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: 15-1320 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 5/24/2024 9:43 am ] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

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

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH JAY HOSPITAL (15-1320) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Jor	n Vanator	T	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	Jon Vanator			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	-39, 308	-485, 545	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	23, 612	0		0	5. 00
6.00 SWING BED - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC (RHC) I	0		68, 810		0	10.00
200. 00 TOTAL	0	-15, 696	-416, 735	0	0	200.00
The above amounts represent "due to" or "due from"	the applicable	program for th	a alamant of t	he shows comple	ov indicated	

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Period: Worksheet S-2
From 01/01/2023 Part I

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provi c	der CC	CN: 15-1320	Peri od:		Workshe	eet S-2	
						From 01/01/ To 12/31/		Part I Date/Ti	me Pre	pared·
								5/24/20	024 9: 4	3 am
	1.00	2.00		3. 00			4. 00			
1. 00	Hospital and Hospital Health Care Co Street: 500 W. VOTAW	PO Box:								1.00
2.00	City: PORTLAND	State: IN	Zip Cod	le: 473	371 Cour	nty: JAY				2.00
		Component Name	CCN	CB:			Payme	ent Syst	em (P,	
			Number	Numl	ber Type	Certi fi ed		, 0, or		
		1.00	2.00	2 /	00 4 00	F 00	V 00	XVIII		
	Hospital and Hospital-Based Componen	1.00	2. 00	3.0	00   4.00	5. 00	6. 00	7. 00	8.00	
3.00		IU HEALTH JAY HOSPITAL	151320	999	915 1	01/01/2004	N	0	Р	3.00
4.00	Subprovider - IPF									4. 00
5.00	Subprovi der - IRF									5.00
6. 00 7. 00	Subprovider - (Other) Swing Beds - SNF	IU HEALTH JAY SWING BED	15Z320	999	15	01/01/2004	N	0	N	6. 00 7. 00
8.00	Swing Beds - NF	TO HEALTH SAT SWING BED	132320	'''	, 13	0170172004	''		'	8.00
9.00	Hospi tal -Based SNF									9. 00
10.00	Hospi tal -Based NF									10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA									11. 00 12. 00
13. 00	Separately Certified ASC									13.00
14. 00	Hospi tal -Based Hospi ce									14. 00
15. 00	Hospital-Based Health Clinic - RHC	IU HEALTH BLACKFORD	158558	999	915	07/01/2023	N	0	0	15. 00
1/ 00	Hearital Based Health Clinia FOLIC	PHYSI CI ANS								14 00
16. 00 17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									16. 00 17. 00
18. 00	Renal Dialysis									18.00
19. 00										19. 00
						From:		To		
20. 00	Cost Reporting Period (mm/dd/yyyy)					1. 00 01/01/2		2. ( 12/31,		20. 00
	Type of Control (see instructions)					2	023	12/31/	2023	21.00
	l				1.00	2. 00		3. (	00	
22. 00	Inpatient PPS Information  Does this facility qualify and is it	currently receiving nav	ments for		N	N				22. 00
22.00	disproportionate share hospital adju				"	14				22.00
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section §		ndment							
22. 01	hospital?) In column 2, enter "Y" fo Did this hospital receive interim UC		al UCPs	for	N N	N				22. 01
22.0.	this cost reporting period? Enter in									22.0.
	for the portion of the cost reportin									
	1. Enter in column 2, "Y" for yes or cost reporting period occurring on o		ion of th	ne						
	instructions)	i arter october i. (see								
22. 02	Is this a newly merged hospital that	requires a final UCP to	be		N	N				22. 02
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th			no						
	period prior to October 1. Enter in for the portion of the cost reportin	a period on or after Octo	ober 1.	110,						
22. 03	Did this hospital receive a geograph			)	N	N		N		22. 03
	rural as a result of the OMB standar									
	adopted by CMS in FY2015? Enter in c for the portion of the cost reportin									
	in column 2, "Y" for yes or "N" for			31						
	reporting period occurring on or aft									
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41 yes or "N" for no.	2.105)? Enter in column :	3, "Y" fo	or						
22. 04	Did this hospital receive a geograph	ic reclassification from	urban to	)						22. 04
	rural as a result of the revised OMB									
	adopted by CMS in FY 2021? Enter in									
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			er.						
	reporting period occurring on or aft	•								
	Does this hospital contain at least									
	counted in accordance with 42 CFR 41	2.105)? Enter in column	3, "Y" f	for						
23 00	yes or "N" for no. Which method is used to determine Me	dicaid days on lines 24 :	and/or 25	5		3 N				23. 00
_0.00	below? In column 1, enter 1 if date									25.00
	if date of discharge. Is the method			cost						
	reporting period different from the reporting period? In column 2, ente									
	proporting period: In corumn 2, ente	i i ioi yes oi ii ioi	110.		I	I	1			I

complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.

58.00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 9: 43 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 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) Teaching Hospitals that Claim Residents in Nonprovider Settings

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

	Inlie	u of Form CMS-2	552-10
	ri od:	Worksheet S-2	1002 10
		Date/Time Pre	
Nonprovi der	Hospi tal	2))	
	2.00	2.00	
		- opon tring	
0. 00	0. 00	0. 000000	64. 00
Unwei ghted	Unwei ghted	Ratio (col. 3/	
FTEs	FTEs in	(col. 3 + col.	
	Hospi tal	4))	
	4 00	5.00	
			65. 00
Unwei ahted	Unwei ahted	Ratio (col. 1/	
FTEs	FTEs in	(col . 1 + col .	
	Hospi tal	2))	
	2.00	2.00	
211001110	. cost reporti	ng perrous	
0. 00	0. 00	0. 000000	66. 00
9			
	nospi tai	7//	
3. 00	4. 00	5. 00	
0. 00			67. 00
1	Unwei ghted FTES Nonprovi der Si te 1.00 is base year  0.00  Unwei ghted FTES Nonprovi der Si te 3.00  0.00  Unwei ghted FTES Nonprovi der Si te 1.00 -Effecti ve fo 0.00  Unwei ghted FTES Nonprovi der Si te 1.00 -Effecti ve fo 3.00	Unwei ghted FTEs in Hospi tal Si te 3.00	From 01/01/2023

116. 00

117. 00

118. 00

Ν

N

"N" for no.

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.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-1320		1/01/2023 2/31/2023	Worksheet S Part I Date/Time P 5/24/2024 9	repared:
		Premi ums	L	osses	Insurance	
		1. 00		2 00	2 00	
18.01 List amounts of malpractice premiums and paid losses:		1.00		2.00	3.00	0 118. 01
18.02 Are malpractice premiums and paid losses reported in a cost of	contor other t	han tho		1. 00 N	2. 00	118. 02
Administrative and General? If yes, submit supporting scheduland amounts contained therein.  19.00 D0 NOT USE THIS LINE	ule listing co	est centers		IV		119. 00
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" alifies for th	for yes or ne Outpatient		N	N	120.00
21.00 Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable devices	charged to		Υ		121. 00
22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1				Υ	5. 00	122. 00
the Worksheet A line number where these taxes are included. 23.00 Did the facility and/or its subproviders (if applicable) pure services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organization	ng, payroll,	and/or		Υ	N	123. 00
for yes or "N" for no.  If column 1 is "Y", were the majority of the expenses, i.e., professional services expenses, for services purchased from ulocated in a CBSA outside of the main hospital CBSA? In colum "N" for no.	unrelated orga	ıni zati ons				
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant ce	enter? Enter "	Y" for yes		N		125. 00
and "N" for no. If yes, enter certification date(s) (mm/dd/y)		fication dat				126. 00
26.00  f this is a Medicare-certified kidney transplant program, er  in column 1 and termination date, if applicable, in column 2.		ircation dat	.e			120.00
27.00 If this is a Medicare-certified heart transplant program, ent in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare-certified liver transplant program, ent						127. 00 128. 00
in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare-certified lung transplant program, ente	er the certifi					129. 00
30.00 If this is a Medicare-certified pancreas transplant program,	enter the cer	ti fi cati on				130.00
date in column 1 and termination date, if applicable, in column 1.00 of this is a Medicare-certified intestinal transplant program date in column 1 and termination date, if applicable, in column 1.00 of the column 1.00 of	m, enter the d	certi fi cati or	n			131. 0
32.00 f this is a Medicare-certified islet transplant program, ent in column 1 and termination date, if applicable, in column 2. 33.00 Removed and reserved		ication date	•			132. 00
34.00 If this is a hospital-based organ procurement organization ((in column 1 and termination date, if applicable, in column 2.  All Providers	, .	ne OPO number	-			134.00
40.00 Are there any related organization or home office costs as december 10? Enter "Y" for yes or "N" for no in column 1. If your are claimed, enter in column 2 the home office chain number.	yes, and home (see instruct	office costs	5	Υ	15H059	140. 00
1.00 2.00  If this facility is part of a chain organization, enter on li		  ah 143 the r	name and	3.00	of the	
home office and enter the home office contractor name and con	ntractor numbe	er.				
41.00 Name: INDIANA UNIVERSITY HEALTH Contractor's Name: WIS	CONSIN PHYSIC VICES	IAN  Contract	or's Nur	mber: 0810	1	141. 00
42.00 Street: 340 WEST TENTH STREET PO Box: 43.00 Ci ty: INDIANAPOLIS State: IN		Zip Code	:	4620	4	142. 00 143. 00
					1. 00	
44.00 Are provider based physicians' costs included in Worksheet A?	?				Υ	144. 00
				1. 00	2. 00	
45.00 If costs for renal services are claimed on Wkst. A, line 74, inpatient services only? Enter "Y" for yes or "N" for no in one, does the dialysis facility include Medicare utilization f	column 1. If o	column 1 is		1.00	2.00	145. 00
period? Enter "Y" for yes or N" for no in column 2. 46.00 Has the cost allocation methodology changed from the previous	sly filed cost	report?		N		146. 00

Health Financial Systems	IU HEALTH J	AY HOSPITAL		In l	ieu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-1320	Period: From 01/01/20 To 12/31/20		repared:
					1.00	_
147.00 Was there a change in the statist	cal hasis? Enter "V" for	ves or "N" for	no		1.00 N	147. 00
148.00 Was there a change in the order of					N N	148. 00
149.00Was there a change to the simplif				or no.	N N	149. 00
		Part A	Part B		Title XIX	
		1. 00	2.00	3.00	4. 00	
Does this facility contain a prov 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 - IRF		N	N N	N	N	157. 00
158. 00 SUBPROVI DER						158. 00
159. OO SNF 160. OO HOME HEALTH AGENCY		N	N N	N	N	159. 00 160. 00
161. OO CMHC		N	N N	N N	N N	161. 00
TOT. OO CWITC			I IV	IN IN	IV	101.00
					1.00	
Multicampus				C + 0DCA 0		4.5.00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has o	ne or more campu	uses in diti	rerent CBSAS?	N	165. 00
Enter 1 101 years 1 1 101 ha	Name	County	State	Zip Code   CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00 4.00	5. 00	
166.00  f   line 165 is yes, for each 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)					0.	00 166. 00
					1.00	
Health Information Technology (HI	T) incentive in the Ameri	can Recovery and	d Reinvestm	ent Act	1.00	
167.00 Is this provider a meaningful use				CITE ACE	Υ	167. 00
168.00 If this provider is a CAH (line 10	05 is "Y") and is a meani	ngful user (line		'), enter the		168. 00
reasonable cost incurred for the	•	,				
168.01 If this provider is a CAH and is					N	168. 01
exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 iš "Y") and				ne 0.	00169.00
transition ractor. (See Instruction	JII3)			Begi nni ng	Endi ng	
				1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporti ng			170. 00
				1. 00	2.00	
171.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (9	reported on Wkst. S-3, Pt umn 1. If column 1 is yes	. I, line 2, col	. 6? Enter	Y		42 171. 00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/24/2024 9:43 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost 1.00 N reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Υ 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5 00 Are the cost report total expenses and total revenues different from 5 00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the Ν 8.00 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 N 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions N 15.00 Part B Y/N Y/N Date Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R Report only? N N 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions) 17.00 Was the cost report prepared using the PS&R Report for Υ 04/01/2024 04/01/2024 17 00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems IU HEALTH JA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	AY HOSPITAL Provider (	CN: 15-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S Part II Date/Time F 5/24/2024 9	S-2 Prepared:
		Descr	iption	Y/N	Y/N	10 4111
			0	1. 00	3.00	
0. 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	
1. 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 Capital Related Cost	EPT CHILDRENS I	HOSPI TALS)			
2. 00 3. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made du	ing the cost	N Y	22. 00 23. 00
4. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	eporting period?	N	24. 00
5. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period	? If yes, see	N	25. 00
6. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	f yes, see	N	26. 00		
7. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I1	ges, submit	N	27. 00
8. 00	Interest Expense Were new loans, mortgage agreements or letters of credit en	ntered into du	ring the cost	t reporting	N	28. 00
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	•	ebt Service F	Reserve Fund)	N	29. 00
0. 00	treated as a funded depreciation account? If yes, see institution account. If yes, see institution account		debt? If yes	s, see	N	30.00
1. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes	s, see	N	31.00
	Purchased Services Have changes or new agreements occurred in patient care set		ed through co	ontractual	N	32. 00
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33.00
4 00	Provider-Based Physicians Were services furnished at the provider facility under an a	arrangement wi	th provider-b	pased physicians?	Y	34.00
4.00	If yes, see instructions.	arrangement wi	in provider-i	based physicians:	'	34.00
5. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based	N	35. 00
	, , , , , , , , , , , , , , , , , , ,			Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
6. 00 7. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the	home office	? Y		36. 00 37. 00
8. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home of			e N		38. 0
9. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions.			s, Y		39. 00
0. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	00	2.	00	
	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
2. 00	respectively. Enter the employer/company name of the cost report	I NDI ANA UNI VEI	RSITY HEALTH			42.00
3. 00	preparer. Enter the telephone number and email address of the cost	317-962-1093		RUTTER@I UHEALT	H. ORG	43.00

Health Financial Systems	IU HEALTH JAY	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEM	ENT QUESTIONNAIRE	Provi der C	CN: 15-1320	Peri od:	Worksheet S-2	
				From 01/01/2023 To 12/31/2023		nared:
				10 12/31/2023	5/24/2024 9: 4	3 am
		3.	. 00			
Cost Report Preparer Contact Informati	on					
41.00 Enter the first name, last name and the	e title/position	DI RECTOR				41.00
held by the cost report preparer in co	lumns 1, 2, and 3,					
respecti vel y.						
42.00 Enter the employer/company name of the	cost report					42. 00
preparer.						
43.00 Enter the telephone number and email a						43. 00
report preparer in columns 1 and 2, re	specti vel y.					

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-1320

	te/Time Prepa 24/2024 9:43	
	Days / 0/P	alli
	its / Trips	
	Title V	
Li ne No. Avai lable		
	5. 00	
PART I - STATISTICAL DATA		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 21 7,665 21,120.00	0	1.00
8 exclude Swing Bed, Observation Bed and		
Hospice days)(see instructions for col. 2		
for the portion of LDP room available beds)		
2.00   HMO and other (see instructions)		2. 00
3.00 HM0 IPF Subprovi der		3.00
4.00 HM0 I RF Subprovi der		4. 00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	5. 00
6.00 Hospital Adults & Peds. Swing Bed NF	0	6. 00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	۷	7. 00
8.00 INTENSIVE CARE UNIT		8. 00
9. 00 CORONARY CARE UNIT		9. 00
10. 00 BURN INTENSIVE CARE UNIT		10. 00
11. 00 SURGI CAL I NTENSI VE CARE UNI T		11. 00
12.00 OTHER SPECIAL CARE (SPECIFY)		12.00
13. 00 NURSERY 43. 00		13. 00
14.00 Total (see instructions) 21 7,665 21,120.00	•	14. 00
15.00 CAH visits	1	15. 00
15. 10 REH hours and visits 0.00	0	15. 10
16. 00   SUBPROVI DER - I PF   40. 00   0   0	0	16.00
17. 00 SUBPROVI DER - I RF		17.00
18. 00 SUBPROVI DER		18.00
19.00 SKILLED NURSING FACILITY		19.00
20.00 NURSING FACILITY		20.00
21.00 OTHER LONG TERM CARE	•	21.00
22.00 HOME HEALTH AGENCY		22. 00
23.00  AMBULATORY SURGICAL CENTER (D. P. )	1	23. 00
24. 00  HOSPI CE	1	24. 00
24. 10  HOSPICE (non-distinct part) 30.00		24. 10
25. 00 CMHC - CMHC		25. 00
26. 00 RHC (CONSOLI DATED)  88. 00	•	26. 00
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89. 00	•	26. 25
27.00   Total (sum of lines 14-26)	•	27. 00
28.00 Observation Bed Days 29.00 Ambulance Trips		28. 00 29. 00
29.00   Ambulance Trips 30.00   Employee discount days (see instruction)		30. 00
31.00 Employee discount days (see Histruction)	•	31. 00
32.00 Labor & delivery days (see instructions)	•	32. 00
32.01 Total ancillary labor & delivery room		32. 00
outpati ent days (see instructions)		02.01
33.00 LTCH non-covered days		33. 00
33.01 LTCH site neutral days and discharges		33. 01
34.00 Temporary Expansion COVID-19 PHE Acute Care 30.00 0	o	34. 00

Provider CCN: 15-1320

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am

						5/24/2024 9: 4	3 am
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	382	9	880			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	312	78				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	211	0	211			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	250			6. 00
7.00	Total Adults and Peds. (exclude observation	593	9	1, 341			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	500	0	0	0.00	100.01	13.00
14.00	Total (see instructions)	593 0	1	1, 341	0. 00	190. 34	ł
15. 00	CAH visits	0	0	0			15.00
15. 10	REH hours and visits	0	U	0	0.00	0.00	15. 10
16. 00 17. 00	SUBPROVIDER - I PF	U	٩	U	0.00	0. 00	16. 00 17. 00
18. 00	SUBPROVI DER - I RF SUBPROVI DER	+					18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPICE						24. 00
24. 10	HOSPICE (non-distinct part)			17			24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RHC (CONSOLI DATED)	2, 018	o	8, 884	0.00	1. 85	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	2,0.0	0	0,001	0.00	0. 00	1
27. 00	Total (sum of lines 14-26)	ı .	Š	· ·	0.00	192. 19	27. 00
28. 00	Observation Bed Days		9	735	0.00	.,,	28.00
29. 00	Ambul ance Trips	0	ĺ	, 55			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31. 00
32. 00	Labor & delivery days (see instructions)	0	o	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)			_			
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34. 00
		. '	'		. '	'	

Provider CCN: 15-1320

					12/31/2023	5/24/2024 9: 4	
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14.00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)		0	133	4	284	1.00
2. 00 3. 00 4. 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			88	24 0 0		2. 00 3. 00 4. 00
5. 00 6. 00 7. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						8. 00 9. 00 10. 00 11. 00 12. 00
13. 00 14. 00 15. 00 15. 10	NURSERY Total (see instructions) CAH visits REH hours and visits	0.00	0	133	4	284	13. 00 14. 00 15. 00 15. 10
16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RHC (CONSOLIDATED)	0.00	0	0	O	0	16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01 34. 00	LTCH site neutral days and discharges	0. 00 0. 00		0			26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00 33. 01 34. 00

	Financial Systems  FAL-BASED RHC/FQHC STATISTICAL DATA	IU HEALTH JA		CN: 15-1320	Peri od:	eu of Form CMS Worksheet S-	8
				CCN: 15-8558	From 01/01/2023 To 12/31/2023	3	
			ooportorre		10 12,01,202	5/24/2024 9:	
					RHC I	Cost	_
					1	. 00	$\dashv$
	Clinic Address and Identification						
. 00	Street		0.		400 PILGRIM S		1.
				ty 00	State 2.00	ZIP Code 3.00	
. 00	City, State, ZIP Code, County		HARTFORD CITY	00		N 47348	2.0
- 00	THOCH TALL BACED FOLIO ONLY D	"D" C				1.00	0 0
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	or "U" for u		nt Award	Date	0 3.0
					1. 00	2.00	
	Source of Federal Funds						
. 00	Community Health Center (Section 330(d), PHS						4. 0
. 00	Migrant Health Center (Section 329(d), PHS Ad Health Services for the Homeless (Section 340						5. ( 6. (
. 00	Appalachian Regional Commission	J(u), FIIS ACL)					7.
. 00	Look-Alikes						8.
. 00	OTHER (SPECIFY)						9.
					1. 00	2.00	
0. 00	Does this facility operate as other than a ho	ospital-based R	HC or FOHC? Fr	ter "Y" for	1.00 N	_	0 10.
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of o	ther operation	s in column			
	, nour e. ,	Sun	day	M	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2. 00	3.00	4. 00	5. 00	
1. 00	CLINIC			08: 00	17: 00	08: 00	11. (
	In a second second				1. 00	2. 00	
2. 00	Have you received an approval for an exception is this a consolidated cost report as defined				N Y		12. ( 1 13. (
3.00	30.8? Enter "Y" for yes or "N" for no in colunumber of providers included in this report.	umn 1. If yes,	enter in colum	n 2 the	'		13.0
	numbers below. If line 13, column 1, is "Y", are you reporti				d N		0 13. (
3. 01	in CMS Pub. 100-02, chapter 13, section 80.2; yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated	dated RHC group	ings and compl	ete a	s		
3. 01	yes, enter in column 2 the number of consolid	dated RHC group RHC grouping. onsolidated RHC	ings and compl Consolidated s in the group	ete a RHC grouping: ing or		CCN	
3. 01	yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered co	dated RHC group RHC grouping. onsolidated RHC	ings and compl Consolidated s in the group	ete a RHC grouping ing or Provi	der name	CCN 2, 00	
	yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered co	dated RHC group RHC grouping. onsolidated RHC	ings and compl Consolidated s in the group	ete a RHC grouping ing or Provi	der name 1.00	CCN 2.00 158558	14. (
	yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of comprised exclusively of new consolidated RHG	dated RHC group RHC grouping. onsolidated RHC Cs in the group	ings and compl Consolidated s in the group ing.	ete a RHC grouping ing or Provi	der name 1.00 ACKFORD XIX	2.00 158558 Total Visits	_
3. 01 4. 00	yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of comprised exclusively of new consolidated RHG	dated RHC group RHC grouping. onsolidated RHC Cs in the group	ings and compl Consolidated s in the group ing.	ete a RHC grouping ing or Provi	der name 1.00 ACKFORD	2. 00 158558	_

Health Financial Systems	IU HEALTH JA	AY HOSPITAL	In Lieu of Form CMS-2552-			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1320	Peri od:	Worksheet S-8	
		Component	CCN: 15-8558	From 01/01/2023 To 12/31/2023		
				RHC I	Cost	
		Cou	inty			
		4.	00			
2.00 City, State, ZIP Code, County						2. 00
	Tuesday	Wednesday		Thursday		
	to	from	to	from	to	
	6. 00	7.00	8. 00	9. 00	10.00	
Facility hours of operations (1)						
11. 00 CLINIC	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11. 00

HOSPI 1	Financial Systems IU HEALTH JAY HOSPI TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro			Peri od:	u of Form CMS-2 Worksheet S-10			
				From 01/01/2023 To 12/31/2023	Parts I & II	narad:		
				To 12/31/2023	Date/Time Prep 5/24/2024 9:4	gareu. 3 am		
					1. 00			
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				1.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 401127	1.00		
	Medicaid (see instructions for each line)							
. 00	Net revenue from Medicaid				4, 873, 357	2.00		
. 00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00		
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental			i d?	N	4.00		
. 00								
. 00	Medi cai d charges				20, 113, 145	6.00		
. 00	Medicaid cost (line 1 times line 6)		8, 067, 926	7.00				
. 00								
0.00	Children's Health Insurance Program (CHIP) (see instructions for e Net revenue from stand-alone CHIP	each iine	2)		0	9.00		
0.00	Stand-allone CHIP charges				0	10.00		
1. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00		
2. 00	1	∍ instruc	rtions)		0	12. 00		
2.00	Other state or local government indigent care program (see instruc				0	12.0		
3. 00	Net revenue from state or local indigent care program (Not include			)	16	13. 0		
4. 00								
00	10)	. og. a (.	.or moradou			14. 00		
5. 00	State or local indigent care program cost (line 1 times line 14)				45	15.00		
6.00	Difference between net revenue and costs for state or local indige	ent care	program (see	instructions)	29	16.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state	e/local indig	ent care program	s (see			
	instructions for each line)							
7. 00		-	-		0			
8. 00	Government grants, appropriations or transfers for support of hosp				0	18. 00		
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	ndigent d	care programs	(sum of lines	3, 194, 598	19. 00		
	10, 12 did 10)		Uni nsured	Insured	Total (col. 1			
			pati ents	pati ents	+ col . 2)			
			1. 00	2. 00	3. 00			
	Uncompensated care cost (see instructions for each line)			-l	1 (00 0(0			
0.00	Charity care charges and uninsured discounts (see instructions)	,	1, 587, 51		1, 698, 969			
1. 00	Cost of patients approved for charity care and uninsured discounts	s (see	636, 79	6 86, 949	723, 745	21.00		
2. 00	instructions)	F 00	E 10		E 102	22.00		
2. 00	Payments received from patients for amounts previously written off	i as	5, 19	2 0	5, 192	22. 00		
3. 00	charity care Cost of charity care (see instructions)		631, 60	4 86, 949	718, 553	33 U		
3. 00	cost of chartty care (see thistructions)		031,00	4 00, 747	710, 333	23.00		
					1. 00			
4. 00	00 Does the amount on line 20 col. 2, include charges for patient days beyond a length of stay limit							
	imposed on patients covered by Medicaid or other indigent care pro							
25.00	If line 24 is yes, enter the charges for patient days beyond the i	i ndi gent	care program	's Length of	0	25. 00		
	stay limit							
5. 01	Charges for insured patients' liability (see instructions)				40, 916			
	Bad debt amount (see instructions)				2, 110, 590			
7. 00	,				291, 727			
6. 00 7. 00 7. 01	Medicare allowable bad debts (see instructions)				448, 811	27. 0		
7. 00 7. 01 8. 00	Medicare allowable bad debts (see instructions)	to (oos :	notmustic=-\			27. 0 28. 0		

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

823, 668 29. 00 1, 542, 221 30. 00 4, 736, 819 31. 00

10SPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN: 1	15-1320	Peri od: From 01/01/2023 To 12/31/2023		pared	
					1. 00		
	PART II - HOSPITAL DATA						
	Uncompensated and Indigent Care Cost-to-Charge Ratio						
. 00	Cost to charge ratio (see instructions)					1.	
	Medicaid (see instructions for each line)				1	4	
. 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 supplemen		om Medica	ai d'?		4.	
. 00	If line 4 is no, then enter DSH and/or supplemental payments f Medicaid charges	rom wedicald				5.	
. 00 . 00	Medicald charges Medicald cost (line 1 times line 6)					7.	
. 00	Difference between net revenue and costs for Medicaid program	(see instruction	nne)			8.	
. 00	Children's Health Insurance Program (CHIP) (see instructions f		113)			- 0.	
. 00	Net revenue from stand-alone CHIP	or cach title)				9.	
0.00	Stand-alone CHIP charges					10.	
	Stand-alone CHIP cost (line 1 times line 10)			111.			
	Difference between net revenue and costs for stand-alone CHIP		12.				
	Other state or local government indigent care program (see ins	tructions for e	each line)	)		1	
3. 00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)						
4. 00	Charges for patients covered under state or local indigent car	e program (Not	i ncl uded	in lines 6 or		14.	
	10)						
5. 00	State or local indigent care program cost (line 1 times line 1					15.	
6. 00	Difference between net revenue and costs for state or local in					16.	
	Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)	IP and State/Io	ocai indi	gent care progra	ms (see		
7. 00	Private grants, donations, or endowment income restricted to f	funding charity	care			17.	
8. 00	Government grants, appropriations or transfers for support of					18.	
	Total unreimbursed cost for Medicaid , CHIP and state and Loca			s (sum of lines		19.	
	8, 12 and 16)	3	1 3				
		U	ni nsured	Insured	Total (col. 1		
		р	oati ents	pati ents	+ col . 2)		
			1. 00	2. 00	3. 00		
	Uncompensated care cost (see instructions for each line)	, 1				4	
0.00	Charity care charges and uninsured discounts (see instructions					20.	
1. 00	Cost of patients approved for charity care and uninsured disco	unts (see				21.	
2. 00	instructions) Payments received from patients for amounts previously written	off as				22.	
<u>.</u> . UU	charity care	UII as				22.	
3. 00	Cost of charity care (see instructions)					23.	
. 00						120.	
					1.00		
. 00	Does the amount on line 20 col. 2, include charges for patient	days beyond a	length of	f stay limit		24.	
	imposed on patients covered by Medicaid or other indigent care	program?	Ü	•			
5. 00	If line 24 is yes, enter the charges for patient days beyond t	he indigent car	re program	m's length of		25	
	stav limit	-		-		1	

25. 01

26.00

27. 00

27. 01 28.00

29.00

30.00 31.00

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)

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)

	FINANCIAL SYSTEMS	TU HEALTH JAY		CN: 15-1320	Peri od:	Worksheet A	2332-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider C		From 01/01/2023		
				-	To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cati	Reclassi fi ed	3 alli
	oost conton boson per on	our ur roo	0 (110)	+ col . 2)	ons (See A-6)	Trial Balance	
				Í		(col. 3 +-	
						col . 4)	
	CENEDAL CEDVICE COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		0		0 1, 225, 847	1, 225, 847	1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB		0	1	0 75, 227	75, 227	1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT-POB		O		0 35, 030		1. 02
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ		0		9, 433	9, 433	1. 03
1.04	00104 CAP REL COSTS-BLDG & FIXT-RHC		0		96, 848		1. 04
2. 00 2. 01	00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB		0		0 1, 021, 127 0 22, 245	1, 021, 127 22, 245	2. 00 2. 01
2.01	00201 CAP REL COSTS-MVBLE EQUIP - MOB		0		0 22, 243	22, 243	2.01
2. 03	00203 CAP REL COSTS-MVBLE EQUIP - WJ		0		o o	0	2. 03
2.04	00204 CAP REL COSTS-MVBLE EQUIP - RHC		0		0 0	0	2. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	9, 578	77, 726	1		3, 065, 056	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	251, 416	9, 567, 039	1		9, 661, 089	5.00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB	630, 842 0	3, 600, 948 194, 134	1		2, 843, 263 118, 798	7. 00 7. 01
7.01	00701 OPERATION OF PLANT - MOB	0	115, 702	1		80, 629	7. 01
7. 03	00703 OPERATION OF PLANT - WJ	o	0	)	0 0	0	7. 03
7.04	00704 OPERATION OF PLANT - RHC	0	0		0 0	0	7. 04
8.00	00800 LAUNDRY & LINEN SERVICE	18, 362	6, 383		•	85, 703	8. 00
9.00	00900 HOUSEKEEPI NG	459, 969	444, 978			775, 274	1
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	323, 476	414, 397	1	3 -444, 815 0 353, 196	293, 058 353, 196	1
13. 00	01300 NURSING ADMINISTRATION	1, 084, 009	574, 313	1		1, 475, 791	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 790			160, 983	1
15.00	01500 PHARMACY	597, 917	2, 424, 733	3, 022, 65	0 -1, 947, 232	1, 075, 418	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	)	0 0	0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 559, 160	1, 395, 330	2, 954, 49	0 -458, 300	2, 496, 190	30.00
40. 00	04000 SUBPROVI DER - I PF	1, 337, 100	1, 373, 330	2, 934, 49	0 -430, 300	2, 470, 170	40.00
43. 00	04300 NURSERY	Ö	O		0 0	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	874, 120	1, 272, 523	2, 146, 64	3 -731, 536	1, 415, 107	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0		0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 079, 240	828, 314	1, 907, 55	4 -654, 943	1, 252, 611	1
60. 00	06000 LABORATORY	0	2, 607, 351	1		2, 606, 557	
65.00	06500 RESPI RATORY THERAPY	480, 862	218, 948	699, 81	0 -153, 574	546, 236	65. 00
66. 00	06600 PHYSI CAL THERAPY	564, 421	94, 768	1		650, 140	
67. 00	06700 OCCUPATIONAL THERAPY	99, 104 19, 821	0	99, 10		99, 104	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	19, 821	3, 849	19, 82 3, 84		19, 821 3, 595	
71. 00	1	o	3, 047	1	0 58, 044	58, 044	1
72.00		0	0		0 21, 788	21, 788	
73. 00	1	0	0	1	0 2, 375, 125		1
76. 00	03160 CARDI OPULMONARY	181, 995	124, 991	306, 98	6 -62, 397	244, 589	1
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	77. 00 78. 00
78.00	OUTPATIENT SERVICE COST CENTERS	UU		<u>'</u>	0	0	78.00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	291, 520	1, 246, 251	1, 537, 77	1 -177, 731	1, 360, 040	88. 00
90.00	09000 CLI NI C	0	0	1	0 0	0	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	692, 309	560, 290			810, 067	90. 01
90. 02 90. 03	09002 JAY FAMILY MEDICINE	897, 344	719, 093	1		1, 105, 704	
90. 03	09003 WOUND CLINIC 09004 OP ORTHO CLINIC	0	445 132	1		0 132	90. 03 90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	324, 898	260, 295	1		386, 951	
90. 06	09006 INFUSION CLINIC	89, 932	36, 213	1		98, 829	
90. 07	09007 HEALTH BEGINNINGS PROGRAM	377, 009	151, 535	528, 54	4 -120, 928	407, 616	90. 07
91.00	09100 EMERGENCY	1, 452, 159	2, 294, 079	3, 746, 23	-475, 251	3, 270, 987	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0/ 020	(0.011	14/ 04	4/ 052	100 007	92.00
93. 00	04950 OUTPATIENT PSYCH OTHER REIMBURSABLE COST CENTERS	86, 929	60, 011	146, 94	0 -46, 053	100, 887	93.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	C		0 0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	- 1	_	1			
118.00		12, 446, 392	29, 306, 561	41, 752, 95	3 51, 182	41, 804, 135	118. 00
466 -	NONREI MBURSABLE COST CENTERS	=1			-		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	146 629	18 74 609	1			190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	146, 628 0	74, 608	221, 23	6 -51, 182 0 0		192.00
	07950 VACANT	0	0	ol l	o o		194. 00
	2 07952 WEST JAY CLINIC	Ö	0		0 0	0	194. 02
194.03	3 07953 JAY MERIDIAN URGENT CARE	0		)	0 0	0	194. 03

