH TIP		ON 45 4044		u of Form CMS	
RECLAS	SI FI CATI ONS			Provi der CC	N: 15-1311	Peri od: From 01/01/2023	Worksheet A-	
						To 12/31/2023	Date/Time Pr 5/29/2024 2:	
	Cost Center	Increases Line #	Salary	Other				
	2. 00	3.00	4.00	5. 00				
1 00	A - DEPRECIATION	1 00	al	F71 010				1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	571, 019 1, 060, 374				1. 00 2. 00
3. 00	ON NEE GOSTO MVBEE EGOTT	0.00	Ö	0				3. 00
4.00		0.00	0	0				4. 00
5. 00 6. 00		0. 00 0. 00	0	0				5. 00 6. 00
7. 00		0.00	0	0				7. 00
8.00		0.00	O	Ö				8. 00
9.00		0.00	0	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10.00
12. 00		0.00	0	0				12. 00
13.00		0.00	O	0				13. 00
14.00		0.00	0	0				14. 00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
10.00	0		— — ŏ	1, 631, 393				10.00
4 00	B - INTEREST	1.5.1						4
1. 00	CAP REL COSTS-BLDG & FIXT -	1. 01	0	513, 352				1. 00
	0	+		513, 352				
	D - EMPLOYEE BENEFITS		-1					
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00 0. 00	0	2, 012, 335				1. 00 2. 00
3.00		0.00	0	0				3. 00
4.00		0.00	0	0				4. 00
5.00		0.00	0	0				5. 00
6. 00 7. 00		0. 00 0. 00	0	0				6. 00 7. 00
8. 00		0.00	o	o				8. 00
9.00		0.00	O	0				9. 00
10. 00 11. 00		0. 00 0. 00	0	0				10. 00 11. 00
12. 00		0.00	0	0				12. 00
13. 00		0.00	O	Ō				13. 00
14. 00		0.00	0	0				14. 00
15. 00 16. 00		0. 00 0. 00	0	0				15. 00 16. 00
17. 00		0.00	0	o				17. 00
18. 00		0.00	O	0				18. 00
19. 00		0.00	0	0 2, 012, 335				19. 00
	E - CAFETERIA		U _I	2,012,333				+
1.00	CAFETERI A	1100	245, 592	188, 893				1.00
	F - MEDICAL SUPPLIES		245, 592	188, 893				-
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	332, 945				1.00
2. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	o	251, 455				2. 00
0.00	PATI ENT	70.00		(4(070				0.00
3. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	646, 073				3. 00
4.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	4				4. 00
5.00	HOUSEKEEPI NG	9.00	0	261				5. 00
6. 00 7. 00	DI ETARY	10. 00 0. 00	0	14				6. 00 7. 00
8. 00		0.00	o	Ö				8. 00
9.00		0.00	O	0				9. 00
10. 00 11. 00	NURSING ADMINISTRATION SPEECH PATHOLOGY	13. 00 68. 00	0	107				10. 00 11. 00
12. 00	ELECTROCARDI OLOGY	69.00	0	1, 983				12. 00
14.00		0.00	o	0				14. 00
15.00		0.00	0	0				15. 00
16. 00 17. 00		0. 00 0. 00	0	0				16. 00 17. 00
18. 00		0.00	0	0				18. 00
19. 00		0.00		0				19. 00
	O G - DRUGS		0	1, 232, 846				-
1.00	PHARMACY	15. 00	0	82, 684				1.00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	О	5, 260, 295				2. 00
3.00		0.00	0	0				3. 00
4. 00 5. 00		0. 00 0. 00	0	0				4. 00 5. 00
	1 1	0.00	<u> </u>	0				1 0.00

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

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

					5/29/20	24 2: 28 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	O	0		10.00
11. 00		0.00	o	0		11. 00
12.00		0.00	O	0		12. 00
14.00		0.00	o	0		14. 00
15. 00		0.00	o	0		15. 00
	0 = = = = =			5, 342, 979		
	H - ORTHOPEDIC CLERICAL STAFF					
1.00	OCCUPATI ONAL THERAPY	67. 00	40, 027	0		1. 00
2.00	SPEECH PATHOLOGY	68.00	1, 959	0		2. 00
	0 — — — — —		41, 986			
	J - MAINTENANCE & LEASE EXPEN	ISE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	154, 009		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	O	1, 939		2. 00
3.00	OPERATION OF PLANT	7. 00	O	18, 763		3. 00
	0 — — — — — —					
	L - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	70, 220		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 321		2. 00
	0 — — — — —					
	N - INFUSION DRUGS	<u> </u>	<u> </u>	·		
1.00	BLOOD DI SORDER DRUGS	73. 02	0	1, 091, 193		1.00
		$$ \dagger		1, 091, 193		
500.00	Grand Total: Increases		287, 578	12, 260, 243		500. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10

Provider CCN: 15-1311 Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					1	o 12/31/2023 Date/lime Pr 5/29/2024 2:	
		Decreases		1		,, 5, =,, ===	
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6. 00 A - DEPRECIATION	7. 00	8. 00	9. 00	10. 00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	477, 278	9		1.00
2.00	OPERATION OF PLANT	7. 00	0	34, 742	9		2. 00
3.00	DI ETARY	10. 00	0	21, 460	1		3. 00
4.00	NURSI NG ADMI NI STRATI ON	13.00	0	264, 048	1		4. 00
5. 00 6. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	39, 972 40, 171	1		5. 00 6. 00
7. 00	OPERATING ROOM	50. 00 50. 00	0	360, 606	1		7. 00
8. 00	ANESTHESI OLOGY	53.00	o	8, 988			8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	207, 985	o		9. 00
10.00	RESPIRATORY THERAPY	65. 00	0	13, 673	1		10.00
11. 00	PHYSI CAL THERAPY	66.00	0	49, 776	1		11. 00
12. 00 13. 00	ELECTROCARDI OLOGY	69.00	0	51, 166	1		12.00
14. 00	ONCOLOGY CARDIAC REHABILITATION	73. 01 76. 97	0	676 14, 177	1		13. 00 14. 00
15. 00	EMERGENCY	91.00	0	17, 604	1		15. 00
16. 00	PHYSICIANS' PRIVATE OFFICES	192.00	O	29, 071	I .		16. 00
	0 — — — — —		0	1, 631, 393			_
	B - INTEREST						
1. 00	ADMI NI STRATI VE & GENERAL			513, 352			1. 00
	D - EMPLOYEE BENEFITS		UU	513, 352			-
1.00	ADMINISTRATIVE & GENERAL	5. 00	ol	57, 160	ol		1.00
2. 00	OPERATION OF PLANT	7.00	o	154, 689	1		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	134, 316	1		3. 00
4.00	DI ETARY	10. 00	0	79, 138	o		4. 00
5.00	NURSING ADMINISTRATION	13. 00	0	106, 343	1		5. 00
6.00	PHARMACY	15. 00	0	108, 535	1		6. 00
7. 00	ADULTS & PEDIATRICS	30. 00	0	230, 431	1		7. 00
8.00	OPERATING ROOM	50.00	0	193, 422	1		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	257, 701	1		9. 00
10. 00 11. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	115, 077 164, 992	1		10. 00 11. 00
12. 00	OCCUPATI ONAL THERAPY	67. 00	0	22, 223			12.00
13. 00	SPEECH PATHOLOGY	68. 00	Ö	1, 409	- 1		13. 00
14. 00	ELECTROCARDI OLOGY	69.00	o	88, 625	1		14. 00
15.00	ONCOLOGY	73. 01	О	28, 511	O		15. 00
16.00	CARDIAC REHABILITATION	76. 97	0	44, 474	0		16. 00
17. 00	EMERGENCY	91. 00	0	189, 262	1		17. 00
18.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	15, 010	1		18. 00
19. 00	OCCUPATI ONAL MEDI CI NE	1 <u>92.</u> 01	— — 	2 <u>1, 0</u> 17 2, 012, 335			19. 00
	E - CAFETERIA		<u> </u>	2,012,333	1		
1.00	DI ETARY	10.00	245, 592	188, 893	0		1.00
	0		245, 592	188, 893			
4 00	F - MEDI CAL SUPPLIES	44.00		4 005			1.00
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 005			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	O O	112 1, 237	-		2. 00 3. 00
4.00	OPERATION OF PLANT	0. 00	0	1, 237	1		4. 00
5. 00	PHARMACY	15. 00	o	1, 986	1		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	39, 237	1		6. 00
7.00	OPERATING ROOM	50.00	0	1, 044, 640	0		7. 00
8.00	LABORATORY	60.00	0	30, 656			8. 00
9.00	RESPI RATORY THERAPY	65.00	0	26, 059			9. 00
10.00	PHYSI CAL THERAPY	66.00	0	9, 761			10.00
11. 00 12. 00	OCCUPATI ONAL THERAPY	67. 00 0. 00	0	418 0	1		11. 00 12. 00
14. 00	ONCOLOGY	73. 01	0	10, 000			14. 00
15. 00	CARDI AC REHABI LI TATI ON	76. 97	0	6, 837	1		15. 00
16.00	EMERGENCY	91.00	O	55, 744	1		16. 00
17.00	OCCUPATIONAL MEDICINE	192. 01	0	989	o		17. 00
18. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	283			18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00		3, 882			19. 00
	O G - DRUGS		0	1, 232, 846	1		-
1. 00	PHARMACY	15.00	ol	5, 115, 814	. 0		1. 00
2. 00	OPERATION OF PLANT	7.00	o	452	I .		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	19, 608	1		3. 00
4.00	OPERATING ROOM	50. 00	О	36, 404			4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	0	84, 312			5. 00
6.00	RESPIRATORY THERAPY	65.00	0	743	1		6. 00
7.00	PHYSI CAL THERAPY	66.00	0	406	1		7. 00
8.00	ELECTROCARDI OLOGY	69. 00	0	24, 051	0		8. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 IU HEALTH TIPTON HOSPITAL Provider CCN: 15-1311

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 2:28 pm

		Decreases				072772021 2.2	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
9.00	ONCOLOGY	73. 01	0	10, 275	0		9. 00
10.00	CARDIAC REHABILITATION	76. 97	0	25	0		10.00
11. 00	EMERGENCY	91.00	0	41, 077	0		11. 00
12.00	OCCUPATIONAL MEDICINE	192. 01	0	9, 396	0		12. 00
14.00	ADMINISTRATIVE & GENERAL	5. 00	0	205	0		14.00
15.00	CENTRAL SERVICES & SUPPLY	14.00	0	211	0		15. 00
	0		0	5, 342, 979			
	H - ORTHOPEDIC CLERICAL STAFF						
1.00	PHYSI CAL THERAPY	66.00	41, 986	0	0		1. 00
2.00		0.00	0	0	0		2. 00
	0		41, 986	0			
	J - MAINTENANCE & LEASE EXPEN	ISE					
1.00	PHYSI CAL THERAPY	66.00	0	173, 831	10		1. 00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	880	0		2. 00
3.00		0.00	0	0	0		3. 00
	0		0	174, 711]
	L - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	72, 541	12		1. 00
2.00		0.00	0	0	12		2. 00
	0		0	72, 541			
	N - INFUSION DRUGS						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 091, 193	0		1. 00
	0 — — — — — —		o	1, 091, 193			
500.00	Grand Total: Decreases		287, 578	12, 260, 243			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1311

				To	12/31/2023	Date/Time Prep 5/29/2024 2:28	pared: 8 nm
				Acqui si ti ons		0727720212.2	5 piii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	0	0	0	0	0	1. 00
2.00	Land Improvements	0	0	0	0	0	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	3, 139, 179	0	0	0	0	4. 00
5.00	Fixed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	14, 011, 166	1, 034, 548	0	1, 034, 548		6. 00
7.00	HIT designated Assets	755, 571	0	0	0	5, 460	•
8.00	Subtotal (sum of lines 1-7)	17, 905, 916	1, 034, 548	0	1, 034, 548	345, 640	1
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	17, 905, 916	1, 034, 548	0	1, 034, 548	345, 640	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
		/ 00	Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6. 00	7. 00				
1. 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES	0				1. 00
	Land	0	U				
2.00	Land Improvements	0	0				2. 00 3. 00
3. 00 4. 00	Buildings and Fixtures Building Improvements	3, 139, 179	277 122				4.00
5.00	Fixed Equipment	3, 139, 179	377, 123				5. 00
6.00	Movable Equipment	14, 705, 534	8, 972, 464				6.00
7. 00	HIT designated Assets	750, 111	750, 111				7. 00
8. 00	Subtotal (sum of lines 1-7)	18, 594, 824	10, 099, 698				8.00
9. 00	Reconciling Items	10, 374, 624	10, 077, 070				9. 00
10. 00	Total (line 8 minus line 9)	18, 594, 824	10, 099, 698				10.00
10.00	Trotal (Trile o milias Trile 7)	10, 074, 024	10, 077, 070			'	10.00

Heal tl	n Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 15-1311	Peri od:	Worksheet A-7	
					From 01/01/2023		
					To 12/31/2023	Date/Time Pre 5/29/2024 2:2	parea: 8 nm
				SUMMARY OF CAF	PLTAL	3/2//2024 2.2	l piii
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
						instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0		0	0 0	0	1. 00
1. 01	CAP REL COSTS-BLDG & FLXT - INTERES	0		0	0 0	0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0		0	0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0		0	0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description		Total (1) (su	ım			
		Capi tal -Relate					
		d Costs (see	through 14)				
		instructions)	45.00	_			
	DART II. PERMUNILIATION OF AMOUNTS FROM WORK	14.00	15.00			-	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	CSHEET A, COLUM	N 2, LINES I	and 2			4 00
1.00	CAP REL COSTS-BLDG & FLXT	0		0			1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0		0			1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0		U			2.00
3. 00	Total (sum of lines 1-2)	ı o		U			3. 00

Heal th	Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2023	Worksheet A-7 Part III	
					o 12/31/2023	Date/Time Pre	
		COME	PUTATION OF RA	TIOS	ALLOCATION OF	5/29/2024 2: 28 OTHER CAPITAL	3 pm
		COM	OTATION OF ICA	1105	ALLOCATION OF	OTHER GALLIAE	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio (col. 1 - col.	instructions)		
				2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE					_	
1.00	CAP REL COSTS-BLDG & FLXT	3, 889, 290					1.00
1.01	CAP REL COSTS-BLDG & FIXT - INTERES	0	٧	44 705 504	0.00000		1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	14, 705, 534		14, 705, 534			2.00
3. 00	Total (sum of lines 1-2)	18, 594, 824	TION OF OTHER (18, 594, 824		O F CAPITAL	3. 00
		ALLUCA	ITON OF OTHER O	CAPITAL	SUIVIIVIARY	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS CE				4 400 700	454.000	1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	, and the second se		1, 180, 789		1.00
1. 01 2. 00	CAP REL COSTS-BLDG & FIXT - INTERES CAP REL COSTS-MVBLE EQUIP	0			172, 355 1, 231, 953		1. 01 2. 00
3.00	Total (sum of lines 1-2)	0			2, 585, 097		2. 00 3. 00
3.00	Total (Suil of Titles 1-2)	U	SI	JMMARY OF CAPI		154, 009	3.00
			30	DIMINIARY OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
	DART III DECONCILIATION OF CARLTAL COCTE OF	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS 0	70, 220) 0	1, 405, 018	1. 00
1.00	CAP REL COSTS-BLDG & FIXT - INTERES	513, 352		1		685, 707	1. 00
2.00	CAP REL COSTS-BLDG & TTXT - TWIERES	0 0 0				1, 234, 274	2. 00
3.00	Total (sum of lines 1-2)	513, 352					
0.00	1.000. (00 01 111100 1 2)	010,002	, 2, 541	1	-1	0,021,777	0.00

					o 12/31/2023		
				Expense Classification on		5/29/2024 2: 2	8 PIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3. 00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 0	1. 00
	COSTS-BLDG & FLXT (chapter 2)						
1. 01	Investment income - CAP REL COSTS-BLDG & FIXT - INTERES (chapter 2)	В	-2, 664, 278	CAP REL COSTS-BLDG & FIXT - INTERES	1. 01	9	1. 01
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4. 00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -1, 673, 995		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	4, 883, 060			0	12. 00
13.00	Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		0		0. 00 0. 00	0	
16. 00	and others Sale of medical and surgical supplies to other than patients		0		0.00	0	16. 00
17. 00	Sale of drugs to other than	В	-102, 045	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
19. 00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20.00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review – physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL	А	779, 048	CAP REL COSTS-BLDG & FIXT	1. 00	9	26. 00
26. 01	COSTS-BLDG & FLXT Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT -	1. 01	0	26. 01
27. 00	COSTS-BLDG & FIXT - INTERES Depreciation - CAP REL	А	32, 696	INTERES CAP REL COSTS-MVBLE EQUIP	2. 00	9	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99