Heal th Financ	ial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CA	TION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
				F	rom 01/01/2023		
				1	o 12/31/2023	Date/Time Pre	pared:
						5/24/2024 9: 4	3 am
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
200. 00	TOTAL (SUM OF LINES 118 through 199)	12, 593, 020	29, 381, 187	41, 974, 207	0	41, 974, 207	200. 00

Provider CCN: 15-1320

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

Date/Time Prepared: 5/24/2024 9:43 am

			5/24/2024 9:43 am	_
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-589, 525	1	1.0	
1.01 O0101 CAP REL COSTS-BLDG & FIXT-MOB	-75, 227	[ 0	1.0	11
1.02 O0102 CAP REL COSTS-BLDG & FLXT-POB	-61, 278	-26, 248	1.0	)2
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ	-9, 433	o	1.0	)3
1.04 O0104 CAP REL COSTS-BLDG & FIXT-RHC	-2, 916	93, 932	1.0	)4
2.00 00200 CAP REL COSTS-MVBLE EQUIP	400, 701	1	2.0	
2. 01   00201 CAP REL COSTS-MVBLE EQUIP - MOB	0		2. 0	
2. 02   00202 CAP REL COSTS-MVBLE EQUIP - POB		1	2.0	
2. 03   00203 CAP REL COSTS-MVBLE EQUIP - WJ			2.0	
2. 04   00204 CAP REL COSTS-MVBLE EQUIP - RHC	0.40.544	0 01 - 1	2.0	
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-849, 511		4.0	
5.00 00500 ADMINISTRATIVE & GENERAL	-1, 950, 063		5. 0	
7.00 O0700 OPERATION OF PLANT	-99, 422	2, 743, 841	7.0	
7.01  OO701 OPERATION OF PLANT - MOB	0	118, 798	7.0	)1
7.02   00702 OPERATION OF PLANT - POB	0	80, 629	7. 0	)2
7.03 00703 OPERATION OF PLANT - WJ	0	ol ol	7.0	)3
7.04 00704 OPERATION OF PLANT - RHC	0	ol ol	7.0	)4
8.00 00800 LAUNDRY & LINEN SERVICE	0	85, 703	8.0	00
9. 00   00900   HOUSEKEEPI NG	0	1	9.0	
10. 00 01000 DI ETARY	1, 946		10.0	
11. 00 01100 CAFETERI A	1, 710		11.0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	_			
	138, 321		13.0	
14. 00 01400 CENTRAL SERVICES & SUPPLY	50.00	160, 983	14.0	
15. 00   01500   PHARMACY	-52, 097		15. 0	
16.00 01600 MEDICAL RECORDS & LIBRARY	0		16. 0	
17. 00 01700 SOCI AL SERVI CE	0	0	17. 0	Ю
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS	-748, 312	1, 747, 878	30.0	)()
40. 00   04000   SUBPROVI DER - 1 PF	0	ol ol	40.0	00
43. 00 04300 NURSERY	0	ol ol	43. 0	
ANCILLARY SERVICE COST CENTERS		-1		
50. 00 05000 OPERATING ROOM	-291, 744	1, 123, 363	50.0	10
52. 00 05200 DELIVERY ROOM & LABOR ROOM	271,711		52.0	
53. 00   05300   ANESTHESI OLOGY		-	53.0	
	_	- 1		
	73, 539		54.0	
60. 00   06000   LABORATORY	0	, , , , , , ,	60.0	
65. 00 06500 RESPI RATORY THERAPY	39, 175		65. 0	
66. 00  06600 PHYSI CAL THERAPY	-45, 602		66. 0	
67. 00 06700 OCCUPATI ONAL THERAPY	0	99, 104	67.0	0
68. 00   06800   SPEECH PATHOLOGY	0	19, 821	68. 0	)()
69. 00   06900   ELECTROCARDI OLOGY	0	3, 595	69. 0	)()
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	58, 044	71. 0	00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	21, 788	72.0	00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1	73. 0	
76. 00 03160 CARDI OPULMONARY	44, 966	_, -, -,	76. 0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	1	77.0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY				
	0	ų o	78. 0	JU
OUTPATIENT SERVICE COST CENTERS		1 400 001		
88.00   08800   RURAL HEALTH CLINIC (RHC)	62, 286	1	88. 0	
90. 00  09000   CLI NI C	0		90. 0	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	-30, 378	779, 689	90.0	11
90.02 O9002 JAY FAMILY MEDICINE	-81, 147	1, 024, 557	90.0	)2
90. 03   09003   WOUND CLINIC	0	0	90.0	)3
90. 04   09004 OP ORTHO CLINIC	0	132	90.0	)4
90.05 09005 JAY FAMILY FIRST HEALTH CARE	-15, 189	1	90.0	
90. 06 09006 INFUSION CLINIC	0	98, 829	90. 0	
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	407, 616	90. 0	
91. 00   09100   EMERGENCY	-265, 785		91.0	
	-200, 700	3,003,202		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	_	100 007	92. 0	
93. 00 04950 OUTPATIENT PSYCH	0	100, 887	93. 0	Ü
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	102. 0	Ю
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-4, 406, 695	37, 397, 440	118. 0	Ю
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18	190. 0	00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES		1	192. 0	
193. 00 19300 NONPALD WORKERS		1,0,034	193. 0	
			193. 0	
194. 00 07950 VACANT				
194. 02 07952 WEST JAY CLINIC	0		194. 0	
194. 03 07953 JAY MERI DI AN URGENT CARE	0		194. 0	
200.00   TOTAL (SUM OF LINES 118 through 199)	-4, 406, 695	37, 567, 512	200.0	Ю
				_

Provider CCN: 15-1320

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am

					5/24/2	2024 9:43 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2.00	3. 00	4. 00	5. 00		
1 00	A - CAFETERIA	11 00	17/ 700	17/ 407		1 00
1. 00	CAFETERI A	11.00	17 <u>6, 7</u> 89 176, 789	17 <u>6, 4</u> 07 176, 407		1.00
	B - DRUGS RECLASS		170, 707	170, 407		
1.00	PHARMACY	15. 00	0	79, 570		1.00
2. 00	DRUGS CHARGED TO PATIENTS	73. 00	Ö	2, 375, 125		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	О		4. 00
5.00		0.00	0	О		5. 00
6.00		0.00	o	О		6. 00
7.00		0.00	0	О		7. 00
8.00		0.00	0	О		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	0	O		10.00
11. 00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13. 00 14. 00		0.00	0	0		13. 00 14. 00
15. 00		0. 00 0. 00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	o	0		17. 00
			— — <del>ŏ</del>	2, 454, 695		171.00
	C - SUPPLIES/IMPLANTS		-1	_,,		
1.00	CENTRAL SERVICES & SUPPLY	14. 00	0	149, 704		1.00
2.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	58, 044		2. 00
	PATI ENTS			04 700		
3.00	I MPL. DEV. CHARGED TO PATIENTS	72. 00	0	21, 788		3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	2, 336		4. 00
5. 00	HOUSEKEEPI NG	9. 00	o	1, 396		5. 00
6.00	DI ETARY	10.00	0	866		6. 00
7.00	NURSING ADMINISTRATION	13.00	0	144		7. 00
8.00	PHYSI CAL THERAPY	66. 00	0	288		8. 00
9.00	CARDI OPULMONARY	76. 00	0	652		9. 00
10.00	HEALTH BEGINNINGS PROGRAM	90. 07	0	70		10.00
11. 00	OUTPATIENT PSYCH	93.00	0	250		11. 00
12.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	190		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17. 00			— — o	0 235, 728		17. 00
	D - LAUNDRY		U <sub>I</sub>	233, 720		
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	65, 953		1.00
2. 00	Estation & Estate Senting	0.00	o	0		2. 00
3. 00		0.00	Ö	ō		3. 00
4.00		0.00	0	О		4. 00
5.00		0.00	0	О		5. 00
6.00		0.00	0	О		6. 00
7.00		0.00	0	О		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	0	O		10.00
11.00		0.00	0	0		11.00
12. 00		0.00	0			12. 00
	E - DEPRECIATION		0	65, 953		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 154, 744		1.00
2.00	CAP REL COSTS-BLDG & TTXT	1. 01	0	75, 227		2.00
2.00	FI XT-MOB	1.01	J	70,227		2.00
3.00	CAP REL COSTS-BLDG &	1. 02	0	35, 030		3. 00
	FI XT-POB					
4.00	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	0	9, 433		4. 00
5.00	CAP REL COSTS-BLDG &	1. 04	0	2, 000		5. 00
	FI XT-RHC		_			
6.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 015, 795		6.00
7. 00	CAP REL COSTS-MVBLE EQUIP -	2. 01	0	22, 245		7. 00
8. 00	MOB	0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	o	0		12. 00
	. '		-1	-1		

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 9:43 am Provider CCN: 15-1320

					5/24/2024 9: 4	3 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
12.00	2. 00	3.00	4. 00	5.00		12.00
13.00		0.00	0			13.00
14. 00		0. 00 0. 00	0	_		14. 00
15. 00 16. 00		0.00	0			15. 00
17. 00		0.00	0			16. 00 17. 00
18. 00		0.00	0			18.00
19. 00		0.00	0			19.00
20. 00		0.00	0			20.00
21. 00		0.00	0			21.00
21.00			0			21.00
	F - PROPERTY TAXES			2, 314, 474		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 767		1. 00
1.00	TOTALS		0	5, 767		1.00
	G - PROPERTY INSURANCE		<u> </u>	0, 707		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	36, 328		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0			2. 00
2.00	0		$ \frac{1}{0}$	41, 660		2.00
	H - HOUSEKEEPING SUPPLIES		<del>-</del>	,		
1.00	HOUSEKEEPI NG	9. 00	0	4, 496		1. 00
2.00		0.00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0			4. 00
5.00		0.00	0			5. 00
6.00		0.00	0			6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0			8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0			10. 00
11.00		0.00	0	0		11. 00
12.00		0.00	0			12. 00
13.00		0.00	0			13.00
14.00		0.00	0	0		14. 00
15.00		0.00	0			15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	0	0		19. 00
20.00		0.00	0			20. 00
	0		0	4, 496		
	J - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0			1. 00
2.00		0. 00	0			2. 00
3.00		0.00	0			3. 00
4.00		0.00	0			4. 00
5.00		0.00	0			5. 00
6.00		0.00	0			6. 00
7.00		0.00	0			7. 00
8.00		0.00	0			8. 00
9.00		0.00	0			9. 00
10.00		0.00	0			10.00
11. 00		0.00	0			11.00
12.00		0.00	0			12.00
13.00		0.00	0			13.00
14.00		0.00	0	_		14.00
15. 00		0.00	0			15. 00
16.00		0.00	0	_		16.00
17. 00 18. 00		0. 00 0. 00	0	_		17. 00 18. 00
		0.00	0	_		
19. 00 20. 00		0.00	0	0		19. 00 20. 00
20.00		0.00	0			20.00
21.00		0.00	0			21.00
22.00			0			22.00
	Q - LEASE EXPENSE		0	2, 990, 404		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	29, 008		1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1. 00	0			2.00
2.00	FIXT-RHC	1.04	U	74, 040	<u>'</u>	2.00
	TOTALS — — —	+	<sub>0</sub>	123, 856	<del>,</del>	
500 00	Grand Total: Increases		176, 789			500.00
	1	I	, ,,,,	. 5,, 550	ı	5. 50

RECLASSI FI CATI ONS

Provider CCN: 15-1320

Period: Worksheet A-6 From 01/01/2023

12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 176, 789 176, 407 0 1.00 176, 789 176, 407 B - DRUGS RECLASS 1.00 PHARMACY 15.00 1,843,944 0 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 0 2.00 4.00 9,632 2.00 3.00 CENTRAL SERVICES & SUPPLY 14.00 ol 0 3.00 142 0 0 4.00 ADULTS & PEDIATRICS 30.00 13, 357 4.00 5.00 OPERATING ROOM 50.00 0 15, 206 0 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 73,833 0 6.00 7 00 I ABORATORY 60 00 o 0 7 00 0 8.00 RESPIRATORY THERAPY 65.00 0 134 8.00 9.00 PHYSICAL THERAPY 66.00 o 39 0 9.00 CARDI OPULMONARY 76.00 0 1,899 0 10.00 10.00 0 RURAL HEALTH CLINIC (RHC) 0 88 00 11 00 61, 235 11 00 FAMILY PRACTICE OF JAY 12.00 90.01 0 144, 178 0 12.00 COUNTY 13.00 JAY FAMILY MEDICINE 90.02 0 149, 212 0 13.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 0 14.00 75, 967 14.00 15.00 INFUSION CLINIC 90.06 0 10, 423 0 15.00 EMERGENCY 91.00 0 0 16.00 55, 438 16.00 17.00 OUTPATIENT PSYCH 93.00 o 54 0 17.00 2, 454, 695 0 SUPPLI ES/I MPLANTS 1.00 CENTRAL SERVICES & SUPPLY 14. 00 0 366 0 1.00 0 2.00 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 2.00 3.00 0 0 OPERATION OF PLANT 7.00 16,838 3.00 4.00 OPERATION OF PLANT - MOB 7.01 0 105 0 4.00 o 0 5.00 PHARMACY 15.00 596 5.00 0 0 ADULTS & PEDIATRICS 30.00 6.00 32.682 6.00 OPERATING ROOM 0 0 7.00 50.00 78.807 7.00 2, 137 8.00 RADI OLOGY-DI AGNOSTI C 54.00 0 0 8.00 0 9.00 LABORATORY 60.00 0 785 9.00 o 0 10 00 RESPIRATORY THERAPY 65 00 13 491 10 00 0 11.00 ELECTROCARDI OLOGY 69.00 250 11.00 12.00 RURAL HEALTH CLINIC (RHC) 88.00 o 1,050 0 12.00 13.00 FAMILY PRACTICE OF JAY 90.01 ol 0 13.00 11, 256 COUNTY 90.02 14.00 JAY FAMILY MEDICINE 0 10.175 0 14 00 15.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 7, 517 0 15.00 16.00 INFUSION CLINIC 90.06 0 3,870 0 16.00 55,800 17.00 EMERGENCY\_ 91.00 0 17.00 235, 728 LAUNDRY 1.00 ADMINISTRATIVE & GENERAL 5. 00 21 0 1.00 OPERATION OF PLANT - POB 7.02 0 2.00 43 0 2.00 3.00 DI ETARY 10.00 0 127 0 3.00 4.00 ADULTS & PEDIATRICS 30.00 0 18, 457 0 4.00 0 5.00 OPERATING ROOM 50.00 0 15.174 5.00 0 0 6.00 RADI OLOGY-DI AGNOSTI C 54.00 11,654 6.00 7.00 PHYSICAL THERAPY 66.00 0 2, 989 0 7.00 0 8.00 FAMILY PRACTICE OF JAY 90.01 0 746 8.00 COUNTY 9 00 JAY FAMILY MEDICINE 90 02 0 0 9 00 341 10.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 462 0 10.00 91.00 o 0 11.00 EMERGENCY 15, 721 11.00 0 12.00 PHYSICIANS' PRIVATE OFFICES 192.00 218 0 12.00 65, 953 - DEPRECIATION EMPLOYEE BENEFITS DEPARTMENT 1.00 0 9 4.00 3,077 1.00 0 ADMINISTRATIVE & GENERAL 2.00 5.00 53, 604 2.00 7.00 9 3.00 OPERATION OF PLANT 1, 173, 403 3.00 OPERATION OF PLANT - MOB 7. 01 0 75, 227 9 4.00 4.00 5.00 OPERATION OF PLANT - POB 7.02 0 35, 030 5.00 0 DI ETARY 10.00 9 6.00 23.050 6.00 7.00 PHARMACY 15.00 0 40, 366 9 7.00

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53, 985

365, 750

322, 519

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COUNTY

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11. 00 12. 00

13.00

14.00

ADULTS & PEDIATRICS

RADI OLOGY-DI AGNOSTI C

RURAL HEALTH CLINIC (RHC)

FAMILY PRACTICE OF JAY

RESPIRATORY THERAPY

OPERATING ROOM

CARDI OPULMONARY

RECLASSI FI CATIONS

Provider CCN: 15-1320

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

5/24/2024 9:43 am Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 WOUND CLINIC 15.00 90.03 445 0 15 00 1, 579 16, 00 JAY FAMILY FIRST HEALTH CARE 90.05 0 0 16.00 0 17.00 INFUSION CLINIC 90.06 0 17.00 445 HEALTH BEGINNINGS PROGRAM 90.07 0 26, 082 18.00 0 18.00 19.00 **LEMERGENCY** 91.00 0 70, 228 0 19.00 OUTPATIENT PSYCH 93.00 0 20.00 0 13, 158 20.00 21.00 PHYSICIANS' PRIVATE OFFICES 192.00 9, 432 21.00 0 2, 314, 474 PROPERTY TAXES 5. 00 5, 767 1.00 ADMINISTRATIVE & GENERAL 00 13 1.00 TOTAL S 5.767 G - PROPERTY INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5.00 0 12 1.00 41, 660 2.00 0 0.00 12 2.00 41, 660 H - HOUSEKEEPING SUPPLIES 1.00 ADMINISTRATIVE & GENERAL 5.00 0 43 0 1.00 OPERATION OF PLANT - MOB 2.00 7.01 0 0 2.00 0 1, 395 0 3 00 10.00 DI FTARY 3 00 4.00 NURSING ADMINISTRATION 13.00 0 13 0 4.00 CENTRAL SERVICES & SUPPLY o 0 5.00 14.00 5.00 0 PHARMACY 0 197 6.00 15.00 6.00 7.00 ADULTS & PEDIATRICS 30.00 0 706 0 7.00 OPERATING ROOM 50.00 0 0 8.00 750 8.00 RADI OLOGY-DI AGNOSTI C 54.00 o 0 9.00 9.00 36 10.00 LABORATORY 60.00 0 0 10 00 11.00 RESPIRATORY THERAPY 65.00 0 0 11.00 PHYSICAL THERAPY o 0 12.00 66.00 15 12.00 0 ELECTROCARDI OLOGY 69.00 0 13.00 13.00 14.00 CARDI OPUL MONARY 76.00 0 6 14 00 FAMILY PRACTICE OF JAY 90.01 0 109 0 15.00 15.00 COUNTY 16.00 JAY FAMILY MEDICINE 90.02 0 0 16.00 466 JAY FAMILY FIRST HEALTH CARE 17 00 90 05 0 85 0 17 00 18.00 INFUSION CLINIC 90.06 0 9 0 18.00 19.00 HEALTH BEGINNINGS PROGRAM 90.07 o 0 19.00 EMERGENCY\_ 20.00 91.00 0 O 20.00 640 4.496 EMPLOYEE BENEFITS 1.00 ADMINISTRATIVE & GENERAL 5.00 58, 607 0 1.00 2 00 OPERATION OF PLANT 7 00 0 0 169, 278 2 00 3.00 LAUNDRY & LINEN SERVICE 8.00 0 4, 995 0 3.00 4.00 HOUSEKEEPI NG 9.00 0 135, 565 0 4.00 5.00 DI ETARY 10.00 0 67, 913 0 5.00 0 NURSING ADMINISTRATION 0 13.00 182, 662 6.00 6.00 7.00 PHARMACY 15.00 0 141, 699 0 7.00 8.00 ADULTS & PEDIATRICS 30.00 o 339, 113 0 8.00 OPERATING ROOM 50.00 0 255, 849 0 9.00 9.00 0 0 54.00 10.00 RADI OLOGY-DI AGNOSTI C 10.00 244, 764 11.00 RESPIRATORY THERAPY 65.00 0 117, 099 0 11.00 PHYSICAL THERAPY o 0 12.00 66.00 6, 294 12.00 0 CARDI OPULMONARY 76.00 0 13.00 45.174 13.00 14 00 RURAL HEALTH CLINIC (RHC) 88 00 0 18, 598 0 14 00 FAMILY PRACTICE OF JAY 90.01 0 279, 968 0 15.00 15.00 COUNTY JAY FAMILY MEDICINE 90.02 0 350, 539 0 16.00 16.00 0 17.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 112,632 17.00 18.00 INFUSION CLINIC 90.06 0 12, 569 0 18.00 o 94, 909 0 19.00 HEALTH BEGINNINGS PROGRAM 90.07 19.00 0 91.00 ol 277. 424 20.00 **LEMERGENCY** 20.00 0 21.00 OUTPATIENT PSYCH 93.00 33, 091 0 21.00 22.00 PHYSICIANS' PRIVATE OFFICES 192.00 41, 722 0 22.00 2, 990, 464 Q - LEASE EXPENSE 1.00 OPERATION OF PLANT 7.00 0 29,008 9 1.00 2.00 RURAL HEALTH CLINIC (RHC) 88. 00 94, 848 9 2.00 T0TALS 123, 856 500.00 Grand Total: Decreases 176, 789 500.00 8, 413, 500

Provi der CCN: 15-1320

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2023 Part I

				-	To 12/31/2023	B Date/Time Prep 5/24/2024 9:4	
				Acqui si ti ons	,	0,21,2021 ,11	<u> </u>
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	989, 148	0		0 0	0	1. 00
2.00	Land Improvements	0	0	(	0 0	0	2. 00
3.00	Buildings and Fixtures	18, 977, 852	0	(	0 0	0	3. 00
4.00	Building Improvements	0	359, 981	(	0 359, 981	0	4. 00
5.00	Fi xed Equipment	0	0	(	0 0	0	5. 00
6.00	Movable Equipment	9, 823, 231	1, 840, 577	(	0 1, 840, 577	107, 155	6. 00
7.00	HIT designated Assets	0	0	(	0 0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	29, 790, 231	2, 200, 558	(	0 2, 200, 558	107, 155	8. 00
9.00	Reconciling Items	0	0	(	0 0	0	9. 00
10.00	Total (line 8 minus line 9)	29, 790, 231	2, 200, 558		0 2, 200, 558	107, 155	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	989, 148	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	18, 977, 852	0				3. 00
4.00	Building Improvements	359, 981	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	11, 556, 653	5, 153, 615			ļ	6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	31, 883, 634	5, 153, 615			ļ	8. 00
9.00	Reconciling Items	0	0			ļ	9. 00
10. 00	Total (line 8 minus line 9)	31, 883, 634	5, 153, 615				10. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS IU HEALTH JAY HOSPITAL

Provider CCN: 15-1320

					To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
			SU	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUMI	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(	0	0	1.00
1. 01	CAP REL COSTS-BLDG & FLXT-MOB	0	0	(	0	0	1. 01
1. 02	CAP REL COSTS-BLDG & FIXT-POB	0	0	(	0	0	1. 02
1. 03	CAP REL COSTS-BLDG & FIXT-WJ	0	0	(	0	0	1. 03
1.04	CAP REL COSTS-BLDG & FIXT-RHC	0	0	9	0	0	1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	9	0	0	2. 00
2. 01	CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB	0	0	,	0	0	2. 01
2. 02 2. 03	CAP REL COSTS-MVBLE EQUIP - POB		0	)		0 0	2. 02 2. 03
2. 03	CAP REL COSTS-MVBLE EQUIP - WJ		0			0	2. 03
3. 00	Total (sum of lines 1-2)		0			· ·	3. 00
0.00	Trotal (Sam St Trines 1 2)	SUMMARY OF	CAPITAL		<u>,                                      </u>		0.00
	Cost Center Description		Γotal (1) (sum				
		Capi tal -Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	14.00		nd ?			
1. 00	CAP REL COSTS-BLDG & FIXT	NSTILLT A, COLONI	1 2, LINES I al	nu z			1. 00
1. 01	CAP REL COSTS-BLDG & FLXT-MOB	0	0				1. 01
1. 02	CAP REL COSTS-BLDG & FIXT-POB	o	0				1. 02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	o	o				1. 03
1.04	CAP REL COSTS-BLDG & FLXT-RHC	0	0				1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0				2. 01
2. 02	CAP REL COSTS-MVBLE EQUIP - POB	0	0				2. 02
2. 03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0				2. 03
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0				2. 04
3. 00	Total (sum of lines 1-2)	0	0				3. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 15-1320	From 01/01/2023	Worksheet A-7 Part III Date/Time Prepared:

RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
		COM	L PUTATION OF RAT	TIOS	ALLOCATION OF	5/24/2024 9: 4 OTHER CAPITAL	3 am
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col.	Ratio (see instructions)	Insurance	
		1. 00	2.00	2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	0.00	11.00	0.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(	1.000000	0	1.00
1. 01	CAP REL COSTS-BLDG & FLXT-MOB	0	_	1	0.00000	0	1. 01
1. 02	CAP REL COSTS-BLDG & FLXT-POB	0		1		0	1. 02
1.03	CAP REL COSTS BLDG & FLXT BUG	0	_	1		0	1.03
1. 04 2. 00	CAP REL COSTS-BLDG & FIXT-RHC CAP REL COSTS-MVBLE EQUIP	0	_	1	0.00000	0	1. 04 2. 00
2. 00	CAP REL COSTS-MVBLE EQUIP - MOB		1	1		0	2. 00
2. 02	CAP REL COSTS-MVBLE EQUIP - POB		_			0	2. 02
2. 03	CAP REL COSTS-MVBLE EQUIP - WJ		Ö	d		o	2. 03
2.04	CAP REL COSTS-MVBLE EQUIP - RHC	0	0	ol c	0. 000000	0	2. 04
3.00	Total (sum of lines 1-2)	0	0	(	1. 000000	0	3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
		6. 00	d Costs 7.00	through 7) 8.00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	0.00	7. 00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0		594, 227	0	1. 00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0	) c	0	0	1. 01
1.02	CAP REL COSTS-BLDG & FLXT-POB	0	_	(	-26, 248	0	1. 02
1.03	CAP REL COSTS-BLDG & FLXT-WJ	0	_	1	0	0	1. 03
1.04	CAP REL COSTS-BLDG & FIXT-RHC	0		_	,0,,02	0	1. 04
2.00	CAP REL COSTS MYDLE FOULD MOD	0				0	2.00
2. 01 2. 02	CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB	0	_		22, 245	0	2. 01 2. 02
2. 02	CAP REL COSTS-MVBLE EQUIP - WJ		_			0	2. 02
2. 04	CAP REL COSTS-MVBLE EQUIP - RHC					Ö	2. 04
3.00	Total (sum of lines 1-2)				2, 100, 652	0	3. 00
			Sl	JMMARY OF CAPIT	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	· •		
					d Costs (see	through 14)	
		11.00	12.00	13.00	instructions) 14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	15. 00	
1.00	CAP REL COSTS-BLDG & FIXT	I 0	36, 328	5, 767	7	636, 322	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT-MOB			1		0	1. 01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0	(	0	-26, 248	1. 02
1.03	CAP REL COSTS-BLDG & FLXT-WJ	0	0	C	0	0	1. 03
1.04	CAP REL COSTS-BLDG & FLXT-RHC	0	0			93, 932	1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	0	-,	1	1	1, 421, 828	2.00
2. 01	CAP REL COSTS MYRLE FOULD DOR	0	0		0	22, 245	2. 01
2. 02 2. 03	CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ		_			0	2. 02 2. 03
2. 03	CAP REL COSTS-MVBLE EQUIP - WJ		_			0	2. 03
3.00	Total (sum of lines 1-2)		_	5, 767	o o	2, 148, 079	3. 00
	·				•		

Peri od: From 01/01/2023 Provider CCN: 15-1320

				Fr To	om 01/01/2023 12/31/2023		
				Expense Classification on	Worksheet A	5/24/2024 9: 43	3 am
				To/From Which the Amount is t	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2. 00 358, 298	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00 9	1. 00
1 01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL			CAR DEL COSTO DI DO A	1 01		1 01
1. 01	COSTS-BLDG & FIXT-MOB (chapter			CAP REL COSTS-BLDG & FIXT-MOB	1. 01	0	1. 01
1. 02	2) Investment income - CAP REL		0	CAP REL COSTS-BLDG &	1. 02	0	1. 02
1.02	COSTS-BLDG & FLXT-POB (chapter			FI XT-POB	1.02	Ĭ	1. 02
1. 03	2)  Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	0	1. 03
	COSTS-BLDG & FLXT-WJ (chapter						
1. 04	2)  Investment income - CAP REL		0	CAP REL COSTS-BLDG &	1. 04	o	1. 04
	COSTS-BLDG & FIXT-RHC (chapter			FI XT-RHC			
2. 00	2)   Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP -	2. 01	0	2. 01
2.01	COSTS-MVBLE EQUIP - MOB			MOB	2.01		2.01
2. 02	(chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP -	2. 02	0	2. 02
	COSTS-MVBLE EQUIP - POB			РОВ			
2. 03	(chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP -	2. 03	0	2. 03
	COSTS-MVBLE EQUIP - WJ			WJ			
2.04	(chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP -	2. 04	o	2. 04
	COSTS-MVBLE EQUIP - RHC			RHC			
3.00	(chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4. 00
	discounts (chapter 8)		9				
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by	В	-35, 371	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service		0		0. 00	О	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10.00	Provi der-based physician	A-8-2	-392, 359			0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12.00	(chapter 23)	A 0 1	2 047 402				12.00
12. 00	Related organization transactions (chapter 10)	A-8-1	2, 047, 492			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee		0	ON ETERNA	0. 00	o	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than				2.23		
17. 00	patients Sale of drugs to other than		0		0. 00	О	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
	abstracts		U				
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
00.05	books, etc.)		_			_	00.00
20. 00 21. 00	Vending machines Income from imposition of		O O		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
	1. 1-23 mod. odi o ovoi paymonts	ı I	l	l		'	

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 01/01/2023 Date/Time Prepared: 5/24/2024 9:43 am Provider CCN: 15-1320