					12/31/2023	5/29/2024 2: 2	
				Expense Classification on	Worksheet A		
				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	
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	MI SCELLANEOUS I NCOME	В	-87, 117	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
33. 01	INVESTMENT FEES	A	8, 002	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	MI SCELLANEOUS I NCOME	В	-47, 280	HOUSEKEEPI NG	9. 00	0	33. 02
33. 03	MI SCELLANEOUS I NCOME	В	0	NURSING ADMINISTRATION	13.00	0	33. 03
33.04	MI SCELLANEOUS I NCOME	В	111	PHARMACY	15. 00	0	33. 04
33. 05	MI SCELLANEOUS I NCOME	В	-60	RADI OLOGY-DI AGNOSTI C	54.00	0	33. 05
33.06	MI SCELLANEOUS I NCOME	В	-19, 542	ELECTROCARDI OLOGY	69. 00	0	33. 06
33.07	MEDICAID HOSPITAL ASSESSMENT	A	-2, 308, 969	ADMINISTRATIVE & GENERAL	5.00	0	33. 07
	FEE						
33.08	ASSISTED LIVING DEPRECIATION -	A	-125, 777	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 08
	BLDG						
33.09	PATIENT PHONES - SALARY	A	-3, 296	ADMINISTRATIVE & GENERAL	5. 00	0	33. 09
33. 10	PATIENT PHONES - BENEFITS	A	-507	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 10
33. 11	EMPLOYEE BENEFITS	A	-2, 012, 335	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 11
33. 12	LEASE DEPRECIATION - CARRY	A	284	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 12
	FORWARD A						
33. 13	EQUIPMENT DEPRECIATION - CARRY	A	-3, 456	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 13
	FORWA						
33. 14	RECRUI TI NG	A	0	OPERATING ROOM	50.00	0	33. 14
33. 15	MARKETI NG	A	-56, 884	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	MARKETI NG	A	-541	DI ETARY	10.00	0	33. 16
33. 17	MARKETI NG	A	-101	CARDIAC REHABILITATION	76. 97	0	33. 17
50.00	TOTAL (sum of lines 1 thru 49)		-3, 402, 982				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(1) Do	scription - all chapter referen	soc in this col	ump portain to	CMC Dub 1E 1			

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 15-1311 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: From 01/01/2023 Date/Time Prepared: From 01/01/20

				10 12/31/2023	5/29/2024 2:28	
	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	
	HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAIMED	
1.00	1. 00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	128, 107	171, 892	1.00
2.00	1. 01	CAP REL COSTS-BLDG & FIXT -	HOME OFFICE ALLOCATION	2, 836, 633	0	2.00
3.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	142, 339	0	3.00
3.01	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE ALLOCATION	1, 885, 611	1, 820	3. 01
3.02	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	6, 150, 831	6, 971, 017	3. 02
3.03	7. 00	OPERATION OF PLANT	HOME OFFICE ALLOCATION	171, 892	0	3. 03
3.04		ADMINISTRATIVE & GENERAL	RELATED PARTY	293, 623	128, 126	3. 04
3.05	7. 00	OPERATION OF PLANT	RELATED PARTY	331, 196	10, 912	3. 05
3.06		NURSING ADMINISTRATION	RELATED PARTY	0	5, 260	3.06
3.07	15. 00	PHARMACY	RELATED PARTY	243, 347	127, 029	3. 07
3.08	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	125, 076	9, 539	3. 08
3.09	4.00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	2, 548	2, 548	3. 09
3. 10			SHARED EMPLOYEES	162, 281	162, 281	3. 10
3. 11			SHARED EMPLOYEES	27, 094	27, 094	3. 11
3. 12			SHARED EMPLOYEES	46, 176	46, 176	3. 12
3. 13	l .	ł	SHARED EMPLOYEES	543, 979	·	3. 13
3. 14	l .		SHARED EMPLOYEES	166, 250	·	3. 14
3. 15			SHARED EMPLOYEES	634, 517	634, 517	3. 15
3. 16			SHARED EMPLOYEES	21, 038	·	3. 16
3. 17			SHARED EMPLOYEES	1, 667, 107	1, 667, 107	3. 17
3. 18			SHARED EMPLOYEES	261, 854	·	3. 18
3. 19		l l	SHARED EMPLOYEES	1, 340, 638		3. 19
3. 20	l .	l l	SHARED EMPLOYEES	26, 674	26, 674	3. 20
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			17, 208, 811	12, 325, 751	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.

1100 110	to both postor to not kelloot 11, out all of 2, the allount all outside a so that outs the outside the same to								
				Related Organization(s) and/	or Home Office				
						l			
						l			
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2. 00	3.00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

	Comonic undor the tro mining		
6.00	В	0.00 IU HEALTH 100.00	6. 00
7.00	F	0.00 IU WEST 100.00	7. 00
8.00	F	0.00 IU NORTH 100.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

					To 12/31/2023	Date/Time Pr 5/29/2024 2:	repared: 28 pm
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			ENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED C	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO						
1.00	-43, 785						1.00
2.00	2, 836, 633						2. 00
3.00	142, 339						3. 00
3. 01	1, 883, 791	1					3. 01
3.02	-820, 186						3. 02
3.03	171, 892						3. 03
3.04	165, 497	0					3. 04
3.05	320, 284	0					3. 05
3.06	-5, 260	0					3. 06
3.07	116, 318						3. 07
3.08	115, 537	0					3. 08
3.09	0						3. 09
3. 10	0	0					3. 10
3. 11	0	0					3. 11
3. 12	0	0					3. 12
3. 13	0	0					3. 13
3.14	0	0					3. 14
3. 15	0	0					3. 15
3. 16	0	0					3. 16
3. 17	0	0					3. 17
3. 18	0	0					3. 18
3. 19	0	0					3. 19
3. 20	0	0					3. 20
4.00	0	0					4.00
5.00	4, 883, 060						5. 00

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

nas no	been posted to worksheet A,	cordining 1 and/or 2, the amount arrowable should be marcated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED 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.

	HOME OFFICE	6.00
7.00	HEALTHCARE	7.00
8.00	HEALTHCARE	8.00
9. 00		9.00
10.00		10.00
9. 00 10. 00 100. 00		100.00

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

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

West. A Line # Cost Center/Physician Identifier Remuneration Provider Component							To 12/31/2023	B Date/Time Pre 5/29/2024 2:2	
Identifier Remuneration Component Component Hours		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		
1.00				Remuneration	Component	Component			
1.00									
2.00		1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
3. 00	1.00	30. 00	ADULTS & PEDIATRICS	536, 952	536, 952	0	0	0	1. 00
4. 00	2.00	50. 00	OPERATING ROOM	463, 250	463, 250	0	0	0	2. 00
1.00	3.00			583, 657	583, 657	0	0	0	3.00
Column C	4.00	69. 00	ELECTROCARDI OLOGY	67, 503	67, 503	0	0	0	4.00
7.00	5.00	91. 00	EMERGENCY	1, 340, 638	22, 633	1, 318, 005	0	0	5. 00
8.00	6.00	0.00		0	0	0	0	0	6. 00
9.00	7.00	0.00		0	0	0	0	0	7. 00
10 00 00 00 00 0	8.00	0.00		0	0	0	0	0	8. 00
200.00	9.00	0.00		0	0	0	0	0	9. 00
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cost of Identifier Unadjusted RCE Limit Cost of Identifier Cost of		0.00		0	0	0	0	0	
Identifier	200.00					1, 318, 005		_	
1.00		Wkst. A Line #							
1.00			ldenti fi er	Limit					
1.00					Limit			Insurance	
1.00									
2. 00	1 00								1 00
3. 00					· -	-	_		
4. 00 69. 00 ELECTROCARDI OLOGY 5. 00 0 0 0 0 0 0 0 0 5. 00 6. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				l ~	l ~	· ·	0	_	
S. 00				0	0	0	0		
6.00				0	0	0	0	_	
7. 00			EMERGENCY	0	0	0	0		
8.00				0	0	0	0	_	
9. 00				0	0	0	0		
10.00				0	0	0	0	_	
New Year Cost Center/Physician I dentifier Provider Component Share of col. 14 Provider Component Share of col. 15.00 Provider Compo				0	0	0	0	_	
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14 1.00 15.00 16.00 17.00 18.00 1.00 2.00 15.00 16.00 17.00 18.00 1.00 2.00 15.00 16.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00		0.00		0	0	0	0	_	
Identifier Component Share of col. 14		WI+ A I : //	Cook Cooks (Dhareisis	0	A-1:+1 DCF	DOF	0	0	200.00
Share of col. 14		WKSt. A Line #			, ,		Adjustment		
1.00 2.00 15.00 16.00 17.00 18.00			rdentrirer		LIIIII	Di Sai i Owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRI CS 0 0 0 536, 952 1.00 2.00 50.00 OPERATI NG ROOM 0 0 0 463, 250 2.00 3.00 53.00 ANESTHESI OLOGY 0 0 0 583, 657 3.00 4.00 69.00 ELECTROCARDI OLOGY 0 0 0 67, 503 4.00 5.00 91.00 EMERGENCY 0 0 0 0 22, 633 5.00 6.00 0.00 0 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 7.00 8.00 0.00 0 0 0 0 0 9.00 9.00 0.00 0 0 0 0 0 9.00 10.00 0 0 0 0 0 0 9.00									
1. 00 30. 00 ADULTS & PEDIATRICS 0 0 536, 952 1. 00 2. 00 50. 00 OPERATI NG ROOM 0 0 0 463, 250 2. 00 3. 00 53. 00 ANESTHESI OLOGY 0 0 0 583, 657 3. 00 4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 67, 503 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 0 22, 633 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 0 0		1. 00	2.00		16, 00	17. 00	18. 00		
2. 00 50. 00 OPERATI NG ROOM 0 0 463, 250 2. 00 3. 00 53. 00 ANESTHESI OLOGY 0 0 0 583, 657 3. 00 4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 67, 503 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 22, 633 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 9. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 9. 00	1.00								1, 00
3. 00 53. 00 ANESTHESI OLOGY 0 0 0 583, 657 3. 00 4. 00 69. 00 ELECTROCARDI OLOGY 0 0 0 67, 503 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 0 22, 633 5. 00 6. 00 0 0 0 0 0 6. 00 7. 00 0 0 0 0 0 0 7. 00 8. 00 0 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 10. 00 10. 00 0 0 0 0 0 0 0 0						0			
4. 00 69. 00 ELECTROCARDI OLOGY 0 0 67, 503 4. 00 5. 00 91. 00 EMERGENCY 0 0 0 22, 633 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 6. 00 8. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0. 00 0 0 0 0 0 10. 00		1		l o	l	0		1	
5. 00 91. 00 EMERGENCY 0 0 0 22, 633 5. 00 6. 00 0. 00 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 10. 00 0 0 0 0 0 0 10. 00	4.00	69. 00	ELECTROCARDI OLOGY	0	0	0	67, 503		4. 00
6. 00 0. 00 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 0 0 0 0 10. 00	5.00			0	0	0			5. 00
8. 00 0. 00 9. 00 0. 00 10. 00 0. 00 0 0	6.00	0.00		0	0	0	0		6. 00
8. 00 0. 00 9. 00 0. 00 10. 00 0. 00 0 0				0	0	0	0		
9.00 0.00 0.00 0 0 0 9.00 10.00 0 0 0 10.00				0	0	0	0		4
10.00 0.00 10.00 10.00	9.00			0	0	0	0		9. 00
200. 00 0 0 1, 673, 995 200. 00	10.00	0.00		0	0	0	0		10.00
	200.00			0	0	0	1, 673, 995		200.00

| 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: 15-1311

				To	12/31/2023	Date/Time Pre 5/29/2024 2:2	pared:
			CAP	TAL RELATED CO	STS	3/27/2024 2.2	o piii
	Cost Center Description	Net Expenses	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	EMPLOYEE	
		for Cost		INTERES		BENEFITS	
		Allocation				DEPARTMENT	
		(from Wkst A					
		col. 7) 0	1. 00	1. 01	2. 00	4. 00	
	GENERAL SERVICE COST CENTERS	0 1	1.00	1.01	2.00	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	1, 405, 018	1, 405, 018				1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES	685, 707	0				1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 234, 274		220,	1, 234, 274		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 896, 221	6, 083	3, 472	5, 343	1, 911, 119	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 694, 562	87, 150	49, 275	76, 559	74, 513	5. 00
7.00	00700 OPERATION OF PLANT	4, 158, 028	338, 183	169, 988	297, 088	138, 504	7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	0	0	-	0	0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	74, 169	22, 387		19, 666	0	8. 00
9.00	00900 HOUSEKEEPI NG	724, 478	13, 364		11, 740	89, 254	9. 00
10.00	01000 DI ETARY	205, 200	18, 854		16, 563	20, 573	10.00
11.00	01100 CAFETERI A	434, 485	39, 813		34, 974	43, 446	
13.00	01300 NURSI NG ADMI NI STRATI ON	825, 800	23, 076	· ·	20, 272	113, 454	13.00
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	342, 505 1, 282, 022	28, 957 15, 907	· ·	25, 438 13, 974	0 135, 360	14. 00 15. 00
15.00	I NPATIENT ROUTINE SERVICE COST CENTERS	1, 202, 022	15, 907	9,001	13, 974	133, 300	13.00
30. 00	03000 ADULTS & PEDIATRICS	1, 484, 317	163, 814	93, 517	143, 906	223, 523	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	1, 404, 317	103, 014	75, 517	143, 700	223, 323	30.00
50.00	05000 OPERATING ROOM	2, 106, 143	168, 621	96, 262	148, 130	184, 290	50.00
53. 00	05300 ANESTHESI OLOGY	50, 860	3, 184		2, 797	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 425, 131	87, 352	49, 867	76, 737	202, 563	54.00
60.00	06000 LABORATORY	1, 783, 534	35, 806	20, 441	31, 455	0	60. 00
65.00	06500 RESPI RATORY THERAPY	758, 235	2, 090	1, 193	1, 836	121, 345	65. 00
66. 00	06600 PHYSI CAL THERAPY	848, 322	38, 872	· ·	34, 148	134, 631	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	261, 577	10, 688		9, 389	43, 161	67. 00
68. 00	06800 SPEECH PATHOLOGY	47, 706	523		459	7, 777	68. 00
69. 00	06900 ELECTROCARDI OLOGY	588, 619	22, 958		20, 168	97, 577	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	251, 455	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	646, 073	0		0	0	72.00
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 03480 ONCOLOGY	4, 169, 102 187, 420	0 13, 949	· ·	12, 254	0 28, 439	73. 00 73. 01
73. 01	07301 BLOOD DI SORDER DRUGS	1, 091, 193	13, 949	7, 903	12, 254	28, 439	73.01
76. 00	03160 CARDI OPULMONARY	1,091,193	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	168, 585	24, 129	·	21, 196	25, 741	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	24, 127		21, 170	23, 741	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		0		0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	-1	· · · · · · · · · · · · · · · · · · ·	-1	-1		
91.00	09100 EMERGENCY	2, 941, 371	98, 187	56, 052	86, 254	203, 657	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			·			92. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00		38, 772, 112	1, 263, 947	677, 652	1, 110, 346	1, 887, 808	118. 00
	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CLANS' PRI VATE OFFI CES	73, 801	126, 962		111, 533	11, 328	
	19201 OCCUPATIONAL MEDICINE	120, 141	14, 109	1	12, 395	11, 983	
192. 02 200. 00	19202 VACANT SPACE	0	0	0	0	0	192. 02 200. 00
200.00	1 1		^			0	200.00
201.00		38, 966, 054	1, 405, 018	685, 707	1, 234, 274	1, 911, 119	
202.00	Tronne (Sum Trines Tro thirough 201)	30, 700, 034	1, 400, 010	1 333, 707	1, 207, 274	1, 711, 117	1202.00