24. 00 A t 1 25. 00 U p	Cost Center Description  Adjustment for respiratory Cherapy costs in excess of imitation (chapter 14) Adjustment for physical Cherapy costs in excess of imitation (chapter 14)	Basi s/Code (2) 1. 00 A-8-3	Amount 2.00	Expense Classification on To/From Which the Amount is t	o be Adjusted	5/24/2024 9: 4:	<i>-</i>
24. 00 A t 1 25. 00 U p	Adjustment for respiratory therapy costs in excess of imitation (chapter 14) adjustment for physical therapy costs in excess of	1. 00	2. 00	Cost Center			
24. 00 A t 1 25. 00 U p	Adjustment for respiratory therapy costs in excess of imitation (chapter 14) adjustment for physical therapy costs in excess of	1. 00	2. 00	Cost Center			
24. 00 A t 1 25. 00 U p	therapy costs in excess of imitation (chapter 14) adjustment for physical therapy costs in excess of				Li ne #	Wkst. A-7 Ref.	
24. 00 A t 1 25. 00 U p	therapy costs in excess of imitation (chapter 14) adjustment for physical therapy costs in excess of	A-8-3		3. 00	4. 00	5. 00	
24. 00 A t 1 25. 00 U	imitation (chapter 14) Adjustment for physical Cherapy costs in excess of		O	RESPI RATORY THERAPY	65. 00		23. 00
25. 00 U	therapy costs in excess of						İ
25. 00 U	imitation (chapter 14)	A-8-3	Oli	PHYSI CAL THERAPY	66. 00		24. 00
р	Jtilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	ohysicians' compensation						
	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
С	COSTS-BLDG & FLXT						
	Depreciation - CAP REL COSTS-BLDG & FIXT-MOB			CAP REL COSTS-BLDG & FIXT-MOB	1. 01	0	26. 01
	Depreciation - CAP REL			CAP REL COSTS-BLDG &	1. 02	0	26. 02
1	COSTS-BLDG & FIXT-POB Depreciation - CAP REL		•	FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ	1. 03	0	26. 03
	COSTS-BLDG & FIXT-WJ Depreciation - CAP REL			CAP REL COSTS-BLDG &	1. 04	0	26. 04
С	COSTS-BLDG & FLXT-RHC		ļ	FIXT-RHC		-	
	Depreciation - CAP REL		O	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
27. 01 D	Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP -	2. 01	0	27. 01
	COSTS-MVBLE EQUIP - MOB Depreciation - CAP REL		<b>I</b>	MOB CAP REL COSTS-MVBLE EQUIP -	2. 02	0	27. 02
1 .	COSTS-MVBLE EQUIP - POB Depreciation - CAP REL		I i	POB CAP REL COSTS-MVBLE EQUIP -	2. 03	0	27. 03
С	COSTS-MVBLE EQUIP - WJ		\	WJ CAP REL COSTS-MVBLE EQUIP -		0	
	Depreciation - CAP REL COSTS-MVBLE EQUIP - RHC			RHC	2. 04	0	27. 04
	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00 A	Adjustment for occupational	A-8-3	Ö	OCCUPATI ONAL THERAPY	67. 00	Ŭ.	30.00
	therapy costs in excess of imitation (chapter 14)						ı
	Hospice (non-distinct) (see nstructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00 A	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of imitation (chapter 14)						Î.
	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32. 00
33. 00 E	EMPLOYEE BENEFITS	А		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
	HOSPITAL ASSESSMENT FEES MISCELLANEOUS INCOME	A B		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 01 33. 02
1	MI SCELLANEOUS I NCOME	В	-26, 248	CAP REL COSTS-BLDG &	1. 02	9	33. 02
33. 04 C	CONTRACTED HOSPITALIST	A		FIXT-POB ADULTS & PEDIATRICS	30.00	0	33. 04
1	CONTRACTED CRNA	A		OPERATING ROOM	50.00	0	33. 05
	MEDICARE DEPRECIATION EXPENSE MEDICARE DEPRECIATION EXPENSE	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG &	1. 00 1. 01	9	33. 06 33. 07
				FIXT-MOB		,	
33. 08 M	MEDICARE DEPRECIATION EXPENSE	A		CAP REL COSTS-BLDG & FIXT-POB	1. 02	9	33. 08
	MEDICARE DEPRECIATION EXPENSE	A	-9, 433	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	9	33. 09
1	MEDICARE DEPRECIATION EXPENSE	A A	0	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP -	2. 00 2. 01	9	33. 10 33. 11
33. 12 M	MISCELLANEOUS INCOME	В		MOB JAY FAMILY MEDICINE	90. 02	0	33. 12
	MARKETING EXPENSES	A	•	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
1	MARKETING EXPENSES	A	-1, 800	OPERATING ROOM	50.00	0	33. 14
1	MI SCELLANEOUS NON-ALLOWABLE MI SCELLANEOUS NON-ALLOWABLE	A A	0		0. 00 0. 00	0	33. 15 33. 16
1	MISC NON-ALLOWABLE	A	ol		0.00	0	33. 17
1	MISC NON-ALLOWABLE	A	O		0.00	0	33. 18
33. 19 M	MISCELLANEOUS INCOME	В		CAP REL COSTS-BLDG & FIXT-RHC	1. 04	9	33. 19
	MI SCELLANEOUS I NCOME	В	0		0.00	0	33. 20
	MISCELLANEOUS INCOME MISC NON-ALLOWABLE	B A	0		0. 00 0. 00	0	33. 21 33. 22
1	MISC NON-ALLOWABLE	A	0		0.00	0	

Heal th	Financial Systems		IU HEALTH JA	Y HOSPITAL	In Li∈	eu of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES					Peri od:	Worksheet A-8	
					From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:4	pared: 3 am
				Expense Classification or	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	
50.00	TOTAL (sum of lines 1 thru 49)		-4, 406, 695				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).
- A. Costs if cost, including applicable overhead, can be determined.

  B. Amount Received if cost cannot be determined.

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

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

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

Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 9: 43 am

				10 12/31/2023	5/24/2024 9:4	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	<u> </u>
				Allowable Cost		
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1. 00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	-399, 561	29, 008	1. 00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	136, 477	0	2. 00
3.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2, 197, 992	0	3. 00
3. 01	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE	6, 374, 951	6, 673, 311	3. 01
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	0	57, 039	4. 00
4.01	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY	816, 049	471, 414	4. 01
4.02	7. 00	OPERATION OF PLANT	RELATED PARTY	63, 395	162, 817	4. 02
4.03	10. 00	DI ETARY	RELATED PARTY	9, 321	7, 375	4. 03
4.04	13. 00	NURSING ADMINISTRATION	RELATED PARTY	345, 422	207, 101	4. 04
4.05	15. 00	PHARMACY	RELATED PARTY	166, 125	218, 222	4. 05
4.06	50.00	OPERATING ROOM	RELATED PARTY	0	10, 756	4. 06
4.07	54. 00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	139, 017	65, 478	4. 07
4.08	65. 00	RESPI RATORY THERAPY	RELATED PARTY	57, 542	18, 367	4. 08
4.09	66. 00	PHYSI CAL THERAPY	RELATED PARTY	28, 340	73, 942	4. 09
4. 10	76. 00	CARDI OPULMONARY	RELATED PARTY	55, 600	10, 634	4. 10
4. 11	88. 00	RURAL HEALTH CLINIC (RHC)	RHC EXPENSE	1, 095, 077	1, 032, 791	4. 11
4. 12	1. 04	CAP REL COSTS-BLDG & FIXT-RH	SHARED EMPLOYEES	94, 848	94, 848	4. 12
4. 13	4. 00	EMPLOYEE BENEFITS DEPARTMENT	SHARED EMPLOYEES	14, 872	14, 872	4. 13
4.14	5. 00	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	5, 026	5, 026	4. 14
4. 15	10.00	DI ETARY	SHARED EMPLOYEES	38, 353	38, 353	4. 15
4. 16	13. 00	NURSING ADMINISTRATION	SHARED EMPLOYEES	113, 098	113, 098	4. 16
4. 17	15. 00	PHARMACY	SHARED EMPLOYEES	109, 498	109, 498	4. 17
4. 18	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	761, 225	761, 225	4. 18
4. 19	50.00	OPERATING ROOM	SHARED EMPLOYEES	12, 870	12, 870	4. 19
4. 20	60.00	LABORATORY	SHARED EMPLOYEES	2, 305, 680	2, 305, 680	4. 20
4. 21	66. 00	PHYSI CAL THERAPY	SHARED EMPLOYEES	541, 766	541, 766	4. 21
4. 22	67. 00	OCCUPATIONAL THERAPY	SHARED EMPLOYEES	99, 104	99, 104	4. 22
4. 23	68. 00	SPEECH PATHOLOGY	SHARED EMPLOYEES	19, 821	19, 821	4. 23
4.24	76. 00	CARDI OPULMONARY	SHARED EMPLOYEES	25, 996	25, 996	4. 24
4. 25	88. 00	RURAL HEALTH CLINIC (RHC)	SHARED EMPLOYEES	60	60	4. 25
4. 26	90. 01	FAMILY PRACTICE OF JAY COUNT	SHARED EMPLOYEES	31, 398	31, 398	4. 26
4.27	90. 02	JAY FAMILY MEDICINE	SHARED EMPLOYEES	111, 322	111, 322	4. 27
4. 28	90. 05	JAY FAMILY FIRST HEALTH CARE	SHARED EMPLOYEES	15, 639	15, 639	4. 28
4. 29	91.00	EMERGENCY	SHARED EMPLOYEES	1, 614, 732	1, 614, 732	4. 29
4.30	0.00		SHARED EMPLOYEES	0	0	4. 30
4.31	0.00		SHARED EMPLOYEES	0	0	4. 31
4.32	0.00			0	0	4. 32
4.33	0.00			0	0	4. 33
5.00	TOTALS (sum of lines 1-4).			17, 001, 055	14, 953, 563	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 11	to been peeted to not concern, cordinate a raid and a concern a cordinate are successful and a cordinate a cordinate are successful.							
					Related Organization(s) and/or Home Office			
		Symbol (1)	Name	Percentage of	Name	Percentage of		
				Ownershi p		Ownershi p		
		1. 00	2. 00	3.00	4. 00	5. 00		
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

i ei iiibui	Schieff under title Aviii.		
6.00	В	0.00 IU HEALTH BALL 100.00	6. 00
7.00	В	0.00 IU HEALTH 100.00	7.00
8.00		0.00	8.00
9.00		0.00	9. 00
10.00		0.00	10.00
	G. Other (financial or		100.00
	non-financial) specify:		

Heal th	Financial Systems	IU HEALTH J	AY HOSPITAL		In Li€	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider 0	CCN: 15-1320	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2023 To 12/31/2023		
			•	Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of	N	lame	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2. 00	3. 00	4	1. 00	5. 00	

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

  F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

8.00

9.00

10.00

100.00

8.00

9.00

10.00

100.00

Health Financial Systems	IU HEALTH JAY I	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-1320	Peri od: From 01/01/2023	Worksheet A-8-1
OFFICE COSTS				Date/Time Prepared: 5/24/2024 9:43 am
Related Organization(s) and/or Home Office				
Type of Business				
6. 00				

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

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
  B. Corporation, partnership, or other organization has financial interest in provider.
  C. Provider has financial interest in corporation, partnership, or other organization.
  D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

  F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1320

					1	Γο 12/31/2023	3 Date/Time Pre 5/24/2024 9:4	epared: 43 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1. 00	90. 01	FAMILY PRACTICE OF JAY	30, 378	30, 378	0	C	0	1. 00
2. 00	00.00	COUNTY JAY FAMILY MEDICINE	01 007	01 007	0	l c		2. 00
2. 00 3. 00		JAY FAMILY MEDICINE JAY FAMILY FIRST HEALTH CARE	81, 007 15, 189	81, 007 15, 189			1	
4. 00		EMERGENCY	1, 531, 170			1		
5. 00	0.00	EMERGENOT	1, 331, 170	203, 703		ď	ól ő	
6. 00	0.00		0	0		Ĭ		6. 00
7. 00	0.00		Ö	Ö	0	l d	o o	7. 00
8. 00	0.00		0	0	0	C	o	8. 00
9.00	0.00		0	0	0	C	o	9. 00
10.00	0.00		0	0	0	C	0	10.00
200.00			1, 657, 744				0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		ldenti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	1, 00	2.00	8.00	9. 00	Education 12.00	12 13. 00	14.00	
1. 00		FAMILY PRACTICE OF JAY	0.00					1. 00
1.00	70.01	COUNTY	Ĭ				)	1.00
2.00	90. 02	JAY FAMILY MEDICINE	0	0	0	l c	o	2. 00
3.00	90. 05	JAY FAMILY FIRST HEALTH CARE	0	0	0	l c	o	3. 00
4.00	91. 00	EMERGENCY	0	0	0	C	o o	4. 00
5.00	0.00		0	0	0	C	0	5. 00
6.00	0.00		0	0	0	C	0	6. 00
7. 00	0.00		0	0	0	C	0	
8. 00	0. 00		0	0	0	C	0	
9. 00	0. 00		0	0	_	C	1	
10.00	0. 00		0	0	_	C	1	
200.00	Wkst. A Line #	Coat Cantar/Dhyaiaian	Provi der	0	RCE	Adi ustmant	0	200. 00
	WKST. A LINE #	Cost Center/Physician Identifier	Component	Adjusted RCE Limit	Di sal I owance	Adjustment		
		ruentiniei	Share of col.	Limit	Di Sai i Owance			
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00	90. 01	FAMILY PRACTICE OF JAY	0	0	0	30, 378	3	1. 00
		COUNTY						
2.00		JAY FAMILY MEDICINE	0			81, 007		2. 00
3.00		JAY FAMILY FIRST HEALTH CARE	0	0	_	10,10,		3. 00
4.00		EMERGENCY	0	0			1	4. 00
5.00	0.00		0	0		C		5. 00
6.00	0.00		0	0	_	C		6. 00
7.00	0.00			0	_		)	7. 00
8.00	0.00		0	0	_			8. 00
9. 00 10. 00	0. 00 0. 00			0			1	9. 00 10. 00
200.00	0.00			-	_	_		200.00
200.00	1		1	1	1	J 72, 337	<b>'</b> I	200.00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320

					Tc		Date/Time Pre 5/24/2024 9:4	
					CAPITAL REL	ATED COSTS		
		Cost Center Description	Net Expenses for Cost	BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FI XT-POB	BLDG & FIXT-WJ	
			Allocation		TTXT-MOB	1171-100		
			(from Wkst A col. 7)					
			0	1. 00	1. 01	1. 02	1. 03	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT	636, 322	636, 322			<u> </u>	1. 00
1. 01	00101	CAP REL COSTS-BLDG & FIXT-MOB	O	0	0			1. 01
1. 02 1. 03		CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ	-26, 248 0	0		-26, 248 0	0	1. 02 1. 03
1.04	00104	CAP REL COSTS-BLDG & FIXT-RHC	93, 932	0	0	0	0	1. 04
2. 00 2. 01		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB	1, 421, 828 22, 245					2. 00 2. 01
2.02	00202	CAP REL COSTS-MVBLE EQUIP - POB	0					2. 02
2. 03 2. 04		CAP REL COSTS-MVBLE EQUIP - WJ CAP REL COSTS-MVBLE EQUIP - RHC	0					2. 03 2. 04
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2, 215, 545	0	0	0	0	4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	7, 711, 026 2, 743, 841	72, 617 144, 265		0	0	5. 00 7. 00
7. 01	00701	OPERATION OF PLANT - MOB	118, 798	0		0	0	7. 01
7. 02 7. 03	1	OPERATION OF PLANT - POB OPERATION OF PLANT - WJ	80, 629 0	0	0	0	0	7. 02 7. 03
7.04	00704	OPERATION OF PLANT - RHC	0	0	0	0	0	7. 04
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	85, 703 775, 274	4, 609 4, 671	0	0	0	8. 00 9. 00
10.00	01000	DI ETARY	295, 004	15, 029	0	0	0	10. 00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	353, 196 1, 614, 112	18, 117 7, 216	0	0	0	11. 00 13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	160, 983	0	0	0	0	14. 00
15. 00 16. 00	1	PHARMACY   MEDI CAL RECORDS & LI BRARY	1, 023, 321 0	7, 759 0		0	0	15. 00 16. 00
17. 00	01700	SOCIAL SERVICE	0	0		0	0	17. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 747, 878	76, 466	O	0	0	30. 00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40. 00
43. 00		NURSERY LARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	43. 00
50.00	05000	OPERATING ROOM	1, 123, 363	30, 974		0	0	50.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM   ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54.00		RADI OLOGY-DI AGNOSTI C	1, 326, 150	37, 725		0	0	54.00
60. 00 65. 00		LABORATORY RESPI RATORY THERAPY	2, 606, 557 585, 411	20, 290 5, 672		0	0	60. 00 65. 00
66.00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	604, 538	26, 133 3, 631	0	0	0	66. 00 67. 00
67. 00 68. 00		SPEECH PATHOLOGY	99, 104 19, 821	3, 631	0	0	0	68. 00
69. 00 71. 00		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 595	0		0	0	69. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	58, 044 21, 788	0	0	0	0	
73. 00 76. 00		DRUGS CHARGED TO PATIENTS CARDIOPULMONARY	2, 375, 125 289, 555	0	0	0	0	
77. 00		ALLOGENEIC HSCT ACQUISITION	287, 555	0	0	0	0	77. 00
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
88. 00	08800	RURAL HEALTH CLINIC (RHC)	1, 422, 326	0	0	0	0	
90. 00 90. 01		CLINIC  FAMILY PRACTICE OF JAY COUNTY	0 779, 689	0	0	0	0	90. 00 90. 01
90. 02	09002	JAY FAMILY MEDICINE	1, 024, 557	0	0	0	0	90. 02
90. 03 90. 04		WOUND CLINIC OP ORTHO CLINIC	0 132	0	0	0	0	90. 03 90. 04
90. 05	09005	JAY FAMILY FIRST HEALTH CARE	371, 762	39, 610		Ö	ő	90. 05
90. 06 90. 07		INFUSION CLINIC HEALTH BEGINNINGS PROGRAM	98, 829 407, 616	4, 795 28, 848		0	0	90. 06 90. 07
91. 00	09100	EMERGENCY	3, 005, 202			0	ő	91. 00
92. 00 93. 00	1	OBSERVATION BEDS (NON-DISTINCT PART OUTPATIENT PSYCH	100, 887	12, 190	o	0	0	92. 00 93. 00
	OTHER	REIMBURSABLE COST CENTERS						
102.00		OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00	)	SUBTOTALS (SUM OF LINES 1 through 117)	37, 397, 440	597, 675	0	0	0	118. 00
190. 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	5, 982	O	0	0	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	170, 054	0	0	0	0	192. 00
193.00	19300	NONPALD WORKERS	0	0	0	0	1 0	193. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-1320	Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

					5/24/2024 9: 4	3 am
			CAPITAL REL	ATED COSTS		
					I	
Cost Center Description	Net Expenses	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ	
	for Cost		FIXT-MOB	FI XT-POB		
	Allocation					
	(from Wkst A					
	col. 7)					
	0	1.00	1. 01	1. 02	1. 03	
194. 00 07950 VACANT	0	20, 212	0	C	0	194. 00
194.02 07952 WEST JAY CLINIC	0	0	0	C	0	194. 02
194.03 07953 JAY MERIDIAN URGENT CARE	0	12, 453	0	C	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers		0	0	-26, 248	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	37, 567, 512	636, 322	0	-26, 248	0	202. 00

Provider CCN: 15-1320

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 9:43 am

			CAP	ITAL RELATED CO	OSTS	5/24/2024 9: 4	3 am
	Cost Center Description	BLDG &	MVBLE EQUIP	MVBLE FOULP -	MVBLE EQUIP -	MVBLE FOLLE -	
	oost conto. Dood i pti on	FIXT-RHC		MOB	POB	WJ	
CENED	AL SERVICE COST CENTERS	1. 04	2. 00	2. 01	2. 02	2. 03	
	CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101	CAP REL COSTS-BLDG & FIXT-MOB						1. 01
	CAP REL COSTS-BLDG & FIXT-POB						1. 02
	CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-RHC	93, 932					1. 03 1. 04
	CAP REL COSTS-MVBLE EQUIP	75, 752	1, 421, 828				2. 00
1	CAP REL COSTS-MVBLE EQUIP - MOB		0	22, 245			2. 01
1	CAP REL COSTS MYBLE EQUIP - POB		0	0	0		2. 02
-	CAP REL COSTS-MVBLE EQUIP - WJ CAP REL COSTS-MVBLE EQUIP - RHC		0	0	0	0	
	EMPLOYEE BENEFITS DEPARTMENT	0	0	Ö	1	0	1
	ADMINISTRATIVE & GENERAL	0	162, 259		0	0	1
	OPERATION OF PLANT	0	322, 351		· ·	0	
	OPERATION OF PLANT - MOB OPERATION OF PLANT - POB	0	0	507 0	0	0	7. 01 7. 02
	OPERATION OF PLANT - WJ	0	0	Ö	· ·	Ö	7. 03
1	OPERATION OF PLANT - RHC	0	0	0	1	0	
1	LAUNDRY & LINEN SERVICE	0	10, 298		1	0	
	HOUSEKEEPI NG DI ETARY	0	10, 437 33, 582		1	0	
	CAFETERI A	0	40, 482		· ·	Ö	1
	NURSING ADMINISTRATION	0	16, 124	1	· ·	0	13. 00
	CENTRAL SERVICES & SUPPLY	0	17 227	1	_	0	14.00
	PHARMACY MEDICAL RECORDS & LIBRARY	0	17, 337 0		· ·	0	15. 00 16. 00
	SOCIAL SERVICE	0	0		1	Ö	
	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDIATRICS SUBPROVIDER - IPF	0	170, 859 0	1		0	
1	NURSERY	0	0	•		0	1
ANCI L	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0	69, 210	1		0	
	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	0	l .	0	
1	RADI OLOGY-DI AGNOSTI C	0	84, 294		· ·	Ö	1
	LABORATORY	0	45, 337		1	0	
	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	12, 674 58, 392		l .	0	65. 00 66. 00
	OCCUPATIONAL THERAPY	0	8, 114		· ·	0	67. 00
68. 00 06800	SPEECH PATHOLOGY	0	104		0	0	68. 00
	ELECTROCARDI OLOGY	0	0	0	0	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
	DRUGS CHARGED TO PATIENTS	0	0	ő	o	0	1
	CARDI OPULMONARY	0	0	1, 550	0	0	
	ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	1
	CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	U	0	0	0	0	78. 00
	RURAL HEALTH CLINIC (RHC)	93, 932	0	0	0	0	88. 00
	CLINIC	O	0	0	1	0	1
	FAMILY PRACTICE OF JAY COUNTY JAY FAMILY MEDICINE	0	0	8, 930 8, 728		0	
	WOUND CLINIC	0	0	8, 728		0	1
90. 04 09004	OP ORTHO CLINIC	o	0	0		0	90. 04
	JAY FAMILY FIRST HEALTH CARE	0	88, 507		l .	0	
	INFUSION CLINIC HEALTH BEGINNINGS PROGRAM	0	10, 714 64, 460		0	0	90. 06 90. 07
1	EMERGENCY	ol	82, 699		ol	0	1
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART		•				92. 00
	OUTPATIENT PSYCH	0	27, 237	0	0	0	93. 00
	REIMBURSABLE COST CENTERS OPIOID TREATMENT PROGRAM	0	0	0	0	Ω	102. 00
SPECIA	AL PURPOSE COST CENTERS						]
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	93, 932	1, 335, 471	22, 245	0	0	118. 00
	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	ما	10 0/7	Ιο	O	0	190. 00
	PHYSICIANS' PRIVATE OFFICES	0	13, 367 0				190.00
193. 00 19300	NONPALD WORKERS	o	Ö	Ö	o	0	193. 00
194. 00 07950		0	45, 164		0		194. 00
	WEST JAY CLINIC JAY MERIDIAN URGENT CARE	0	0 27, 826	0	· ·		194. 02 194. 03
171.03 07733	JOHN MERITARY ORDERT OFFICE	<u> </u>	21,020	1 0	<u> </u>	0	117 1. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320
From 01/01/2023
To 12/31/2023
Date/Time Prepared:

						5/24/2024 9:4	3 am
		CAPITAL RELATED COSTS					
	Cost Center Description	BLDG &	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	
		FI XT-RHC		MOB	POB	WJ	
		1. 04	2. 00	2. 01	2. 02	2. 03	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	93, 932	1, 421, 828	22, 245	0	0	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2023	Part
To 12/31/2023	Date/Time Prepared:
5/24/2024 9:43 am	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320

					0 12/31/2023	5/24/2024 9: 4	
	Cost Center Description	CAPITAL RELATED COSTS MVBLE EQUIP - RHC	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	PLANT	
	CENEDAL CEDILICE COCT CENTEDO	2. 04	4. 00	4A	5. 00	7. 00	
1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 2. 03	GENERAL SERVICE COST CENTERS  O0100 CAP REL COSTS-BLDG & FIXT  O0101 CAP REL COSTS-BLDG & FIXT-MOB  O0102 CAP REL COSTS-BLDG & FIXT-POB  O0103 CAP REL COSTS-BLDG & FIXT-WJ  O0104 CAP REL COSTS-BLDG & FIXT-RHC  O0200 CAP REL COSTS-MVBLE EQUIP  O0201 CAP REL COSTS-MVBLE EQUIP - MOB  O0202 CAP REL COSTS-MVBLE EQUIP - POB  O0203 CAP REL COSTS-MVBLE EQUIP - WJ						1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 2. 03
2. 03 2. 04 4. 00 5. 00 7. 00 7. 01 7. 02 7. 03 7. 04	00203 CAP REL COSTS-MVBLE EQUIP - WJ 00204 CAP REL COSTS-MVBLE EQUIP - RHC 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00704 OPERATION OF PLANT - RHC	0 0 0 0 0	2, 215, 545 44, 266 111, 071 0 0 0	7, 991, 619 3, 321, 528	896, 706 32, 209 21, 767 0	4, 218, 234 23, 040 28, 568 0	2. 03 2. 04 4. 00 5. 00 7. 00 7. 01 7. 02 7. 03 7. 04
8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 0 0 0 0 0 0	3, 233 80, 986 25, 827 31, 127 190, 859 0 105, 274 0	103, 843 871, 368 369, 442 442, 922 1, 828, 311 160, 983	28, 034 235, 241 99, 738 119, 575 493, 585 43, 460 311, 460	27, 592 27, 964 89, 977 108, 465 43, 200 0 46, 452 0	8. 00 9. 00 10. 00 11. 00 13. 00 14. 00
30. 00 40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0 0 0	274, 524 0 0		0	457, 782 0 0	30. 00 40. 00 43. 00
50. 00 52. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05300 ANESTHESI OLOGY  05400 RADI OLOGY-DI AGNOSTI C  06000 LABORATORY  06500 RESPI RATORY THERAPY  06600 PHYSI CAL THERAPY  06700 OCCUPATI ONAL THERAPY  06800 SPEECH PATHOLOGY	0 0 0 0 0 0	153, 905 0 0 190, 020 0 84, 664 99, 376 17, 449 3, 490	0 0 1, 638, 189 2, 672, 184 688, 421 788, 439 128, 298	0 0 442, 259 721, 404 185, 852 212, 853 34, 636	525, 323 0 0 225, 848 121, 471 33, 956 156, 449 21, 739 279	60. 00 65. 00 66. 00 67. 00
69. 00 71. 00 72. 00 73. 00 76. 00 77. 00 78. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03160 CARDIOPULMONARY 07700 ALLOGENEIC HSCT ACQUISITION	0 0 0 0 0 0	0 0 0 0 0 32,043 0	3, 595 58, 044 21, 788 2, 375, 125 323, 148 0	971 15, 670 5, 882 641, 208	0 0 0 0 70, 421 0	69. 00 71. 00 72. 00 73. 00 76. 00 77. 00
88. 00 90. 00 90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC 09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	0 0 0 0 0 0	51, 327 0 121, 893 157, 994 0 0 57, 204 15, 834 66, 379	1, 191, 279 0 132 557, 226 130, 172	0 245, 809 321, 607 0 36 150, 433 35, 142	146, 276 0 405, 663 396, 512 0 243, 639 28, 707 172, 707	90. 00 90. 01
91. 00 92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	255, 679 15, 305 0	0 155, 619	42, 012	221, 575 72, 976 0	92. 00
118.00		0	2, 189, 729	37, 272, 868	7, 904, 989	3, 696, 581	118. 00
192. 00 193. 00 194. 00	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN D 19200 PHYSICIANS' PRIVATE OFFICES D 19300 NONPAID WORKERS D 07950 VACANT 2 07952 WEST JAY CLINIC	0 0 0 0	0 25, 816 0 0 0	195, 870 0 65, 376	52, 879 0 17, 649	121, 007	192. 00 193. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Period: From 01/01/2023	Worksheet B Part I		
				o 12/31/2023		pared: 3 am	
	CAPITAL RELATED COSTS						
Cost Center Description	MVBLE EQUIP -	EMPLOYEE	Subtotal	ADMI NI STRATI VE			
	RHC	BENEFITS DEPARTMENT		& GENERAL	PLANT		
	2. 04	4. 00	4A	5. 00	7. 00		
194.03 07953 JAY MERIDIAN URGENT CARE	0	0	40, 279	10, 874	74, 555	194. 03	
200.00 Cross Foot Adjustments			(			200.00	
201.00 Negative Cost Centers	0	0	-26, 248	0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 215, 545	37, 567, 512	7, 991, 619	4, 218, 234	202. 00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1320

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared:

5/24/2024 9:43 am

Cost Center Description OPERATION OF OPERATION OF OPERATION OF OPERATION OF LAUNDRY & LINEN SERVICE PLANT - MOB PLANT - POB PLANT - WJ PLANT - RHC 7.03 7. 04 7.01 7.02 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.02 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1 03 1.04 00104 CAP REL COSTS-BLDG & FIXT-RHC 1.04 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.01 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.02 2 02 2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 2.03 2.04 00204 CAP REL COSTS-MVBLE EQUIP - RHC 2 04 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT - MOB 174, 554 7.01 00702 OPERATION OF PLANT - POB 130, 964 7.02 7.02 7.03 00703 OPERATION OF PLANT - WJ 0 7.03 00704 OPERATION OF PLANT - RHC 0 7.04 7.04 00800 LAUNDRY & LINEN SERVICE 0 0 0 159, 469 8.00 8.00 0 0 9.00 00900 HOUSEKEEPI NG C 0 9 00 01000 DI ETARY 0 10.00 10.00 11.00 01100 CAFETERI A 0 0 0 0 0 11.00 0 01300 NURSING ADMINISTRATION 13.00 0 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 15.00 01500 PHARMACY 0 0 0 0 15.00 o 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 0 0 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 159, 469 30.00 0 30.00 04000 SUBPROVIDER - IPF 0 0 0 ol 40.00 0 40.00 04300 NURSERY 0 43.00 0  $\Gamma$ 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 8,050 93, 963 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 0 0 0 0 0 0 0 0 0 0 0 0 52 00 0 05300 ANESTHESI OLOGY 0 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 54.00 60.00 06000 LABORATORY 00000 0 0 60.00 0 0 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68 00 06800 SPEECH PATHOLOGY 0 68 00 Ω 0 0 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 73 00 Ω 0 76.00 03160 CARDI OPULMONARY 13, 338 0 0 0 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 0 0 0 0 0 88.00 0 90.00 09000 CLI NI C 0 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 0 0 90. 01 90.01 76.834 0 0 90 02 09002 JAY FAMILY MEDICINE 75, 100 C 0 0 90 02 90. 03 09003 WOUND CLINIC 90.03 0 90 04 09004 OP ORTHO CLINIC 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 90.05 90.05 1, 232 0 0 90.06 09006 INFUSION CLINIC 0 0 90.06 09007 HEALTH BEGINNINGS PROGRAM 0 0 90.07 90.07 0 0 0 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 OUTPATIENT PSYCH 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 174, 554 93, 963 0 159, 469 118. 00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 37,001 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 0 194. 00 07950 VACANT 0 0 194.00 C 0 0 194. 02 194. 02 07952 WEST JAY CLINIC 0 C 194. 03 07953 JAY MERIDIAN URGENT CARE 0 C 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 0 0 201.00 201 00 Negative Cost Centers

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CO		Peri od:	Worksheet B	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/24/2024 9: 4	3 am
Cost Center Description	OPERATION OF	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	
	PLANT - MOB	PLANT - POB	PLANT - WJ	PLANT - RHC	LINEN SERVICE	
	7. 01	7. 02	7. 03	7. 04	8. 00	
202.00 TOTAL (sum lines 118 through 201)	174, 554	130, 964		0	159, 469	202. 00

Provider CCN: 15-1320

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2024 | Prepared: | To 12/31/2