Provider CCN: 15-1311

				''	0 12/31/2023	5/29/2024 2: 2	
	Cost Center Description	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	
	'		& GENERAL	PLANT	PLANT -	LINEN SERVICE	
					OFFSI TE		
		4A	5. 00	7. 00	7. 01	8. 00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FLXT						1. 00
	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
1	00500 ADMINISTRATIVE & GENERAL	6, 982, 059					5. 00
	00700 OPERATION OF PLANT	5, 101, 791	1, 113, 703				7. 00
	00701 OPERATION OF PLANT - OFFSITE	0	0	l ~	0		7. 01
	00800 LAUNDRY & LINEN SERVICE	129, 002	28, 161		0	020, 707	8. 00
	00900 HOUSEKEEPI NG	846, 465			0	1	9. 00
	D1000 DI ETARY	271, 953		· ·	0	1	10.00
	01100 CAFETERI A	575, 446			0	0	11. 00
1	01300 NURSING ADMINISTRATION	995, 776		· ·	0	0	13. 00
	01400 CENTRAL SERVICES & SUPPLY	413, 431	90, 252			-	14. 00
	D1500 PHARMACY	1, 456, 344	317, 918	121, 912	0	0	15. 00
	NPATIENT ROUTINE SERVICE COST CENTERS		T .				
	03000 ADULTS & PEDI ATRI CS	2, 109, 077	460, 409	1, 255, 488	0	328, 737	30. 00
	ANCILLARY SERVICE COST CENTERS	0.700.447	F00.4/0	4 000 000			F0 00
1	D5000 OPERATING ROOM	2, 703, 446					50.00
1	D5300 ANESTHESI OLOGY	58, 659			0	•	53.00
	D5400 RADI OLOGY-DI AGNOSTI C	1, 841, 650			0	1	54. 00
	06000 LABORATORY	1, 871, 236			0	1	60.00
	06500 RESPI RATORY THERAPY	884, 699		·	0	· -	65.00
	06600 PHYSI CAL THERAPY	1, 062, 365			0		66.00
1	06700 OCCUPATI ONAL THERAPY	326, 573		· ·	0		67.00
- 1	06800 SPEECH PATHOLOGY	56, 553					68. 00
	06900 ELECTROCARDI OLOGY	742, 428				0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	251, 455				1	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	646, 073	141, 037		0	1	72.00
1	D7300 DRUGS CHARGED TO PATIENTS	4, 169, 102			0	0	73.00
	03480 ONCOLOGY	250, 025			0		73. 01
1	07301 BLOOD DI SORDER DRUGS	1, 091, 193	238, 206		0	0	73. 02
	03160 CARDI OPULMONARY	0	0	0		0	76.00
	07697 CARDI AC REHABI LI TATI ON	253, 425	55, 322		0	1	76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	_			77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS D9100 EMERGENCY	3, 385, 521	739, 056	752, 513	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 363, 321		752, 513	U	0	91.00
	OTHER REIMBURSABLE COST CENTERS	U					92.00
	10200 OPLOLD TREATMENT PROGRAM	0	0	0	0		102. 00
	SPECIAL PURPOSE COST CENTERS	U			U	U	102.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	38, 475, 747	6, 875, 025	6, 107, 359	0	328, 737	110 00
	NONREI MBURSABLE COST CENTERS	30, 473, 747	0, 675, 025	0, 107, 339	0	320, 737	1110.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	323, 624	70, 647	0	0	0	192. 00
	19201 OCCUPATIONAL MEDICINE	166, 683					192. 00
4	19202 VACANT SPACE	100,003	30, 367	100, 133	0		192. 01
200. 00	Cross Foot Adjustments	0			U		200. 00
200.00	Negative Cost Centers	0	0	n	0	n	201.00
202.00	TOTAL (sum lines 118 through 201)	38, 966, 054	6, 982, 059	6, 215, 494	_	l	
202.00	TOTAL (Sum TITIOS TTO LITTOUGH ZOT)	50, 700, 034	1 0, 702, 037	0, 213, 474	U	1 320, 737	1202.00

| 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: 15-1311

				1	o 12/31/2023	Date/Time Pre	
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	NURSI NG	5/29/2024 2: 2 CENTRAL	o piii
	cost center bescription	HOUSEKEELTING	DILIANI	CALLILITA	ADMI NI STRATI ON	SERVICES &	
					ADMIT IN STRUCT	SUPPLY	
		9.00	10.00	11. 00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS				'		
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	1, 133, 668					9. 00
10.00	01000 DI ETARY	22, 791	498, 611				10.00
11. 00	01100 CAFETERI A	48, 125	0	1, 054, 318	3		11.00
13.00	01300 NURSING ADMINISTRATION	27, 895	0	53, 667	1, 471, 576		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	35, 003	0	C	0	760, 616	14.00
15. 00	01500 PHARMACY	19, 228	0	71, 842	0	1, 487	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	198, 017	498, 379	159, 196	624, 126	20, 458	30. 00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	203, 829	0	123, 035		149, 382	
	05300 ANESTHESI OLOGY	3, 849	0	C		0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	105, 590	0	125, 700		4, 287	1
60.00	06000 LABORATORY	43, 282	0	88, 780		16, 454	1
65. 00	06500 RESPI RATORY THERAPY	2, 527	0	68, 226		15, 306	
	06600 PHYSI CAL THERAPY	46, 988	0	88, 875		484	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	12, 920	0	25, 406		0	
68. 00	06800 SPEECH PATHOLOGY	632	0	4, 472		0	68. 00
	06900 ELECTROCARDI OLOGY	27, 752	0	55, 85 <i>6</i>		1, 535	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	-1	145, 573	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(-	374, 025	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(ή	0	
	03480 ONCOLOGY	16, 861	0	20, 553		3, 290	1
	07301 BLOOD DI SORDER DRUGS	0	0	(0	
	03160 CARDI OPULMONARY	0	0	(- 1	0	
	07697 CARDI AC REHABI LI TATI ON	29, 166	0	18, 079		144	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(1	0	
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C) 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	118, 687	222	120 FE	220 244	27 200	01 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	118, 087	232	130, 553	328, 246	27, 388	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						92.00
	10200 OPI OI D TREATMENT PROGRAM	0	0	(0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	U	<u> </u>		<u>)</u>		102.00
118. 00		963, 142	498, 611	1, 034, 240	1, 459, 524	759, 813	110 00
	NONREIMBURSABLE COST CENTERS	703, 142	470, 011	1, 034, 240	1, 407, 524	107,013	1.10.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	153, 471	ol	9, 325	ol ol	167	192. 00
	19201 OCCUPATI ONAL MEDI CI NE	17, 055	0	10, 753			192. 01
	19202 VACANT SPACE	1,,555	o O	10, 750			192. 02
200.00	Cross Foot Adjustments		ĭ		1	O	200. 00
201.00	Negative Cost Centers		o	(ا ا	0	201. 00
202.00		1, 133, 668	498, 611	1, 054, 318	1, 471, 576	760, 616	1
							1

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1311 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/29/2024 2:28 pm Cost Center Description **PHARMACY** Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 15.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 OPERATION OF PLANT - OFFSITE 7.01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 1, 988, 731 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 30.00 5, 893 5, 659, 780 5, 659, 780 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 106 5, 408, 456 0 5, 408, 456 50.00 05300 ANESTHESI OLOGY 53.00 99, 717 0 99, 717 53.00 05400 RADI OLOGY-DI AGNOSTI C 3, 161, 374 0 54 00 1 831 3, 161, 374 54 00 06000 LABORATORY 0 60.00 0 2, 702, 664 2, 702, 664 60.00 06500 RESPIRATORY THERAPY 0 1, 179, 907 1, 179, 907 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 1, 516, 439 1, 516, 439 66.00 06700 OCCUPATIONAL THERAPY 0 0 459, 793 459, 793 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 75, 177 75, 177 68.00 06900 ELECTROCARDI OLOGY 1, 213, 682 0 1, 213, 682 69.00 525 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 451, 920 451, 920 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 0 1, 161, 135 1, 161, 135 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 551, 985 6, 631, 198 0 6, 631, 198 73.00 03480 ONCOLOGY 73.01 3,064 520, 687 520, 687 73.01 406, 206 73. 02 07301 BLOOD DI SORDER DRUGS 0 73.02 1, 735, 605 1, 735, 605 03160 CARDI OPULMONARY 0 76 00 76 00 76. 97 07697 CARDIAC REHABILITATION 584, 268 584, 268 76.97 0 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77 00 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 91.00 09100 EMERGENCY 13.121 5, 495, 317 0 5, 495, 317 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 38, 057, 119 1, 988, 731 118.00 0 38, 057, 119 118.00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 557, 234 557, 234 192.00 0 192. 01 19201 OCCUPATIONAL MEDICINE 0 351, 701 351, 701 192. 01 0 192. 02 19202 VACANT SPACE 0 192 02 C 0 200.00 Cross Foot Adjustments C 0 200.00 0 201.00 201.00 Negative Cost Centers 0 1, 988, 731 38, 966, 054 202.00

38, 966, 054

202.00

TOTAL (sum lines 118 through 201)

| 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: 15-1311

				To	12/31/2023	Date/Time Pre 5/29/2024 2:2	
			CAPITAL RELATED COSTS		3/27/2024 2.2	o piii	
			OF THE RESTREE SOUTS				
	Cost Center Description	Directly	BLDG & FIXT	BLDG & FIXT -	MVBLE EQUIP	Subtotal	
		Assigned New		INTERES			
		Capi tal					
		Related Costs	1.00	1 01	2.00	2.4	
	GENERAL SERVICE COST CENTERS	0	1. 00	1.01	2. 00	2A	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 00	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	o	6, 083	3, 472	5, 343	14, 898	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	o	87, 150		76, 559	212, 984	5. 00
7.00	00700 OPERATION OF PLANT	0	338, 183	169, 988	297, 088	805, 259	7. 00
7.01	00701 OPERATION OF PLANT - OFFSITE	0	0	0	0	0	7. 01
8.00	00800 LAUNDRY & LINEN SERVICE	0	22, 387	12, 780	19, 666	54, 833	8. 00
9.00	00900 HOUSEKEEPI NG	0	13, 364		11, 740	32, 733	9. 00
10.00	01000 DI ETARY	0	18, 854		16, 563	46, 180	10. 00
11. 00	01100 CAFETERI A	0	39, 813		34, 974	97, 515	11. 00
13.00	01300 NURSING ADMINISTRATION	0	23, 076		20, 272	56, 522	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	28, 957		25, 438	70, 926	14. 00
15. 00	01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l U	15, 907	9, 081	13, 974	38, 962	15. 00
30. 00	03000 ADULTS & PEDIATRICS	l ol	163, 814	93, 517	143, 906	401, 237	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	103, 014	73, 517	143, 700	401, 237	30.00
50.00	05000 OPERATING ROOM	l ol	168, 621	96, 262	148, 130	413, 013	50.00
53. 00	05300 ANESTHESI OLOGY	l ol	3, 184		2, 797	7, 799	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	87, 352		76, 737	213, 956	54.00
60.00	06000 LABORATORY	o	35, 806	20, 441	31, 455	87, 702	60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 090	1, 193	1, 836	5, 119	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	38, 872		34, 148	79, 412	
67. 00	06700 OCCUPATI ONAL THERAPY	0	10, 688		9, 389	21, 835	
68. 00	06800 SPEECH PATHOLOGY	0	523		459	1, 070	
69. 00	06900 ELECTROCARDI OLOGY	0	22, 958		20, 168	56, 232	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	_	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	ı	0	0	72. 00 73. 00
73. 00	03480 ONCOLOGY	0	13, 949	_	12, 254	34, 166	1
73. 01	07301 BLOOD DI SORDER DRUGS		13, 747	7, 703	12, 234	0	73. 01
76. 00	03160 CARDI OPULMONARY		0	Ö	0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	24, 129		21, 196	59. 099	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	o	0		0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	O	0	О	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	0	98, 187	56, 052	86, 254	240, 493	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92. 00
	OTHER REIMBURSABLE COST CENTERS	1		,			
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
440.00	SPECIAL PURPOSE COST CENTERS		4 0/0 047	(77 (50	4 440 044	0.054.045	440.00
118. 00		0	1, 263, 947	677, 652	1, 110, 346	3, 051, 945	1118.00
102 00	NONREI MBURSABLE COST CENTERS 19200 PHYSI CLANS' PRI VATE OFFI CES	l ol	126, 962	0	111, 533	238, 495	102 00
	19200 PHYSICIANS PRIVATE OFFICES 19201 OCCUPATIONAL MEDICINE	0	126, 962		12, 395	238, 495 34, 559	
	19202 VACANT SPACE		14, 109 0	0,033	12, 373		192. 01
200.00			0		٩		200. 00
201.00	1 1		0	0	o		201. 00
202.00		0	1, 405, 018	685, 707	1, 234, 274	3, 324, 999	
		. '					•

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Part | Part | Prepared: | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

				11	0 12/31/2023	5/29/2024 2:2	
	Cost Center Description	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	LAUNDRY &	Э ріп
	·	BENEFITS	& GENERAL	PLANT	PLANT -	LINEN SERVICE	
		DEPARTMENT			OFFSI TE		
		4. 00	5. 00	7. 00	7. 01	8. 00	
4 00	GENERAL SERVICE COST CENTERS		I				4 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 00 1. 01
2.00	00200 CAP REL COSTS-BLDG & FIXT - INTERES						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	14, 898					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	581	213, 565				5. 00
7. 00	00700 OPERATION OF PLANT	1, 080					7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE	1,000	01,070				7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	Ö	861	23, 199	0		8. 00
9. 00	00900 HOUSEKEEPI NG	696			0		9. 00
10.00	01000 DI ETARY	160	1		0	0	10.00
11. 00	01100 CAFETERI A	339			0	0	11. 00
13.00	01300 NURSING ADMINISTRATION	884	6, 649	23, 914	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 760	30, 008	0	0	14.00
15. 00	01500 PHARMACY	1, 055	9, 724	16, 484	0	0	15. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	1, 742	14, 082	169, 758	0	78, 893	30. 00
	ANCILLARY SERVICE COST CENTERS		I	T			
50. 00	05000 OPERATING ROOM	1, 437	18, 051				50. 00
53. 00	05300 ANESTHESI OLOGY	0	392	·	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 579		·	0	_	54. 00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	946	12, 494 5, 907		0		60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 049	7, 093		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	336	1		0	_	67. 00
68. 00	06800 SPEECH PATHOLOGY	61	378		0	_	68. 00
69. 00	06900 ELECTROCARDI OLOGY	761	4, 957	23, 791	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 679		0	_	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4, 314		0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	27, 837	0	0	0	73. 00
73. 01	03480 ONCOLOGY	222	1, 669	14, 455	0	0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	0	7, 286	0	0	0	73. 02
76.00	03160 CARDI OPULMONARY	0	0	0	0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	201	1, 692	25, 004	0	0	76. 97
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	_	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
91. 00	09100 EMERGENCY	1, 588	22, 605	101, 749	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
100.00	OTHER REIMBURSABLE COST CENTERS		1 0	1 0	0	0	100.00
102.00	10200 OPLOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118. 00		14, 717	210, 291	825, 791	0	78, 893	110 00
110.00	NONREI MBURSABLE COST CENTERS	14, / 1 /	210, 291	023, 791	0	70,093	116.00
192 00	19200 PHYSI CLANS' PRI VATE OFFI CES	88	2, 161	0	0	0	192. 00
	19201 OCCUPATI ONAL MEDI CI NE	93			0		192. 00
	19202 VACANT SPACE	73	1, 113	·	0		192. 01
200.00	1 1		Ĭ		9		200. 00
201.00	3	0	l 0	0	0	0	201. 00
202.00	3	14, 898	213, 565	840, 412	_		
		,	,			•	'

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part II
To 1/21/2022 Part/Time Propagate Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1311

Cost Center Description HOUSEKEEPING DIETARY CAFETERIA NURSING CENTR ADMINISTRATION SERVICE	S & Y
	Υ
SUPPI	
9.00 10.00 11.00 13.00 14.0)
GENERAL SERVICE COST CENTERS	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	1. 00
1.01 OO101 CAP REL COSTS-BLDG & FIXT - INTERES	1. 01
2.00 OO200 CAP REL COSTS-MVBLE EQUIP	2. 00
4.00 OO400 EMPLOYEE BENEFITS DEPARTMENT	4. 00
5.00 OO500 ADMINISTRATIVE & GENERAL	5. 00
7. 00 00700 OPERATI ON OF PLANT	7. 00
7. 01 OO701 OPERATI ON OF PLANT - OFFSI TE	7. 01
8.00 OOSOO LAUNDRY & LINEN SERVICE	8. 00
9. 00 00900 HOUSEKEEPI NG 52, 930 10.000	9.00
10. 00 01000 DI ETARY	10.00
11. 00 01100 CAFETERI A 2, 247 0 145, 200 14	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 1, 302 0 7, 391 96, 662	13.00
	15, 328 14. 00
15. 00 01500 PHARMACY 898 0 9, 894 0	206 15.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 9, 245 68, 726 21, 924 40, 997	2, 833 30. 00
ANCI LLARY SERVI CE COST CENTERS	2, 633 30.00
	0, 686 50. 00
53. 00 05300 ANESTHESI OLOGY 180 0 0	0 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 4, 930 0 17, 311 710	594 54.00
60. 00 06000 LABORATORY 2, 021 0 12, 227 0	2, 279 60.00
65. 00 06500 RESPI RATORY THERAPY 118 0 9, 396 0	2, 119 65.00
66. 00 06600 PHYSI CAL THERAPY 2, 194 0 12, 240 0	67 66.00
67. 00 06700 OCCUPATI ONAL THERAPY 603 0 3, 499 0	0 67.00
68. 00 06800 SPEECH PATHOLOGY 29 0 616 0	0 68.00
69. 00 06900 ELECTROCARDI OLOGY 1, 296 0 7, 692 3, 124	213 69.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O O O O O	0, 159 71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 1	1, 792 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0	0 73.00
73. 01 03480 0NCOLOGY 787 0 2, 831 4, 296	456 73.01
73. 02 07301 BLOOD DI SORDER DRUGS 0 0 0 0	0 73.02
76. 00 03160 CARDI OPULMONARY 0 0 0 0	0 76.00
76. 97 07697 CARDI AC REHABI LI TATI ON 1, 362 0 2, 490 2, 838	20 76. 97
77.00 OT7700 ALLOGENEIC HSCT ACQUISITION O O O	0 77.00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0	0 78.00
OUTPATIENT SERVICE COST CENTERS	0.700
91. 00 09100 EMERGENCY 5, 541 32 17, 980 21, 561	3, 793 91. 00
92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART	92. 00
OTHER REI MBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O	0 102. 00
SPECIAL PURPOSE COST CENTERS	0 102.00
	5, 217 118. 00
NONREI MBURSABLE COST CENTERS	13, 217 110.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 7, 165 0 1, 284 0	23 192. 00
192. 01 19201 OCCUPATI ONAL MEDI CI NE 796 0 1, 481 792	88 192. 01
192. 02 19202 VACANT SPACE 0 0 0 0	0 192. 02
200.00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers 0 0 0	0 201.00
202.00 TOTAL (sum lines 118 through 201) 52,930 68,758 145,200 96,662 10	5, 328 202. 00