				'	o 12/31/2023	Date/lime Pre   5/24/2024 9:4	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON		
		9. 00	10. 00	11. 00	13. 00	SUPPLY 14.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 CAP REL COSTS-BLDG & FLXT-MOB						1.01
1. 02 1. 03	00102 CAP REL COSTS BLDG & FLXT WIL						1. 02
1.03	OO1O3  CAP REL COSTS-BLDG & FIXT-WJ  OO1O4  CAP REL COSTS-BLDG & FIXT-RHC						1. 03 1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2.03	00203 CAP REL COSTS-MVBLE EQUI P - WJ						2. 03
2. 04 4. 00	OO204   CAP REL COSTS-MVBLE EQUIP - RHC   OO400   EMPLOYEE BENEFITS DEPARTMENT						2. 04 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - MOB						7. 01
7. 02	00702 OPERATION OF PLANT - POB						7. 02
7. 03 7. 04	00703 OPERATION OF PLANT - WJ						7.03
7. 04 8. 00	OO704   OPERATION OF PLANT - RHC   OO800   LAUNDRY & LINEN SERVICE						7. 04 8. 00
9. 00	00900 HOUSEKEEPING	1, 134, 573					9. 00
10.00	01000 DI ETARY	24, 832	583, 989			•	10.00
11. 00	01100 CAFETERI A	29, 934	0				11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	11, 922	0	45, 351			13. 00
14. 00	O1400   CENTRAL SERVI CES & SUPPLY   O1500   PHARMACY	12 020	0	0	-	204, 443	1
15. 00 16. 00	01600 MEDICAL RECORDS & LIBRARY	12, 820	0	28, 092 0		1, 058 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	o	Ö			Ö	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	126, 340	583, 989	98, 927	693, 440	25, 888	30. 00
40. 00	04000 SUBPROVI DER - I PF	0	0				1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43. 00
50. 00	05000 OPERATING ROOM	144, 982	0	50, 025	382, 015	19, 953	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0			· ·	1
53.00	05300 ANESTHESI OLOGY	О	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	62, 330	0	56, 588		6, 354	1
60.00	06000 LABORATORY	33, 524	0	,		593	1
65. 00 66. 00	06500   RESPI RATORY   THERAPY   06600   PHYSI CAL   THERAPY	9, 371 42, 459	0	23, 462 20, 316		,	1
67. 00	06700 OCCUPATI ONAL THERAPY	6, 628	0	6, 472		0	1
68. 00	06800 SPEECH PATHOLOGY	154	0	449		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	O	0	0	0	215	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	49, 844	1
72. 00	07200 NPL. DEV. CHARGED TO PATIENTS	0	0	0	0	18, 710	1
73. 00 76. 00	07300   DRUGS CHARGED TO PATIENTS   03160   CARDI OPULMONARY	19, 435	0	0 10, 248	_	0 351	
	07700 ALLOGENEIC HSCT ACQUISITION	17, 433	0	10, 240			77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	o	0	Ō	0		1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC (RHC)	40, 370	0			902	
	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY	111, 956	0	0 67, 779	_	0 9, 462	
90.01	09002 JAY FAMILY MEDICINE	109, 431	0	80, 634	·		1
	09003 WOUND CLINIC	0	Ö	00,001		0,000	1
90.04	09004 OP ORTHO CLINIC	О	0	0	0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	67, 240	0	30, 654		6, 297	1
90.06	09006 I NFUSI ON CLI NI C	7, 923	0	4, 090			1
90. 07 91. 00	09007   HEALTH   BEGINNINGS   PROGRAM   09100   EMERGENCY	47, 664 61, 151	0	19, 237 76, 454		0 41, 529	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	01, 131	U	70, 434	042, 574	41, 329	92.00
	04950 OUTPATIENT PSYCH	20, 140	0	10, 787	0	63	1
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	990, 606	583, 989	687, 906	2, 417, 698	204, 443	110 00
118.00	NONREI MBURSABLE COST CENTERS	990, 606	583, 989	087, 900	2, 417, 098	204, 443	]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 884	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	80, 111	o	12, 990	-		192. 00
193.00	19300 NONPALD WORKERS	0	O	0	0		193. 00
	07950 VACANT	33, 396	0	0	0		194. 00
	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE	0 20, 576	0		0		194. 02 194. 03
200.00		20,370	U	١		١	200. 00
	1 1 222 222 23	<u> </u>			1	1	

Health Fina	ancial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOC	ATION - GENERAL SERVICE COSTS		Provi der (		Peri od: From 01/01/2023	Worksheet B Part I	
					To 12/31/2023		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		9. 00	10.00	11. 00	13.00	14. 00	
201.00	Negative Cost Centers	0	(	0	0 0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	1, 134, 573	583, 98	9 700, 89	2, 422, 369	204, 443	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | Part | | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320

			T	o 12/31/2023	Date/Time Pre 5/24/2024 9:4	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	Intern &	
		RECORDS & LI BRARY			Residents Cost & Post	
					Stepdown	
	15. 00	16. 00	17.00	24. 00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	21.00	20.00	
1. 00   00100   CAP REL COSTS-BLDG & FLXT						1.00
1. 01   00101   CAP REL COSTS-BLDG & FLXT-MOB 1. 02   00102   CAP REL COSTS-BLDG & FLXT-POB						1. 01 1. 02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ						1. 03
1. 04 O0104 CAP REL COSTS-BLDG & FIXT-RHC						1.04
2. 00   00200   CAP REL COSTS-MVBLE EQUIP 2. 01   00201   CAP REL COSTS-MVBLE EQUIP - MOB						2. 00 2. 01
2. 02   00201 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2. 03   OO2O3   CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
2. 04   00204 CAP REL COSTS-MVBLE EQUIP - RHC 4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						2. 04 4. 00
5. 00   00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 OO701 OPERATION OF PLANT - MOB						7. 01
7.02   00702   OPERATION OF PLANT - POB 7.03   00703   OPERATION OF PLANT - WJ						7. 02 7. 03
7. 04   00704   OPERATION OF PLANT - RHC						7. 04
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY						9. 00 10. 00
11. 00   01100   CAFETERI A						11.00
13.00 01300 NURSING ADMINISTRATION						13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	1 552 572					14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	1, 553, 573	C				15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	Ö	Č				17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 ( 000)			F 024 210	1 0	1 20 00
30. 00   03000   ADULTS & PEDIATRICS 40. 00   04000   SUBPROVI DER -   1 PF	6, 002	(	1		l .	30. 00 40. 00
43. 00 04300 NURSERY	Ö	C	1			43. 00
ANCI LLARY SERVI CE COST CENTERS	1 4 020			2 070 /50	1 0	1 50 00
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	4, 838	(	1			50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	o	C	o o	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 556	C	0	2, 435, 124		54. 00
60. 00   06000   LABORATORY 65. 00   06500   RESPI RATORY   THERAPY	0	(	) 0 0 0	3, 603, 382 952, 432		60. 00 65. 00
66. 00   06600   PHYSI CAL THERAPY	O	C				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C	0	197, 773		67. 00
68. 00   06800  SPEECH PATHOLOGY 69. 00   06900  ELECTROCARDI OLOGY	0	(	) O	30, 678 4, 781		68. 00 69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(		123, 558		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	C	1			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 503, 297	(	0 0			
76.00   03160   CARDI OPULMONARY 77.00   07700   ALLOGENEI C HSCT ACQUISITION	320	C			l .	1
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	C	•			1
0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC (RHC)	l ol	(	ol o	2, 186, 618	0	88. 00
90. 00   09000   CLINIC		C		2, 160, 616	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	o	C	0	1, 973, 347		90. 01
90. 02   09002   JAY FAMILY MEDICINE	0	0	0	2, 451, 594	1	90. 02
90. 03   09003   WOUND CLINIC 90. 04   09004   OP ORTHO CLINIC		(		0 168	_	90. 03 90. 04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	o	C	o o	1, 121, 082		90. 05
90. 06   09006   NFUSION CLINIC	5, 686	C	0	262, 121		90.06
90. 07   09007   HEALTH   BEGI NNI NGS   PROGRAM 91. 00   09100   EMERGENCY	29, 874	(		1, 122, 006 5, 366, 387		90. 07 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	27,074		7	3, 300, 307	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0	C	0	301, 597	0	93. 00
OTHER REIMBURSABLE COST CENTERS  102. 00 10200 OPI 0I D TREATMENT PROGRAM	O	(	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS			,			102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 553, 573	C	0	36, 465, 956	0	118. 00
NONREIMBURSABLE COST CENTERS  190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	C	0	70, 293	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	Č	o o		0	192. 00
193. 00 19300 NONPALD WORKERS	0	(	0	227 429		193. 00
194.00 07950 VACANT 194.02 07952 WEST JAY CLINIC		(	0 0	237, 428 0		194. 00 194. 02
	,					

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-1320	Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023		nared·
				10 12/01/2020	5/24/2024 9: 4	3 am
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVI	CE Subtotal	Intern &	
		RECORDS &			Residents Cost	
		LI BRARY			& Post	
					Stepdown	
					Adjustments	
	15. 00	16.00	17. 00	24.00	25. 00	
194.03 07953 JAY MERIDIAN URGENT CARE	0	C	)	0 146, 284	1 0	194. 03
200.00 Cross Foot Adjustments				(	0	200. 00
201.00 Negative Cost Centers	0	C		0 -26, 248	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 553, 573	C	o	0 37, 567, 512	2 0	202. 00

IU HEALTH JAY HOSPITAL

| Period: | Worksheet B | From 01/01/2023 | Part | | Date/Time Prepared: | 5/24/2024 9:43 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320

			5/24/2024 9:	
	Cost Center Description	Total	0,21,2021 71	10 4
		26.00		
GENE	RAL SERVICE COST CENTERS			
	OO CAP REL COSTS-BLDG & FIXT			1. 00
	1 CAP REL COSTS-BLDG & FIXT-MOB			1. 01
	2 CAP REL COSTS-BLDG & FIXT-POB			1. 02
1	03 CAP REL COSTS-BLDG & FIXT-WJ			1. 03
1	04 CAP REL COSTS-BLDG & FIXT-RHC			1. 04
1	O CAP REL COSTS-MVBLE EQUIP			2.00
1	OT CAP REL COSTS-MVBLE EQUIP - MOB			2. 01
1	22 CAP REL COSTS-MVBLE EQUIP - POB			2. 02
1	03 CAP REL COSTS-MVBLE EQUIP - WJ			2. 03
	04 CAP REL COSTS-MVBLE EQUIP - RHC			2. 04
1	OO EMPLOYEE BENEFITS DEPARTMENT			4. 00
	OO ADMINISTRATIVE & GENERAL OO OPERATION OF PLANT			5. 00
	11 OPERATION OF PLANT - MOB			7. 00 7. 01
	12 OPERATION OF PLANT - MOB			7. 01
	03 OPERATION OF PLANT - FOB			7. 02
	04 OPERATION OF PLANT - RHC			7. 03
	OO LAUNDRY & LINEN SERVICE			8. 00
	O HOUSEKEEPI NG			9. 00
	DO DI ETARY			10. 00
	O CAFETERI A			11. 00
	OO NURSI NG ADMI NI STRATI ON			13. 00
1	OO CENTRAL SERVICES & SUPPLY			14. 00
	DO PHARMACY			15. 00
	00 MEDICAL RECORDS & LIBRARY			16. 00
1	OO SOCIAL SERVICE			17. 00
	TIENT ROUTINE SERVICE COST CENTERS	'		
	O ADULTS & PEDIATRICS	5, 034, 318		30.00
40.00 0400	O SUBPROVIDER - IPF	0		40. 00
43.00 0430	NURSERY	0		43. 00
ANCI	LLARY SERVICE COST CENTERS			
50.00 0500	OO OPERATING ROOM	2, 979, 658		50. 00
52.00 0520	OO DELIVERY ROOM & LABOR ROOM	0		52. 00
53.00 0530	OO ANESTHESI OLOGY	0		53. 00
54.00 0540	OO RADI OLOGY-DI AGNOSTI C	2, 435, 124		54.00
	OO LABORATORY	3, 603, 382		60.00
65. 00 0650	O RESPIRATORY THERAPY	952, 432		65. 00
1	OO PHYSI CAL THERAPY	1, 221, 035		66. 00
1	OO OCCUPATI ONAL THERAPY	197, 773		67. 00
1	OO SPEECH PATHOLOGY	30, 678		68. 00
	O ELECTROCARDI OLOGY	4, 781		69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	123, 558		71. 00
	O I MPL. DEV. CHARGED TO PATIENTS	46, 380		72. 00
	DO DRUGS CHARGED TO PATIENTS	4, 519, 630		73. 00
	O CARDI OPULMONARY	532, 287		76. 00
	OO ALLOGENEIC HSCT ACQUISITION	0		77. 00
	OO CAR T-CELL IMMUNOTHERAPY	0		78. 00
	ATLENT SERVICE COST CENTERS	2 10/ /10		00 00
	OO RURAL HEALTH CLINIC (RHC)	2, 186, 618 0		88. 00
	00 CLINIC 01 FAMILY PRACTICE OF JAY COUNTY	-		90. 00 90. 01
	12 JAY FAMILY MEDICINE	1, 973, 347		90.01
	JAY FAMILY MEDICINE  13 WOUND CLINIC	2, 451, 594 0		90. 02
	04 OP ORTHO CLINIC	168		90. 03
	15 JAY FAMILY FIRST HEALTH CARE	1, 121, 082		90.04
	16 INFUSION CLINIC	262, 121		90.06
	17 HEALTH BEGINNINGS PROGRAM	1, 122, 006		90.00
	O EMERGENCY	5, 366, 387		91. 00
-	O OBSERVATION BEDS (NON-DISTINCT PART	0,000,007		92. 00
	O OUTPATIENT PSYCH	301, 597		93. 00
	R REIMBURSABLE COST CENTERS	001/07/		70.00
	O OPI OI D TREATMENT PROGRAM	0		102. 00
	TAL PURPOSE COST CENTERS	<u> </u>		T = 1 5 5
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	36, 465, 956		118. 00
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	70, 293		190. 00
	O PHYSI CI ANS' PRI VATE OFFI CES	673, 799		192. 00
	NONPALD WORKERS	073, 777		193. 00
194. 00 0795		237, 428		194. 00
	22 WEST JAY CLINIC	237, 120		194. 02
	3 JAY MERIDIAN URGENT CARE	146, 284		194. 03
200.00	Cross Foot Adjustments	0		200. 00
201.00	Negative Cost Centers	-26, 248		201. 00
202. 00	TOTAL (sum lines 118 through 201)	37, 567, 512		202. 00
	, (1 oag., 201)	,,   0.2		1 30

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 9:43 am | Prepared | 1/24/2024 9:43 am | Prepared | 1/2 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

						5/24/2024 9: 4	
				CAPITAL REL	ATED COSTS		
	Cost Center Description	Directly	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ	
		Assigned New Capital		FIXT-MOB	FI XT-POB		
		Related Costs					
	GENERAL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	1. 03	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FIXT-MOB						1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT-POB						1. 02
1. 03 1. 04	00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-RHC						1. 03 1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2. 03 2. 04	00203 CAP REL COSTS-MVBLE EQUIP - WJ 00204 CAP REL COSTS-MVBLE EQUIP - RHC						2. 03 2. 04
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	72, 617		0	1	5. 00
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB	0	144, 265 0	1	0	1	7. 00 7. 01
7. 01	00701 OFERATION OF PLANT - MOB		0	0	0	1	7. 01
7. 03	00703 OPERATION OF PLANT - WJ	0	0	0	0	0	7. 03
7.04	00704 OPERATION OF PLANT - RHC	0	0	0	0	1	7. 04
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	4, 609 4, 671		0	1	8. 00 9. 00
10. 00	01000 DI ETARY	l o	15, 029		0	1	10.00
11. 00	01100 CAFETERI A	o	18, 117		0	1	11. 00
13. 00 14. 00	01300 NURSING ADMINISTRATION	0	7, 216 0	1	0	1	13. 00 14. 00
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	7, 759		0		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	1	0	1	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	O	76, 466	O	0	0	30. 00
40. 00	04000 SUBPROVI DER - I PF	l o	0		0		40. 00
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000  OPERATING ROOM		30, 974	O	0	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	0		0		52. 00
53.00	05300 ANESTHESI OLOGY	o	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	37, 725		0	0	54.00
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	20, 290 5, 672		0	0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	O	26, 133	1	0	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 631	0	0	1	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	47	0	0	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	0	0	0	1	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	· -	0	1	
73. 00 76. 00	07300 DRUGS CHARGED TO PATIENTS 03160 CARDI OPULMONARY	0	0	0	0	0	73. 00 76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	1	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	1	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
88. 00 90. 00	08800 RURAL HEALTH CLINIC (RHC) 09000 CLINIC		0	0	0	1	88. 00 90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY		0	0	0	ő	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0	0	0	0	90. 02
90. 03 90. 04	09003 WOUND CLINIC 09004 OP ORTHO CLINIC	0	0	0	0	0	90. 03 90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	39, 610		0	Ö	90.05
90. 06	09006 INFUSION CLINIC	0	4, 795		0	0	90. 06
90. 07	09007 HEALTH BEGINNINGS PROGRAM	0	28, 848		0	0	90. 07
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART		37, 011	0	O	0	91. 00 92. 00
93. 00	04950 OUTPATIENT PSYCH	0	12, 190	0	0	0	93. 00
100.00	OTHER REIMBURSABLE COST CENTERS			-			100 00
102.00	10200  OPIOID TREATMENT PROGRAM   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	102. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	597, 675	0	0	0	118. 00
100 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		5, 982	O	0		190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN   19200 PHYSICIANS' PRIVATE OFFICES		5, <del>9</del> 82 0	1	0	•	190.00
193.00	19300 NONPALD WORKERS		0	0	0	0	193. 00
194.00	0 07950  VACANT	<u> </u> 0	20, 212	0	0	0	194. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-1320	Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

					5/24/2024 9: 4	3 am
			CAPITAL REL	LATED COSTS		
Cost Center Description	Directly	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ	
	Assigned New		FIXT-MOB	FI XT-P0B		
	Capi tal					
	Related Costs					
	0	1.00	1. 01	1. 02	1. 03	
194. 02 07952 WEST JAY CLINIC	0	0	0	0	0	194. 02
194.03 07953 JAY MERIDIAN URGENT CARE	0	12, 453	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	-26, 248	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	0	636, 322	0	-26, 248	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/24/2024 9:43 am CAPITAL RELATED COSTS MVBLE EQUIP -BLDG & MVBLE EQUIP MVBLE EQUIP - MVBLE EQUIP -Cost Center Description FLXT-RHC MOB P<sub>0</sub>B W.J 2.00 1.04 2.01 2.03 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 00102 CAP REL COSTS-BLDG & FIXT-POB 1.02 1 02 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.03 00104 CAP REL COSTS-BLDG & FIXT-RHC 1.04 1.04 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.01 2.01 2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.02 2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 2.03 00204 CAP REL COSTS-MVBLE EQUIP - RHC 2 04 2. 04 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 162, 259 1, 451 0 0 0 5.00 7.00 00700 OPERATION OF PLANT 0000000000000 7.00 322, 351 0 C 00701 OPERATION OF PLANT - MOB 7.01 507 0 7.01 7.02 00702 OPERATION OF PLANT - POB 0 7.02 00703 OPERATION OF PLANT - WJ 7.03 C 0 0 0 0 0 0 0 7.03 00704 OPERATION OF PLANT - RHC 7.04 0 0 7 04 00800 LAUNDRY & LINEN SERVICE 8.00 10, 298 0 8.00 9.00 00900 HOUSEKEEPI NG 10, 437 0 9.00 01000 DI ETARY 33, 582 10.00 10.00 0 01100 CAFETERIA 0 40, 482 11 00 0 11 00 13.00 01300 NURSING ADMINISTRATION 16, 124 0 0 13.00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 15 00 01500 PHARMACY 17, 337 0 15 00 0 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 0 16.00 01700 SOCIAL SERVICE 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 170, 859 O 0 n 30 00 40.00 04000 SUBPROVI DER - I PF 0 0 0 0 40.00 04300 NURSERY 0 0 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50 00 0 936 50 00 69, 210 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 C 05300 ANESTHESI OLOGY 0 53.00 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 84, 294 0 0 54.00 06000 LABORATORY 0 60.00 45.337 0 60.00 65.00 06500 RESPIRATORY THERAPY 12, 674 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 58, 392 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 8, 114 67.00 0 06800 SPEECH PATHOLOGY 0 68.00 104 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 C 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 1,550 0 76.00 0 o 77.00 07700 ALLOGENEIC HSCT ACQUISITION C 0 77.00 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 93, 932 n O 0 0 88.00 0 90.00 09000 CLI NI C C 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0 C 8, 930 0 90.01 90.02 09002 JAY FAMILY MEDICINE 8.728 0 90.02 0 0 09003 WOUND CLINIC 90.03 90.03 C 09004 OP ORTHO CLINIC 90 04 Ω Λ 90 04 09005 JAY FAMILY FIRST HEALTH CARE 0 0 90.05 88, 507 0 90.05 143 0 09006 INFUSION CLINIC 0 90.06 10, 714 C 0 90.06 0 09007 HEALTH BEGINNINGS PROGRAM 90.07 90.07 64, 460 0 0 0 91.00 09100 EMERGENCY 82, 699 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 OUTPATIENT PSYCH 93.00 27, 237 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 93, 932 1, 335, 471 22, 245 0 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 13, 367 0 0 190, 00 0 C 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 VACANT 0 0 194, 00 45, 164 194. 02 07952 WEST JAY CLINIC 0 0 0 0 194. 02 194.03 07953 JAY MERIDIAN URGENT CARE 27,826 0 0 194. 03

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320
From 01/01/2023
To 12/31/2023
Date/Time Prepared:

						5/24/2024 9: 4	3 am
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	BLDG &	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	
		FIXT-RHC		MOB	POB	WJ	
		1. 04	2.00	2. 01	2. 02	2. 03	
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	93, 932	1, 421, 828	22, 245	0	0	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 9:43 am | Prepared | 1/24/2024 9:43 am | Prepared | 1/2 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

					0 12/31/2023	5/24/2024 9: 4	
		CAPI TAL RELATED COSTS					
	Cost Center Description	MVBLE EQUIP -	Subtotal	EMPLOYEE	ADMI NI STRATI VE	OPERATION OF	
	·	RHC		BENEFITS	& GENERAL	PLANT	
		2.04	2A	DEPARTMENT 4.00	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 1. 02	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB						1. 01 1. 02
1. 02	00103 CAP REL COSTS-BLDG & FIXT-WJ						1. 02
1. 04	00104 CAP REL COSTS-BLDG & FIXT-RHC						1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01 2. 02	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 01 2. 02
2. 02	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 02
2.04	00204 CAP REL COSTS-MVBLE EQUIP - RHC						2. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	236, 327 466, 616			l	5. 00 7. 00
7. 01	00701 OPERATION OF PLANT - MOB		507				1
7. 02	00702 OPERATION OF PLANT - POB	0	0	C	644	3, 340	1
7. 03	00703 OPERATION OF PLANT - WJ	0	0			0	7. 03
7. 04 8. 00	00704 OPERATION OF PLANT - RHC 00800 LAUNDRY & LINEN SERVICE	0	14, 907		_	0 3, 226	7. 04 8. 00
9. 00	00900 HOUSEKEEPING	0	15, 108				9. 00
10.00	01000 DI ETARY	0	48, 611	C	2, 949	10, 519	10.00
11.00	01100 CAFETERI A	0	58, 599				1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	23, 340 0				13. 00 14. 00
15. 00	01500 PHARMACY	0	25, 096			l e	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	C	0	0	17. 00
30. 00	O3000 ADULTS & PEDIATRICS	0	247, 325		18, 119	53, 517	30.00
40. 00	04000 SUBPROVI DER - I PF	0	247, 323		1	1	40.00
43.00	04300 NURSERY	0	0	C	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	101, 120		11, 004	61, 412	E0 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	101, 120			01,412	50. 00 52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	122, 019				1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0	65, 627 18, 346		,	14, 201 3, 970	1
66. 00	06600 PHYSI CAL THERAPY		84, 525				1
67. 00	06700 OCCUPATI ONAL THERAPY	0	11, 745			l	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	151	C	_	33	68.00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	69. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			o o	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0				
76.00	03160 CARDI OPULMONARY	0	1, 550		1		1
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0			0	
	OUTPATIENT SERVICE COST CENTERS		_	_	_		
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	93, 932		1	l	
90. 00 90. 01	09000   CLINIC   09001   FAMILY PRACTICE OF JAY COUNTY	0	0 8, 930			0 47, 424	90. 00 90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	8, 728		,		1
90. 03	09003 WOUND CLINIC	0	0			0	90. 03
90. 04	09004 OP ORTHO CLINIC	0	122 242	0	1	0	90. 04
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	0	128, 260 15, 509		4, 448 1, 039		1
90. 07	09007 HEALTH BEGINNINGS PROGRAM	0	93, 308				
91. 00	09100 EMERGENCY	0	119, 710				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		20, 427		4 040	0 504	92.00
93. 00	O4950   OUTPATI ENT PSYCH   OTHER REIMBURSABLE COST CENTERS	] 0	39, 427	C	1, 242	8, 531	93. 00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	С	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	, ,	0	2, 049, 323	C	233, 764	432, 148	J118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	19, 349		155	4 187	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		0	1			192. 00
	19300 NONPALD WORKERS	0	. 0	C	_		193. 00
	007950 VACANT 207952 WEST JAY CLINIC	0	65, 376 0				194. 00 194. 02
174.02	-JOT TOZINEST SKI OLIMIO	1 9	0	1	·ı 0	1 0	11/7.02

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC		Peri od:	Worksheet B	
				From 01/01/2023 To 12/31/2023		pared: 3 am
	CAPITAL COSTS					
Cost Center Description	RELATED COSTS MVBLE EQUIP - RHC	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	
	2.04	24	DEPARTMENT	F 00	7.00	
104 03 070F3 LAV MEDI DI ANI LIDCENT CADE	2.04	2A	4. 00	5. 00	7.00	104 02
194.03 07953 JAY MERIDIAN URGENT CARE 200.00  Cross Foot Adjustments	٩	40, 279 0	(	322		194. 03 200. 00
201. 00 Negative Cost Centers	0	-26, 248	(	0		201.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 148, 079	(	236, 327	493, 132	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320

Period: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/24/2024 9:43 am Cost Center Description OPERATION OF OPERATION OF OPERATION OF OPERATION OF LAUNDRY & LINEN SERVICE PLANT - MOB PLANT - POB PLANT - WJ PLANT - RHC 7.01 7.03 7. 04 7.02 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.02 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1 03 1.04 00104 CAP REL COSTS-BLDG & FIXT-RHC 1.04 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.01 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.02 2 02 2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 2.03 2.04 00204 CAP REL COSTS-MVBLE EQUIP - RHC 2 04 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 OPERATION OF PLANT - MOB 4.152 7.01 00702 OPERATION OF PLANT - POB 3, 984 7.02 7.02 7.03 00703 OPERATION OF PLANT - WJ 0 7.03 00704 OPERATION OF PLANT - RHC 0 7.04 7.04 00800 LAUNDRY & LINEN SERVICE 00000 0 0 8.00 18, 962 8.00 0 0 9.00 00900 HOUSEKEEPI NG C 0 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 0 0 0 11.00 0 01300 NURSING ADMINISTRATION 0 13.00 0 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 0 14.00 0 0 15.00 01500 PHARMACY 0 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 01700 SOCIAL SERVICE 0 0 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 18, 962 30.00 0 0 30.00 0 ol 04000 SUBPROVIDER - IPF 0 0 40.00 0 40.00 04300 NURSERY 0 0 43.00  $\Gamma$ 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 191 2, 858 0 0 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52 00 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 54.00 60.00 06000 LABORATORY 00000 0 60.00 0 0 0 06500 RESPIRATORY THERAPY 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0 67.00 68 00 06800 SPEECH PATHOLOGY Ω 0 68 00 0 0 69.00 06900 ELECTROCARDI OLOGY C 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73 00 73 00 Ω 0 76.00 03160 CARDI OPULMONARY 317 0 0 0 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 0 78.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 0 0 0 0 0 88.00 0 90.00 09000 CLI NI C 0 0 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 1,829 0 0 0 0 0 0 90. 01 90.01 0 0 90 02 09002 JAY FAMILY MEDICINE 1.786 Ω 0 0 90 02 90. 03 09003 WOUND CLINIC 90.03 0 90 04 09004 OP ORTHO CLINIC 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 90.05 90.05 29 0 0 90.06 09006 INFUSION CLINIC 0 C 0 0 90.06 09007 HEALTH BEGINNINGS PROGRAM 0 0 0 90.07 90.07 0 0 91.00 09100 EMERGENCY 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 OUTPATIENT PSYCH 93.00 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 4, 152 2, 858 0 18, 962 118. 00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 1, 126 0 0 192.00 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 194. 00 07950 VACANT 0 0 194.00 0 0 194. 02 07952 WEST JAY CLINIC 0 194. 02 0 C 194. 03 07953 JAY MERIDIAN URGENT CARE 0 C 0 0 0 194. 03 200.00 Cross Foot Adjustments 200.00 0 0 201.00 201 00 Negative Cost Centers

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C		Peri od:	Worksheet B	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	
					5/24/2024 9: 4	3 am
Cost Center Description	OPERATION OF	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	
	PLANT - MOB	PLANT - POB	PLANT - WJ	PLANT - RHC	LINEN SERVICE	
	7. 01	7. 02	7.03	7. 04	8. 00	
202.00 TOTAL (sum lines 118 through 201)	4, 152	3, 984		0 0	18, 962	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 9:43 am | Prepared | 1/24/2024 9:43 am | Prepared | 1/2 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

		Luguesussana	2157187		0 12/31/2023	5/24/2024 9: 4	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		0.00	10.00	11 00		SUPPLY	
	GENERAL SERVICE COST CENTERS	9. 00	10. 00	11.00	13.00	14. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 1. 02	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB						1.01
1. 02	00103 CAP REL COSTS-BLDG & FIXT-FOB						1. 02 1. 03
1. 04	00104 CAP REL COSTS-BLDG & FIXT-RHC						1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2. 02 2. 03	OO202   CAP REL COSTS-MVBLE EQUIP - POB   OO203   CAP REL COSTS-MVBLE EQUIP - WJ						2. 02 2. 03
2.04	00204 CAP REL COSTS-MVBLE EQUIP - RHC						2. 04
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7. 00 7. 01	00700 OPERATION OF PLANT - MOB						7. 00 7. 01
7. 02	00702 OPERATION OF PLANT - POB						7. 02
7. 03	00703 OPERATION OF PLANT - WJ						7. 03
7.04	00704 OPERATION OF PLANT - RHC						7. 04
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	25, 333					8. 00 9. 00
10.00	01000 DI ETARY	554	62, 633				10.00
11. 00	01100 CAFETERI A	668	0	75, 483			11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	266	0	4, 884		4 005	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0 286	0	0 3, 025	-	1, 285 7	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0,023		0	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.004	(0.400	40 (55	40.770	1/0	
30. 00 40. 00	03000 ADULTS & PEDI ATRI CS 04000 SUBPROVI DER - 1 PF	2, 821	62, 633 0			163 0	1
43. 00	04300 NURSERY	0	0			0	1
	ANCILLARY SERVICE COST CENTERS			-			
50.00	05000 OPERATING ROOM	3, 239	0	· ·		125	1
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	0	0			0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 392	0	6, 094		40	
60.00	06000 LABORATORY	749	0			4	60.00
65. 00	06500 RESPI RATORY THERAPY	209	0	2, 527	0	71	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	948 148	0	2, 188 697	10	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	3	0	48		0	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	1	1	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	-	313	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0   0		118 0	1
76. 00	1	434	0	1, 104		2	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		1	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC)	901	0	445	83	6	88. 00
90.00		0	0			0	1
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	2, 500	0	7, 299	2, 888	59	
90. 02	09002 JAY FAMILY MEDICINE	2, 443	0	8, 684		55	
90. 03 90. 04	O9003   WOUND CLINIC   O9004   OP ORTHO CLINIC	0	0	0	-	0	1
90.04	09005 JAY FAMILY FIRST HEALTH CARE	1, 501	0	3, 301	-	40	1
90. 06		177	0	440		20	1
90. 07		1, 064	0	2, 072		0	1
91.00		1, 365	0	8, 234	12, 769	261	
92. 00 93. 00		450	0	1, 162	0	0	92. 00 93. 00
	OTHER REIMBURSABLE COST CENTERS	430		1, 102	<u> </u>	<u> </u>	73.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS  SUBTOTALS (SUM OF LINES 1 through 117)	22, 118	62, 633	74, 084	48, 042	1 205	118. 00
	NONREI MBURSABLE COST CENTERS	22, 110	02, 033	74,004	46, 042	1, 285	]116.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	221	0				190.00
	) 19200 PHYSICIANS' PRIVATE OFFICES ) 19300 NONPAID WORKERS	1, 789 0	0	1, 399	93		192. 00 193. 00
	07950 VACANT	746	0		-		193.00
194. 02	2 07952 WEST JAY CLINIC	0	0	0	0	0	194. 02
	07953 JAY MERIDIAN URGENT CARE	459	0	0	0		194. 03
200.00	Cross Foot Adjustments	<u> </u>					200. 00

Health Financial	Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CA	APITAL RELATED COSTS		Provi der CO		Peri od:	Worksheet B	
					From 01/01/2023 To 12/31/2023		pared:
						5/24/2024 9: 4	
Cost	t Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
					ADMI NI STRATI ON	SERVICES &	
						SUPPLY	
		9. 00	10.00	11.00	13. 00	14.00	
201. 00 Nega	ative Cost Centers	0	0		0 0	0	201.00
202. 00 TOTA	AL (sum lines 118 through 201)	25, 333	62, 633	75, 48	48, 135	1, 285	202. 00

Heal th Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320
Period: From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared:

			T	o 12/31/2023	Date/Time Pre 5/24/2024 9:4	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	Subtotal	Intern &	
		RECORDS & LI BRARY			Residents Cost & Post	
					Stepdown	
	15. 00	16. 00	17.00	24. 00	Adjustments 25.00	
GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	21.00	20.00	
1. 00   00100   CAP REL COSTS-BLDG & FLXT						1.00
1. 01   00101   CAP REL COSTS-BLDG & FIXT-MOB 1. 02   00102   CAP REL COSTS-BLDG & FIXT-POB						1. 01 1. 02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ						1. 03
1. 04 O0104 CAP REL COSTS-BLDG & FLXT-RHC						1. 04
2. 00   00200   CAP REL COSTS-MVBLE EQUIP 2. 01   00201   CAP REL COSTS-MVBLE EQUIP - MOB						2. 00 2. 01
2. 02   00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2. 03   00203   CAP   REL   COSTS-MVBLE   EQUI P -   WJ						2. 03
2. 04   00204 CAP REL COSTS-MVBLE EQUIP - RHC 4. 00   00400 EMPLOYEE BENEFITS DEPARTMENT						2. 04 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT						7. 00
7. 01   00701   OPERATION OF PLANT - MOB 7. 02   00702   OPERATION OF PLANT - POB						7. 01 7. 02
7. 03   00703   OPERATION OF PLANT - WJ						7. 02
7. 04   OPERATION OF PLANT - RHC						7. 04
8. 00   00800  LAUNDRY & LI NEN SERVI CE 9. 00   00900  HOUSEKEEPI NG						8. 00 9. 00
10. 00   01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00   01500   PHARMACY	43, 054					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	C	1			16. 00
17. 00 01700 SOCIAL SERVICE I NPATIENT ROUTINE SERVICE COST CENTERS	0		) 0			17. 00
30. 00 03000 ADULTS & PEDIATRICS	166	C	0	428, 139	0	30. 00
40. 00 04000 SUBPROVI DER - I PF	0	C	1			40.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	(	0	0	0	43. 00
50. 00 05000 OPERATI NG ROOM	134	C	1		0	50. 00
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0	(	0	0		52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	99			169, 125	1	54. 00
60. 00 06000 LABORATORY	0	C	0	107, 751	0	60. 00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	0	(	0	30, 619 112, 255		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	C		16, 155		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	C	0	422		68. 00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	(	0	30 776		69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	41, 660	C	0	60, 621		73. 00
76.00   03160   CARDI OPULMONARY 77.00   07700   ALLOGENEI C HSCT ACQUI SITION	9	(	0			•
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	Ö	C				78. 00
OUTPATIENT SERVICE COST CENTERS	0			124 001	1 0	88. 00
88. 00   08800   RURAL HEALTH CLINIC (RHC) 90. 00   09000   CLINIC	0	(	0	124, 981 0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	C	0	78, 198		90. 01
90. 02   09002   JAY FAMILY MEDICINE 90. 03   09003   WOUND CLINIC	0	0	0	82, 892		90. 02 90. 03
90. 03   09003   WOUND CLINIC 90. 04   09004   OP ORTHO CLINIC	0	C		1	0	90.03
90.05 09005 JAY FAMILY FIRST HEALTH CARE	O	Ċ	ō	167, 341	0	90. 05
90. 06   09006   NFUSION CLINIC	158	C	0	21, 638		90.06
90. 07   09007   HEALTH   BEGI NNI NGS   PROGRAM 91. 00   09100   EMERGENCY	0 828	(		124, 381 196, 069		90. 07 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			1	,	0	92. 00
93. 00   04950   OUTPATI ENT PSYCH   OTHER REIMBURSABLE COST CENTERS	0	C	0	50, 812	0	93. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	C	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	40.054			4 070 040		440.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	43, 054	C	0	1, 979, 943	1 0	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C				190. 00
192. 00 19200  PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300  NONPALD WORKERS	0	(	0	39, 906 0		192. 00 193. 00
194. 00 07950 VACANT		C	o o	80, 790	0	194. 00
194. 02 07952 WEST JAY CLINIC	0	C	0	0	0	194. 02

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der C	CN: 15-1320	Peri od:	Worksheet B	
				From 01/01/2023		
				To 12/31/2023		
					5/24/2024 9: 4	3 8111
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVI	CE Subtotal	Intern &	
		RECORDS &			Residents Cost	
		LI BRARY			& Post	
					Stepdown	
					Adjustments	
	15. 00	16.00	17. 00	24. 00	25. 00	
194.03 07953 JAY MERIDIAN URGENT CARE	0	0	)	0 49, 776	0	194. 03
200.00 Cross Foot Adjustments				0	0	200. 00
201.00 Negative Cost Centers	0	0		0 -26, 248	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	43, 054	0	)	0 2, 148, 079	0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: 5/24/2024 9:43 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

				5/24/2024 9: 4	3 am
		Cost Center Description	Total		
			26. 00		
	<b>GENER</b>	AL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1. 00
1.01	00101	CAP REL COSTS-BLDG & FIXT-MOB			1. 01
1.02	00102	CAP REL COSTS-BLDG & FIXT-POB			1. 02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ			1. 03
1.04	00104	CAP REL COSTS-BLDG & FIXT-RHC			1. 04
2.00	1	CAP REL COSTS-MVBLE EQUIP			2.00
2. 01	1	CAP REL COSTS-MVBLE EQUIP - MOB			2. 01
2. 02	1	CAP REL COSTS-MVBLE EQUIP - POB			2. 02
2. 03	1	CAP REL COSTS-MVBLE EQUIP - WJ			2. 03
2.03	1	CAP REL COSTS-MVBLE EQUIP - RHC			2. 03
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4. 00
	1	1			1
5.00		ADMINISTRATIVE & GENERAL			5. 00
7.00	1	OPERATION OF PLANT			7. 00
7. 01	1	OPERATION OF PLANT - MOB			7. 01
7. 02		OPERATION OF PLANT - POB			7. 02
7. 03	1	OPERATION OF PLANT - WJ			7. 03
7.04	1	OPERATION OF PLANT - RHC			7. 04
8. 00	1	LAUNDRY & LINEN SERVICE			8. 00
9. 00	1	HOUSEKEEPING			9. 00
10. 00	01000	DI ETARY			10. 00
11. 00	01100	CAFETERI A			11. 00
13.00	01300	NURSING ADMINISTRATION			13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY			14. 00
15.00	01500	PHARMACY			15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY			16. 00
17.00	1	SOCIAL SERVICE			17. 00
		IENT ROUTINE SERVICE COST CENTERS	<u>'</u>		1
30.00		ADULTS & PEDIATRICS	428, 139		30.00
40. 00	1	SUBPROVIDER - I PF	0		40. 00
43. 00	1	NURSERY	o		43. 00
43.00	_	LARY SERVICE COST CENTERS	<u> </u>		43.00
50. 00	_	OPERATING ROOM	193, 061		50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0		52. 00
53. 00	1	ANESTHESI OLOGY	0		53. 00
	1	1	-1		1
54.00	1	RADI OLOGY-DI AGNOSTI C	169, 125		54.00
60.00	1	LABORATORY	107, 751		60.00
65. 00	1	RESPI RATORY THERAPY	30, 619		65. 00
66. 00	1	PHYSI CAL THERAPY	112, 255		66. 00
67. 00	1	OCCUPATI ONAL THERAPY	16, 155		67. 00
68. 00	1	SPEECH PATHOLOGY	422		68. 00
69. 00		ELECTROCARDI OLOGY	30		69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	776		71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	292		72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	60, 621		73. 00
76.00	03160	CARDI OPULMONARY	14, 384		76. 00
77.00	07700	ALLOGENEIC HSCT ACQUISITION	0		77. 00
78.00	07800	CAR T-CELL IMMUNOTHERAPY	o		78. 00
	OUTPA	TIENT SERVICE COST CENTERS			1
88. 00		RURAL HEALTH CLINIC (RHC)	124, 981		88. 00
90.00		CLINIC	ol		90.00
90. 01		FAMILY PRACTICE OF JAY COUNTY	78, 198		90. 01
90. 02	1	JAY FAMILY MEDICINE	82, 892		90. 02
90. 03		WOUND CLINIC	02, 072		90. 03
90. 04		OP ORTHO CLINIC	1		90. 04
90. 05	1	JAY FAMILY FIRST HEALTH CARE	167, 341		90. 05
90.06		INFUSION CLINIC	21, 638		90.06
90. 00	1	HEALTH BEGINNINGS PROGRAM	124, 381		90. 07
90.07		EMERGENCY	196, 069		90.07
91.00		OBSERVATION BEDS (NON-DISTINCT PART	170, 009		91.00
	1	` `	EO 010		1
93. 00		OUTPATIENT PSYCH	50, 812		93. 00
100.00		REI MBURSABLE COST CENTERS	<u></u>		100 00
102.00		OPI OI D TREATMENT PROGRAM	0		102. 00
440.55		AL PURPOSE COST CENTERS	4 670 0:-1		440 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1, 979, 943		118. 00
4		I MBURSABLE COST CENTERS			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 912		190. 00
		PHYSICIANS' PRIVATE OFFICES	39, 906		192. 00
		NONPALD WORKERS	0		193. 00
		VACANT	80, 790		194. 00
		WEST JAY CLINIC	ol		194. 02
		JAY MERIDIAN URGENT CARE	49, 776		194. 03
200.00		Cross Foot Adjustments	o		200.00
201.00	1	Negative Cost Centers	-26, 248		201. 00
202.00	1	TOTAL (sum lines 118 through 201)	2, 148, 079		202. 00
	1		., ,		

Provider CCN: 15-1320

Peri od: From 01/01/2023 To 12/31/2023 Date/Ti me Prepared: 5/24/2024 9: 43 am

			CAP	ITAL RELATED CO	OSTS	5/24/2024 9: 4	3 am
		DI DO O FLYT				DI DO A	
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	BLDG & FIXT-MOB	BLDG & FLXT-POB	BLDG & FIXT-WJ	BLDG & FIXT-RHC	
		(SQS/IIIC TEET)	(SQUARE	(SQUARE	(SQUARE	(SQUARE	
		1.00	FEET-MOB)	FEET-POB)	FEET-WJ)	FEET-RHC)	
	GENERAL SERVICE COST CENTERS	1. 00	1. 01	1. 02	1. 03	1. 04	
1.00	00100 CAP REL COSTS-BLDG & FLXT	82, 010					1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB	0	21, 755				1. 01
1. 02 1. 03	00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ	0	0	9, 538	3, 728		1. 02 1. 03
1.03	00103 CAP REL COSTS-BLDG & FIXT-RHC		0	0	3, 720	3, 149	1
2.00	00200 CAP REL COSTS-MVBLE EQUIP					•	2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2. 02 2. 03	O0202 CAP REL COSTS-MVBLE EQUIP - POB   O0203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 02 2. 03
2.03	00203 CAP REL COSTS-MVBLE EQUIP - WS						2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	O	0	_	0	0	
5.00	00500 ADMI NI STRATI VE & GENERAL	9, 359	1, 419		0	0	
7. 00 7. 01	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB	18, 593 0	0 496		0	0	7. 00 7. 01
7. 02	00702 OPERATION OF PLANT - POB	Ö	0		o	0	
7. 03	00703 OPERATION OF PLANT - WJ	0	0		0	0	
7.04	00704 OPERATION OF PLANT - RHC	0 594	0		0	0	
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	602	0		0	0	ı
10.00	01000 DI ETARY	1, 937	0		0	0	10.00
11. 00	01100 CAFETERI A	2, 335	0	0	0	0	11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	930	0	0	0	0	13. 00 14. 00
15. 00	01500 PHARMACY	1,000	0	0	0	0	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	O	0	ı
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	9, 855	0	0	0	0	30.00
40. 00	04000 SUBPROVI DER - I PF	0	0		o	0	
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS  05000 OPERATI NG ROOM	3, 992	915	6, 402	O	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 442	913		0	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	4, 862	0	0	0	0	1
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 615 731	0	0	0	0	60. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 368	0	Ö	o	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	468	0	0	0	0	67. 00
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	6	0	0	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	0	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
76. 00 77. 00	03160 CARDI OPULMONARY 07700 ALLOGENEI C HSCT ACQUI SITI ON	0	1, 516 0	0	0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	_	0	0	1
	OUTPATIENT SERVICE COST CENTERS	I al			ام	0.440	
88. 00 90. 00	08800 RURAL HEALTH CLINIC (RHC) 09000 CLINIC	0	0		0	3, 149 0	1
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	8, 733		0	0	
90. 02	09002 JAY FAMILY MEDICINE	0	8, 536	0	О	0	90. 02
90. 03	09003 WOUND CLINIC	0	0		0	0	90. 03
90. 04 90. 05	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	5, 105	0 140		0	0	90. 04 90. 05
90.06	09006 I NFUSI ON CLINIC	618	0		0	0	1
90. 07	09007 HEALTH BEGINNINGS PROGRAM	3, 718	0	_	0	0	
91.00	09100 EMERGENCY	4, 770	0	0	0	0	
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	1, 571	0	0	n	0	92. 00 93. 00
	OTHER REIMBURSABLE COST CENTERS				•		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
118. 00	SPECIAL PURPOSE COST CENTERS   SUBTOTALS (SUM OF LINES 1 through 117)	77, 029	21, 755	7, 017	0	3 140	118. 00
	NONREI MBURSABLE COST CENTERS		21,733	7,017	<u> </u>	J, 147	1, 13, 50
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0		0		190. 00
	19200   PHYSICIANS' PRIVATE OFFICES   19300   NONPAID WORKERS	0	0	, , ,	3, 728 0		192. 00 193. 00
	19300  NONPATO WORKERS   07950  VACANT	2, 605	0		=		193.00
					-1		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1320

						5/24/2024 9: 4	3 am
			CAP	ITAL RELATED C	0STS		
					I		
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ		
		(SQUARE FEET)	FIXT-MOB	FI XT-P0B		FI XT-RHC	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE	
			FEET-MOB)	FEET-POB)	FEET-WJ)	FEET-RHC)	
		1.00	1. 01	1. 02	1. 03	1. 04	
194. 02 07952	WEST JAY CLINIC	0	0	C	0	0	194. 02
194. 03 07953	JAY MERIDIAN URGENT CARE	1, 605	0	C	0	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	636, 322	0	-26, 248	o o	93, 932	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	7. 759078	0. 000000	0.000000	0. 000000	29. 829152	203. 00
204.00	Cost to be allocated (per Wkst. B,						204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part						205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Provider CCN: 15-1320

Period: Worksheet B-1
From 01/01/2023
To 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am

							5/24/2024 9: 4	3 am
				CAP	ITAL RELATED CO	OSTS		
		Cost Center Description	MVBLE EQUIP	MVRLE FOLLE -	MVRLE FOLLE -	MVBLE EQUIP -	MVRLE FOLLE -	
		COST CONTENT DESCRIPTION	(SQUARE FEET)	MOB	POB	WJ	RHC	
			,	(SQUARE	(SQUARE	(SQUARE	(SQUARE	
				FEET-MOB)	FEET-POB)	FEET-WJ)	FEET-RHC)	
	CENED	AL CEDIU CE COCT CENTEDO	2. 00	2. 01	2.02	2. 03	2. 04	
1. 00		AL SERVICE COST CENTERS  CAP REL COSTS-BLDG & FIXT						1.00
1. 01		CAP REL COSTS-BLDG & FIXT-MOB						1. 01
1. 02		CAP REL COSTS-BLDG & FIXT-POB						1. 02
1.03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1. 03
1.04	1	CAP REL COSTS-BLDG & FIXT-RHC						1. 04
2.00		CAP REL COSTS-MVBLE EQUIP	82, 010	l .				2. 00
2. 01	1	CAP REL COSTS MVDLE EQUIP - MOB	0	21, 755				2. 01
2. 02 2. 03		CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ	0	0	9, 538	3, 728		2. 02 2. 03
2.03		CAP REL COSTS-MVBLE EQUIP - WS	0	0	0	3, 720	3, 149	2.03
4.00	1	EMPLOYEE BENEFITS DEPARTMENT	0	Ö	0	0	0,117	4. 00
5.00		ADMINISTRATIVE & GENERAL	9, 359	1, 419	0	0	0	5. 00
7.00		OPERATION OF PLANT	18, 593	ł		0	0	
7. 01		OPERATION OF PLANT - MOB	0	496		0	0	7. 01
7. 02 7. 03	1	OPERATION OF PLANT - POB OPERATION OF PLANT - WJ	0	0		0	0 0	7. 02 7. 03
7. 03 7. 04	1	OPERATION OF PLANT - WS	0	0		0	0	7.03
8.00		LAUNDRY & LINEN SERVICE	594	0	0	0	Ö	8.00
9. 00	1	HOUSEKEEPI NG	602	Ö	Ö	0	0	9. 00
10.00	01000	DI ETARY	1, 937	0	0	0	0	10. 00
11. 00	1	CAFETERI A	2, 335	l e		0	0	11. 00
13.00		NURSI NG ADMI NI STRATI ON	930	1	1	0	0	13.00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 000	0		0	0	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	1,000		·	0	0	16. 00
17. 00	1	SOCIAL SERVICE	0	l ő		0	ő	17. 00
		IENT ROUTINE SERVICE COST CENTERS						
30. 00	1	ADULTS & PEDIATRICS	9, 855	l .		0	0	
40. 00 43. 00		SUBPROVIDER - IPF NURSERY	0	0		0	0	40.00
43.00		LARY SERVICE COST CENTERS	U	0		U	0	43. 00
50.00		OPERATING ROOM	3, 992	915	6, 402	0	0	50. 00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	1	ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 60. 00	1	RADI OLOGY-DI AGNOSTI C	4, 862	0	0	0	0	54. 00 60. 00
65. 00	1	LABORATORY RESPI RATORY THERAPY	2, 615 731		0	0	0	65.00
66. 00	1	PHYSI CAL THERAPY	3, 368			0	0	66. 00
67. 00		OCCUPATIONAL THERAPY	468	0	0	0	0	67. 00
68. 00		SPEECH PATHOLOGY	6	0	0	0	0	68. 00
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	69. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	] 0	0	0	•
73. 00	1	DRUGS CHARGED TO PATIENTS	0	Ö	Ö	0	0	
76.00	03160	CARDI OPULMONARY	0	1, 516	0	0	0	76. 00
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0		0	0	1
78. 00		CAR T-CELL IMMUNOTHERAPY TIENT SERVICE COST CENTERS	0	0	0	0	0	78. 00
88. 00		RURAL HEALTH CLINIC (RHC)	0	0	0	0	3, 149	88. 00
90.00		CLINIC	0	0		0	0	90.00
90. 01		FAMILY PRACTICE OF JAY COUNTY	0	8, 733		0	0	90. 01
90. 02		JAY FAMILY MEDICINE	0	8, 536	1	0	0	90. 02
90. 03 90. 04	1	WOUND CLINIC	0	0		0	0	90. 03 90. 04
90. 04		OP ORTHO CLINIC JAY FAMILY FIRST HEALTH CARE	5, 105	0 140		0	0	90.04
90. 06	1	INFUSION CLINIC	618	l		0	ő	90.06
90. 07		HEALTH BEGINNINGS PROGRAM	3, 718	l .	0	0	0	90. 07
91.00		EMERGENCY	4, 770	0	0	0	0	91. 00
92.00	1	OBSERVATION BEDS (NON-DISTINCT PART	4 574					92.00
93. 00		OUTPATIENT PSYCH REIMBURSABLE COST CENTERS	1, 571	0	0	0	0	93. 00
102.00		OPLOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECI.	AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	77, 029	21, 755	7, 017	0	3, 149	118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0		0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0		3, 728		192. 00
193.00	19300	NONPALD WORKERS	0	0	0	0	0	193. 00
194.00	07950	VACANT	2, 605	0	0	0	0	194. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1320

Peri od: From 01/01/2023 To 12/31/2023 Worksheet B-1 Date/Ti me Prepared: 5/24/2024 9:43 am

						5/24/2024 9:4	з am
			CAP	ITAL RELATED CO	OSTS		
	Cost Center Description	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	
	·	(SQUARE FEET)	MOB	POB	WJ	RHC	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE	
			FEET-MOB)	FEET-POB)	FEET-WJ)	FEET-RHC)	
		2.00	2. 01	2. 02	2. 03	2. 04	
194.020	7952 WEST JAY CLINIC	0	0	0	0	0	194. 02
194. 03 0	7953 JAY MERIDIAN URGENT CARE	1, 605	0	0	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	1, 421, 828	22, 245	0	0	0	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	17. 337252	1. 022524	0.000000	0. 000000	0. 000000	203. 00
204.00	Cost to be allocated (per Wkst. B,						204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part						205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Health Financial Systems	IU HEALTH JAY			In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2023	Worksheet B-1	
				o 12/31/2023	Date/Time Pre	oared:
					5/24/2024 9: 4	3 am
Cost Center Description	EMPLOYEE F BENEFITS	Reconciliation	ADMI NI STRATI VE		OPERATION OF PLANT - MOB	
	DEPARTMENT		& GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	(SQUARE	
	(GROSS		(71000111111111111111111111111111111111	(SQS/IIIC TEET)	FEET-MOB)	
	SALARI ES)					
OFFICE AND ASSOCIATION	4. 00	5A	5. 00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS  1.00 O0100 CAP REL COSTS-BLDG & FIXT	Г		Ι			1. 00
1. 01   00101 CAP REL COSTS-BLDG & FIXT-MOB						1. 00
1.02 00102 CAP REL COSTS-BLDG & FIXT-POB						1. 02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ						1. 03
1. 04   00104 CAP REL COSTS-BLDG & FIXT-RHC						1. 04
2. 00   00200   CAP REL COSTS-MVBLE EQUI P 2. 01   00201   CAP REL COSTS-MVBLE EQUI P - MOB						2. 00 2. 01
2. 02   00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 01
2. 03   00203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
2.04 O0204 CAP REL COSTS-MVBLE EQUIP - RHC						2. 04
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT	12, 583, 442	7 004 (40	00 (00 141			4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	251, 416 630, 842	-7, 991, 619	29, 602, 141 3, 321, 528			5. 00 7. 00
7. 01   00701   0PERATION OF PLANT - MOB	030, 842	0	119, 305		19, 840	7. 00
7. 02 00702 OPERATION OF PLANT - POB	o	0	80, 629		0	7. 02
7.03 OO703 OPERATION OF PLANT - WJ	o	0	C	0	0	7. 03
7. 04   00704   OPERATION OF PLANT - RHC	0	0	0	0	0	7. 04
8.00   00800   LAUNDRY & LI NEN SERVI CE 9.00   00900   HOUSEKEEPI NG	18, 362	0	103, 843 871, 368		0	8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY	459, 969 146, 687	0	369, 442		0	9. 00 10. 00
11. 00 01100 CAFETERI A	176, 789	0	442, 922		0	11. 00
13.00 01300 NURSING ADMINISTRATION	1, 084, 009	0	1, 828, 311	930	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	160, 983		0	14. 00
15. 00 01500 PHARMACY	597, 917	0	1, 153, 691	1, 000	0	15.00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	0	0	i d	0	0	16. 00 17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			<u> </u>		17.00
30. 00 03000 ADULTS & PEDIATRICS	1, 559, 160	0	2, 269, 727	9, 855	0	30. 00
40. 00   04000   SUBPROVI DER -   PF	0	0			0	40.00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	C	0	0	43. 00
50. 00 05000 OPERATI NG ROOM	874, 120	0	1, 378, 388	11, 309	915	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	O	0	C	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	1 (20 100	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 60. 00   06000   LABORATORY	1, 079, 240	0	1, 638, 189 2, 672, 184		0	54. 00 60. 00
65. 00 06500 RESPIRATORY THERAPY	480, 862	0	688, 421		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	564, 421	0	788, 439		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	99, 104	0	128, 298		0	67. 00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	19, 821	0			0	68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	58, 044		0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	ō	O	21, 788		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	2, 375, 125		0	73. 00
76. 00   03160   CARDI OPULMONARY	181, 995	0	323, 148		1, 516	76. 00
77.00   07700   ALLOGENEIC HSCT ACQUISITION 78.00   07800   CAR T-CELL IMMUNOTHERAPY	0	0		_	0	77. 00 78. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70.00
88.00 08800 RURAL HEALTH CLINIC (RHC)	291, 520	0	1, 567, 585	3, 149	0	88. 00
90. 00   09000   CLI NI C	0	0	010 510	0 700	0	90.00
90. 01   09001   FAMILY PRACTICE OF JAY COUNTY 90. 02   09002   JAY FAMILY MEDICINE	692, 309 897, 344	0	910, 512 1, 191, 279		8, 733 8, 536	90. 01 90. 02
90. 03   09003   WOUND CLINI C	077, 344	0	1, 171, 2/7	0, 530	0, 530	90. 02
90. 04   09004   OP ORTHO CLINIC	ō	O	132	0	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	324, 898	0	557, 226		140	90. 05
90. 06   09006   I NFUSI ON CLI NI C	89, 932	0	130, 172		0	90. 06
90. 07   09007   HEALTH BEGINNINGS PROGRAM 91. 00   09100   EMERGENCY	377, 009	0	567, 303		0	90. 07 91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 452, 159	U	3, 380, 591	4, 770	U	91.00
93. 00   04950   0UTPATI ENT   PSYCH	86, 929	0	155, 619	1, 571	0	93. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	C	0	0	102. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	12, 436, 814	-7, 991, 619	29, 281, 249	79, 579	19, 840	118. 00
NONREI MBURSABLE COST CENTERS		. ,				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19, 367			190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPALD WORKERS	146, 628	0	195, 870	6, 249 0		192. 00 193. 00
194. 00 07950 VACANT	0	0	65, 376	2, 605		194. 00
194.02 07952 WEST JAY CLINIC	o	0	c	0		194. 02

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2023	Worksheet B-1	
					Date/Time Prep 5/24/2024 9:43	
Cost Center Description	EMPLOYEE	Reconciliation	ADMI NI STRATI V	E OPERATION OF	OPERATION OF	
	BENEFITS		& GENERAL	PLANT	PLANT - MOB	
	DEDARTMENT		(ACCUM COST)	(SUIMBE EEET)	(SULIADE	

						5/24/2024 9:4	<u>3 am</u>
	Cost Center Description	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	
		BENEFITS		& GENERAL	PLANT	PLANT - MOB	
		DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	(SQUARE	
		(GROSS				FEET-MOB)	
		SALARI ES)					
		4. 00	5A	5. 00	7. 00	7. 01	
194. 03 07953	JAY MERIDIAN URGENT CARE	0	0	40, 279	1, 605	0	194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	2, 215, 545		7, 991, 619	4, 218, 234	174, 554	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 176068		0. 269968	46. 451717	8. 798085	203. 00
204.00	Cost to be allocated (per Wkst. B,	0		236, 327	493, 132	4, 152	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000		0. 007983	5. 430431	0. 209274	205. 00
	[11]						
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
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 IU HEALTH JAY HOSPITAL Provider CCN: 15-1320 

					Т	o 12/31/2023	Date/Time Pre 5/24/2024 9:4	
		Cost Center Description	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
			PLANT - POB	PLANT - WJ	PLANT - RHC	LINEN SERVICE		
			(SQUARE FEET-POB)	(SQUARE FEET-WJ)	(SQUARE FEET-RHC)	(TOTAL PATIENT DAYS)		
			7. 02	7. 03	7. 04	8. 00	9. 00	
		AL SERVICE COST CENTERS			I	1		
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB						1. 00 1. 01
1. 01	1	CAP REL COSTS-BLDG & FIXT-POB						1. 02
1. 03	1	CAP REL COSTS-BLDG & FIXT-WJ						1. 03
1.04	00104	CAP REL COSTS-BLDG & FIXT-RHC						1. 04
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 2. 02	1	CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB						2. 01 2. 02
2. 02		CAP REL COSTS-MVBLE EQUIP - WJ						2. 02
2.04	1	CAP REL COSTS-MVBLE EQUIP - RHC						2. 04
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 7. 00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT						5. 00 7. 00
7. 00 7. 01	1	OPERATION OF PLANT - MOB						7.00
7. 02		OPERATION OF PLANT - POB	8, 923					7. 02
7.03	1	OPERATION OF PLANT - WJ	0	3, 728				7. 03
7. 04	1	OPERATION OF PLANT - RHC	0	0				7. 04
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	0		880	88, 501	8. 00 9. 00
10. 00	1	DI ETARY	o	0	Ö	o o	1, 937	1
11. 00	01100	CAFETERI A	О	0	C	0	2, 335	1
13. 00	1	NURSING ADMINISTRATION	0	0	C	0	930	1
14.00	1	CENTRAL SERVICES & SUPPLY	0	0	0	0	1 000	14.00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	0		0	1,000	1
17. 00	1	SOCIAL SERVICE	o	0			Ö	
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDI ATRI CS	0	0				
40. 00 43. 00	1	SUBPROVIDER - IPF NURSERY	0	0			0	40. 00 43. 00
43.00		LARY SERVICE COST CENTERS	U <sub>I</sub>	0		0		43.00
50.00		OPERATING ROOM	6, 402	0	C	0	11, 309	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	0		0	0	
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0		0	0 4, 862	
60.00	1	LABORATORY	0	0		0	2, 615	ı
65.00	1	RESPI RATORY THERAPY	o	0	C	0	731	65. 00
66. 00	1	PHYSI CAL THERAPY	0	0	C	0	3, 312	1
67.00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0		0	517	67. 00 68. 00
68. 00 69. 00	1	ELECTROCARDI OLOGY	0	0	1 0	0	12	1
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0	C	0	Ö	
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	1
73. 00		DRUGS CHARGED TO PATIENTS	0	0	C	0	0	
76. 00 77. 00		CARDIOPULMONARY ALLOGENEIC HSCT ACQUISITION	0	0		0		76. 00 77. 00
		CAR T-CELL IMMUNOTHERAPY	o	0		o o		78. 00
	OUTPA	TIENT SERVICE COST CENTERS						
88. 00		RURAL HEALTH CLINIC (RHC)	0	0		0	3, 149	
90. 00 90. 01		CLINIC FAMILY PRACTICE OF JAY COUNTY	0	0		0	0 8, 733	
90. 01		JAY FAMILY MEDICINE	o	0		o	8, 536	
90. 03	09003	WOUND CLINIC	О	0	C	0	0	90. 03
90. 04		OP ORTHO CLINIC	0	0	0	0	0	
90. 05 90. 06		JAY FAMILY FIRST HEALTH CARE	0	0		0	5, 245 618	1
		HEALTH BEGINNINGS PROGRAM	0	0		0	3, 718	
91.00	09100	EMERGENCY	o	0	C	0		91.00
		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 00		OUTPATIENT PSYCH REIMBURSABLE COST CENTERS	0	0	C	0	1, 571	93. 00
102 00		OPIOID TREATMENT PROGRAM	ol	0	C	0	0	102. 00
.02.00		AL PURPOSE COST CENTERS	51			1		102.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6, 402	0	3, 149	880	77, 271	118. 00
100.00	NONRE	IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	ما	^			774	100 00
190. UC	19000 19200	PHYSICIANS' PRIVATE OFFICES	2, 521	0 3, 728		0		190. 00 192. 00
		NONPAID WORKERS	2, 321	0, 720		o o		193. 00
194.00	07950	VACANT	О	0	0	0	2, 605	194. 00
		WEST JAY CLINIC	0	0		0		194. 02
194. 03	o <sub>1</sub> 07953	JAY MERIDIAN URGENT CARE	ı o	0	1 0	0	1, 605	194. 03