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCAT	TION OF CAPITAL RELATED COSTS		Provi der Co		Peri od:	Worksheet B	
					From 01/01/2023	Part II	
					To 12/31/2023	Date/Time Pre 5/29/2024 2:2	parea:
	Cost Center Description	PHARMACY	Subtotal	Intern &	Total	3/29/2024 2.2	lo piii
	oust defited beschiption	THANWACT	Subtotal	Residents Cos			
				& Post			
				Stepdown			
				Adjustments			
		15.00	24. 00	25. 00	26. 00		
	GENERAL SERVICE COST CENTERS	10.00	21100	20.00	20.00		
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
4	00700 OPERATION OF PLANT						7. 00
	00701 OPERATION OF PLANT - OFFSITE						7. 01
4	00800 LAUNDRY & LINEN SERVICE						8. 00
	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSI NG ADMINI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
	01500 PHARMACY	77, 223					15. 00
		11,223					15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	220	000 ///		0 809, 666		20.00
	03000 ADULTS & PEDIATRICS	229	809, 666		0 809, 666		30. 00
	ANCILLARY SERVICE COST CENTERS	227	676, 970		0 (7/ 070		F0 00
	05000 OPERATING ROOM	237			0 676, 970		50.00
	05300 ANESTHESI OLOGY	0	11, 671		0 11, 671		53.00
	05400 RADI OLOGY-DI AGNOSTI C	71	341, 969		0 341, 969		54.00
	06000 LABORATORY	0	153, 828		0 153, 828		60.00
	06500 RESPI RATORY THERAPY	0	25, 771	•	0 25, 771		65. 00
	06600 PHYSI CAL THERAPY	0	113, 658	•	0 113, 658		66. 00
	06700 OCCUPATI ONAL THERAPY	0	31, 645		0 31, 645		67. 00
	06800 SPEECH PATHOLOGY	0	2, 313	•	0 2, 313		68. 00
4	06900 ELECTROCARDI OLOGY	20	98, 086	•	98, 086		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	21, 838	•	0 21, 838		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	56, 106		0 56, 106		72. 00
	07300 DRUGS CHARGED TO PATIENTS	60, 265	88, 102	l .	0 88, 102		73. 00
	03480 ONCOLOGY	119	59, 001		0 59, 001		73. 01
	07301 BLOOD DI SORDER DRUGS	15, 773	23, 059		0 23, 059		73. 02
	03160 CARDI OPULMONARY	0	0		0		76. 00
	07697 CARDI AC REHABI LI TATI ON	0	92, 706		92, 706		76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0		78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	509	415, 851		0 415, 851		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPIOID TREATMENT PROGRAM	0	0		0		102. 00
5	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	77, 223	3, 022, 240		0 3, 022, 240		118. 00
1	NONREI MBURSABLE COST CENTERS						
192. 00	19200 PHYSICIANS' PRIVATE OFFICES	0	249, 216		0 249, 216		192. 00
192. 01	19201 OCCUPATIONAL MEDICINE	O	53, 543		0 53, 543		192. 01
192. 02	19202 VACANT SPACE	O	0		0		192. 02
200.00	Cross Foot Adjustments		0		0		200.00
201.00	Negative Cost Centers	o	0		0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	77, 223	3, 324, 999		0 3, 324, 999		202. 00
		•					

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1311 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 2:28 pm CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT BLDG & FIXT -MVBLE EQUIP **EMPLOYEE** Reconciliation (SQUARE FEET) INTERES (SOUARE FEFT) **BENEFITS** (SQUARE FEET) DEPARTMENT (GROSS SALARI ES) 1.00 1. 01 2.00 5A 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 201,652 1.01 00101 CAP REL COSTS-BLDG & FIXT - INTERES 172, 392 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 201, 652 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 10, 803, 284 4 00 873 873 873 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 12,508 12, 388 12,508 421, 211 -6, 982, 059 5.00 48, 537 7.00 00700 OPERATION OF PLANT 42, 736 48, 537 782, 942 0 7.00 7.01 00701 OPERATION OF PLANT - OFFSITE 0 7.01 00800 LAUNDRY & LINEN SERVICE 3, 213 3 213 3, 213 8 00 8 00 0 9.00 00900 HOUSEKEEPI NG 1,918 1, 918 1, 918 504, 541 0 9.00 01000 DI ETARY 2,706 2, 706 2, 706 116, 295 10.00 10.00 0 01100 CAFETERI A 5, 714 5, 714 5, 714 245, 592 11.00 11.00 0 01300 NURSING ADMINISTRATION 3, 312 13.00 3.312 3, 312 641, 337 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 4, 156 4, 156 4, 156 0 14.00 01500 PHARMACY 15.00 2, 283 2, 283 2, 283 765, 171 0 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 23, 511 23, 511 23, 511 1, 263, 561 0 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24, 201 24, 201 24, 201 1, 041, 763 0 50.00 53.00 05300 ANESTHESI OLOGY 457 53.00 457 457 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 12.537 12, 537 12, 537 1, 145, 056 0 54.00 5, 139 06000 LABORATORY 5, 139 60.00 60.00 5, 139 65.00 06500 RESPIRATORY THERAPY 300 300 300 685, 946 65.00 66.00 06600 PHYSI CAL THERAPY 5, 579 5, 579 761, 048 66.00 1,607 0 06700 OCCUPATIONAL THERAPY 67.00 1,534 442 1,534 243, 980 0 67.00 06800 SPEECH PATHOLOGY 43, 963 68.00 75 22 68.00 69.00 06900 ELECTROCARDI OLOGY 3, 295 3. 295 3, 295 551, 590 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 C C 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0 73.00 03480 ONCOLOGY 73 01 2,002 2,002 2,002 160, 759 0 73.01 07301 BLOOD DI SORDER DRUGS 73.02 0 73.02 03160 CARDI OPULMONARY 76.00 76.00 0 07697 CARDIAC REHABILITATION 76. 97 76.97 3, 463 145, 512 0 3.463 3.463 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77 00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 14 092 91.00 91 00 09100 EMERGENCY 14 092 14 092 1 151 243 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 0 0 102. 00 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 181, 405 170, 367 181, 405 10, 671, 510 -6, 982, 059 118. 00 NONREI MBURSABLE COST CENTERS 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 18, 222 18, 222 64, 036 0 192. 00 192. 01 19201 OCCUPATIONAL MEDICINE 2, 025 0 192. 01 2.025 2.025 67, 738 192. 02 19202 VACANT SPACE 0 192. 02 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 405, 018 685, 707 1, 234, 274 1, 911, 119 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 203.00 6. 967538 3.977603 6. 120812 0.176902 Cost to be allocated (per Wkst. B, 204.00 14.898 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001379 205. 00 II) 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 In Lieu of Form CMS-2552-10 IU HEALTH TIPTON HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1311 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/29/2024 2:28 pm Cost Center Description ADMINISTRATIVE OPERATION OF OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL PLANT -LINEN SERVICE (SQUARE FEET) PLANT (ACCUM. COST) (SQUARE FEET) OFFSI TE (TOTAL PATIENT (SQUARE FEET) DAYS) 5.00 7.00 9.00 7.01 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 CAP REL COSTS-BLDG & FIXT - INTERES 1. 01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 31, 983, 995 5.00 5.00 00700 OPERATION OF PLANT 5, 101, 791 7.00 116, 395 7.00 00701 OPERATION OF PLANT - OFFSITE 7.01 23, 339 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 129,002 3, 213 0 1,589 8.00 1, 918 9.00 00900 HOUSEKEEPI NG 846, 465 0 134, 603 9.00 2, 706 2, 706 01000 DI ETARY 10.00 271, 953 0 0 10.00 11.00 01100 CAFETERI A 575, 446 5, 714 0 0 5, 714 11.00 13.00 01300 NURSING ADMINISTRATION 995, 776 3, 312 0 0 3, 312 13.00 4, 156 4, 156 14.00 01400 CENTRAL SERVICES & SUPPLY 413, 431 0 0 14.00 01500 PHARMACY 0 15.00 1, 456, 344 2, 283 0 2, 283 15.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 109, 077 23, 511 0 1, 589 23, 511 30.00 30.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 703, 446 24, 201 0 24, 201 50.00 53.00 05300 ANESTHESI OLOGY 58, 659 457 0 0 457 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 1,841,650 12, 537 0 12, 537 54.00 60.00 06000 LABORATORY 0 5, 139 1, 871, 236 5, 139 60 00 0 65.00 06500 RESPIRATORY THERAPY 884, 699 300 0 300 65.00 06600 PHYSI CAL THERAPY 3, 972 66.00 1,062,365 1,607 0 0 0 0 0 0 5, 579 66.00 1, 092 1, 534 67 00 06700 OCCUPATIONAL THERAPY 326.573 67 00 442 06800 SPEECH PATHOLOGY 68.00 56, 553 22 53 75 68.00 69. 00 06900 ELECTROCARDI OLOGY 742, 428 3, 295 0 3, 295 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 251, 455 0 0 0 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 646,073 0 72 00 C 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 169, 102 0 73.00 03480 ONCOLOGY 250, 025 0 2,002 73.01 2,002 1, 091, 193 0 73. 02 | 07301 | BLOOD DI SORDER DRUGS 0 73.02

76. 00	03160 CARDI OPULMONARY	0	o	0	O	0	76.00
76. 97	07697 CARDIAC REHABILITATION	253, 425	3, 463	0	0	3, 463	76. 97
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
	DUTPATIENT SERVICE COST CENTERS				<u>.</u>		
	09100 EMERGENCY	3, 385, 521	14, 092	0	0		91.00
⊢	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
μ.	OTHER REIMBURSABLE COST CENTERS						
⊢	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0 1	102. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	31, 493, 688	114, 370	5, 117	1, 589	114, 356 1	118. 00
-	NONREI MBURSABLE COST CENTERS						
	19200 PHYSI CI ANS' PRI VATE OFFI CES	323, 624	0	18, 222	0	18, 222 1	
	19201 OCCUPATI ONAL MEDI CI NE	166, 683	2, 025	0	0	2, 025 1	
	19202 VACANT SPACE	0	0	0	0	l l	192. 02
200.00	Cross Foot Adjustments					l l	200. 00
201.00	Negative Cost Centers					l l	201. 00
202. 00	Cost to be allocated (per Wkst. B,	6, 982, 059	6, 215, 494	0	328, 737	1, 133, 668 2	202. 00
000 00	Part I)	0.010000	F0 400000	0.000000	00/ 000045	0 400000	200 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 218299	53. 400009	0. 000000	206. 882945	8. 422309 2	
204.00	Cost to be allocated (per Wkst. B,	213, 565	840, 412	O	78, 893	52, 930 2	204. 00
205 00	Part II)	0. 006677	7. 220345	0. 000000	49. 649465	0. 393230 2	005 00
205. 00	Unit cost multiplier (Wkst. B, Part	0.006677	7. 220345	0.000000	49. 649465	0. 393230 2	205. 00
206.00	NAHE adjustment amount to be allocated					2	206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,					2	207. 00
	Parts III and IV)						

Heal th	Financial Systems	IU HEALTH TIPTO	ON HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		eri od:	Worksheet B-1	
				FI	rom 01/01/2023 0 12/31/2023	Date/Time Pre	nared.
					1270172020	5/29/2024 2: 2	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(FTE' S)	ADMI NI STRATI ON	SERVICES &	(COSTED	
				(0) 0507	SUPPLY	REQUIS.)	
				(DI RECT	(COSTED		
		10.00	11. 00	NURSI NG HOURS) 13.00	REQUIS.) 14. 00	15. 00	
	GENERAL SERVICE COST CENTERS	10.00	11.00	13.00	14.00	15.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT - INTERES						1. 01
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - OFFSITE						7. 01
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	6, 442	44 000				10.00
11.00	01100 CAFETERI A	0	11, 080				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	564		1 212 040		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	755	1	1, 313, 848	F 242 22F	14.00
15. 00	01500 PHARMACY	J U	755	0	2, 568	5, 342, 335	15. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	6, 439	1, 673	27 701	25 220	15 021	30.00
30.00	ANCI LLARY SERVI CE COST CENTERS	0, 439	1,073	37, 701	35, 338	15, 831	30.00
50. 00	05000 OPERATING ROOM	0	1, 293	20, 548	258, 035	16, 402	50.00
53. 00	05300 ANESTHESI OLOGY		1, 2/3		230, 033	0, 402	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		1, 321	1	7, 405	4, 919	
60.00	06000 LABORATORY		933		28, 422	0	
65. 00	06500 RESPI RATORY THERAPY	o	717		26, 438	0	
66.00	06600 PHYSI CAL THERAPY	0	934		836	0	•
67.00	06700 OCCUPATI ONAL THERAPY	0	267	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	47	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	587	2, 873	2, 651	1, 410	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	251, 455	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	646, 073	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	4, 169, 102	1
73. 01	03480 ONCOLOGY	0	216		5, 683	8, 232	
73. 02	07301 BLOOD DI SORDER DRUGS	0	0	0	0	1, 091, 193	1
76.00	03160 CARDI OPULMONARY	0	100	0	240	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	190	1	248	0	1
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	1	0	0	
76.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		ų o	<u> </u>		78.00
91. 00	09100 EMERGENCY	3	1, 372	19, 828	47, 309	35, 246	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1, 372	17,020	47, 307	33, 240	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						/2.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	C	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS	<u> </u>		,	<u> </u>		102.00
118.00		6, 442	10, 869	88, 164	1, 312, 461	5, 342, 335	118.00
	NONREI MBURSABLE COST CENTERS	2,	,		., ,	27 0 127 000	1
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	98	0	289	0	192. 00
	19201 OCCUPATIONAL MEDICINE	O	113	728	1, 098	0	192. 01
192. 02	19202 VACANT SPACE	0	0	o	0		192. 02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	498, 611	1, 054, 318	1, 471, 576	760, 616	1, 988, 731	202.00
	Part I)						
203.00		77. 400031	95. 155054		0. 578922	0. 372259	
204.00	***	68, 758	145, 200	96, 662	105, 328	77, 223	204. 00
	Part II)						
205.00		10. 673393	13. 104693	1. 087409	0. 080168	0. 014455	205.00
201 01	NAUF adjustment amount to be allegated						204 00
206.00							206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
201.00	Parts III and IV)						207.00
	1 - 1	, 1			ļ		1

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:2	pared: 8 pm
		Title	XVIII	Hospi tal	Cost	
·				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
				_	_	1

			7,111	Costs		
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 CENTER						
30. 00 03000 ADULTS & PEDIATRICS	5, 659, 780		5, 659, 780	0	0	30.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	5, 408, 456		5, 408, 456	0	0	50.00
53. 00 05300 ANESTHESI OLOGY	99, 717		99, 717	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 161, 374		3, 161, 374	0	0	54.00
60. 00 06000 LABORATORY	2, 702, 664		2, 702, 664	0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 179, 907	0	1, 179, 907	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 516, 439	0	1, 516, 439	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	459, 793	0	459, 793	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	75, 177	0	75, 177	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 213, 682		1, 213, 682	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	TLENT 451, 920		451, 920	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 161, 135		1, 161, 135	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 631, 198		6, 631, 198	0	0	73. 00
73. 01 03480 ONCOLOGY	520, 687		520, 687	0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	1, 735, 605		1, 735, 605	0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0		0	0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	584, 268		584, 268	0	0	76. 97
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						
91. 00 09100 EMERGENCY	5, 495, 317		5, 495, 317	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 809, 065		809, 065		0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0		0		0	102. 00
200.00 Subtotal (see instructions)	38, 866, 184	0	38, 866, 184	0	0	200. 00
201.00 Less Observation Beds	809, 065		809, 065		0	201. 00
202.00 Total (see instructions)	38, 057, 119	0	38, 057, 119	0	0	202. 00

Health Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:2	pared: 8 pm
		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	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 736, 037		5, 736, 03	7		30.00
ANCILLARY SERVICE COST CENTERS				<u> </u>		1
50, 00 05000 OPERATING ROOM	1 021 705	24 253 482	25 275 18	7 0 213983	0.000000	1 50 00

cost center bescription	Піраттепт	outpatrent	+ col . 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 736, 037		5, 736, 037			30.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 021, 705	24, 253, 482	25, 275, 187	0. 213983	0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	46, 332	1, 737, 463	1, 783, 795	0. 055902	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	498, 610	12, 651, 605	13, 150, 215	0. 240405	0.000000	54.00
60. 00 06000 LABORATORY	889, 559	6, 903, 875	7, 793, 434	0. 346787	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	653, 605	1, 428, 694	2, 082, 299	0. 566637	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	512, 257	2, 808, 887	3, 321, 144	0. 456601	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	265, 646	699, 335	964, 981	0. 476479	0.000000	67. 00
68.00 06800 SPEECH PATHOLOGY	49, 130	82, 746	131, 876	0. 570058	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	459, 367	5, 594, 343	6, 053, 710	0. 200486	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	127, 460	2, 098, 759	2, 226, 219	0. 202999	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 214, 235	7, 889, 554	9, 103, 789	0. 127544	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 648, 051	20, 849, 075	22, 497, 126	0. 294758	0.000000	73.00
73. 01 03480 0NCOLOGY	482	2, 972, 579	2, 973, 061	0. 175135	0.000000	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0	9, 599, 721	9, 599, 721	0. 180797	0.000000	73. 02
76. 00 03160 CARDI OPULMONARY	0	0	0	0.000000	0.000000	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	794, 751	794, 751	0. 735159	0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0.000000	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0.000000	0. 000000	78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	301, 651	16, 693, 610		l l	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 974	1, 877, 931	1, 879, 905	0. 430375	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0			102. 00
200.00 Subtotal (see instructions)	13, 426, 101	118, 936, 410	132, 362, 511			200. 00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	13, 426, 101	118, 936, 410	132, 362, 511			202. 00