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1320	Peri od: Worksheet B-1
		From 01/01/2023   To 12/31/2023   Date/Time Prepared:

				Т	o 12/31/2023	Date/Time Pre 5/24/2024 9:4	
	Cost Center Description	OPERATION OF	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		PLANT - POB	PLANT - WJ	PLANT - RHC	LINEN SERVICE	(SQUARE FEET)	
		(SQUARE	(SQUARE	(SQUARE	(TOTAL PATIENT		
		FEET-POB)	FEET-WJ)	FEET-RHC)	DAYS)		
		7. 02	7. 03	7. 04	8. 00	9. 00	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	130, 964	0	0	159, 469	1, 134, 573	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	14. 677127	0. 000000	0. 000000	181. 214773	12. 819889	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	3, 984	0	0	18, 962	25, 333	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 446487	0. 000000	0. 000000	21. 547727	0. 286245	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Financial Systems	TO HEALTH SAL				u or form CMS	
COST AFFOCATION - STATISTICAL RASIS		F		rom 01/01/2023	Date/Time Pre	pared:
Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	(DIRECT NRSING	SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	
	10.00	11. 00	13. 00	14. 00	15. 00	
GENERAL SERVICE COST CENTERS	1		T			
00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-PUJ 00104 CAP REL COSTS-BLDG & FIXT-RHC 00200 CAP REL COSTS-BUDG & FIXT-RHC 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - RHC 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - WJ 00704 OPERATION OF PLANT - WJ 00704 OPERATION OF PLANT - RHC 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	6, 904 0 0 0 0 0	1, 009 0 625 0	4, 667 0 0 0	238, 076 1, 232 0 0	0	16. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS   03000   ADULTS & PEDI ATRI CS   04000   SUBPROVI DER -   PF	6, 904		0	30, 147 0	0	40. 00
	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05300 ANESTHESI OLOGY  05400 RADI OLOGY-DI AGNOSTI C  06000 LABORATORY  06500 RESPI RATORY THERAPY  06600 PHYSI CAL THERAPY  06700 OCCUPATI ONAL THERAPY  06800 SPEECH PATHOLOGY  06900 ELECTROCARDI OLOGY  07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS  07200 I MPL. DEV. CHARGED TO PATI ENTS  07300 DRUGS CHARGED TO PATI ENTS  03160 CARDI OPULMONARY  07700 ALLOGENEI C HSCT ACQUI SI TI ON  07800 CAR T-CELL I IMMUNOTHERAPY  OUTPATI ENT SERVICE COST CENTERS  08800 RURAL HEALTH CLINIC (RHC)	000000000000000000000000000000000000000	0 0 1, 259 1, 206 522 452 144 10 0 0 0 0 228 0 0	0 0 0 0 0 1 1 0 0 0 0 0 0 1 5 0 0 0 0 0	23, 236 0 0 7, 399 690 13, 241 0 0 250 58, 044 21, 788 0 409 0 0	0 0 5, 619 0 0 0 0 0 0 0 0 2, 375, 125 505 0	52. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 00 77. 00 78. 00 90. 00
09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC 09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	0 0 0 0 0 0	1, 794 0 0 682 91 428 1, 701	517 0 0 124 91 312 1, 238	11, 019 10, 115 0 0 7, 333 3, 689 0 48, 361	0 0 0 0 8, 984 0 47, 199	90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						100.05
SPECIAL PURPOSE COST CENTERS						102.00
NONREI MBURSABLE COST CENTERS	6, 904			238, 076		
019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 019200 PHYSICIANS' PRIVATE OFFICES 019300 NONPAID WORKERS 07950 VACANT 07952 WEST JAY CLINIC	0 0 0 0	289	9	0 0 0 0	0 0 0	190. 00 192. 00 193. 00 194. 00 194. 02
	COST CENTER DESCRIPTION  COST CENTER DESCRIPTION  GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT-WOB  00101 CAP REL COSTS-BLDG & FIXT-MOB  00102 CAP REL COSTS-BLDG & FIXT-WD  00103 CAP REL COSTS-BLDG & FIXT-WJ  00104 CAP REL COSTS-BLDG & FIXT-WJ  00104 CAP REL COSTS-BLDG & FIXT-WJ  00200 CAP REL COSTS-WUBLE EQUIP P MOB  00201 CAP REL COSTS-WUBLE EQUIP P MOB  00202 CAP REL COSTS-MVBLE EQUIP P POB  00203 CAP REL COSTS-MVBLE EQUIP P RHC  00400 EMPLOYEE BENEFITS DEPARTMENT  00500 ADMIN ISTRATIVE & GENERAL  00700 OPERATION OF PLANT POB  00701 OPERATION OF PLANT POB  00702 OPERATION OF PLANT POB  00703 OPERATION OF PLANT POB  00703 OPERATION OF PLANT POB  00704 OPERATION OF PLANT PUB  00704 OPERATION OF PLANT PUB  00800 LAUNDRY & LINEN SERVICE  00900 HOUSEKEEPING  101000 DIETARY  01100 CAFETERIA  01300 NURSING ADMINISTRATION  01400 CENTRAL SERVICES & SUPPLY  01500 PHARMACY  01600 MEDI CAL RECORDS & LI BRARY  01700 SOCI AL SERVICE  INPATI ENT ROUTINE SERVICE COST CENTERS  03000 ADULTS & PEDIATRICS  04000 SUBPROVIDER - IPF  04300 INDELTS REPOLATRICS  04000 SUBPROVIDER - IPF  04300 INDELTS REPOLATRICS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM  05200 ORDOR RESPIRATORY THERAPY  06800 SPEECH PATHOLOGY  06900 ELECTROCARDIOLOGY  07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS  07200 IMPL. DEV. CHARGED TO PATIENTS  073160 CARDIOLOGY	COST CENTER DESCRIPTION	COST CENTER DESCRIPTION	COST CORTOR DESCRIPTION   DIETARY (MEALS SERVED)   NURSING (MEALS SER	Cost Center Description	Cost Center Description

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	narad:
					10 12/31/2023	5/24/2024 9: 4	
	Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	
		(MEALS SERVED)	(MAN HOURS)	ADMI NI STRATI O	N SERVICES &	(COSTED	
					SUPPLY	REQUIS.)	
				(DIRECT NRSIN	IG (COSTED		
				HRS)	REQUIS.)		
		10.00	11. 00	13. 00	14. 00	15. 00	
194. 03 079	953 JAY MERIDIAN URGENT CARE	0	0	)	0	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	583, 989	700, 896	2, 422, 36	9 204, 443	1, 553, 573	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	84. 587051	44. 946518	519. 04199	0. 858730	0. 632934	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	62, 633	75, 483	48, 13	1, 285	43, 054	204. 00
205 00	Unit aget multiplian (What D Dont	0 071007	4 040517	10 21200	0 005307	0.017540	205 00

9. 071987

4. 840516

10. 313906

0.005397

0. 017540 205. 00

206. 00

207. 00

205.00

206.00

207.00

11)

Unit cost multiplier (Wkst. B, Part

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1320 Period: Worksheet B-1

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am Cost Center Description MEDI CAL SOCIAL SERVICE RECORDS & LI BRARY (TIME SPENT) (GROSS CHARGES) 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 1.01 1.02 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.03 1.03 00104 CAP REL COSTS-BLDG & FIXT-RHC 1.04 1.04 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.01 2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.02 00203 CAP REL COSTS-MVBLE EQUIP - WJ 2 03 2 03 00204 CAP REL COSTS-MVBLE EQUIP - RHC 2.04 2.04 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7 00 7 00 7.01 00701 OPERATION OF PLANT - MOB 7.01 00702 OPERATION OF PLANT - POB 7.02 7.02 7.03 00703 OPERATION OF PLANT - WJ 7 03 7.04 00704 OPERATION OF PLANT - RHC 7.04 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 90, 908, 813 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6.864.951 0 30 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 04300 NURSERY 43.00 0 43 00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 7, 420, 758 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 14. 494. 285 54.00 0 54.00 0 60.00 06000 LABORATORY 10, 049, 969 60.00 65.00 06500 RESPIRATORY THERAPY 2, 374, 274 0 65.00 06600 PHYSI CAL THERAPY 1, 898, 322 66.00 66.00 06700 OCCUPATIONAL THERAPY 346, 805 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 14,602 0 68.00 69.00 06900 ELECTROCARDI OLOGY 130, 304 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 226, 319 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 328, 698 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 14, 294, 652 0 73.00 76.00 03160 CARDI OPULMONARY 2, 709, 630 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 77 00 0 77 00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 1, 697, 771 0 88.00 90.00 09000 CLI NI C 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 919, 837 0 90.01 09002 JAY FAMILY MEDICINE 90. 02 915, 358 0 90.02 90.03 09003 WOUND CLINIC 0 90 03 0 90.04 09004 OP ORTHO CLINIC 0 0 90.04 90. 05 09005 JAY FAMILY FIRST HEALTH CARE 370, 307 90.05 0 90.06 09006 INFUSION CLINIC 2, 100, 886 0 90.06 09007 HEALTH BEGINNINGS PROGRAM 90 07 90 07 0 91.00 09100 EMERGENCY 23, 002, 909 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 93.00 04950 OUTPATIENT PSYCH 748.176 0 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 90, 908, 813 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 0 194. 00 07950 VACANT 0 0 194.00 194.02 07952 WEST JAY CLINIC 194. 02

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-1320	Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Ti me Prepared:		
		5/24/2024 0: 42 am		

					.2, 0 ., 2020	5/24/2024 9: 4	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE				
		RECORDS &					
		LI BRARY	(TIME SPENT)				
		(GROSS					
		CHARGES)					
		16. 00	17. 00				
194. 03	07953 JAY MERIDIAN URGENT CARE	0	0				194. 03
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	0				202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000				203. 00
204. 00	Cost to be allocated (per Wkst. B,	0	0	)			204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000				205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						[

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1320	Peri od: Worksheet C

12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am Title XVIII Hospi tal Cost Costs Total Cost Therapy Limit Cost Center Description Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 5. 00 1.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30 00 5, 034, 318 5.034.318 0 Ω 40.00 04000 SUBPROVI DER - I PF 0 0 40.00 04300 NURSERY o 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 2, 979, 658 2, 979, 658 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 53.00 0 2, 435, 124 2, 435, 124 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 Λ 60.00 06000 LABORATORY 3, 603, 382 3, 603, 382 0 60.00 65.00 06500 RESPIRATORY THERAPY 952, 432 952, 432 65.00 06600 PHYSI CAL THERAPY 1, 221, 035 1, 221, 035 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 197, 773 197, 773 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 30,678 30, 678 0 68.00 06900 ELECTROCARDI OLOGY 69.00 4, 781 4, 781 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 123, 558 71 00 123 558 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 46, 380 46, 380 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 519, 630 4, 519, 630 0 73.00 03160 CARDI OPULMONARY 76.00 532, 287 532, 287 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77 00 0 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 2, 186, 618 0 88.00 2.186.618 0 0 0 0 0 0 0 90.00 09000 CLI NI C 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 973, 347 1, 973, 347 0 90.01 09002 JAY FAMILY MEDICINE 90. 02 2, 451, 594 2, 451, 594 0 90.02 09003 WOUND CLINIC 90.03 90 03 C 0 90.04 09004 OP ORTHO CLINIC 168 168 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 1, 121, 082 1, 121, 082 0 90.05 90.06 09006 INFUSION CLINIC 262, 121 262, 121 0 90.06 09007 HEALTH BEGINNINGS PROGRAM 90.07 90.07 1, 122, 006 1, 122, 006 0 91.00 09100 EMERGENCY 5, 366, 387 5, 366, 387 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 999, 612 1, 999, 612 92.00 0 93.00 04950 OUTPATIENT PSYCH 301, 597 301, 597 0 0 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 200.00 Subtotal (see instructions) 38, 465, 568 38, 465, 568 0 0 200. 00 1, 999, 612 0 201. 00 201.00 1, 999, 612 Less Observation Beds 0 202.00 Total (see instructions) 36, 465, 956 36, 465, 956 0 202. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	HOSPITAL In Lie			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1320	Peri od:	Worksheet C		

From 01/01/2023 To 12/31/2023 Part I Date/Time Prepared: 5/24/2024 9:43 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 822, 430 2, 822, 430 30.00 30.00 40.00 04000 SUBPROVIDER - IPF 40.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 80, 902 0.401530 0.000000 50.00 05000 OPERATING ROOM 7, 339, 856 7, 420, 758 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 14, 110, 827 14, 494, 285 54.00 383.458 0.168006 0.000000 54.00 10, 049, 969 0.358547 0.000000 60.00 06000 LABORATORY 534, 169 9, 515, 800 60 00 65.00 06500 RESPIRATORY THERAPY 573, 632 1, 800, 642 2, 374, 274 0.401147 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 218, 138 1, 680, 184 1, 898, 322 0.643218 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 163, 951 182, 854 0.000000 67.00 346, 805 0.570271 67.00 68.00 06800 SPEECH PATHOLOGY 13,648 954 14, 602 2.100945 0.000000 68.00 06900 ELECTROCARDI OLOGY 299 130,005 130, 304 0.036691 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 45,035 181, 284 226, 319 0.545946 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 277. 528 0.141102 72 00 51, 170 328, 698 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 234, 735 13, 059, 917 14, 294, 652 0.316176 0.000000 73.00 03160 CARDI OPULMONARY 181, 454 2, 709, 630 0.000000 76.00 2, 528, 176 0.196443 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 n 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 1, 697, 771 1, 697, 771 88.00 0 90 00 09000 CLI NI C 0.000000 0.000000 90 00 09001 FAMILY PRACTICE OF JAY COUNTY 0 919, 837 90.01 919, 837 2.145322 0.000000 90.01 90.02 09002 JAY FAMILY MEDICINE 915, 358 915, 358 2.678290 0.000000 90.02 90.03 09003 WOUND CLINIC 0 0.000000 0.000000 90.03 0 09004 OP ORTHO CLINIC 0.000000 90.04 0 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 370, 307 370, 307 3.027439 0.000000 90.05 09006 INFUSION CLINIC 0 90.06 2, 100, 886 2, 100, 886 0.124767 0.000000 90.06 90 07 09007 HEALTH BEGINNINGS PROGRAM 0 0.000000 0 000000 90 07 91.00 09100 EMERGENCY 356,063 22, 646, 846 23, 002, 909 0. 233292 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 11,049 4, 031, 472 4, 042, 521 0.494645 0.000000 92.00 04950 OUTPATIENT PSYCH 748, 176 93.00 748, 176 0.403110 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 6, 670, 133 84, 238, 680 90, 908, 813 200. 00 201.00 Less Observation Beds 201. 00 6, 670, 133 84, 238, 680 90, 908, 813 202. 00 202.00 Total (see instructions)

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1320
Period: From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

			To 12/31/2023	Date/Time Prepared: 5/24/2024 9:43 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30. 00
40. 00   04000   SUBPROVI DER - I PF				40. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00   05000   OPERATING ROOM	0. 000000			50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00   06000   LABORATORY	0. 000000			60. 00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 00 03160 CARDI OPULMONARY	0. 000000			76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC (RHC)				88. 00
90. 00  09000   CLI NI C	0. 000000			90. 00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000			90. 01
90.02 09002 JAY FAMILY MEDICINE	0. 000000			90. 02
90. 03   09003   WOUND CLINIC	0. 000000			90. 03
90. 04   09004   OP ORTHO CLINIC	0. 000000			90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0. 000000			90. 05
90. 06   09006   I NFUSI ON CLI NI C	0. 000000			90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0. 000000			90. 07
91. 00   09100   EMERGENCY	0. 000000			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
93. 00 O4950 OUTPATIENT PSYCH	0. 000000			93. 00
OTHER REIMBURSABLE COST CENTERS				
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1320	Peri od: Worksheet C

To 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am Title XIX Hospi tal PPS Costs Total Cost Therapy Limit Cost Center Description Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 2.00 4. 00 1.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 30 00 5, 034, 318 5.034.318 5.034.318 40.00 04000 SUBPROVI DER - I PF 0 40.00 04300 NURSERY 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 979, 658 2, 979, 658 2, 979, 658 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 0 2, 435, 124 2, 435, 124 2, 435, 124 54.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 60.00 06000 LABORATORY 3, 603, 382 3, 603, 382 3, 603, 382 60.00 65.00 06500 RESPIRATORY THERAPY 952, 432 952, 432 0 0 0 952, 432 65.00 1, 221, 035 1, 221, 035 06600 PHYSI CAL THERAPY 1, 221, 035 66.00 66.00 06700 OCCUPATIONAL THERAPY 197, 773 197, 773 67.00 197, 773 67.00 68.00 06800 SPEECH PATHOLOGY 30,678 30, 678 30,678 68.00 06900 ELECTROCARDI OLOGY 69.00 4, 781 4, 781 0 4, 781 69.00 123, 558 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 123, 558 71 00 123 558 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 46, 380 46, 380 46, 380 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 4, 519, 630 4, 519, 630 4, 519, 630 73.00 0 03160 CARDI OPULMONARY 76.00 532, 287 532, 287 532, 287 76.00 07700 ALLOGENEIC HSCT ACQUISITION 77 00 77 00 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 2, 186, 618 0 2, 186, 618 88.00 2.186.618 0 90.00 09000 CLI NI C 90.00 0 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 973, 347 1, 973, 347 1, 973, 347 90.01 90. 02 09002 JAY FAMILY MEDICINE 2, 451, 594 2, 451, 594 0 2, 451, 594 90.02 09003 WOUND CLINIC 90.03 90.03 C 0 90.04 09004 OP ORTHO CLINIC 168 168 168 90.04 09005 JAY FAMILY FIRST HEALTH CARE 1, 121, 082 1, 121, 082 1, 121, 082 90.05 90.05 0 90.06 09006 INFUSION CLINIC 262, 121 262, 121 262, 121 90.06 09007 HEALTH BEGINNINGS PROGRAM 90.07 1, 122, 006 1, 122, 006 1, 122, 006 90 07 91.00 09100 EMERGENCY 5, 366, 387 5, 366, 387 5, 366, 387 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 999, 612 1, 999, 612 1, 999, 612 92.00 92.00 93.00 04950 OUTPATIENT PSYCH 301, 597 301, 597 301, 597 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 200.00 Subtotal (see instructions) 38, 465, 568 38, 465, 568 0 38, 465, 568 200. 00 1, 999, 612 201. 00 201.00 1, 999, 612 1, 999, 612 Less Observation Beds 36, 465, 956 202. 00 202.00 Total (see instructions) 36, 465, 956 36, 465, 956

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1320	Period: Worksheet C From 01/01/2023 Part I

To 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 822, 430 30.00 30.00 2,822,430 40.00 04000 SUBPROVIDER - IPF 40.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 80, 902 0.401530 0.000000 50.00 05000 OPERATING ROOM 7, 339, 856 7, 420, 758 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 14, 110, 827 383.458 14, 494, 285 0.168006 0.000000 54.00 54.00 0.000000 60.00 06000 LABORATORY 534, 169 9, 515, 800 10, 049, 969 0.358547 60 00 65.00 06500 RESPIRATORY THERAPY 573, 632 1, 800, 642 2, 374, 274 0.401147 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 218, 138 1, 680, 184 1, 898, 322 0.643218 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 163, 951 182, 854 67.00 346, 805 0.570271 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 13,648 954 14, 602 2.100945 0.000000 68.00 06900 ELECTROCARDI OLOGY 299 130,005 130, 304 0.036691 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 45,035 181, 284 226, 319 0.545946 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 277. 528 0.141102 72 00 51, 170 328, 698 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 234, 735 13, 059, 917 14, 294, 652 0.316176 0.000000 73.00 03160 CARDI OPULMONARY 2, 709, 630 76.00 181, 454 2, 528, 176 0.196443 0.000000 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 0.000000 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 n 0.000000 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 1, 697, 771 1, 697, 771 1. 287935 0.000000 88.00 0 90 00 09000 CLI NI C 0.000000 0.000000 90 00 09001 FAMILY PRACTICE OF JAY COUNTY 0 919, 837 90.01 919, 837 2.145322 0.000000 90.01 90.02 09002 JAY FAMILY MEDICINE 915, 358 915, 358 2.678290 0.000000 90.02 0 90.03 09003 WOUND CLINIC 0.000000 0.000000 90.03 0 09004 OP ORTHO CLINIC 90.04 0 0.000000 0.000000 90.04 0 90.05 09005 JAY FAMILY FIRST HEALTH CARE 370, 307 370, 307 3.027439 0.000000 90.05 09006 INFUSION CLINIC 0 90.06 2, 100, 886 2, 100, 886 0.124767 0.000000 90.06 90 07 09007 HEALTH BEGINNINGS PROGRAM 0 0.000000 0 000000 90 07 91.00 09100 EMERGENCY 356,063 22, 646, 846 23, 002, 909 0. 233292 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 11,049 4, 031, 472 4, 042, 521 0.494645 0.000000 92.00 04950 OUTPATIENT PSYCH 748, 176 93.00 748, 176 0.403110 0.000000 93.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPIOID TREATMENT PROGRAM 102.00 200.00 Subtotal (see instructions) 6, 670, 133 84, 238, 680 90, 908, 813 200. 00 201.00 Less Observation Beds 201. 00 84, 238, 680 6, 670, 133 90, 908, 813 202. 00 202.00 Total (see instructions)

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-1320
From 01/01/2023
To 12/31/2023
Date/Time Prepared:

Cost Center Description				10 12/31/2023	5/24/2024 9:43 am	
NPATI ENT ROUTINE SERVICE COST CENTERS   10.00   10.00   300.00   ADULTS & PEDIATRICS   40.00   40.00   50.00   40.00   50.00   50.00   40.00   50.0			Title XIX	Hospi tal		
NPATIENT ROUTINE SERVICE COST CENTERS   30.00   303000 ADULTS & PEDIATRIC S   40.00   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   4040000   404000000   40400000   404000000   404000000   404000000   404000000   404000000   404000000   404000000   4040000000   4040000000   4040000000   40400000000	Cost Center Description	PPS Inpatient				
INPATI ENT ROUTINE SERVICE COST CENTERS   30.00   03.00   ADULTS & PEDIATRIC S   40.00   40.						
30. 00   03000   ADULTS & PEDIATRICS   30. 00   43. 00   04300   SUBPROVIDE RF - 1 PF   40. 00   43. 00   43. 00   04300   SUBPROVIDE RF - 1 PF   43. 00		11. 00				
A0, 00   04000  SUBPROVIDER - IPF   40, 00   43. 00   4						
A3. 00   DASON   DASSERY						
ANCILLARY SERVICE COST CENTERS   50.00						
50.00   05000   05000   05000   05000   052.00   05000   05000   052.00   05000   051.00   05000   051.00   05000   051.00   05000   051.00   05000   051.00   05000   051.00   05000   051.00   05000   051.00   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   050000   0500000   0500000   0500000   0500000   05000000   05000000   05000000   05000000   05000000   050000000   050000000   050000000   050000000   0500000000					43.	. 00
52.00   52.00   52.00   53.0						
53. 00   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   05400   056						
54. 00   05400   RADI OLOGY-DI AGNOSTI C   0. 168006   0. 6000   0. 6000   LABORATORY   0. 358547   0. 60. 00   0. 6000   CABORATORY   0. 358547   0. 60. 00   0. 6000   RESPI RATORY THERAPY   0. 4011147   65. 00   0. 6000   RESPI RATORY THERAPY   0. 643218   0. 60. 00   0. 6000   PAPSI CAL THERAPY   0. 570271   67. 00   0. 60. 00   0. 60000   0. 60000   0. 60000   0. 60000   0. 60000   0. 60000   0. 60000   0. 60000   0. 60000   0						
60. 00   06000   LABORATORY   0. 358547   60. 00   06500   RESPI RATORY THERAPY   0. 401147   65. 00   06600   PHYSI CAL THERAPY   0. 643218   66. 00   06600   PHYSI CAL THERAPY   0. 643218   66. 00   06600   PHYSI CAL THERAPY   0. 570271   67. 00   0700   0CCUPATIONAL THERAPY   0. 570271   67. 00   0700   0CCUPATIONAL THERAPY   0. 370271   67. 00   0700   0CCUPATIONAL THERAPY   0. 036691   68. 00   06600   SELECTROCARDIOLOGY   0. 036691   69. 00   071. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0. 545946   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 141102   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 141102   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 316176   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 316176   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 196443   76. 00   07700   ALLOGENEIC CHSCT ACQUISITION   0. 000000   07700   07700   ALLOGENEIC CHSCT ACQUISITION   0. 000000   07700   07700   ALLOGENEIC CHSCT SETVICE COST CENTERS   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0. 000000   07700						
65. 00   06500   RSPSPI RATORY THERAPY   0. 401147   65. 00   06000   PHYSI CAL THERAPY   0. 643218   66. 00   06700   0CCUPATI ONAL THERAPY   0. 570271   67. 00   06700   0CCUPATI ONAL THERAPY   0. 570271   67. 00   06800   SPEECH PATHOLOGY   2. 100945   68. 00   06900   ELECTROCARDI OLOGY   0. 036691   69. 00   06900   ELECTROCARDI OLOGY   0. 036691   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0. 545946   71. 00   07300   O7300   DRUGS CHARGED TO PATI ENTS   0. 141102   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 316176   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 316176   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 316176   73. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   DRUGS CHARGED TO PATI ENTS   0. 316176   75. 00   07500   07500   DRUGS CHARGED TO PATI ENTS   0. 0000000   76. 00   000000   77. 00   000000   77. 00   000000   77. 00   000000   77. 00   000000   000000   000000   000000   000000						
66. 00   06600   PHYSICAL THERAPY   0. 643218   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0. 570271   67. 00   68. 00   06800   SPEECH PATHOLOGY   2. 100945   68. 00   06900   ELECTROCARDI OLOGY   0. 036691   69. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0. 545946   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0. 141102   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0. 316176   73. 00   7300   DRUGS CHARGED TO PATIENTS   0. 316176   73. 00   77. 00   77. 00   0700   ALLOGENEI C HSCT ACQUISITION   0. 090400   0. 09040   0. 000000   77. 00   0. 000000   77. 00   0. 000000   77. 00   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000						
67. 00						
68. 00						
69. 00   06900   ELECTROCARDIOLOGY   0.036691   69. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.545946   71. 00   72.00   MPL. DEV. CHARGED TO PATIENTS   0.316176   72. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   0.316176   73. 00   73.00   07300   DRUGS CHARGED TO PATIENTS   0.316176   73. 00   76. 00   03160   CARDI OPULMONARY   0.196443   76. 00   07000   CARDI OPULMONARY   0.000000   77. 00   07000   CARDI OPULMONARY   0.000000   77. 00   07000   CAR T-CELL IMMUNOTHERAPY   0.000000   78. 00   07000   CAR T-CELL IMMUNOTHERAPY   0.000000   07000   CLI NI C   0.000000   09. 01   09000   09. 01   09000   CLI NI C   0.000000   09. 01   09000   09. 01   090000   09000   09000   09000   09000   090000   090000   090000   090000   090000   09000						
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0.545946   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.141102   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.141102   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0.196443   76. 00   76. 00   77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0.000000   77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0.000000   078. 00   07800   CART -CELL IMMUNOTHERAPY   0.000000   000000   000000   000000   000000						
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0.141102   72. 00   73.00   DRUGS CHARGED TO PATIENTS   0.316176   73. 00   73.00   DRUGS CHARGED TO PATIENTS   0.316176   73. 00   73.00						
73. 00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 545946				
76. 00		0. 141102				
77. 00   07700   ALLOGENEIC HSCT ACQUISITION   0.000000   77. 00   78. 00   07800   CAR T-CELL IMMUNOTHERAPY   0.000000   78. 00   000000   0.0000000   0.000000   0.0000000   0.0000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000						
78. 00	76. 00   03160   CARDI OPULMONARY	0. 196443			76.	. 00
SERVICE COST CENTERS	77.00  07700 ALLOGENEIC HSCT ACQUISITION					
88. 00   08800   RURAL HEALTH CLINIC (RHC)   1.287935   88. 00   09000   CLINIC   0.000000   90. 00		0. 000000			78.	. 00
90. 00   09000   CLINI C   0.000000   90. 01   09001   FAMI LY PRACTICE OF JAY COUNTY   2.145322   90. 01   90. 02   09002   JAY FAMI LY MEDICI NE   2.678290   90. 02   90. 03   09003   WOUND CLINI C   0.000000   90. 03   09003   WOUND CLINI C   0.000000   90. 04   90. 04   090						
90. 01						
90. 02   09002   JAY FAMILY MEDICINE   2. 678290   90. 02   09003   WOUND CLINIC   0. 000000   90. 03   90. 04   09004   09004   09004   09005   09005   JAY FAMILY FIRST HEALTH CARE   3. 027439   90. 05   90. 06   09006   INFUSION CLINIC   0. 124767   90. 06   90. 07   09007   HEALTH BEGINNINGS PROGRAM   0. 000000   90. 07   91. 00   09100   EMERGENCY   0. 233292   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0. 494645   92. 00   04950   0UTPATIENT PSYCH   0. 403110   93. 00   0THER REIMBURSABLE COST CENTERS   102. 00   10200   OPIOID TREATMENT PROGRAM   200. 00   201. 00   Less Observation Beds   201. 00   201. 00   201. 00   Less Observation Beds   201. 00						
90. 03   09003   WOUND CLINI C   0.000000   90. 04   09004   0P ORTHO CLINI C   0.000000   90. 04   90. 05   09005   JAY FAMILY FIRST HEALTH CARE   3.027439   90. 05   90. 06   09006   INFUSI ON CLINI C   0.124767   90. 06   90. 07   09007   HEALTH BEGINNI NGS PROGRAM   0.000000   90. 07   91. 00   09100   EMERGENCY   0.233292   91. 00   09200   OBSERVATI ON BEDS (NON-DI STINCT PART   0.494645   0.4950   OUTPATI ENT PSYCH   0.403110   000000   000000   000000   000000   000000	90.01 09001 FAMILY PRACTICE OF JAY COUNTY				90.	. 01
90. 04   09004   0P ORTHO CLINIC   0.000000   90.05   09005   JAY FAMILY FIRST HEALTH CARE   3.027439   90.05   90.06   09006   INFUSION CLINIC   0.124767   90.06   90.07   09007   HEALTH BEGINNINGS PROGRAM   0.000000   90.07   91.00   09100   EMERGENCY   0.233292   91.00   09200   0BSERVATION BEDS (NON-DISTINCT PART   0.494645   0.4950   0UTPATIENT PSYCH   0.403110   001HER REI MBURSABLE COST CENTERS   102.00   10200   OPI OI D TREATMENT PROGRAM   Subtotal (see instructions)   Less Observation Beds   201.00   201.00   201.00   Less Observation Beds   201.00   201						
90. 05						
90. 06   09006   INFUSION CLINIC   0. 124767   90. 06   09007   HEALTH BEGINNINGS PROGRAM   0. 000000   91. 00   09100   EMERGENCY   0. 233292   91. 00   09200   09200   09200   09200   09200   09200   09200   0000000000						
90. 07   09007   HEALTH BEGINNINGS PROGRAM   0. 000000   91. 00   09100   EMERGENCY   0. 233292   91. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0. 494645   04950   OUTPATIENT PSYCH   0. 403110   070   OTHER REIMBURSABLE COST CENTERS   102. 00   10200   OPIOID TREATMENT PROGRAM   102. 00   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201						
91. 00   09100   EMERGENCY   0. 233292   91. 00   92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART   0. 494645   92. 00   04950   OUTPATI ENT PSYCH   0. 403110   93. 00   OTHER REI MBURSABLE COST CENTERS   102.00   OPI 0I D TREATMENT PROGRAM   200. 00   Subtotal (see instructions)   Less Observation Beds   201. 00   201. 00   Control of the c						
92. 00   09200   08SERVATI ON BEDS (NON-DISTINCT PART   0.494645   0.403110   93. 00   04950   0UTPATI ENT PSYCH   0.403110   0.4031					90.	. 07
93. 00 04950 OUTPATIENT PSYCH 0. 403110 93. 00 OTHER REIMBURSABLE COST CENTERS  102. 00 10200 OPI 0I D TREATMENT PROGRAM 102. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 2201. 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						
102.00		0. 403110			93.	. 00
200.00         Subtotal (see instructions)         200.00           201.00         Less Observation Beds         201.00						
201.00 Less Observation Beds 201.00						
202.00   Total (see instructions)						
	202.00 Total (see instructions)				202.	. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2023	Part II
To 12/31/2023	Date/Time Prepared:
5/24/2024 9:43 am	