Health Financial Systems	IU HEALTH TIPTO	N HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1311	From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prep 5/29/2024 2:28	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				

Title XVIII Hospital Cost					5/29/2024 2:28 pm
NPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.0ULTS & PEDI ATRI CS 30.00 30.00 30.0ULTS & PEDI ATRI CS 30.00 30.00 30.0ULTS & PEDI ATRI CS 30.00			Title XVIII	Hospi tal	Cost
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30000 ADULTS & PEDIATRICS 30.00 30000 ADULTS & PEDIATRICS 30.00 30000 ADULTS & PEDIATRICS 50.00 300000 30000 ADULTS & PEDIATRICS 50.00000 50.00000 50.00000 50.00000 60.00 60.00	Cost Center Description	PPS Inpatient			
IMPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 ADULTS & PEDIATRICS 50.00 50.0000 50.0000 50.00000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.00000 50.0000 50.0000 50.0000 50.0000 50.0000 50.0000 50.000000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.00000 50.0000000 50.0000000 50.00000000 50.0000000 50.0000000 50.0000000 50.0000000 50.0000					
30. 00		11. 00			
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM 0.000000 53. 00 05300 AMESTHESI DLOGY 0.000000 54. 00 05400 RADI OLOGY-DI AGNOSTIC 0.000000 54. 00 06400 RADI OLOGY-DI AGNOSTIC 0.000000 65. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 06500 RESPI RATORY THERAPY 0.000000 66. 00 06600 PHSTI CAL THERAPY 0.000000 66. 00 06600 PHSTI CAL THERAPY 0.000000 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 68. 00 06800 SPEECH PATHOLOGY 0.000000 68. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.000000 73. 00 73. 00 73.0					30.00
53. 00 05300 ANESTHESI OLOGY 0.000000 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 60. 00 60. 00 06000 LABORATORY 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 67. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.000000 68. 00 68. 00 06800 SPECEH PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 72. 00 73. 01 03480 ONCOLOGY 0.000000 73. 00 76. 00 03160 CARDI OPULMONARY 0.000000 73. 00 77. 00 07697 CARDI AC REHABI LI TATI ON 0.000000 76. 97 77. 00 07700 LALOGENEI C HSCT ACQUI SI TI ON 0.000000 77. 00 78. 00 07700 LALOGENEI C HSCT ACQUI SI TI ON 0.000000 77. 00 78. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 92. 00					
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0.000000 0.000000 0.00000 0.000000 0.000000 0.000000 0.000000 0.0000000 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 0.000000 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 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		1			
60. 00 06000 LABORATORY 0. 000000 65. 00 65. 00 66. 00 06500 RESPI RATORY THERAPY 0. 000000 65. 00 06600 PHYSI CAL THERAPY 0. 000000 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 68. 00 06800 SPEECH PATHOLOGY 0. 000000 68. 00 06900 ELECTROCARDI OLOGY 0. 000000 071. 00 07100 MeDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 072. 00 1MPL DEV. CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 0000000 0. 0000000 0. 000000 0. 0000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0.		1			
65. 00		1			
66. 00 06600 PHYSICAL THERAPY 0. 0.000000 67. 00 67. 00 667. 00 06700 0CCUPATIONAL THERAPY 0. 0.000000 67. 00 6800 SPEECH PATHOLOGY 0. 0.000000 68. 00 69. 0					
67. 00					65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0. 000000			
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
71. 00	68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 01 03480 ONCOLOGY 0. 000000 73. 01 03480 ONCOLOGY 0. 000000 73. 01 03. 02 07301 BLOOD DI SORDER DRUGS 0. 000000 73. 02 03160 CARDI OPULMONARY 0. 0. 000000 76. 00 076. 97 076. 97 CARDI AC REHABILI TATI ON 0. 000000 76. 97 077. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 00000 00000 00000 00000 000000	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 73. 01 03480 ONCOLOGY 0. 000000 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0. 000000 73. 02 76. 00 03160 CARDI OPULMONARY 0. 0. 000000 76. 97 07697 CARDI AC REHABILI TATI ON 0. 000000 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 78. 00 00000 0000 00000 00000 00000 00000 0000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
73. 01 03480 ONCOLOGY 0.000000 73. 01 73. 02 07301 BLOOD DI SORDER DRUGS 0.000000 73. 02 76. 00 03160 CARDI OPULMONARY 0.000000 76. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 77. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78. 00 OUTPATI ENT SERVI CE COST CENTERS 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 92. 00 OTHER REI MBURSABLE COST CENTERS 102. 00 10200 OPI OI D TREATMENT PROGRAM 92. 00 Subtotal (see instructions) Less Observation Beds 201. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73. 02 76. 00 76. 00 76. 00 76. 07 77. 00 77. 00 77. 00 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 00000 00000 000000 000000 000000	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03160 CARDI OPULMONARY 0.000000 76. 97 76. 97 77. 97 77. 97 77. 98 77. 90 7	73. 01 03480 ONCOLOGY	0. 000000			73. 01
76. 97 77. 00 77. 00 77. 00 77. 00 78	73. 02 07301 BLOOD DI SORDER DRUGS	0. 000000			73. 02
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0.000000 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78. 00 000000 000000 000000 000000 000000	76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0. 000000 78. 00 000000 000000 000000 0000000 000000	76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS O. 000000 91. 00 O9100 EMERGENCY O. 000000 O9200 OBSERVATION BEDS (NON-DISTINCT PART O. 000000 OTHER REIMBURSABLE COST CENTERS O10.00 O10200 OPIOID TREATMENT PROGRAM O10.00 OUTPATIENT OUTP	77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
91. 00	78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0THER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00 201.	OUTPATIENT SERVICE COST CENTERS				
OTHER REI MBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 200.00 Subtotal (see instructions) 200.00 201.00 Less Observation Beds 201.00	91. 00 09100 EMERGENCY	0. 000000			91. 00
102. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OTHER REIMBURSABLE COST CENTERS				
201. 00 Less Observation Beds 201. 00	102.00 10200 OPIOID TREATMENT PROGRAM			·	102. 00
	200.00 Subtotal (see instructions)				200. 00
202. 00 Total (see instructions) 202. 00	201.00 Less Observation Beds				201. 00
	202.00 Total (see instructions)				202. 00

llaal +b	Financial Customs	IU HEALTH TIP	TON HOODITAL		المانا	eu of Form CMS-2	DEED 10
	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	TO HEALTH TIP	Provider CO	CN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I	pared:
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	5, 659, 780		5, 659, 78	30 0	5, 659, 780	30. 00
	ANCILLARY SERVICE COST CENTERS					1	
	05000 OPERATING ROOM	5, 408, 456		5, 408, 4!		5, 408, 456	
	05300 ANESTHESI OLOGY	99, 717		99, 7		99, 717	
	05400 RADI OLOGY-DI AGNOSTI C	3, 161, 374		3, 161, 3		3, 161, 374	
	06000 LABORATORY	2, 702, 664		2, 702, 6		2, 702, 664	
	06500 RESPI RATORY THERAPY	1, 179, 907		1, 179, 90		1, 179, 907	1
	06600 PHYSI CAL THERAPY	1, 516, 439		1, 516, 4		1, 516, 439	
	06700 OCCUPATI ONAL THERAPY	459, 793		459, 79		459, 793	
	06800 SPEECH PATHOLOGY	75, 177		75, 1		75, 177	
	06900 ELECTROCARDI OLOGY	1, 213, 682		1, 213, 68		1, 213, 682	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	451, 920		451, 93		451, 920	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 161, 135		1, 161, 1	35 0	1, 161, 135	/2.00

6, 631, 198

1, 735, 605

5, 495, 317

38, 866, 184

38, 057, 119

809, 065

809, 065

520, 687

584, 268

0

6, 631, 198

1, 735, 605

5, 495, 317

38, 866, 184

38, 057, 119

0

809, 065

809, 065

520, 687

584, 268

0

0

6, 631, 198

1, 735, 605

5, 495, 317

809, 065

38, 866, 184 200. 00

38, 057, 119 202. 00

809, 065 201. 00

520, 687

584, 268

0

0

0 78.00

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73.00

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76. 97

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0 102. 00

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73.02

76.00

76. 97

78.00

91.00

92.00

200.00

201.00

202.00

07300 DRUGS CHARGED TO PATIENTS

07301 BLOOD DI SORDER DRUGS

07697 CARDIAC REHABILITATION

07800 CAR T-CELL IMMUNOTHERAPY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS
102. 00 10200 OPI 0I D TREATMENT PROGRAM

Less Observation Beds

Total (see instructions)

09200 OBSERVATION BEDS (NON-DISTINCT PART

Subtotal (see instructions)

77.00 07700 ALLOGENEIC HSCT ACQUISITION

03160 CARDI OPULMONARY

03480 ONCOLOGY

09100 EMERGENCY

Heal th	Financial Systems	IU HEALTH TIPT	ON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:2	epared: 28 pm
			Ti tl	le XIX	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
		·		+ col. 7)	Ratio	I npati ent	
				·		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 736, 037		5, 736, 03	7		30.00
Ī	ANCLLLADY SEDVICE COST CENTEDS	•		•			1

		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 736, 037		5, 736, 037			30. 00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	1, 021, 705	24, 253, 482			0.000000	50.00
53. 00 05300 ANESTHESI OLOGY	46, 332	1, 737, 463	1, 783, 795	0. 055902	0.000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	498, 610	12, 651, 605	13, 150, 215	0. 240405	0.000000	54. 00
60. 00 06000 LABORATORY	889, 559	6, 903, 875	7, 793, 434	0. 346787	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	653, 605	1, 428, 694	2, 082, 299	0. 566637	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	512, 257	2, 808, 887	3, 321, 144	0. 456601	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	265, 646	699, 335	964, 981	0. 476479	0.000000	67.00
68. 00 06800 SPEECH PATHOLOGY	49, 130	82, 746	131, 876	0. 570058	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	459, 367	5, 594, 343	6, 053, 710	0. 200486	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	127, 460	2, 098, 759	2, 226, 219	0. 202999	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 214, 235	7, 889, 554	9, 103, 789	0. 127544	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 648, 051	20, 849, 075	22, 497, 126	0. 294758	0.000000	73. 00
73. 01 03480 ONCOLOGY	482	2, 972, 579	2, 973, 061	0. 175135	0.000000	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0	9, 599, 721	9, 599, 721	0. 180797	0.000000	73. 02
76. 00 03160 CARDI OPULMONARY	0	0	0	0. 000000	0.000000	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	794, 751	794, 751	0. 735159	0.000000	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0. 000000	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0. 000000	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>					
91. 00 09100 EMERGENCY	301, 651	16, 693, 610	16, 995, 261	0. 323344	0.000000	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 974	1, 877, 931	1, 879, 905	0. 430375	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0			102. 00
200.00 Subtotal (see instructions)	13, 426, 101	118, 936, 410	132, 362, 511		ļ	200. 00
201.00 Less Observation Beds					ļ	201. 00
202.00 Total (see instructions)	13, 426, 101	118, 936, 410	132, 362, 511		ļ	202. 00
			•		'	•

Health Financial Systems	IU HEALTH TIPTO	N HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/29/2024 2:2	
		Title XIX	Hospi tal	PPS	
0 1 0 1 D : 1:	DDC I II I				

			10 12/31/2023	5/29/2024 2: 28 pm
		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 OPERATING ROOM	0. 213983			50. 00
53. 00 05300 ANESTHESI OLOGY	0. 055902			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 240405			54.00
60. 00 06000 LABORATORY	0. 346787			60.00
65. 00 06500 RESPI RATORY THERAPY	0. 566637			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 456601			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 476479			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 570058			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 200486			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 202999			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 127544			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 294758			73.00
73. 01 03480 ONCOLOGY	0. 175135			73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 180797			73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 735159			76. 97
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				
91. 00 09100 EMERGENCY	0. 323344			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 430375			92.00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPI OI D 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
	'			· ·

				'	0 12/31/2023	5/29/2024 2: 2	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
	WALL ABY OFFILE OF SOAT OFFITEDS	1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	F 400 45/	(7/ 070	4 704 407			F0 00
	D5000 OPERATING ROOM	5, 408, 456	676, 970			0	50.00
1	05300 ANESTHESI OLOGY	99, 717	11, 671			0	53. 00
	05400 RADI OLOGY - DI AGNOSTI C	3, 161, 374	341, 969			0	54. 00
	06000 LABORATORY	2, 702, 664	153, 828			0	60.00
	06500 RESPI RATORY THERAPY	1, 179, 907	25, 771			0	65. 00
	06600 PHYSI CAL THERAPY	1, 516, 439				0	66. 00
	06700 OCCUPATI ONAL THERAPY	459, 793	31, 645			0	67. 00
	06800 SPEECH PATHOLOGY	75, 177	2, 313			0	68. 00
	06900 ELECTROCARDI OLOGY	1, 213, 682	98, 086			0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	451, 920	21, 838			0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	1, 161, 135	56, 106			0	72. 00
1	D7300 DRUGS CHARGED TO PATIENTS	6, 631, 198	88, 102			0	73. 00
	03480 ONCOLOGY	520, 687	59, 001	1		0	73. 01
	07301 BLOOD DI SORDER DRUGS	1, 735, 605	23, 059	1, 712, 546	0	0	73. 02
1	03160 CARDI OPULMONARY	0	0	0	0	0	76. 00
	07697 CARDI AC REHABI LI TATI ON	584, 268	92, 706	491, 562	0	0	76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS		115.051		1		
	09100 EMERGENCY	5, 495, 317	415, 851			0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	809, 065	115, 742	693, 323	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
1	10200 OPIOID TREATMENT PROGRAM	0	0 000 01	0	_		102. 00
200.00	Subtotal (sum of lines 50 thru 199)	33, 206, 404	2, 328, 316				200.00
201.00	Less Observation Beds	809, 065	115, 742				201. 00
202. 00	Total (line 200 minus line 201)	32, 397, 339	2, 212, 574	30, 184, 765	0	0	202. 00

Health Financial Systems

IU HEALTH TIPTON HOSPITAL

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

In Lieu of Form CMS-2552-10

Provider CCN: 15-1311

Period: From 01/01/2023 70 12/31/2023 Date/Time Prepared:

				10 12/31/2023	5/29/2024 2: 2	:pareu. !8 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to Charg	e		
	Operating Cost					
	Reduction	8)	/ col. 7)			
	6.00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						4
50. 00 05000 OPERATI NG ROOM	5, 408, 456	25, 275, 187				50. 00
53. 00 05300 ANESTHESI OLOGY	99, 717	1, 783, 795				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 161, 374	13, 150, 215				54. 00
60. 00 06000 LABORATORY	2, 702, 664	7, 793, 434				60.00
65. 00 06500 RESPI RATORY THERAPY	1, 179, 907	2, 082, 299	•			65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 516, 439	3, 321, 144	•			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	459, 793	964, 981				67. 00
68.00 06800 SPEECH PATHOLOGY	75, 177	131, 876	•			68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 213, 682	6, 053, 710	l .			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	451, 920	2, 226, 219				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 161, 135	9, 103, 789				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	6, 631, 198	22, 497, 126				73. 00
73. 01 03480 0NC0L0GY	520, 687	2, 973, 061				73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	1, 735, 605	9, 599, 721				73. 02
76. 00 03160 CARDI OPULMONARY	0	0	0.0000	0		76. 00
76. 97 07697 CARDIAC REHABILITATION	584, 268	794, 751				76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0		77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0		78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	5, 495, 317	16, 995, 261	0. 32334	4		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	809, 065	1, 879, 905	0. 43037	5		92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0.00000	0		102. 00
200.00 Subtotal (sum of lines 50 thru 199)	33, 206, 404	126, 626, 474				200. 00
201.00 Less Observation Beds	809, 065	0				201. 00
202.00 Total (line 200 minus line 201)	32, 397, 339	126, 626, 474				202. 00

	Financial Systems	IU HEALTH TIP				eu of Form CMS-2	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
					From 01/01/2023 To 12/31/2023		narod:
					10 12/31/2023	5/29/2024 2: 2	
-			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 OPERATI NG ROOM	676, 970	25, 275, 187	0. 02678	469, 465	12, 574	50.00
53.00	05300 ANESTHESI OLOGY	11, 671	1, 783, 795	0. 00654	3 21, 075	138	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	341, 969	13, 150, 215	0. 02600	203, 280	5, 286	54.00
60.00	06000 LABORATORY	153, 828	7, 793, 434	0. 01973			60.00
65.00	06500 RESPI RATORY THERAPY	25, 771	2, 082, 299	0. 01237	76 304, 768	3, 772	65. 00
66.00	06600 PHYSI CAL THERAPY	113, 658	3, 321, 144	0. 03422	243, 576	8, 336	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	31, 645	964, 981	0. 03279	129, 665	4, 252	67. 00
68.00	06800 SPEECH PATHOLOGY	2, 313	131, 876	0. 01753	25, 768	452	68. 00
69. 00	06900 ELECTROCARDI OLOGY	98, 086	6, 053, 710	0. 01620	198, 055	3, 209	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 838	2, 226, 219	0.00980	9 64, 002	628	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	56, 106	9, 103, 789	0. 00616	599, 430	3, 694	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	88, 102	22, 497, 126	0. 00391	6 773, 762	3, 030	73.00
73. 01	03480 ONCOLOGY	59, 001	2, 973, 061	0. 01984	5 0	0	73. 01
73. 02	07301 BLOOD DI SORDER DRUGS	23, 059	9, 599, 721	0.00240	0	0	73. 02
76. 00	03160 CARDI OPULMONARY	0	0	0. 00000	0 0	0	76. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	92, 706	794, 751	0. 11664	8	0	76. 97
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
70 00	07800 CAR T CELL IMMUNOTHERARY		l	0 00000	0	l	70 00