						5/24/2024 9: 4	3 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capital	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	_	Amount	
				col. 2)			
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 979, 658	193, 061	2, 786, 59	7 C	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52. 00
53.00	05300 ANESTHESI OLOGY	o	0		o c	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 435, 124	169, 125	2, 265, 99	9 0	0	54.00
60.00	06000 LABORATORY	3, 603, 382	107, 751	3, 495, 63	1 C	0	60.00
65.00	06500 RESPI RATORY THERAPY	952, 432	30, 619	921, 81	3 0	o	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 221, 035	112, 255	1, 108, 78	ol c	o	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	197, 773	16, 155			o	67. 00
68. 00	06800 SPEECH PATHOLOGY	30, 678	422			ol	68. 00
69. 00	06900 ELECTROCARDI OLOGY	4, 781	30			o	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123, 558	776			o	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	46, 380	292			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 519, 630	60, 621			o	73. 00
	03160 CARDI OPULMONARY	532, 287	14, 384			o o	76. 00
	07700 ALLOGENEIC HSCT ACQUISITION	o	0			o	77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	o	0			o	78. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			•	•	
88. 00	08800 RURAL HEALTH CLINIC (RHC)	2, 186, 618	124, 981	2, 061, 63	7 C	0	88. 00
	09000 CLI NI C	o	0		o c	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 973, 347	78, 198	1, 895, 149	9 0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	2, 451, 594	82, 892	2, 368, 70	2 0	0	90. 02
90. 03	09003 WOUND CLINIC	o	0		o c	0	90. 03
90.04	09004 OP ORTHO CLINIC	168	1	16	7 C	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	1, 121, 082	167, 341	953, 74°	1 C	0	90. 05
90.06	09006 INFUSION CLINIC	262, 121	21, 638	240, 48	3 0	0	90. 06
90. 07	09007 HEALTH BEGINNINGS PROGRAM	1, 122, 006	124, 381	997, 62	5 C	0	90. 07
91.00	09100 EMERGENCY	5, 366, 387	196, 069	5, 170, 31	8 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 999, 612	170, 055	1, 829, 55	7 C	0	92.00
93.00	04950 OUTPATIENT PSYCH	301, 597	50, 812	250, 78	5 C	0	93. 00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	(	O C	0	102. 00
200.00	Subtotal (sum of lines 50 thru 199)	33, 431, 250	1, 721, 859	31, 709, 39 <sup>-</sup>	1 C	0	200. 00
201.00	Less Observation Beds	1, 999, 612	170, 055		7 C	0	201. 00
202.00	Total (line 200 minus line 201)	31, 431, 638	1, 551, 804	29, 879, 83	4 C	0	202. 00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provider CCN: 15-1320 Period: From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						5/24/2024 9:	43 am
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	· ·	Capital and	(Worksheet C,	Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATI NG ROOM	2, 979, 658	7, 420, 758	0. 401530			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0. 000000			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 435, 124	14, 494, 285	0. 168006			54. 00
60.00	06000 LABORATORY	3, 603, 382	10, 049, 969	0. 358547			60.00
65. 00	06500 RESPIRATORY THERAPY	952, 432					65. 00
66.00	06600 PHYSI CAL THERAPY	1, 221, 035					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	197, 773					67. 00
68. 00	06800 SPEECH PATHOLOGY	30, 678					68. 00
	06900 ELECTROCARDI OLOGY	4, 781					69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	123, 558					71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	46, 380					72. 00
	07300 DRUGS CHARGED TO PATIENTS	4, 519, 630					73. 00
76. 00	03160 CARDI OPULMONARY	532, 287					76. 00
	07700 ALLOGENEIC HSCT ACQUISITION	002,207	1	0. 000000			77. 00
	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 000000			78. 00
70.00	OUTPATIENT SERVICE COST CENTERS			0.00000			70.00
88. 00	08800 RURAL HEALTH CLINIC (RHC)	2, 186, 618	1, 697, 771	1. 287935			88. 00
90.00	09000 CLINIC	0					90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 973, 347					90. 01
90. 02	09002 JAY FAMILY MEDICINE	2, 451, 594					90. 02
90. 03	09003 WOUND CLINIC	2, 101, 071	0				90. 03
90. 04	09004 OP ORTHO CLINIC	168		0. 000000			90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	1, 121, 082	l .				90. 05
90. 06	09006 INFUSION CLINIC	262, 121	2, 100, 886				90.06
	09007 HEALTH BEGINNINGS PROGRAM	1, 122, 006					90. 07
	09100 EMERGENCY	5, 366, 387					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 999, 612					92. 00
93. 00	04950 OUTPATIENT PSYCH	301, 597					93. 00
73.00	OTHER REIMBURSABLE COST CENTERS	301, 377	140, 170	0. 403110			75.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	n	0.000000			102. 00
200.00		33, 431, 250					200. 00
200.00		1, 999, 612					201.00
201.00	1 1	31, 431, 638	l e				202.00
202.00	Total (Title 200 IIII lius Title 201)	1 31,431,030	1 00,000,303	I	l		1202.00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II	pared:
		Title	xVIII	Hospi tal	Cost	3 alli
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col		column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	193, 061				175	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	_			0	
53. 00 05300 ANESTHESI OLOGY	0	_	0. 00000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	169, 125				1, 422	
60. 00   06000   LABORATORY	107, 751				1, 817	
65. 00 06500 RESPI RATORY THERAPY	30, 619				2, 196	
66. 00 06600 PHYSI CAL THERAPY	112, 255				1, 774	
67. 00 06700 OCCUPATI ONAL THERAPY	16, 155				1, 108	
68.00 06800 SPEECH PATHOLOGY	422				198	
69. 00 06900 ELECTROCARDI OLOGY	30				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	776				47	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	292				28	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 621				1, 495	
76. 00 03160 CARDI OPULMONARY	14, 384	2, 709, 630			369	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)	124, 981		0. 07361		0	
90. 00  09000   CLI NI C	0	· · · · · · · · · · · · · · · · · · ·	0.0000		0	90. 00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	78, 198				0	90. 01
90.02 09002 JAY FAMILY MEDICINE	82, 892	915, 358			0	90. 02
90. 03   09003   WOUND CLINIC	0	0			0	90. 03
90. 04   09004 OP ORTHO CLINIC	1	0	0.00000		0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	167, 341				0	90. 05
90.06 09006 INFUSION CLINIC	21, 638				0	90. 06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	124, 381	l .	0.0000		0	90. 07
91. 00   09100   EMERGENCY	196, 069				66	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	170, 055				0	
93. 00   04950   OUTPATIENT PSYCH	50, 812				0	
200.00   Total (lines 50 through 199)	1, 721, 859	88, 086, 383		1, 003, 761	10, 695	200. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-1320 THROUGH COSTS

					10 12/31/2023	5/24/2024 9: 4	
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
		Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	00.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 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	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0		0 0	0	88. 00
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0		0 0	0	90. 02
90. 03	09003 WOUND CLINIC	o	0		0 0	0	90. 03
90.04	09004 OP ORTHO CLINIC	o	0		0 0	0	90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	o	0		0 0	0	90. 05
90.06	09006 INFUSION CLINIC	o	0		0 0	0	90. 06
90. 07	09007 HEALTH BEGINNINGS PROGRAM	o	0		0 0	0	90. 07
91.00	09100 EMERGENCY	o	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92. 00
93.00	04950 OUTPATIENT PSYCH	o	0		0 0	0	93. 00
200.00	Total (lines 50 through 199)	O	0		0 0	0	200. 00

Heal th Financial	Systems		IU HEALTH JA	Y HOSPI TAL		In Li€	eu of Form CMS-2	2552-10
APPORTI ONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCI LLARY	SERVICE OTHER PASS	S Provider Co		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/24/2024 9:4	
				Title	: XVIII	Hospi tal	Cost	
Cost	Center Description		All Other Medical	Total Cost (sum of cols.	Total Outpatient	Total Charges (from Wkst. C,	Ratio of Cost to Charges	
			Education Cost	•	Cost (sum of cols. 2, 3,		(col . 5 ÷ col .	
				.,	and 4)	2)	(500	

		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
		·	and 4)		(see	
					instructions)	
	4. 00	5. 00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	C	7, 420, 758	0.000000	50. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	C	0	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	C	14, 494, 285	0.000000	54.00
60. 00   06000   LABORATORY	0	0	C	10, 049, 969	0.000000	60.00
65. 00 06500 RESPIRATORY THERAPY	0	0	C	2, 374, 274	0.000000	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0	C	1, 898, 322	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	l c	346, 805	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	l c	14, 602	0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		130, 304	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		226, 319	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		328, 698	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	l	14, 294, 652		73. 00
76. 00 03160 CARDI OPULMONARY	0	0	l c	2, 709, 630	0.000000	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	l c	0	0.000000	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	l c	0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
88. 00 08800 RURAL HEALTH CLINIC (RHC)	0	0	C	1, 697, 771	0.000000	88. 00
90. 00  09000   CLI NI C	0	0		0	0.000000	90. 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	l c	919, 837	0.000000	90. 01
90. 02 09002 JAY FAMILY MEDICINE	0	0	l c	915, 358	0.000000	90. 02
90. 03 09003 WOUND CLINIC	0	0	l c	0	0.000000	90. 03
90. 04   09004 OP ORTHO CLINIC	0	0	l c	0	0.000000	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	l c	370, 307	0.000000	90. 05
90.06 09006 INFUSION CLINIC	0	0		2, 100, 886		
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	0		0	0. 000000	
91. 00 09100 EMERGENCY	0	0	0	23, 002, 909		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1 0	l o	l d	4, 042, 521		
93. 00   04950   OUTPATI ENT PSYCH	0	Ö		748, 176		
200.00 Total (lines 50 through 199)	1 0	l o				200. 00
1	'	ı	'	1 22, 222, 000	1	

Health Financial Systems	IU HEALTH JAY H	HOSPI TAL		In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1320	Peri od:	Worksheet D

From 01/01/2023 Part IV
Date/Time Prepared: THROUGH COSTS 12/31/2023 5/24/2024 9:43 am Title XVIII Hospi tal Cost Outpati ent I npati ent I npati ent Outpati ent Cost Center Description Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col. 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 6, 720 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 121, 849 0 54.00 0 06000 LABORATORY 0 60.00 0.000000 169, 459 60.00 0 65.00 06500 RESPIRATORY THERAPY 0.000000 170, 269 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 30, 001 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.000000 23, 786 67.00 0 0 06800 SPEECH PATHOLOGY 0.000000 68.00 6, 858 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 299 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 13, 626 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 0 72 00 31, 142 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 352, 476 0 73.00 03160 CARDI OPULMONARY 0.000000 0 0 76.00 76.00 69, 521 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 77 00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 0.000000 0 0 0 0 0 0 0 0 0 0 0 0 0 88.00 09000 CLI NI C 90.00 90 00 0.000000 Ω 0 0 0 Ω 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 90.01 0 0 90.01 90.02 09002 JAY FAMILY MEDICINE 0.000000 0 90.02 0 90.03 09003 WOUND CLINIC 0.000000 0 0 90.03 09004 OP ORTHO CLINIC 0 90 04 0.000000 0 90.04 0 09005 JAY FAMILY FIRST HEALTH CARE 90.05 0.000000 0 0 90.05 09006 INFUSION CLINIC 0.000000 0 0 90.06 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 0 90.07 0 91.00 91.00 09100 EMERGENCY 0.000000 7, 755 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0.000000 0 92.00 93. 00 04950 OUTPATIENT PSYCH 0.000000 93.00 0

1, 003, 761

0 200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH JA	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
			F	rom 01/01/2023	Part V	
			1	To 12/31/2023		
					5/24/2024 9: 4	3 am
		litle	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	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. 401530		1, 276, 900	0	0	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0	(	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0	(	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 168006	0	2, 440, 929	100	0	54. 00
60. 00   06000   LABORATORY	0. 358547	0	1, 511, 164	1 0	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 401147	·l o	283, 125	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 643218		491, 967		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 570271		30, 624		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	2. 100945	1	00,02	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 036691	1	18, 424	<u> </u>	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 545946		24, 073		0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 141102	ł .	55, 031		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 141102				0	73. 00
	1	1	1, 723, 065		0	1
76. 00   03160   CARDI OPULMONARY	0. 196443		687, 112		0	76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000		(	1	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(	) 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	1	Ī	ı	T		
88.00 08800 RURAL HEALTH CLINIC (RHC)		_		_	_	88. 00
90. 00 09000 CLI NI C	0. 000000	1		1	_	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	2. 145322	1	232, 593		0	90. 01
90. 02   09002   JAY FAMILY MEDICINE	2. 678290	•	398, 441	28, 388	0	90. 02
90. 03   09003   WOUND CLI NI C	0. 000000		(	0	0	90. 03
90. 04  09004  OP ORTHO CLINIC	0. 000000		(	0	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	3. 027439	0	63, 932	5, 948	0	90. 05
90.06 09006 INFUSION CLINIC	0. 124767	0	522, 109	702	0	90. 06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0. 000000	0	(	o	0	90. 07
91. 00 09100 EMERGENCY	0. 233292	. 0	2, 981, 746	0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 494645	0	908, 088	301	0	92. 00
93. 00 04950 OUTPATIENT PSYCH	0. 403110	1	26, 177		0	93. 00
200.00 Subtotal (see instructions)		0	13, 675, 500		n	200. 00
201.00 Less PBP Clinic Lab. Services-Program			10,070,000			201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	13, 675, 500	181, 393	n	202. 00
	I	1			·	1-32.00

							To 12/31/2023	Date/Time Pr 5/24/2024 9:	epared: 43 am
					Title	XVIII	Hospi tal	Cost	
			Cos	sts					
		Cost Center Description	Cost		Cost				
			Rei mbursed	Rei	mbursed				
			Servi ces	Serv	ices Not				
			Subject To	Sub	ject To				
			Ded. & Coins.	Ded.	& Coins.				
			(see inst.)	(see	einst.)				
			6. 00		7. 00				
		LARY SERVICE COST CENTERS							
50.00		OPERATING ROOM	512, 714	H	0				50.00
52.00		DELIVERY ROOM & LABOR ROOM	0		0				52.00
53.00	05300	ANESTHESI OLOGY	0		0				53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	410, 091		17				54.00
60.00	06000	LABORATORY	541, 823	3	o				60.00
65.00	06500	RESPI RATORY THERAPY	113, 575	5	o				65. 00
66.00	06600	PHYSI CAL THERAPY	316, 442	2	o				66. 00
67.00	06700	OCCUPATI ONAL THERAPY	17, 464	ı İ	ol				67. 00
68.00	06800	SPEECH PATHOLOGY	0	ol	ol				68. 00
69. 00	06900	ELECTROCARDI OLOGY	676	,	ol				69. 00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 143	3	ol				71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	7, 765		o				72. 00
73. 00	4	DRUGS CHARGED TO PATIENTS	544, 792		38, 584				73. 00
76. 00		CARDI OPULMONARY	134, 978		0				76. 00
77. 00		ALLOGENEIC HSCT ACQUISITION	0		o				77. 00
78. 00	4	CAR T-CELL IMMUNOTHERAPY	0		o				78. 00
		TIENT SERVICE COST CENTERS		1					1
88. 00		RURAL HEALTH CLINIC (RHC)							88. 00
90. 00		CLINIC	0		o				90.00
90. 01		FAMILY PRACTICE OF JAY COUNTY	498, 987	,	51, 320				90. 01
90. 02		JAY FAMILY MEDICINE	1, 067, 141		76, 031				90. 02
90. 03		WOUND CLINIC	0		0				90. 03
90. 04		OP ORTHO CLINIC	0		Ö				90. 04
90. 05	4	JAY FAMILY FIRST HEALTH CARE	193, 550	á	18, 007				90. 05
90. 06	4	INFUSION CLINIC	65, 142	1	88				90.06
90. 07		HEALTH BEGINNINGS PROGRAM	00,112		0				90. 07
91. 00		EMERGENCY	695, 617	,	o				91.00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	449, 181	1	149				92. 00
93. 00		OUTPATIENT PSYCH	10, 552		0				93. 00
200.00		Subtotal (see instructions)	5, 593, 633		184, 196				200. 00
200.00	1	Less PBP Clinic Lab. Services-Program	3, 373, 033		104, 170				201. 00
201.00	1	Only Charges	U	Ί					201.00
202.00		Net Charges (line 200 - line 201)	5, 593, 633	3	184, 196				202. 00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
		Ti tl	e XIX	Hospi tal	PPS	J dili
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	428, 139	54, 481	373, 65	8 1, 615	231. 37	30. 00
40. 00 SUBPROVI DER - I PF	0	0	)	0 0	0.00	40. 00
43. 00 NURSERY	0			0 0	0.00	43. 00
200.00 Total (lines 30 through 199)	428, 139		373, 65	8 1, 615		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	9	2, 082				30. 00
40. 00   SUBPROVI DER - I PF	0	0	)			40. 00
43. 00 NURSERY	0	0				43. 00
200.00 Total (lines 30 through 199)	9	2, 082	1			200. 00

Health Financial Systems	IU HEALTH JA	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II	pared:
		Ti tl	Title XIX		PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capi tal Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	193, 061	7, 420, 758			0	00.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	1 0.0000		0	
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	169, 125				41	54. 00
60. 00   06000   LABORATORY	107, 751				70	60. 00
65. 00 06500 RESPI RATORY THERAPY	30, 619			· ·	66	
66. 00 06600 PHYSI CAL THERAPY	112, 255				0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	16, 155				0	67. 00
68. 00   06800   SPEECH PATHOLOGY	422				0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	30				0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	776				0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	292				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 621	14, 294, 652	0. 00424	1 15, 099	64	73. 00
76. 00 03160 CARDI OPULMONARY	14, 384	2, 709, 630	0. 00530	8 0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000	0 0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC (RHC)	124, 981	1, 697, 771	0. 07361		0	88. 00
90. 00  09000  CLI NI C	0	0	0.00000	0	0	90. 00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	78, 198		0. 08501	3 0	0	90. 01
90.02 09002 JAY FAMILY MEDICINE	82, 892	915, 358			0	90. 02
90. 03   09003   WOUND CLINIC	0	0	0.00000	0 0	0	90. 03
90. 04   09004   OP ORTHO CLINIC	1	0	0.00000	0 0	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	167, 341	370, 307	0. 45189	8 0	0	90. 05
90.06 09006 INFUSION CLINIC	21, 638	2, 100, 886	0. 01029	9 0	0	90. 06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	124, 381	0	0.00000	0 0	0	90. 07
91. 00   09100   EMERGENCY	196, 069				131	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	170, 055				0	
93. 00   04950 OUTPATIENT PSYCH	50, 812				0	
200.00   Total (lines 50 through 199)	1, 721, 859	88, 086, 383		45, 586	372	200. 00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	R PASS THROUGH COST	S Provider C		Period: From 01/01/2023 To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
40. 00   04000   SUBPROVI DER - I PF	l ol	0		0	0	40.00
43. 00 04300 NURSERY	l ol	0		0	0	43.00
200.00 Total (lines 30 through 199)	o	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
·	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,		,		
	instructions)	minus col. 4)				
	4.00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 61	5 0.00	9	30.00
40. 00   04000   SUBPROVI DER - 1 PF	ol	0		0.00	0	40.00
43. 00   04300 NURSERY		0		0.00	0	43.00
200.00 Total (lines 30 through 199)		0	1, 61	5	9	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
40. 00   04000   SUBPROVI DER - 1 PF	o					40.00
43. 00   04300   NURSERY	0					43.00
200.00 Total (lines 30 through 199)	o					200.00
	. ,					•

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: Provi der CCN: 15-1320 THROUGH COSTS

					10 12/31/2023	5/24/2024 9: 4:	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	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 OPERATI NG ROOM	0	0		0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
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	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
76.00	03160 CARDI OPULMONARY	0	0		0 0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC (RHC)	0	0		0 0	0	88. 00
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	O	0		0 0	0	90. 02
90. 03	09003 WOUND CLINIC	0	0		0 0	0	90. 03
90.04	09004 OP ORTHO CLINIC	O	0		0	0	90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	o	0		0	0	90. 05
90.06	09006 INFUSION CLINIC	o	0		0 0	0	90. 06
90. 07	09007 HEALTH BEGINNINGS PROGRAM	o	0		0 0	0	90. 07
91.00	09100 EMERGENCY	o	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	O			0	0	92. 00
93.00	04950 OUTPATIENT PSYCH	0	0		0	0	93. 00
200.00	Total (lines 50 through 199)	0	0		0	0	200. 00
	-	•					

Health Financial Systems	Financial Systems IU HEALTH JAY HOSPITAL				In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CO		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Prep 5/24/2024 9:43		
		Ti tl	e XIX	Hospi tal	PPS		
Cost Center Description	All Other Medical	Total Cost (sum of cols.	Total Outpatient	Total Charges (from Wkst. C.			

			7	o 12/31/2023	Date/Time Pre 5/24/2024 9:4	
		Ti tl	e XIX	Hospi tal	PPS	<u> </u>
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	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)	
	4.00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	0	(	7, 420, 758	0.000000	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	(	0	0.000000	
53. 00   05300   ANESTHESI OLOGY	0	0	(	0	0.000000	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	(	14, 494, 285	0.000000	54.00
60. 00  06000  LABORATORY	0	0	(	10, 049, 969	0.000000	60.00
65. 00   06500   RESPI RATORY THERAPY	0	0	(	2, 374, 274	0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	(	1, 898, 322	0. 000000	66. 00
67. 00  06700 OCCUPATI ONAL THERAPY	0	0	(	346, 805	0.000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	(	14, 602	0. 000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	130, 304	0.000000	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	226, 319	0.000000	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	328, 698	0.000000	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	14, 294, 652	0.000000	73. 00
76. 00   03160   CARDI OPULMONARY	0	0	(	2, 709, 630	0.000000	76. 00
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
OUTPATIENT SERVICE COST CENTERS						
88.00   08800   RURAL HEALTH CLINIC (RHC)	0	0	(	1, 697, 771	0.000000	
90. 00  09000   CLI NI C	0	0	(	0	0.000000	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	(	919, 837	0.000000	90. 01
90.02   09002   JAY FAMILY MEDICINE	0	0	(	915, 358	0.000000	90. 02
90. 03  09003 WOUND CLINIC	0	0	(	0	0.000000	
90. 04   09004 OP ORTHO CLINIC	0	0	(	0	0.000000	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	(	370, 307	0.000000	
90.06   09006   INFUSION CLINIC	0	0	(	2, 100, 886	0.000000	90. 06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	0	(	0	0.000000	90. 07
91. 00   09100   EMERGENCY	0	0	(	23, 002, 909		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	4, 042, 521		
93. 00   04950   OUTPATI ENT PSYCH	0	0	(	748, 176		1
200.00   Total (lines 50 through 199)	0	0	(	88, 086, 383		200. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
ADDODELONMENT OF LNDATLENT/OUTDATLENT	ANCILLARY CERVICE OTHER DACC Drovides CCN, 15 1220	Dariad: Waskahaat D

Peri od: From 01/01/2023 To 12/31/2023 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Worksheet D Part IV THROUGH COSTS Date/Time Prepared: 5/24/2024 9:43 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 9.00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0.000000 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 3, 489 0 54.00 0 06000 LABORATORY 6, 488 60.00 0.000000 0 60.00 0 65.00 06500 RESPIRATORY THERAPY 0.000000 5, 155 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 0 66.00 06700 OCCUPATIONAL THERAPY 0 0.000000 67.00 67 00 Ω 0 0 06800 SPEECH PATHOLOGY 68.00 0.000000 C 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.000000 0 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 15,099 0 73.00 03160 CARDI OPULMONARY 0.000000 0 76.00 0 0 0 76.00 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77 00 0.000000 Ω 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC (RHC) 88.00 0.000000 0 0 0 88.00 09000 CLI NI C 0 0.000000 Ω 0 0 0 0 0 0 0 0 0 0 0 Ω 90 00 90 00 09001 FAMILY PRACTICE OF JAY COUNTY 0 90.01 0.000000 0 0 90.01 09002 JAY FAMILY MEDICINE 0.000000 90.02 90.02 0 90.03 09003 WOUND CLINIC 0.000000 0 0 90.03 09004 OP ORTHO CLINIC 0 90 04 0.000000 0 90.04 0 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 0 90.05 09006 INFUSION CLINIC 0.000000 0 90.06 90.06 90. 07 09007 HEALTH BEGINNINGS PROGRAM 0.000000 0 90.07 0 91. 00 09100 EMERGENCY 0.000000 91.00 15, 355 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 92.00

0.000000

45, 586

0

93.00 0

0 200.00

93. 00 04950 OUTPATIENT PSYCH

Total (lines 50 through 199)

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1320 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 9:43 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From Rei mbursed 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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 401530 79, 260 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 53 00 0 O 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0.168006 0 113, 757 0 54.00 60.00 06000 LABORATORY 0. 358547 113, 813 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.401147 0 65.00 16 217 0 06600 PHYSI CAL THERAPY 0 66.00 0.643218 6, 218 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.570271 745 0 67.00 68.00 06800 SPEECH PATHOLOGY 2. 100945 0 0 68.00 06900 ELECTROCARDI OLOGY 0.036691 1 316 69 00 69 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.545946 8, 187 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 141102 6, 953 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.316176 0 616, 905 73.00 0 03160 CARDI OPULMONARY 76.00 0 0.196443 21, 391 Ω 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC (RHC) 88.00 90.00 09000 CLI NI C 0.000000 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 2. 145322 90.01 90.01 22, 759 0 0 0 0 0 0 0 0 0 0 0 09002 JAY FAMILY MEDICINE 90.02 90.02 2.678290 0 14,828 0 09003 WOUND CLINIC 90.03 90.03 0.000000 0 0 90.04 09004 OP ORTHO CLINIC 0.000000 0 90.04 0 09005 JAY FAMILY FIRST HEALTH CARE 9, 205 90. 05 3.027439 90.05 09006 INFUSION CLINIC 0.124767 19, 199 90.06 90.06 0 09007 HEALTH BEGINNINGS PROGRAM 90.07 0.000000 C 0 90.07 91.00 09100 EMERGENCY 0. 233292 368, 715 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0. 494645 0 61, 184 0 92.00 04950 OUTPATIENT PSYCH 93.00 93.00 0 0.403110 31.410 Ω 200.00 Subtotal (see instructions) 1, 512, 062 0 200. 00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges

ol

1, 512, 062

0 202.00

202.00

Net Charges (line 200 - line 201)

| Peri od: | Worksheet D | From 01/01/2023 | Part V | To | 12/31/2023 | Date/Ti me | Prepared:

					To 12/31/2023	Date/Time Pre 5/24/2024 9:4	epared: 13 am
			Ti tl	e XIX	Hospi tal	PPS	
	·	Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	LLARY SERVICE COST CENTERS						
	OO OPERATING ROOM	31, 825	0				50. 00
	DO DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 0530	OO ANESTHESI OLOGY	0	0				53. 00
54.00 0540	DO RADI OLOGY-DI AGNOSTI C	19, 112	0				54.00
60.00 0600	00 LABORATORY	40, 807	0				60.00
65. 00 0650	00 RESPIRATORY THERAPY	6, 505	0				65. 00
66. 00 0660	00 PHYSI CAL THERAPY	4,000	0				66. 00
67. 00 0670	OO OCCUPATIONAL THERAPY	425	0				67. 00
68. 00 0680	OO SPEECH PATHOLOGY	0	0	)			68. 00
69. 00 0690	00 ELECTROCARDI OLOGY	48	0				69. 00
71. 00 0710	OO MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 470	0				71. 00
72. 00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	981	0				72. 00
73. 00 0730	OO DRUGS CHARGED TO PATIENTS	195, 051	0				73. 00
76. 00 0316	60 CARDI OPULMONARY	4, 202	Ó	)			76. 00
	OO ALLOGENEIC HSCT ACQUISITION	0	0	)			77. 00
	OO CAR T-CELL IMMUNOTHERAPY	0	0	)			78. 00
	PATIENT SERVICE COST CENTERS		-				1
	OO RURAL HEALTH CLINIC (RHC)						88. 00
	DO CLINIC	0	0	)			90.00
	01 FAMILY PRACTICE OF JAY COUNTY	48, 825		,			90. 01
	02 JAY FAMILY MEDICINE	39, 714	0	,			90. 02
	03 WOUND CLINIC	0	0	,			90. 03
•	04 OP ORTHO CLINIC	0	0	1			90. 04
	05 JAY FAMILY FIRST HEALTH CARE	27, 868	-	1			90. 05
	06 INFUSION CLINIC	2, 395	0	1			90.06
	07 HEALTH BEGINNINGS PROGRAM	2,0,0	0				90. 07
	OO EMERGENCY	86, 018	0				91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART	30, 264	0				92. 00
	50 OUTPATIENT PSYCH	12, 662	0				93. 00
200.00	Subtotal (see instructions)	555, 172	0				200. 00
201.00	Less PBP Clinic Lab. Services-Program	333, 172	١				200. 00
201.00	Only Charges						201.00
202. 00	Net Charges (line 200 - line 201)	555, 172	0				202. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL		In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi d	er CCN: 15-1320	Peri od:	Worksheet D-1
			From 01/01/2023 To 12/31/2023	Date/Time Prepared:
			10 12,01,2020	5/24/2024 9: 43 am
	-	itle XVIII	Hospi tal	Cost

			10 12/01/2020	5/24/2024 9: 4	3 am
		Title XVIII	Hospi tal	Cost	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 076	1.00
2.00	Inpatient days (including private room days, excluding swing-b			1, 615	2.00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be			880	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	211	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	250	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)			200	
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	382	9.00
10 00	newborn days) (see instructions)	alv. (i polvedi po poiveto p	aam daya)	211	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		oom days)	211	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom dove) ofter	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, er		dolli days) ai tei	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e room days)	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI>	( only (including private	e room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar ye			O	13.00
14. 00	Medically necessary private room days applicable to the Progra			0	14.00
	Total nursery days (title V or XIX only)	am (exer during eming bed	aayo,	0	ı
	Nursery days (title V or XIX only)			0	
. 0. 00	SWING BED ADJUSTMENT			5	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
17.00	reporting period	os trirodgir becember or o	i the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.00
	reporting period				
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	266. 32	19.00
	reporting period	3			
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of the	he cost	0.00	20.00
	reporting period				
21.00	Total general inpatient routine service cost (see instructions			5, 034, 318	21.00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)				
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)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	66, 580	24.00
	7 x line 19)				
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: 01 : 1: 0/)		640, 618	
27. 00	General inpatient routine service cost net of swing-bed cost (	(Tine 21 minus Tine 26)		4, 393, 700	27.00
00 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u> </u>	0	00.00
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11 00)		0	30.00
	General inpatient routine service cost/charge ratio (line 27 =	- iine 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	22)/!!	+: 000)	0.00	
	Average per diem private room charge differential (line 32 mir		LI UIIS)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 35)	le 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (1:	4 202 700	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and brivate room cost dr	rrerential (IINe	4, 393, 700	37.00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ICTMENTS			-
			T	2, 720. 56	20 0
					38.00
38. 00	Adjusted general inpatient routine service cost per diem (see	•	l		20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	38)		1, 039, 254	
38. 00 39. 00 40. 00	Adjusted general inpatient routine service cost per diem (see	38) am (line 14 x line 35)			40.00