415, 851 115, 742

2, 328, 316

16, 995, 261 1, 879, 905 126, 626, 474

0.000000

0. 024469

0. 061568

9, 590

3, 452, 545

235 91.00

53, 701 200. 00

0 92.00

78.00

78. 00 07800 CAR T-CELL IMMUNOTHERAPY
OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

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

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATI THROUGH COSTS	ENT ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

					To 12/31/2023	Date/Time Pre 5/29/2024 2:2	pared: 8 pm
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZN	2.00	JA .	3.00	
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
53. 00	05300 ANESTHESI OLOGY	0	Ö	i	0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	O		0 0	0	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0)	0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0)	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0	0	73. 00
	03480 ONCOLOGY	0	0	1	0	0	73. 01
	07301 BLOOD DI SORDER DRUGS	0	0		0	0	73. 02
	03160 CARDI OPULMONARY	0	0		0	0	76.00
	O7697 CARDI AC REHABILITATION O7700 ALLOGENEI C HSCT ACQUISITION	0	0		0	0	76. 97 77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	78.00
76.00	OUTPATIENT SERVICE COST CENTERS		<u> </u>	1	0 0	0	70.00
91. 00	09100 EMERGENCY				0 0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		١		n o	n	92. 00
200.00	,	Ö	O		o o	0	200. 00

	5		FON HOODI TAI			C.E. OHC	2550 40	
Health Financial Systems IU HEALTH TIPTON HOSPITAL In Lieu of Form CMS-255 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1311 Period: Worksheet D							2552-10	
		WICE UTHER PASS	s Provider C		Period: From 01/01/2023	Worksheet D Part IV		
THROU	SH COSTS				To 12/31/2023		pared:	
						5/29/2024 2: 2	8 pm	
				XVIII	Hospi tal	Cost		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,			
		Education Cost		Cost (sum of		(col. 5 ÷ col.		
			4)	col s. 2, 3,	8)	7)		
				and 4)		(see		
						instructions)		
	I	4.00	5. 00	6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS			T	05 075 407			
50. 00	05000 OPERATING ROOM	0	0		0 25, 275, 187	l	1	
53. 00	05300 ANESTHESI OLOGY	0	0		0 1, 783, 795	l		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 13, 150, 215	l		
60.00	06000 LABORATORY	0	0		0 7, 793, 434	l .		
65. 00	06500 RESPI RATORY THERAPY	0	0		0 2, 082, 299	l .	1	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 3, 321, 144	l .		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 964, 981	l		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 131, 876	l		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 6, 053, 710	l		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 226, 219	l e		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 9, 103, 789	l e	1	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 22, 497, 126	l e	1	
73. 01	03480 ONCOLOGY	0	0		0 2, 973, 061		1	
73. 02	07301 BLOOD DI SORDER DRUGS	0	0		0 9, 599, 721			
76. 00	03160 CARDI OPULMONARY	0	0		0 0	0.000000	76. 00	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 794, 751	0.000000		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0.000000		
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0.000000	78. 00	

0 0 0

0 0 0

91.00

92.00

200. 00

0.000000

0.000000

16, 995, 261 1, 879, 905 126, 626, 474

0 0 0

78. 00 07800 CAR T-CELL IMMUNOTHERAPY
OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

91. 00 09100 EMERGENCY

Health Financial Systems	IU HEALTH TIPTO	N HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provi der CO	1	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 2:2	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		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	469, 465		0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	21, 075		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	203, 280		0	0	
60. 00 06000 LABORATORY	0. 000000	410, 109		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	304, 768		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	243, 576		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	129, 665		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	25, 768		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	198, 055		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	64, 002		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	599, 430		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	773, 762		0	0	73. 00
73. 01 03480 ONCOLOGY	0. 000000	0		0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 000000	0		0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0	0	76. 97
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	78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	9, 590		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	92. 00
200.00 Total (lines 50 through 199)		3, 452, 545		0	0	200. 00

Health Financial Systems	IU HEALTH TIP	TON_HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der CO	CN: 15-1311	Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/29/2024 2:2	pared:
		Title	XVIII	Hospi tal	Cost	.о рііі
			Charges	<u> </u>	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 213983		.,		0	
53. 00 05300 ANESTHESI OLOGY	0. 055902	l .	123, 18		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 240405		2, 873, 86		0	
60. 00 06000 LABORATORY	0. 346787		1, 347, 43	0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 566637	0	346, 20		0	00.00
66. 00 06600 PHYSI CAL THERAPY	0. 456601	0	905, 02	21 0	0	00.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 476479	0	190, 22	24 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 570058	0	15, 3°	14 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 200486	0	1, 567, 40	57 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 202999	0	477, 02	23 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 127544	0	2, 685, 44	15 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 294758	0	8, 699, 48	140	0	73. 00
73. 01 03480 ONCOLOGY	0. 175135	0	1, 348, 17	77 0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 180797	0		0 0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76. 00
76. 97 07697 CARDIAC REHABILITATION	0. 735159	0	296, 23	38 0	0	76. 97
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						
91. 00 09100 EMERGENCY	0. 323344	0	3, 288, 08	1, 030	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 430375	0	238, 39	95 0	0	92.00
200.00 Subtotal (see instructions)		0	28, 000, 43	1, 170	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	28, 000, 43	1, 170	0	202. 00

				From 01/01/2023 To 12/31/2023	Part V Date/Time Pre 5/29/2024 2:2	
			XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
ANOULL ADV. CEDVILOE COCT. CENTEDS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	770 004					
50. 00 05000 OPERATING ROOM	770, 084		1			50.00
53. 00 05300 ANESTHESI OLOGY	6, 886	l .	1			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	690, 890	l .	2			54.00
60. 00 06000 LABORATORY	467, 274	l .	2			60.00
65. 00 06500 RESPI RATORY THERAPY	196, 208	l .	2			65. 00
66. 00 06600 PHYSI CAL THERAPY	413, 233	l .)			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	90, 638)			67. 00
68. 00 06800 SPEECH PATHOLOGY	8, 730	l e	1			68. 00
69. 00 06900 ELECTROCARDI OLOGY	314, 255	l e	1			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	96, 835	l e	1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	342, 512	l e	1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 564, 242		1			73. 00
73. 01 03480 ONCOLOGY	236, 113	l	1			73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0	0)			73. 02
76. 00 03160 CARDI OPULMONARY	0	0)			76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	217, 782	ł .	1			76. 97
77.00 O7700 ALLOGENEIC HSCT ACQUISITION	0	0	1			77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0)			78. 00
OUTPATIENT SERVICE COST CENTERS			Г			
91. 00 09100 EMERGENCY	1, 063, 184	l e	1			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	102, 599		1			92.00
200.00 Subtotal (see instructions)	7, 581, 465	374				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	7, 581, 465	374	·			202. 00

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider Co		Period: From 01/01/2023 To 12/31/2023		
		Ti tl	e XIX	Hospi tal	PPS	<u>о р</u>
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26) 1. 00	2.00	2)	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 ADULTS & PEDIATRICS	809, 666	46, 342	763, 32	4 1, 873	407. 54	30.00
200.00 Total (lines 30 through 199)	809, 666		763, 32	4 1, 873		200. 00
Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS		2 2/2				00.00
30.00 ADULTS & PEDIATRICS 200.00 Total (lines 30 through 199)	8		1			30. 00 200. 00

Health Financial Systems	IU HEALTH TIP	TON HOSDITAL		ln lio	u of Form CMS-2	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provider C	^N: 15 1211 I	Period:	Worksheet D	2552-10
APPORTIONWENT OF INPATTENT ANGILLARY SERVICE CAPITA	L C0313	Provider C		From 01/01/2023		
				Γο 12/31/2023	Date/Time Pre	pared:
					5/29/2024 2: 2	8 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		7	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	T					
50.00 05000 OPERATING ROOM	676, 970				0	50. 00
53. 00 05300 ANESTHESI OLOGY	11, 671		•		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	341, 969					54. 00
60. 00 06000 LABORATORY	153, 828		0. 01973	5, 034	99	60.00
65. 00 06500 RESPI RATORY THERAPY	25, 771	2, 082, 299	0. 01237	7, 224	89	65. 00
66. 00 06600 PHYSI CAL THERAPY	113, 658	3, 321, 144	0. 03422	1, 227	42	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	31, 645	964, 981	0. 032793	630	21	67. 00
68. 00 06800 SPEECH PATHOLOGY	2, 313	131, 876	0. 01753	9 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	98, 086	6, 053, 710	0. 01620	256	4	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	21, 838	2, 226, 219	0. 00980	329	3	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	56, 106	9, 103, 789	0. 00616	3	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	88, 102	22, 497, 126	0. 00391	25, 369	99	73. 00
73. 01 03480 ONCOLOGY	59, 001	2, 973, 061	0. 01984	482	10	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	23, 059	9, 599, 721	0. 00240	0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0	0	0. 00000	o o	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	92, 706	794, 751	0. 11664		0	76. 97
77 00 07700 ALLOCENELC USCT ACQUISTION	1	1	0.00000			77 00

415, 851 115, 742

2, 328, 316

16, 995, 261 1, 879, 905 126, 626, 474

0.000000

0.000000

0.024469

0.061568

6, 052

47, 169

77.00

0

0 78.00

148 91.00

530 200. 00

0 92.00

77. 00 07700 ALLOGENEIC HSCT ACQUISITION

78. 00 07800 CAR T-CELL IMMUNOTHERAPY

OUTPATIENT SERVICE COST CENTERS
91. 00 09100 EMERGENCY

200.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Li€	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	Nursing Program Post-Stepdown Adjustments	Nursi ng Program	Adjustments	Allied Health Cost	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, 87 1, 87			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 T	I PTON HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/O THROUGH COSTS	UTPATIENT ANCILLARY SERVICE OTHER P.	ASS Provi der CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prepared:

				To 12/31/2023	Date/Time Pre 5/29/2024 2:2	
		Ti tl	e XIX	Hospi tal	PPS	о рііі
Cost Center Description	Non Physician		Nursi ng		Allied Health	
· ·	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
73. 01 03480 ONCOLOGY	0	0		0	0	73. 01
73. 02 07301 BL00D DI SORDER DRUGS	0	0		0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0	0		0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
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
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0	0		0		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	/
200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Heal th Financial Systems IU HEALTH TIPTON HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1311 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 2: 28 pm PS Cost Center Description All Other Medical Education Cost (sum of cols. Cost (sum of cols. 2, 3, and 4) ANCILLARY SERVICE COST CENTERS In Lieu of Form CMS-2552-10 Worksheet D Part IV Date/Time Prepared: 5/29/2024 2: 28 pm PS Cost (sum of cols. Cost (sum of cols. 2, 3, and 4) ANCILLARY SERVICE COST CENTERS
THROUGH COSTS From 01/01/2023 To 12/31/2023 To 12/31/2
Title XIX Hospital Prepared: 5/29/2024 2:28 pm
Title XIX Hospital PPS Cost Center Description All Other Medical Education Cost (sum of cols. 2, 3, and 4) All Other Medical Education Cost (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 3, and 4) All Other Medical (sum of cols. 4, a
Cost Center Description All Other Medical (sum of cols. Education Cost 4) All Other Medical (sum of cols. 2, 3, and 4) All Other Medical (sum of cols. 2, 3,
Medical (sum of cols. Outpatient (from Wkst. C, to Charges Cost (sum of cols. 2, 3, and 4) (see instructions)
Education Cost 1, 2, 3, and Cost (sum of cols. 2, 3, and 4)
4) cols. 2, 3, 8) 7) (see instructions) 4.00 5.00 6.00 7.00 8.00
and 4) (see instructions) 4.00 5.00 6.00 7.00 8.00
4.00 5.00 6.00 7.00 8.00
4.00 5.00 6.00 7.00 8.00
IANCLILIARY SERVICE COST CENTERS
50. 00 05000 OPERATI NG ROOM 0 0 0 25, 275, 187 0. 000000 50. 00
53. 00 05300 ANESTHESI OLOGY 0 0 1, 783, 795 0. 000000 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 13, 150, 215 0. 000000 54. 00
60. 00 06000 LABORATORY 0 0 7, 793, 434 0. 000000 60. 00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 2, 082, 299 0. 000000 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 3, 321, 144 0. 000000 66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 0 0 964, 981 0. 000000 67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 131, 876 0. 000000 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 6, 053, 710 0. 000000 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 2, 226, 219 0.000000 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 9, 103, 789 0. 000000 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 22, 497, 126 0. 000000 73. 00
73. 01 03480 0NCOLOGY 0 0 2, 973, 061 0. 000000 73. 01
73. 02 07301 BLOOD DI SORDER DRUGS 0 0 9, 599, 721 0. 000000 73. 02
76. 00 03160 CARDI OPULMONARY 0 0 0 0. 000000 76. 00
76. 97 O 76. 97 CARDIAC REHABILITATION 0 0 794, 751 0. 000000 76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION 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

91.00

92.00

200. 00

0.000000

0.000000

16, 995, 261 1, 879, 905 126, 626, 474

0 0 0

91. 00 09100 EMERGENCY

07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	IU HEALTH TIPTO	N HOSDITAI		In lie	eu of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEITHROUGH COSTS		Provi der CC	F	Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/29/2024 2:2	pared:
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col.	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9	
	7)	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0.000000	0	() 0	0	50.00
53. 00 05300 OFERATTING ROOM 53. 00 05300 ANESTHESI OLOGY	0. 000000	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	566			0	54.00
60. 00 06000 LABORATORY	0. 000000	5, 034			0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	7, 224			0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 227		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	630		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	256		Ö	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	329		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	l c	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	25, 369		0	0	73. 00
73. 01 03480 ONCOLOGY	0. 000000	482	C	0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 000000	0		0	0	73. 02
76. 00 03160 CARDI OPULMONARY	0. 000000	0		0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	l	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	l	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 000000	6, 052	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0	1	0	0	92.00

0. 000000 0. 000000

47, 169

0 91.00 0 92.00 0 200.00

0 0 0

0

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

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2023	Part V	
				Го 12/31/2023	Date/Time Pre 5/29/2024 2:2	
		Ti tl	e XIX	Hospi tal	PPS	о рііі
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
·	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 213983		959, 74			
53. 00 05300 ANESTHESI OLOGY	0. 055902		119, 34		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 240405		81, 26		0	54. 00
60. 00 06000 LABORATORY	0. 346787		42, 68		0	60. 00
65. 00 06500 RESPI RATORY THERAPY	0. 566637	0	83		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 456601	0	24, 84		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 476479		31		0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 570058		63		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 200486		26, 56		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 202999		10, 00		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 127544		26, 09		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 294758		745, 43		0	73. 00
73. 01 03480 ONCOLOGY	0. 175135		58, 42	6 0	0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS	0. 180797			0	0	
76. 00 03160 CARDI OPULMONARY	0. 000000			0	0	76. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 735159			0	0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			0	0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
91. 00 09100 EMERGENCY	0. 323344		148, 30	2 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 430375	0		0	0	
200.00 Subtotal (see instructions)		0	2, 244, 51	5 0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	2, 244, 51	5 0	0	202. 00

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CN: 15-1311	Period: From 01/01/2023 To 12/31/2023	5/29/2024 2:	
				e XIX	Hospi tal	PPS	
		Cos					
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
	ANOLLI ADV. CEDVI OF COCT OFNITEDO	6.00	7. 00				
F0 00	ANCI LLARY SERVI CE COST CENTERS	205 270		J			
50.00	05000 OPERATING ROOM	205, 370	C				50.00
53. 00	05300 ANESTHESI OLOGY	6, 672	C				53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	19, 537					54. 00
60.00	06000 LABORATORY	14, 803					60.00
	06500 RESPI RATORY THERAPY	474					65. 00
66.00	06600 PHYSI CAL THERAPY	11, 346					66. 00
	06700 OCCUPATI ONAL THERAPY	150	(67. 00
	06800 SPEECH PATHOLOGY	363					68. 00
	06900 ELECTROCARDI OLOGY	5, 327					69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 031					71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 328	(72. 00
	07300 DRUGS CHARGED TO PATIENTS	219, 724	(73. 00
	03480 ONCOLOGY	10, 232					73. 01
	07301 BLOOD DI SORDER DRUGS	0					73. 02
	03160 CARDI OPULMONARY	0					76. 00
	07697 CARDI AC REHABI LI TATI ON	0	(76. 97
	07700 ALLOGENEIC HSCT ACQUISITION	0					77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	U	C)			78. 00
91. 00	OUTPATIENT SERVICE COST CENTERS 09100 EMERGENCY	47, 953	C	1			91.00
		47, 953	(1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	E 47 210					200.00
200. 00 201. 00		547, 310	(<u>'</u>			200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges						201.00
202. 00		547, 310	C				202. 00
202.00	INEL GHALGES (TITLE 200 - TITLE 201)	347,310	,	7			1202.00

Health Financial Systems	IU F	HEALTH TIPTON HOSPITAL		In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT	OPERATING COST	Provi der	CCN: 15-1311	From 01/01/2023	Worksheet D-1 Date/Time Prep 5/29/2024 2:28	
		Ti t	le XVIII	Hospi tal	Cost	

Cost Center Description DIVIT ALL INFORMER COMPONENTS	-		Title XVIII	Hospi tal	5/29/2024 2: 2 Cost	8 pm
IMPATENT DAYS IMPATENT DAYS Impatient days (Including private room days, and swing-bed days, excluding neaborn) 1,000		Cost Center Description	The state of the s	noop. tu.		
Impartient days (including private room days and seing-bed days, excluding neeborn) 2.03 1.00 Impartient days (including private room days, excluding swing-bed and neeborn days) 3.00 2.00 Impartient days (including private room days, excluding swing-hed and neeborn days) 1.873 2.00 Private room days (excluding swing-bed and observation bed days) 1.790 have only private room days 3.00 Private room days (excluding swing-bed and observation bed days) 1.890 3.00 1.890 3.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 2.00 2.00 2.00 3.00 3.00 2.00 2.00 3.00 3.00 2.00 3.0		PART I - ALL PROVIDER COMPONENTS			1. 00	
Impatient days (including private room days, excluding swing-bed and newborn days) 1,873 2,00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, declared and observation bed days). If you have only private room days (excluding swing-bed and observation bed days). 5.00 Smill-private room days (excluding swing-bed and observation bed days). Through December 31 of the cost room days) are room days). The cost room days (excluding private room days) are pecember 31 of the cost room days). The cost room days are pecember 31 of the cost room days are pecember 31 of the cost room days are pecember 31 of the cost room days). The cost room days are pecember 31 of the cost room days applicable to the Program (excluding swing-bed and newborn days). 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days). 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days). 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days). 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days). 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days). 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days). 13.00 Swing-bed Not type inpatient days applicable to title XVIII only (including private room days). 14.00 Macdally processary private room days applicable to services through December 31 of the cost room days. 15.00 Swing-bed Not type inpatient days applicable t						
do not complete this line. 4. 00 Self-private room days (excluding swing-bed and observation bed days) 5. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed SW frost including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total sing-bed SW type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to this line) 10. 00 Swing-bed SW type inpatient days applicable to title SW including private room days) 11. 00 Swing-bed SW type inpatient days applicable to title SW including private room days) 12. 00 Swing-bed SW type inpatient days applicable to title SW including private room days) 13. 00 Swing-bed SW type inpatient days applicable to title SW including private room days) 14. 00 Swing-bed SW type inpatient days applicable to title SW including private room days) 15. 00 Swing-bed SW type inpatient days applicable to title SW including private room days) 16. 00 Swing-bed SW type inpatient days applicable to title SW or XX only (including private room days) 17. 00 Swing-bed SW type inpatient days applicable to title SW or XX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title SW or XX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to swing-bed SW or this line) 18. 00 Swing-bed NF type inpatient days applicable to swing-bed SW or this line) 18. 00 Swing-bed NF type inpatie				vata room days		
5.00 Semi-private room days (excluding swing-bed and observation bed days) through December 31 or the cost reporting period of swing-bed SWF type inpatient days (including private room days) after December 31 or the cost of the cost reporting period of (if call endar years, enter 0 on this line)	3.00		ys). If you have only pri	vate room days,	U	3.00
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27. 00 Common		x line 20)	, , , , , , , , , , , , , , , , , , ,			
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 335, 838 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) 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) 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 37.00 2, 335, 838 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 835, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335, 836 2, 335,		,	ne 31)			ł
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38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2,848.82 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) 2,421,497 39.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY				
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) 2,421,497 39.00 40.00	20.00				2 242 22	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 inpatient routine service cost (line 39	+ line 40)		2, 421, 497	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH TIPT		CN: 15-1311	Period:	worksheet D-1	
00m 01	THE STEEL ST		Trovider o	014. 10 1011	From 01/01/2023 To 12/31/2023		
			Ti +l /	e XVIII	Hospi tal	5/29/2024 2: 2 Cost	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2. 00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units						42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 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
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3. col. 3.	line 200)			1. 00 1, 013, 435	48. 00
48. 01	Program inpatient cellular therapy acquisiti	on cost (Worksh	et D-6, Part		column 1)	0	48. 01
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48.0°)(see instruc	ctions)		3, 434, 932	49. 00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sum	of Parts I and	0	50. 00
51. 00		atient ancillary	services (fr	om Wkst. D, s	um of Parts II	О	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				0	52. 00
53. 00	Total Program inpatient operating cost exclu	ding capital rel	ated, non-phy	ysician anesth	etist, and	o o	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
	Target amount per discharge Permanent adjustment amount per discharge					0. 00 0. 00	
55. 02	Adjustment amount per discharge (contractor					0.00	
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		caet amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ring cost and tai	get amount (i	THE 50 IIITHUS	111le 53)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,	0.00	59. 00
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 \pm line 54,	or line 55 from	n prior year o	cost report, u	pdated by the	0.00	60. 00
61. 00	market basket) Continuous improvement bonus payment (if line	e 53 ÷ line 54 i	s less than 1	the lowest of	lines 55 plus	0	61. 00
	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of th	ne amount by w	vhich operatir	ıg costs (İine		
	enter zero. (see instructions)	60), 01 1 % 01	the target an	illourit (Trile 50	o), otherwise		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ant (sag instru	rtions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decer	nber 31 of the	e cost reporti	ng period (See	316, 219	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line d	64 plus line 6	55)(title XVII	I only); for	316, 219	66. 00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost re	porting period	0	67. 00
49.00	(line 12 x line 19)	_					
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after be	ecember 31 01	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rout	ine service d	cost (line 37)			70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne 70 ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applications		(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	•			N		74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	COSTS (TIOIII I	WIRSHEEL B, F	art II, Corumii		75. 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:						78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from pr		*.			79. 00
80. 00	Total Program routine service costs for compa		st limitation	n (line 78 mir	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (,					83. 00
84. 00	Program inpatient ancillary services (see in		,				84. 00
85 (N)	Illtilization review - physician compensation	(see Instruction	15.1			I .	85 00

85.00

86.00

87.00

284

2, 848. 82 88. 00 809, 065 89. 00

85. 00 86. 00 Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

Health Financial Systems	IU HEALTH TIP	TON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		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	809, 666	5, 659, 780	0. 14305	6 809, 065	115, 742	90.00
91.00 Nursing Program cost	0	5, 659, 780	0.00000	809, 065	0	91.00
92.00 Allied health cost	0	5, 659, 780	0.00000	809, 065	0	92.00
93.00 All other Medical Education	0	5, 659, 780	0.00000	809.065	0	93.00

Health Financial Systems	IU HEALTH TIPTON HOSPITAL In Lieu				u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT	OPERATING COST		Provi der	CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/29/2024 2:2	pared:
			Ti [•]	tle XIX	Hospi tal	PPS	
0 1 0 1							

		Title XIX	Hospi tal	5/29/2024 2: 2 PPS	8 pm
	Cost Center Description	TI LIE XIX	nospi tai	113	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		2, 013	1. 00
2. 00	Inpatient days (including private room days, excluding swing-b			1, 873	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4 00	do not complete this line.			4 500	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo	21 of the cost	1, 589 111	4. 00 5. 00	
3.00	reporting period	om days) trii odgir becember	31 Of the cost	111	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	29	7. 00
8. 00	Teporting period Total_swing-bed_NF_type_inpatient_days (including private room	n davs) after December 3	1 of the cost	0	8. 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	8	9. 00
10. 00	newborn days) (see instructions)	alv. (i polydina privoto r	nom doug)	0	10. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	Conty (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar ye			· ·	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost		17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	266. 32	19. 00
17.00	reporting period	s through becember 31 or	the cost	200. 32	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period	`		5 (50 700	
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	5, 659, 780 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost reporti	ng perrou (Trie	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)			7 700	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 line 19)	r 31 of the cost reporting	ng period (line	1, 123	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	, ,			
26. 00	Total swing-bed cost (see instructions)	(1: 21 -: 1: 24)		323, 942	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 335, 838	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 /	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	· line 28)		0. 000000	31.00
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin		, i	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	rrerential (line	5, 335, 838	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 848. 82	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			22, 791	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 22, 791	40.00
41. 00	Trotal Trogram general Theatrent Toutine Service Cost (TINE 39	T ITHE 40)	ı	22, 191	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2023	Worksheet D-1	
					To 12/31/2023		
			Ti tl	e XIX	Hospi tal	5/29/2024 2: 2 PPS	o piii
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		·		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						1
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			III lino 10	column 1)	16, 472 0	•
	Total Program inpatient certural therapy acquisitor Total Program inpatient costs (sum of lines of PASS THROUGH COST ADJUSTMENTS				COLUMN 1)	39, 263	
50. 00	Pass through costs applicable to Program inp.	atient routine	services (from	n Wkst. D, sum	of Parts I and	3, 260	50. 00
51.00	Pass through costs applicable to Program inpand IV) Total Program excludable cost (sum of lines!		y services (fr	rom Wkst. D, su	um of Parts II	530 3, 790	
52. 00 53. 00	Total Program excludable cost (sum of fines) Total Program inpatient operating cost exclu- medical education costs (line 49 minus line) TARGET AMOUNT AND LIMIT COMPUTATION	ding capital re	lated, non-phy	ysician anesthe	etist, and	3, 790 35, 473	
54. 00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
	Target amount (line 54 x sum of lines 55, 55					0.00	1
	Difference between adjusted inpatient operations	ing cost and ta	rget amount (I	ine 56 minus I	ine 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	ortina period e	endi na 1996.	0 0. 00	
0.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,						
51. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	which operating	g costs (line	0	61.00
52. 00	enter zero. (see instructions) Relief payment (see instructions)	,	3	· · ·		0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Dece	mber 31 of the	e cost reportir	ng period (See	0	64. 00
55. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)					0	
66. 00	Total Medicare swing-bed SNF inpatient routin CAH, see instructions	•	·	, ,	3,	0	
57. 00 58. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	· ·		·	0 .	0	
59. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			•	9 poi 100	0	
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70 0-
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of	,					70.00
72. 00	Program routine service cost (line 9 x line	71)		ŕ			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•			art II, column		74. 00 75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p					79.00
	Total Program routine service costs for compa		ost limitation	n (line 78 minu	us line 79)		80.00
31. 00 32. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81.00
33. 00	Reasonable inpatient routine service costs (* .				83. 00
34. 00	Program inpatient ancillary services (see in		`				84.00
35. 00 36. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•	,				85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS] 30.00
	Total observation bed days (see instructions	·				284	87. 00

284 87. 00 2, 848. 82 88. 00 809, 065 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	IU HEALTH TIP	TON HOSPITAL		In Lie	eu 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		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	809, 666	5, 659, 780	0. 14305	6 809, 065	115, 742	90.00
91.00 Nursing Program cost	0	5, 659, 780	0.00000	0 809, 065	0	91.00
92.00 Allied health cost	0	5, 659, 780	0.00000	0 809, 065	0	92.00
93 00 All other Medical Education	0	5 659 780	0 00000	0 809 065	0	93 00

INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1311		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Doto/Time Dro	namad.
				10 12/31/2023	Date/Time Pre 5/29/2024 2: 2	.8 pm
		Title	: XVIII	Hospi tal	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	
	TIENT ROUTINE SERVICE COST CENTERS			0.000.440		4
	O ADULTS & PEDI ATRI CS			2, 808, 642		30.00
	LLARY SERVICE COST CENTERS O OPERATING ROOM		0.2120	22 4/0 4/5	100 450	1 0
	IO ANESTHESI OLOGY		0. 21398 0. 05590			
	IO ANESTRESI OLOGY IO RADI OLOGY-DI AGNOSTI C		0.05590			
	O LABORATORY		0. 24040			
	O RESPIRATORY THERAPY		0. 56663			
	O PHYSI CAL THERAPY		0. 45660			
	O OCCUPATI ONAL THERAPY		0. 4764			
	O SPEECH PATHOLOGY		0. 5700!			
	O ELECTROCARDI OLOGY		0. 20048			
	O MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2029			
72. 00 0720	O IMPL. DEV. CHARGED TO PATIENTS		0. 12754	44 599, 430	76, 454	72.00
73.00 0730	DRUGS CHARGED TO PATIENTS		0. 2947	58 773, 762	228, 073	73.00
73. 01 0348	OOOLOGY		0. 17513	35 0	0	73. 0°
	BLOOD DI SORDER DRUGS		0. 18079	97 0	0	73. 02
	O CARDI OPULMONARY		0.00000		0	
	7 CARDIAC REHABILITATION		0. 7351		0	
	O ALLOGENEIC HSCT ACQUISITION		0.00000		0	
	O CAR T-CELL IMMUNOTHERAPY		0.00000	00 0	0	78. 0
	ATIENT SERVICE COST CENTERS					4
	O EMERGENCY		0. 32334			
	O OBSERVATION BEDS (NON-DISTINCT PART		0. 4303		0	1 / 0
200.00	Total (sum of lines 50 through 94 and 96 through 98)	(1)		3, 452, 545		
201. 00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0 450 5 5		201. 0
202. 00	Net charges (line 200 minus line 201)		1	3, 452, 545		202. 0

III III E	LUCCDITAL			6.5. 046.4	2550 40
Health Financial Systems IU HEALTH TIPTON INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1311	Period:	u of Form CMS-2 Worksheet D-3	
	Component (CCN: 15-Z311	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/29/2024 2:2	
	Title	: XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 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. 21398		0	50. 00
53. 00 05300 ANESTHESI OLOGY		0. 05590		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24040		1, 169	54.00
60. 00 06000 LABORATORY		0. 34678	·	6, 969	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 56663		12, 425	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 45660	·	32, 371	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 47647	·	18, 683	1
68. 00 06800 SPEECH PATHOLOGY		0. 57005		1, 655	
69. 00 06900 ELECTROCARDI OLOGY		0. 20048		671	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 20299		67	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 12754		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 29475	·	14, 697	73. 00
73. 01 03480 ONCOLOGY		0. 17513		0	73. 01
73. 02 07301 BLOOD DI SORDER DRUGS		0. 18079		0	73. 02
76. 00 03160 CARDI OPULMONARY		0.00000		0	76. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 73515		0	76. 97
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY		0. 00000	00 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		1			
91. 00 09100 EMERGENCY		0. 32334		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 43037		0	92. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			213, 435		
201. 00 Less PBP Clinic Laboratory Services-Program only charges	s (line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)		I	213, 435		202. 00

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	}
			From 01/01/2023 To 12/31/2023		
	T' 11	VI V		5/29/2024 2: 2	!8 pm
Cook Contain December 1	ΙΙΤΙ	e XIX Ratio of Cos	Hospi tal	PPS	
Cost Center Description		To Charges	t Inpatient Program	Inpatient Program Costs	
		10 Charges	Charges	(col. 1 x col.	
			chai ges	2)	
		1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			26, 918		30.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 21398	33 0	0	50.0
53. 00 05300 ANESTHESI OLOGY		0. 05590	02 0	0	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24040			54.0
50. 00 06000 LABORATORY		0. 34678	5, 034	1, 746	60.0
55. 00 06500 RESPI RATORY THERAPY		0. 56663			
66. 00 06600 PHYSI CAL THERAPY		0. 45660	·	560	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 47647		300	
58. 00 06800 SPEECH PATHOLOGY		0. 57005		0	
59. 00 06900 ELECTROCARDI OLOGY		0. 20048		51	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 20299			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 12754		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 29475			
73. 01 03480 0NC0L0GY		0. 17513		84	
73. 02 07301 BLOOD DI SORDER DRUGS		0. 18079		0	1
76. OO O3160 CARDI OPULMONARY		0.00000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 73515		0	1
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0.00000		0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS		0.00000	00 0	0	78. 0
91. 00 09100 EMERGENCY		0. 32334	14 6, 052	1 057	91. 0
22. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 43037		1, 957	1
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.43037	47, 169		
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		47, 109		201. 0
Net charges (line 200 minus line 201)	3 (11116 01)		47, 169		202. 0

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared: 5/20/2024 2:28 pm

		T: +1 - W// L1	11: 4-1	5/29/2024 2: 2	8 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7, 581, 839	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ons)		0	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)			0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs including REH direc	t araduata madical adua	tion costs from	0	8. 00 9. 00
9.00	Wkst. D, Pt. IV, col. 13, line 200	t graduate medicar educa	THOIT COSTS THOM	U	9.00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 581, 839	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges			0	12 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	10 07)		0	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p	3	9	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e Ratio of line 15 to line 16 (not to exceed 1.000000))		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds lin	ne 11) (see	0	19. 00
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds lir	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			7, 657, 657	21. 00
22. 00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			27 772	25 00
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line		ictions)	37, 773 5, 236, 122	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			2, 383, 762	
	instructions)			,	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)			0	28. 50
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27, 28, 28.50 and 29)			0 2, 383, 762	29. 00 30. 00
31. 00	Primary payer payments			804	31.00
32.00	Subtotal (line 30 minus line 31)			2, 382, 958	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			015.020	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			815, 028 529, 768	
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		668, 514	
37. 00	Subtotal (see instructions)	,		2, 912, 726	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 75	Pioneer ACO demonstration payment adjustment (see instructions N95 respirator payment adjustment amount (see instructions))		0	39. 50 39. 75
39. 75 39. 97	Demonstration payment adjustment amount (see instructions)			0	39. 75 39. 97
39. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruct	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	•		0	39. 99
40.00	Subtotal (see instructions)			2, 912, 726	40. 00
40. 01 40. 02	Sequestration adjustment (see instructions)			58, 255	
40. 02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 02 40. 03
41. 00	Interim payments			2, 768, 751	•
41. 01	Interim payments-PARHM				41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)			05 700	42. 01
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			85, 720	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2 (chapter 1	450, 434	44. 00
00	§115. 2				55
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	91. 00 92. 00
	Time Value of Money (see instructions)				93.00
	· · · · · · · · · · · · · · · · · · ·		<u> </u>		

Health Financial Systems	IU HEALTH TIPTON	HOSPI TAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1311	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/29/2024 2: 2	8 pm
		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

Health Financial Systems IU FANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1311

				10 12/31/2023	5/29/2024 2: 28	
		Title	XVIII	Hospi tal	Cost	
		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		3, 134, 55		2, 606, 451	1.00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0 09/15/2023	162, 300	3. 01
3. 02				0	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51	ADSUSTINIENTS TO TROUBLAND			0		3. 51
3. 52				0		3. 52
3. 53				0	l ol	3. 53
3.54				0	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	162, 300	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 134, 55	4	2, 768, 751	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			"		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52 5. 99	Subtatal (sum of lines F O1 F 40 minus sum of lines			0	0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			U	ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		8, 12	:1	85, 720	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 142, 67	5	2, 854, 471	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00)	1. 00	2. 00	0.00
8.00	Name of Contractor				1	8. 00

Health Financial Systems	IU HEALTH TIPTO	N HOSPITAL			In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICE	S RENDERED			Peri		Worksheet E-1	
		Component CCN: 15-Z311			01/01/2023 12/31/2023		
		Title XVIII		Swi no	g Beds - SNF	Cost	
		Inpatient Part A			Par	t B	
		/-l-l /	A		/ - - /	A	

		Title	XVIII Sv	ving Beds - SNF	Cost	
		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		335, 885		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02	ADDUST MENTS TO TROVIDER		o o		ő	3. 02
3. 03			o o		ő	3. 03
3. 04			0		ő	3. 04
3. 05			o o		ő	3. 05
0.00	Provider to Program		<u> </u>			0.00
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		o	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		335, 885		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
F 00	TO BE COMPLETED BY CONTRACTOR					F 00
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO TROVIDER		0		0	5. 01
5. 03			Ö		0	5. 02
0.00	Provider to Program		J J		Ŭ	0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			o o		ol	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		64, 126		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		400, 011	_	0	7. 00
				Contractor	NPR Date	
		,	`	Number	(Mo/Day/Yr)	
		(J	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Heal th	Financial Systems IU HEALTH TIPTON	N HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUI					epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	9 14		1. 00 2. 00
	2.00 Medicare days (see instructions)				
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
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				6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of colline 168	certified HIT technology	Wkst. S-2, Pt. I		7. 00
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	(======================================			1
30. 00	Initial/interim HIT payment adjustment (see instructions)				30.00
31. 00					31.00
	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)		32. 00

12/31/2023 Date/Time Prepared: 5/29/2024 2:28 pm Title XVIII Swing Beds - SNF Cost Part A Part B 1.00 2.00 COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) 319, 381 0 1.00 Inpatient routine services - swing bed-NF (see instructions) 2.00 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Λ 3.00 89, 594 3.00 Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, see instructions) Nursing and allied health payment-PARHM (see instructions) 3.01 3.01 4.00 Per diem cost for interns and residents not in approved teaching program (see 0.00 4.00 instructions) 5. 00 Program days 111 Λ 5.00 6.00 Interns and residents not in approved teaching program (see instructions) 0 6.00 7.00 Utilization review - physician compensation - SNF optional method only 7.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 408. 975 8.00 8 00 0 Primary payer payments (see instructions) 9.00 0 9.00 10.00 Subtotal (line 8 minus line 9) 408, 975 0 10.00 11.00 Deductibles billed to program patients (exclude amounts applicable to physician 0 11.00 professional services) 408, 975 12 00 Subtotal (line 10 minus line 11) 0 12 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance 800 0 13.00 13.00 for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 0 14.00 15.00 Subtotal (see instructions) 408, 175 0 15.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.00 16.00 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.50 Rural community hospital demonstration project (§410A Demonstration) payment 16.55 0 16.55 adjustment (see instructions) 16. 99 ${\tt Demonstration}\ \ {\tt payment}\ \ {\tt adjustment}\ \ {\tt amount}\ \ {\tt before}\ \ {\tt sequestration}$ 16. 99 0 0 17.00 Allowable bad debts (see instructions) 0 0 17.00 Adjusted reimbursable bad debts (see instructions) 0 17.01 17.01 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 18.00 0 0 19.00 Total (see instructions) 408 175 Ω 19 00 19. 01 Sequestration adjustment (see instructions) 0 19.01 8, 164 19.02 Demonstration payment adjustment amount after sequestration) 19.02 Sequestration adjustment-PARHM pass-throughs 19.03 19.03 19. 25 Sequestration for non-claims based amounts (see instructions) 0 19. 25 20.00 Interim payments 335, 885 20.00 20.01 Interim payments-PARHM 20.01 21.00 Tentative settlement (for contractor use only) 0 21 00 Tentative settlement-PARHM (for contractor use only) 21.01 22.00 Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 21) 64, 126 22.00 Balance due provider/program-PARHM (see instructions) 22.01 22.01 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 23.832 0 23.00 chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment 200.00 Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. 200.00 Cost Reimbursement 201.00 Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line 201.00 66 (title XVIII hospital)) 202.00 Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, line 202.00 200 (title XVIII swing-bed SNF)) 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 current 5-year demonstration peri od) 205.00 Medicare swing-bed SNF target amount 205.00 206.00 Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) 206.00 Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement 207.00 Program reimbursement under the §410A Demonstration (see instructions) 207.00 208.00 Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines 1 208. 00 and 3) 209.00 Adjustment to Medicare swing-bed SNF PPS payments (see instructions) 209.00 210.00 Reserved for future use 210.00 Comparision of PPS versus Cost Reimbursement 215.00 Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see 215.00

instructions)

Health Financial Systems	IU HEALTH TIPTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1311	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/29/2024 2:28 pm
	T' 11 20/111		2 .

				5/29/2024 2: 2	8 pm
		Title XVIII	Hospi tal	Cost	
		1. 00			
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1. 00	Inpatient services			3, 434, 932	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		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)			3, 434, 932	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 469, 281	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	11. 00
12.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12. 00
	had such payment been made in accordance with 42 CFR 413.13(e)	ı			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
14.00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete onl	y if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16. 00	Excess of reasonable cost over customary charges (complete onl	y if line 6 exceeds line	e 14) (see	0	16. 00
47.00	instructions)			0	17. 00
17. 00					
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1 1 10			10.00
18. 00	Direct graduate medical education payments (from Worksheet E-4	i, line 49)		0	18.00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			3, 469, 281	
20.00	Deductibles (exclude professional component)			278, 224	
21. 00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 191, 057	
23. 00	Coinsurance			800	
24. 00	Subtotal (line 22 minus line 23)			3, 190, 257	
25. 00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		25, 468	ı
26. 00	Adjusted reimbursable bad debts (see instructions)			16, 554	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		18, 836	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 206, 811	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	_		0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30. 00	Subtotal (see instructions)			3, 206, 811	
30. 01	Sequestration adjustment (see instructions)			64, 136	•
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31. 00	Interim payments			3, 134, 554	
31. 01	Interim payments-PARHM				31. 01
32. 00	Tentative settlement (for contractor use only)			0	32. 00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02			8, 121	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, mi				33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	chapter 1,	270, 367	34. 00
	§115. 2				

Health Financial Systems

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

Provider CCN: 15-1311

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/29/2024 2:28 pm

oni y)				12/01/2020	5/29/2024 2: 2	8 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	47, 247, 624	l .	0	0	1
2. 00 3. 00	Temporary investments Notes receivable	0		_	0	
4. 00	Accounts receivable	4, 743, 281		0	0	
5. 00	Other recei vabl e	340, 139	ď	Ö	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	0	c	0	0	
7.00	Inventory	1, 055, 753	l .	0	0	
8.00	Prepai d expenses	67, 723	C	0	0	
9. 00 10. 00	Other current assets Due from other funds	0		0	0	
11. 00	Total current assets (sum of lines 1-10)	53, 454, 520	1	_	1	1
11.00	FIXED ASSETS	1 00, 101, 020		,		11.00
12.00	Land	0	C	0	0	12. 00
13.00	Land improvements	0	C	_	1	
14. 00	Accumulated depreciation	0	C	-	1	1
15. 00 16. 00	Buildings Accumulated depreciation	0	C	_	0	
17. 00	Leasehold improvements	3, 139, 179	1	_	0	
18. 00	Accumulated depreciation	-1, 964, 119	1	1	Ö	
19. 00	Fi xed equipment	0	d	0	0	
20.00	Accumulated depreciation	0	C	0	0	
21. 00	Automobiles and trucks	2, 738	1	_	0	
22. 00	Accumulated depreciation	-2, 738	l .	_	0	
23. 00 24. 00	Major movable equipment Accumulated depreciation	15, 517, 447 -11, 576, 832	l .	0	0	
25. 00	Mi nor equi pment depreci abl e	-11, 570, 632		0	0	
26. 00	Accumulated depreciation	Ö		o o	Ö	
27. 00	HIT designated Assets	0	c	0	0	27. 00
28. 00	Accumulated depreciation	0	C	0	0	1
29. 00	Mi nor equi pment-nondepreci abl e	0	C	_	0	
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	5, 115, 675	<u> </u> C	0	0	30. 00
31. 00	Investments	1 0		0	0	31.00
32. 00	Deposits on Leases	Ö	i c	-	· -	1
33.00	Due from owners/officers	0	c	0	0	33. 00
34.00	Other assets	28, 407, 117	1	0	0	1
35.00	Total other assets (sum of lines 31-34)	28, 407, 117	1	1	0	1
36. 00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	86, 977, 312	<u> </u> C	0	0	36.00
37. 00	Accounts payable	3, 297, 162		0	0	37. 00
38. 00	Salaries, wages, and fees payable	781, 874	1	-	Ö	
39. 00	Payroll taxes payable	0) c	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	C	0	0	
41.00	Deferred income	0	C	0	0	
42. 00 43. 00	Accel erated payments	0]		0	42. 00 43. 00
44. 00	Due to other funds Other current liabilities	3, 220, 303		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	7, 299, 339	1	1		
	LONG TERM LIABILITIES	, , , , , , , , , , , , , , , , , , , ,				
46. 00	Mortgage payable	0	C	_	0	
47. 00	Notes payable	9, 655, 000	1	-		1
48. 00	Unsecured Loans	140 544		-	1	1
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	169, 566 9, 824, 566	l .	-	· -	1
51. 00	Total liabilities (sum of lines 45 and 50)	17, 123, 905	l .		l	
	CAPI TAL ACCOUNTS		-			1
52.00	General fund balance	69, 853, 407				52. 00
53.00	Specific purpose fund		C)		53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57. 00	Plant fund balance - invested in plant		•	0	0	1
58. 00	Plant fund balance - reserve for plant improvement,				ő	
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	69, 853, 407		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	86, 977, 312	il c	0	0	60.00
	· · / /	I	I	Ī	ļ	I

Provider CCN: 15-1311

					10 12/31/2023	5/29/2024 2:28	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
				·			
		1 00			4.00	5.00	
1 00	Trund halanan at hankankan as anni ad	1.00	2.00	3. 00	4. 00	5. 00	1 00
1.00	Fund balances at beginning of period		64, 877, 773		C		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		2, 576, 007 67, 453, 780				2.00
3. 00 4. 00	Additions (credit adjustments) (specify)		67, 453, 780			0	3. 00 4. 00
5. 00	TEMP RESTRICTED	2, 399, 628			0	0	4. 00 5. 00
6.00	TEMP RESTRICTED	2, 399, 020					6. 00
7. 00	ROUNDI NG	_1			0		7. 00
8. 00	INCOMPT NO	- 1			0		8. 00
9. 00					0		9. 00
10.00	Total additions (sum of line 4-9)		2, 399, 627				10.00
11. 00	Subtotal (line 3 plus line 10)		69, 853, 407				11. 00
12. 00	Deductions (debit adjustments) (specify)	0	07, 033, 407		0	0	12.00
13. 00	beddetrons (debrt day detiments) (specify)	0			0		13. 00
14. 00					0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			o	0	16. 00
17.00		o			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		0		C		18. 00
19.00	Fund balance at end of period per balance		69, 853, 407		C		19. 00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		4.00	7.00	0.00			
4 00		6. 00	7. 00	8. 00	0		1 00
1.00	Fund balances at beginning of period	0			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0		2.00
4.00	Additions (credit adjustments) (specify)	0	0		U		3. 00 4. 00
5.00	TEMP RESTRICTED		0				5. 00
6.00	TEWN RESTRICTED		0				6. 00
7. 00	ROUNDI NG		0				7. 00
8.00	NOOND! NO		0				8. 00
9. 00			0				9. 00
10.00	Total additions (sum of line 4-9)	o			0		10. 00
11. 00	Subtotal (line 3 plus line 10)	o			0		11. 00
12.00	Deductions (debit adjustments) (specify)		o				12.00
13.00		İ	0				13.00
14.00			0				14. 00
15.00			0				15.00
16.00			0				16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0			0		18. 00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)	1					

Health Financial Systems I STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Peri od: | Worksheet G-2 | From 01/01/2023 | Parts | & | I | | To | 12/31/2023 | Date/Time | Prepared: Provider CCN: 15-1311

		7	Γο 12/31/2023	Date/Time Pre 5/29/2024 2: 2:			
	Cost Center Description	I npati ent	Outpati ent	Total	Э рііі		
		1.00	2. 00	3. 00			
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal	5, 587, 38	1	5, 587, 381	1. 00		
2.00	SUBPROVI DER - I PF				2. 00		
3.00	SUBPROVIDER - IRF				3. 00		
4.00	SUBPROVI DER				4. 00		
5.00	Swing bed - SNF	148, 656	5	148, 656	5. 00		
6.00	Swing bed - NF			0	6. 00		
7.00	SKILLED NURSING FACILITY				7. 00		
8.00	NURSI NG FACILITY				8. 00		
9.00	OTHER LONG TERM CARE	5 70, 00		F 70/ 007	9. 00		
10. 00	Total general inpatient care services (sum of lines 1-9)	5, 736, 037	/	5, 736, 037	10. 00		
11 00	Intensive Care Type Inpatient Hospital Services		T		11 00		
11. 00 12. 00	INTENSIVE CARE UNIT				11. 00 12. 00		
13. 00	BURN INTENSIVE CARE UNIT				13. 00		
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00		
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00		
16. 00	Total intensive care type inpatient hospital services (sum of lines			0	16. 00		
10.00	11-15)	`	1	O	10.00		
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 736, 037	7	5, 736, 037	17. 00		
18. 00	Ancillary services	7, 386, 439		107, 751, 308	18. 00		
19. 00	Outpati ent servi ces	303, 625		18, 875, 166	19. 00		
20. 00	RURAL HEALTH CLINIC			0	20. 00		
21.00	FEDERALLY QUALIFIED HEALTH CENTER		ol ol	0	21. 00		
22. 00	HOME HEALTH AGENCY				22. 00		
23.00	AMBULANCE SERVICES				23. 00		
24.00	CMHC				24. 00		
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00		
26.00	HOSPI CE				26. 00		
27. 00	NONALLOWABLE REVENUE		74, 805	74, 805	27. 00		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	13, 426, 10	119, 011, 215	132, 437, 316	28. 00		
	G-3, line 1)						
00.00	PART II - OPERATING EXPENSES		40.040.004		00.00		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		42, 369, 036		29. 00		
30.00	ADD (SPECIFY)	(30.00		
31. 00 32. 00					31. 00 32. 00		
33. 00		1			33. 00		
34. 00		1			34. 00		
35. 00					35. 00		
36. 00	Total additions (sum of lines 30-35)	ì	ا		36. 00		
37. 00	DEDUCT (SPECIFY)				37. 00		
38. 00		1			38. 00		
39. 00					39. 00		
40.00			ol l		40.00		
41.00					41.00		
42.00	Total deductions (sum of lines 37-41)		0		42.00		
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	42, 369, 036		43.00		
	to Wkst. G-3, line 4)						

	Financial Systems IU HEALTH TIPTO			u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1311	Peri od: From 01/01/2023	Worksheet G-3	
				Date/Time Prepared:	
			L	5/29/2024 2: 2	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)			132, 437, 316	
2.00	Less contractual allowances and discounts on patients' accounts			91, 014, 235	
3.00	Net patient revenues (line 1 minus line 2)			41, 423, 081	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			42, 369, 036	
5.00	Net income from service to patients (line 3 minus line 4)		-945, 955	5. 00	
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	
8. 00 9. 00	Revenues from telephone and other miscellaneous communication	on services		0	
	Revenue from television and radio service Purchase discounts			0	
10. 00 11. 00	Rebates and refunds of expenses			0	
12.00	Parking lot receipts			0	
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 other	than nationts		0	
17. 00	Revenue from sale of drugs to other than patients	than patrents		- 1	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			ő	
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			3, 521, 962	
24. 50	COVI D-19 PHE Fundi ng			0	
25. 00	Total other income (sum of lines 6-24)			3, 521, 962	
26.00	Total (line 5 plus line 25)			2, 576, 007	
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)			2, 576, 007	29. 00