	Financial Systems	IU HEALTH JAY I				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1320	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pre	pared:
			Ti ti	e XVIII	Hospi tal	5/24/2024 9: 4 Cost	<u>3 alli</u>
	Cost Center Description	Total Inpatient CostIn	Total patient Day	Average Per vs Di em (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0		0 0.0	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
44. 00	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
48. 00 48. 01	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition			t III line 10	column 1)	338, 254 0	48. 00 48. 01
	Total Program inpatient costs (sum of lines				cordilli 1)	1, 377, 508	
	PASS THROUGH COST ADJUSTMENTS		•	,			
50. 00	Pass through costs applicable to Program inpa	atient routine se	rvices (fr	om Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillary	servi ces (1	from Wkst. D, s	sum of Parts II	0	51.00
	and IV)						
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		ted non-ni	nysician anesth	netist and	0	52. 00 53. 00
33.00	medical education costs (line 49 minus line !		teu, non pi	ly 31 Cl all alles ti	ictist, and		33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor					0.00	1
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		et amount	(line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ring cost and targ	ct amount	(TTTIC 50 IIITTIGS	11110 33)	ő	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from t	he cost rep	porting period	endi ng 1996,	0.00	59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior vear	cost report. u	updated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if line	e 53 ÷ line 54 is	less than	the lowest of	lines 55 plus	0	
	55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)						
	Relief payment (see instructions)					0	
63.00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	rons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of th	ne cost reporti	ng period (See	574, 038	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the	cost reporting	neriod (See	0	65. 00
03.00	instructions) (title XVIII only)	ts arter becember	31 OF THE	cost reporting	g perrou (see		03.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	plus line	65)(title XVII	I only); for	574, 038	66. 00
67. 00	CAH, see instructions  Title V or XIX swing-bed NF inpatient routing	e costs through D	ecember 31	of the cost re	eporting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter Dec	ember 31 01	the cost repo	n ang perioa	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil				1		70.00
71. 00	Adjusted general inpatient routine service of	,		` ,	,		71.00
72. 00	Program routine service cost (line 9 x line						72. 00
73. 00 74. 00	Medically necessary private room cost applications Total Program general inpatient routine services.						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient 26, line 45)	•		*	Part II, column		75. 00
76. 00	Per diem capital related costs (line 75 ÷ line	•					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	•					77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess		vi der reco	rds)			79. 00
	Total Program routine service costs for compa		t limitatio	on (line 78 mir	nus 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 (	see instructions)					83. 00
84. 00 85. 00	Program inpatient ancillary services (see in:	,	)				84. 00 85. 00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	• •			Γ	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		ine 2)			735 2, 720. 56	1
89. 00	Observation bed cost (line 87 x line 88) (see		2)			1, 999, 612	

Health Financial Systems	IU HEALTH JAY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023		
				To 12/31/2023	Date/Time Prep 5/24/2024 9:4	
		Title	XVIII	Hospi tal	Cost	<u> </u>
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	428, 139	5, 034, 318	0. 08504	4 1, 999, 612	170, 055	90.00
91.00 Nursing Program cost	0	5, 034, 318	0.00000	0 1, 999, 612	0	91.00
92.00 Allied health cost	0	5, 034, 318	0.00000	0 1, 999, 612	0	92.00
93.00 All other Medical Education	0	5, 034, 318	0.00000	0 1, 999, 612	0	93. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 01/01/2023	Worksheet D-1
			Date/Time Prepared: 5/24/2024 9:43 am
	Title XIX	Hospi tal	PPS

Cast Center Description    DATE   ALL PROVIDER CONFORMENTS			Title XIX	Hospi tal	5/24/2024 9: 4: PPS	3 am
PART 1 - ALL PROVIDER CONFORMITS INPATION DAYS IMPACTOR OF A CONTROL O		Cost Center Description	II LIE XIX	1103pi tai	113	
Impart INT DAYS					1. 00	
Inpatient days (Including private room days and swing-bed days, excluding newborn)  2.076   1.00   Inpatient days (Including private room days, excluding swing-bed and newborn days)  3.00   Private room days, (excluding swing-bed and observation bed days). It you have only private room days.  5.00   Total swing-bed SWF type inpatient days (Including private room days). It you have only private room days.  5.00   Total swing-bed SWF type inpatient days (Including private room days). Through December 31 of the cost reporting period (It called reduced reduced the cost reporting period (It called reduced the cost reporting period (It called reduced the cost reporting period (It called t						
Semi-private room days (excluding swing-bed and observation bed days)   Semi-private room days (excluding private room days) after December 31 of the cost reporting pariod   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost   O   6.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting pariod   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (see instructions)   December 31 of the cost reporting period (see instructions)   December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   December 31 of the cost reporting period   December 31 of the cost reporting peri	2.00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-bed and observation bed days)	ped and newborn days)	ivate room days,	1, 615	1. 00 2. 00 3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost roporting period (if calendar year, enter 0 on this line)		Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost		
7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period to Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and to the program period (if calendar year, enter 0 on this line)  7.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions)  8.00 Exceptible SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Exceptible SNF type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Exceptible SNF type inpatient days applicable to title SV or XIX only (including private room days) after through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  8.00 Exceptible SNF type services applicable to services through December 31 of the cost reporting period (including swing-bed days)  8.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including swing-bed SNF services)  8.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period swing-bed SNF services applicable to services after December 31 of the cost reporting period (line SNF type services shough December 31 of the cost reporting period (line SNF type services through December 31 of the cost reporting period (line SNF type services through December 31 of the cost reporting period (line SNF type serv	6. 00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line)   9,00	7. 00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	250	7. 00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)   0.00	8. 00		n days) after December 3	1 of the cost	0	8. 00
through December 31 of the cost reporting period (see Instructions)  1.00 Sing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) after 0 through December 31 of the cost reporting period (in calendar year, enter 0 on this line)  1.00 Sing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Modically necessary private room days applicable to titles V or XIX only (including private room days) 0 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 0 15.00 15.00 Noverly days (title V or XIX only) 0 15.00 Noverly days (title V or XIX only) 0 15.00 Noverly days (title V or XIX only) 0 15.00 Noverly days (title V or XIX only) 1 10.00 Noverly	9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	9	9. 00
December 31 of the cost reporting period (if callendar year, enter 0 on this line)	10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
through December 31 of the cost reporting period  13.00 Ming-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Ming-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nesery days (title V or XIX only)  17.00 Medical pracessary private room days applicable to the Program (excluding swing-bed days)  18.00 SWING BED ADJUSTMENT  19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting r	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  18.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  18.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  18.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period  19.00 Medicaid rate for swing-bed NF service cost (see instructions)  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Concernal inpattent routine service cost net of swing-bed cost (line 21 minus line 26)  20.00 Total swing-bed cost (see instructions)  20.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  20.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  20.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  20.00 Ceneral inpatient routine service cos	12. 00		only (including private	e room days)	0	12. 00
15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19)  26.00 Total swing-bed cost (see instructions)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 Swing-bed cost (see instructions)  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Privater room charges (excluding swing-bed charges)  29.00 Privater room charges (excluding swing-bed charges)  30.00 Swing-bed cost (see instructions)  29.00 Privater room charges (excluding swing-bed charges)  30.00 Swing-bed cost (see instructions)  30.00 Swing	13. 00				0	13. 00
16.00 Nursery days (title V or XIX only)  With SED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (11.00 Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (11.00 Medicaid period			am (excluding swing-bed	days)	0	14. 00 15. 00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost ceporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service cost net of swing-bed cost (line 27 + line 28)  29.00 Private room charges (excluding swing-bed charges)  30.00 Average perivate room per diem charge (line 29 + line 3)  31.00 Average perivate room cost differential (line 3 x line 35)  32.00 Average perivate room cost differential (line 3 x line 35)  33.00 Average perivate room cost differential (line 3 x line 35)  34.00 Average perivate room cost differential (line 3 x line 35)  35.00 General inpatient routine service cost perivate cost perivate room cost differential (line 4 x line 38)  36.00 Proyen mental inpatien	16. 00				0	16. 00
reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 cost in 18)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  27.00 General inpatient routine service cost need of swing-bed cost (line 21 minus line 26)  28.00 Total swing-bed cost (see instructions)  29.00 PRIMATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average perivate room per diem charge (line 29 + line 3)  31.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  33.00 Average per diem private room cost differential (line 34 x line 31)  34.00 Average per diem private room cost differential (line 35)  35.00 Average per diem private room cost differential (line 35)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general	17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
reporting period  20. 00 Medical dirate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21. 00 Total general inpatient routine service cost (see instructions)  22. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 17)  23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 6,580 24.00 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 6,580 24.00 8 wing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average per diem private room per diem charge (line 39 + line 3)  33. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34. 00 Average per diem private room cost differential (line 32 minus line 33)  35. 00 Average per diem private room cost differential (line 32 x line 35)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost (line 97 hine 35)  38. 00 Adjusted general inpatient routine service cost (line 9 x line 35)  38. 00 Addiusted general inpatient routine service cost (line 9 x line 35)  38. 00 Addiusted general inpatient routine service cost (line 9 x line 35)  39. 00 Program general inpatient routine service cost (line 9 x line 35)  39. 00 Program general inpatient routine service cost (line 9 x line 35)	18. 00		es after December 31 of	the cost		18. 00
reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Total swing-bed cost (see instructions)  29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26)  30.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average perioute room per diem charge (line 30 + line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Private room cost differential (line 3 x line 35)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Private poom cost differential (line 3 x line 35)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 Average per alimpatient routine service cost per diem (see instructions)  30.00 Average per alimpatient routine service cost per diem (see instructions)  30.00 Average per alimpatient routine service cost per diem (see instructions)  30.00 Average per alimpatient routine service cost per diem (see i	19. 00		s through December 31 of	the cost	266. 32	19. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 6,580 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  31.00 Average per diem private room per diem charge (line 30 + line 4)  32.00 Average per diem private room cost differential (line 3 x line 31)  33.00 Average per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  38.00 Approach semi-private room cost differential dijustment (line 3 x line 35)  39.00 Private room cost differential routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	20. 00		s after December 31 of t	he cost	0. 00	20. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6,580 24,00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Semi-private room charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 ÷ line 3)  31.00 Average perivate room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential dipustment (line 3 x line 35)  27.00 PRIVATE ROOM DIFFERNIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  36.00 Private room cost differential dipustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  38.00 Agiusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		Swing-bed cost applicable to SNF type services through December		ing period (line		21. 00 22. 00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 + line 3) 31.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	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 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Ajusted 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)  4.393, 700  4.393, 700  4.393, 700  27.00  28.00  28.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  29.00  20.00  30.00	24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	66, 580	24. 00
27. 00  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 + line 4)  Average per diem private room charge differential (line 32 minus line 33) (see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost per diem (see instructions)	25. 00	] 3.	31 of the cost reporting	period (line 8	0	25. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  30.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)		General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 29.00 30.00 30.00 30.00 30.00 30.00 30.00 31.00 32.00 32.00 32.00 33.00 32.00 33.00 32.00 32.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 37.00 37.00	28. 00		d and observation bed ch	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Average per diem private room cost differential (line 4, 393, 700)  37.00 Average per diem private room cost differential (line 4, 393, 700)  37.00 Average per diem private room cost differential (line 4, 393, 700)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 4, 393, 700)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 32.00  32.00 0.00 32.00  33.00 0.00 32.00  34.00 0.00 32.00  34.00 0.00 32.00  34.00 0.00 32.00  34.00 0.00 32.00	29. 00	Private room charges (excluding swing-bed charges)		,	0	29. 00
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 0.00 33.00 0.00 34.00 0.00 36.00 0.00 36.00 0.00 36.00 0.00 36.00 0.00 36.00 0.00 37.00 0.00 36.00 0.00		, , , , , , , , , , , , , , , , , , , ,			-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			FIIne 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 34.00  4, 393, 700  4, 393, 700  2, 720.56  38.00  40.00		, , , , , , , , , , , , , , , , , , , ,				
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 4, 393, 700 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ous line 22)(see instruc	tions)		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  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)  36.00  4, 393, 700  4, 393, 700  37.00  38.00  39.00 Program general inpatient routine service cost per diem (see instructions)  2, 720. 56 39.00  40.00				LI OHS)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 393, 700 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 4, 393, 700 2, 300 37.00			ic 31)			
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,720.56 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	-	
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  2,720.56 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)  2,720.56 39.00 40.00		PART II - HOSPITAL AND SUBPROVIDERS ONLY	ISTMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  24,485 39.00 40.00	20 00				2 720 54	20 00
			•			
41.00   Total Program general inpatient routine service cost (line 39 + line 40) 24,485   41.00		, , , , , , , , , , , , , , , , , , , ,	•			40. 00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)	l	24, 485	41. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH JAY			Period: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description	Total Inpatient Costl	Total	Average Per Diem (col. 1 col. 2)	9	PPS Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	0. 0	00 0	0	42. 00
43. 00	INTENSIVE CARE UNIT						43. 00
	CORONARY CARE UNIT						44. 00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
171.00	Cost Center Description			·			17.00
40.00	December 1 and 1 a	-+ D 2I 2	11: 200)			1.00	40.00
	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisition			III. line 10.	column 1)	13, 336	1
	Total Program inpatient costs (sum of lines					37, 821	
F0 00	PASS THROUGH COST ADJUSTMENTS			- WI+ D	-£ Dt-	2 002	1 50 00
50. 00	Pass through costs applicable to Program inpa	atrent routine s	services (IIO	ıı wkst. D, Suii	i oi Parts i and	2, 082	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillary	y services (fi	om Wkst. D, s	um of Parts II	372	51.00
52. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51)				2, 454	52.00
	Total Program inpatient operating cost exclude		lated, non-phy	sician anesth	etist, and	35, 367	
	medical education costs (line 49 minus line 5	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor u Target amount (line 54 x sum of lines 55, 55.					0.00	1
	Difference between adjusted inpatient operati		rget amount (I	ine 56 minus	line 53)	o o	
58. 00	Bonus payment (see instructions)					0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, oupdated and compounded by the market basket)	or line 55 from	the cost repo	orting period	ending 1996,	0.00	59. 00
60.00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	m prior year o	cost report, u	pdated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (ifling 55.01, orline 59, orline 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of th	he amount by w	which operatin	g costs (line	0	61. 00
	enter zero. (see instructions)	00), 0 0.	tilo tal got al		,, other m. 66		
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ont (coo inctru	ations)			0 0	
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mistru	ctrons)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cost	ts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65.00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line o	64 plus line 6	55)(title XVII	I only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
	(line 13 x line 20)			•	g por rod		
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 facili					I	70.00
71.00	Adjusted general inpatient routine service co	ost per diem (li					71.00
	Program routine service cost (line 9 x line 1 Medically necessary private room cost applica		(line 14 x li	ne 35)			72.00
74. 00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)	)			74. 00
75. 00	Capital-related cost allocated to inpatient 1 26, line 45)	routine service	costs (from V	Vorksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovider recer	1<)			78. 00 79. 00
	Total Program routine service costs for compa				us line 79)		80.00
81.00	Inpatient routine service cost per diem limit	tati on		-	•		81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s						82. 00 83. 00
	Program inpatient ancillary services (see ins		-,				84. 00
85.00	Utilization review - physician compensation	(see instruction					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)				86.00
87. 00	Total observation bed days (see instructions)	)				735	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		line 2)			2, 720. 56 1, 999, 612	1
U 7. UU	Jobsel vation bed cost (Time of X Time oo) (See	THISTI UCTI UHS)				1, 777, 012	1 07.00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 9:43	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	428, 139	5, 034, 318	0. 08504	4 1, 999, 612	170, 055	90.00
91.00 Nursing Program cost	0	5, 034, 318	0.00000	0 1, 999, 612	0	91.00
92.00 Allied health cost	0	5, 034, 318	0.00000	0 1, 999, 612	0	92.00
93.00 All other Medical Education	0	5, 034, 318	0. 00000	1, 999, 612	0	93. 00

Heal th	Financial Systems IU HEALTH JAY	HOSPI TAL		In Li∈	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
		Titl∈	e 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)	
	LNDATI ENT. DOUTLINE CEDIU DE COCT. CENTEDO		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS  03000 ADULTS & PEDIATRICS			880, 690		30. 00
	04000 SUBPROVI DER - I PF			880, 690		40.00
	04300  NURSERY			0		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50.00	05000 OPERATING ROOM		0, 40153	0 6, 720	2, 698	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
	05300 ANESTHESI OLOGY		0.00000		Ō	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0.16800	6 121, 849	20, 471	54. 00
60.00	06000 LABORATORY		0. 35854	7 169, 459	60, 759	60.00
65.00	06500 RESPI RATORY THERAPY		0. 40114	7 170, 269	68, 303	65. 00
	06600 PHYSI CAL THERAPY		0. 64321		19, 297	66. 00
	06700 OCCUPATI ONAL THERAPY		0. 57027			67. 00
	06800 SPEECH PATHOLOGY		2. 10094			
	06900 ELECTROCARDI OLOGY		0. 03669		l .	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 54594			71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 14110			72. 00
	07300 DRUGS CHARGED TO PATIENTS		0. 31617			
	03160 CARDI OPULMONARY		0. 19644		13, 657	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION		0.00000	0	0	77. 00

0.000000

0.000000

0.000000

2. 145322

2.678290

0.000000

0.000000

3.027439

0.124767

0.000000

0. 233292

0.494645

0. 403110

78. 00

90.00

90.01

90.02

90.03

90. 04 90. 05

90.06

91.00

93.00

201.00

202. 00

0 88.00

Ω

0

0 90.07

0 92.00

338, 254 200. 00

1, 809

7, 755

1, 003, 761

1, 003, 761

78. 00 07800 CAR T-CELL IMMUNOTHERAPY

09002 JAY FAMILY MEDICINE

09003 WOUND CLINIC

09100 EMERGENCY

93. 00 | 04950 | OUTPATIENT PSYCH

09004 OP ORTHO CLINIC

09006 INFUSION CLINIC

09000 CLI NI C

88.00

90.00

90.01

90.02

90.03

90. 04

90.05

90.06

90.07

91.00

92.00

200.00

201.00

202.00

OUTPATIENT SERVICE COST CENTERS

08800 RURAL HEALTH CLINIC (RHC)

09001 FAMILY PRACTICE OF JAY COUNTY

09005 JAY FAMILY FIRST HEALTH CARE

09200 OBSERVATION BEDS (NON-DISTINCT PART

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

09007 HEALTH BEGINNINGS PROGRAM

Health Financial Systems	ı	U HEALTH JAY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST	APPORTI ONMENT	Component	CCN: 15-Z320	Period: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/24/2024 9:4	pared:
		Ti tl e		Swing Beds - SNF		
Cost Center Descript	i on		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE	COST CENTERS				1	
30. 00   03000   ADULTS & PEDI ATRI CS   40. 00   04000   SUBPROVI DER - 1 PF						30. 00 40. 00
43. 00 04300 NURSERY						43. 00
ANCILLARY SERVICE COST CEN	ITERS		T			
50. 00   05000   OPERATING ROOM	D DOOM		0. 40153		0	00.00
52. 00   05200   DELI VERY ROOM & LABO   53. 00   05300   ANESTHESI OLOGY	R ROOM		0.00000		0	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C			0. 16800		_	
60. 00   06000 LABORATORY			0. 35854			1
65. 00 06500 RESPIRATORY THERAPY			0. 40114			1
66. 00 06600 PHYSI CAL THERAPY			0. 64321			1
67. 00 06700 OCCUPATIONAL THERAPY			0. 57027	1 47, 975	27, 359	67.00
68. 00 06800 SPEECH PATHOLOGY			2. 10094		2, 275	
69. 00 06900 ELECTROCARDI OLOGY			0. 03669		0	
71. 00 07100 MEDICAL SUPPLIES CHA			0. 54594		2, 563	1
72. 00   07200   IMPL. DEV. CHARGED T			0. 14110		0	
73. 00   07300   DRUGS CHARGED TO PAT 76. 00   03160   CARDI OPULMONARY	TENIS		0. 31617		33, 640	1
77. 00 07700 ALLOGENEI CHSCT ACQU	ISITION		0. 1964 <sup>4</sup> 0. 00000	· ·		1
78. 00 07800 CAR T-CELL IMMUNOTHE			0.00000		_	1
OUTPATIENT SERVICE COST CE	NTERS					
88.00 08800 RURAL HEALTH CLINIC	(RHC)		0.00000		0	88. 00
90. 00  09000   CLI NI C			0.00000		1	
90. 01   09001   FAMILY PRACTICE OF J	AY COUNTY		2. 14532		1	90. 01
90. 02   09002   JAY FAMILY MEDICINE			2. 67829		1	
90. 03   09003   WOUND CLINIC			0.00000		1	70.00
90. 04   09004   OP ORTHO CLINIC 90. 05   09005   JAY FAMILY FIRST HEA	ITH CADE		0. 00000 3. 02743		1	
90. 05 09005 JAT FAMILT FIRST HEA	LIII CARL		0. 12476		0	90.05
90. 07 09007 HEALTH BEGINNINGS PR	OGRAM		0. 00000		0	90.07
91. 00 09100 EMERGENCY			0. 23329		Ö	91.00
92. 00 09200 OBSERVATION BEDS (NO	N-DISTINCT PART		0. 49464		0	1
93. 00 04950 OUTPATIENT PSYCH			0. 40311	0 0	0	93. 00
000 001 1-11 ( 011		>	1		1	1

345, 481

345, 481

202. 00

149, 584 200. 00 201. 00

200.00

201.00 202.00

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

Health Financial Systems	IU HEALTH JAY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CO		Peri od: From 01/01/2023	Worksheet D-3	
				To 12/31/2023	Date/Time Pre 5/24/2024 9:4	pared: 3 am
		Ti tl	e XIX	Hospi tal	PPS	
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	2 00	

	litle XIX	Hospi tal	PPS	
Cost Center Description	Ratio of Co	st Inpatient	I npati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·			
30. 00 03000 ADULTS & PEDI ATRI CS		18, 639		30. 00
40. 00   04000   SUBPROVI DER - 1 PF		C		40.00
43. 00   04300   NURSERY		C		43.00
ANCILLARY SERVICE COST CENTERS	·			
50. 00 05000 OPERATING ROOM	0. 4015	30 C	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.0000	000	0	52.00
53. 00   05300   ANESTHESI OLOGY	0.0000	000	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 1680	006 3, 489	586	54.00
60. 00  06000 LABORATORY	0. 3585	6, 488	2, 326	60.00
65. 00 06500 RESPIRATORY THERAPY	0. 4011	47 5, 155	2, 068	65.00
66. 00   06600   PHYSI CAL THERAPY	0. 6432	.18 C	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 5702	.71 C	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	2. 1009	945 C	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 0366	91 C	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 5459	946 C	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 1411	02	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 3161	76 15, 099	4, 774	73. 00
76. 00   03160   CARDI OPULMONARY	0. 1964	43 C	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.0000	000	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0.0000	000	0	78. 00
OUTPATIENT SERVICE COST CENTERS	·	<u> </u>		
88.00 08800 RURAL HEALTH CLINIC (RHC)	1. 2879	)35 C	0	88. 00
90. 00  09000   CLI NI C	0.0000	000	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	2. 1453	322 C	0	90. 01
90. 02 09002 JAY FAMILY MEDICINE	2. 6782	.90 C	0	90. 02
90. 03   09003   WOUND CLI NI C	0.0000	000	0	90. 03
90. 04   09004   OP ORTHO CLINIC	0.0000	000	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	3. 0274	39	0	90. 05
90. 06 09006 INFUSION CLINIC	0. 1247	'67 C	0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0.0000	000	0	90. 07
91. 00   09100   EMERGENCY	0. 2332	92 15, 355	3, 582	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 4946	45 C	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0. 4031	10	0	93. 00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		45, 586	13, 336	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)	C		201. 00
202.00 Net charges (line 200 minus line 201)		45, 586		202. 00

In Lieu of Form CMS-2552-10
Worksheet E
Part B
B1/2023 Date/Time Prepared:
5/24/2024 9:43 am Peri od: From 01/01/2023 To 12/31/2023

	Title XVIII Hospital	072472024 9.4. Cost	<u> </u>
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	5, 777, 829	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS or REH payments	0	2. 00 3. 00
4. 00	Outlier payment (see instructions)	0	4. 00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0.000	5. 00 6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7. 00
8.00	Transitional corridor payment (see instructions)	0	8. 00
9. 00	Ancillary service other pass through costs including REH direct graduate medical education costs from	0	9. 00
10. 00	Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	5, 777, 829	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		
12. 00	Reasonable charges Ancillary service charges	0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14. 00
15 00	Customary charges	0	15. 00
15. 00 16. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis  Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17. 00
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	18. 00 19. 00
17.00	instructions)		17.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21. 00	<pre>linstructions) Lesser of cost or charges (see instructions)</pre>	5, 835, 607	21. 00
22. 00	Interns and residents (see instructions)	0,033,007	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	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  Deductibles and coinsurance amounts (for CAH, see instructions)	102, 310	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2, 286, 878	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	3, 446, 419	27. 00
28. 00	instructions)   Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
28. 50	REH facility payment amount (see instructions)		28. 50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27, 28, 28.50 and 29) Primary payer payments	3, 446, 419 2, 272	
32. 00	Subtotal (line 30 minus line 31)	3, 444, 147	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33. 00 34. 00	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)	0 432, 753	33. 00 34. 00
	Adjusted reimbursable bad debts (see instructions)	281, 289	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	380, 105	36. 00
37. 00	Subtotal (see instructions)	3, 725, 436	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97 39. 98	Demonstration payment adjustment amount before sequestration  Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		39. 99
40. 00	Subtotal (see instructions)	3, 725, 436	40. 00
40. 01	Sequestration adjustment (see instructions)	74, 509	
40. 02 40. 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs	0	40. 02 40. 03
41. 00	Interim payments	4, 136, 472	41. 00
41. 01	Interim payments-PARHM		41. 01
42. 00	Tentative settlement (for contractors use only)	0	42.00
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)	-485, 545	42. 01 43. 00
43. 01	Balance due provider/program-PARHM (see instructions)	.55, 5 15	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	340, 914	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
90. 00	Original outlier amount (see instructions)	0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)	0.00	92. 00 93. 00
73. UU	Time value of money (see firstitietions)	1 0	73.00

Health Financial Systems	IU HEALTH JAY HOSPITAL In Lie		u of Form CMS-2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1320	Peri od:	Worksheet E	
			From 01/01/2023		
			To 12/31/2023	Date/Time Pre	pared:
				5/24/2024 9: 4	<u>3 am</u>
		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

ANALYSIS 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: 15-1320

Title XVIII					10 12/31/2023	5/24/2024 9: 43	
Manual   M			Ti tl	e XVIII	Hospi tal		
1.00			Inpatie	nt Part A	Pai	rt B	
1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
1.00							
InterIm payments payable on Individual Bills, either submitted or to be submitted or to cost reporting period. If none, write "NOME" or enter a zero. (1)    Program to Provider for Provider	1. 00	Total interim payments paid to provider					1. 00
write "NONE" or enter a zero  No Usts separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  ADJUSTMENTS TO PROVIDER  O 0 0 3.0 3.03 3.03 3.04 3.05 Provider to Program  3.50 ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  O 0 3.5 3.53 3.54 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.53 3.54 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.53 3.54 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.54 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.54 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.54 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.50 ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.5 4 ADJUSTMENTS TO PROGRAM  O 0 3.5 3.5 3.5 4 ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENTS TO PROGRAM  ADJUSTMENT TO P	2. 00	Interim payments payable on individual bills, either		., ,			2. 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)  ADJUSTMENTS TO PROVIDER 09/05/2023 111, 400 09/05/2023 238, 700 3.0 0 3		write "NONE" or enter a zero					
Dayment. If none, write "NONE" or enter a zero. (1)   Program to Provider	3. 00						3. 00
Program to Provider							
3.02					<u> </u>		
3.04   0   0   0   3.0	3. 01		09/05/2023	111, 40	0 09/05/2023	238, 700	3. 01
3.05   Provider to Program     0   0   0   3.0   3.0   3.0   3.0   3.0   5.0   5.0   5.0   5.5   5.0	3.02				0	0	3. 02
3.50   ADJUSTMENTS TO PROGRAM   0	3.03				0	o	3. 03
Provider to Program   ADJUSTMENTS TO PROGRAM   0	3.04				0	o	3. 04
ADJUSTMENTS TO PROGRAM	3.05				0	0	3. 05
3.51							
3.52   Subtotal (sum of lines 3.01-3.49 minus sum of lines   0		ADJUSTMENTS TO PROGRAM		1	-	1	3. 50
3.53   3.54   3.54   3.59   3.50					-	1	3. 51
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)						1	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98    Total interim payments (sum of lines 1, 2, and 3.99)   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR					-		
Contractor   Con		3. 50-3. 98)					
TO BE COMPLÉTED BY CONTRACTOR   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider   TENTATIVE TO PROVIDER   O	4. 00			1, 255, 49	27	4, 136, 472	4. 00
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
Write "NONE" or enter a zero. (1)   Program to Provider   S. 01   TENTATIVE TO PROVIDER   O	5.00						5. 00
Program to Provider							
TENTATIVE TO PROVIDER							
5. 02   0	E 04		I	1			F 04
5.03   Provider to Program   5.50   TENTATIVE TO PROGRAM   0   0   5.50     5.51   0   0   0   5.50     5.52   0   0   0   5.50     5.52   5.52   0   0   0   5.50     5.59   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   0   0   0   5.50     6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0   0   0     6.01   SETTLEMENT TO PROGRAM   39,308   485,545   6.00     7.00   Total Medicare program liability (see instructions)   1,216,189   3,650,927   7.00     Contractor Number (Mo/Day/Yr)   0   1.00   2.00     7.00   Number (Mo/Day/Yr)   0   1.00		TENTATIVE TO PROVIDER		1	-		
Provider to Program							
5.50   TENTATI VE TO PROGRAM   0   0   5.50   5.51   0   0   0   5.50   5.52   0   0   0   5.50   5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   0   0   5.50   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   0   0   0   6.01   SETTLEMENT TO PROGRAM   39, 308   485, 545   6.00   7.00   Total Medicare program liability (see instructions)   1, 216, 189   3, 650, 927   7.00	5.03	Provider to Program		_	<u>U</u>	0	5.03
5.51   0	5 50						5 50
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		TENTALI VE TO TROUKAWI		1	-		
5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00					-		
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	5. 99						5. 99
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 00	Determined net settlement amount (balance due) based on					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  39,308 1,216,189  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6 01						6 01
7.00 Total Medicare program liability (see instructions)  1,216,189  3,650,927 7.00  Contractor Number (Mo/Day/Yr)  0 1.00 2.00				20.20	0	1	
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00					-		
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Trotal medicale program frability (See Histructions)		1,210,18			7.00
0 1.00 2.00							
				0			
	8. 00	Name of Contractor					8. 00

Health Financial Systems IU

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED 

		Component		0 12/31/2023	5/24/2024 9: 43	
		Title	XVIII Sv	ving Beds - SNF		
			t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T	1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		607, 581		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		0		0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	09/05/2023	82, 500		0	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	ADJUSTIMENTS TO TROUBLAND		Ö		ol ol	3. 51
3. 52			Ö		ő	3. 52
3. 53			Ö		ol	3. 53
3.54			O		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		82, 500		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		690, 081		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			l.		
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
_	Provi der 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 E O1 E 40 minus sum of lines		0		0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		23, 612		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		o	6. 02
7. 00	Total Medicare program liability (see instructions)		713, 693		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor		)	1. 00	2. 00	0.00
8. 00	Name of Contractor	I				8. 00

Heal th	Financial Systems IU HEALTH JAY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Peri od: From 01/01/2023 To 12/31/2023		epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	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	14		1.00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 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
	Other Adjustment (specify)				31.00
22.00	Polones due providor (line 0 (or line 10) minus line 20 and	line 21) (occ instruction	)		22.00

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

30. 00 31. 00 32. 00

CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS | Provider CCN: 15-1320 | Period: From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/24/2024 9: 43 am

		Component CCN: 15-Z320	10 12/31/2023	5/24/2024 9:4	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		F70 770	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		579, 778	0	1. 00 2. 00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	· A and sum of Wkst D	151, 080	0	3.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir	The state of the s	· ·	U	3.00
	instructions)	ig bed pass till odgil, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0.00	4. 00
	instructions)				
5.00	Program days		211	0	5. 00
6.00	Interns and residents not in approved teaching program (see in	,		0	6. 00
7.00	Utilization review - physician compensation - SNF optional met	thod only	720.050	0	7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		730, 858	0	8. 00 9. 00
10. 00	Primary payer payments (see instructions) Subtotal (line 8 minus line 9)		730, 858	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	730, 030	0	11.00
11.00	professional services)	cable to physician		0	11.00
12.00	Subtotal (line 10 minus line 11)		730, 858	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	2, 600	0	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)		728, 258	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`	0	0	16.00
16. 50 16. 55	Prioneer ACO demonstration payment adjustment (see instructions	•			16. 50 16. 55
10. 33	Rural community hospital demonstration project (§410A Demonstradjustment (see instructions)	atron) payment	U		16. 55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17. 00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18. 00
19. 00	Total (see instructions)		728, 258	0	19. 00
19. 01	Sequestration adjustment (see instructions)		14, 565	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19. 03
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		690, 081	0	19. 25 20. 00
20. 00	Interim payments  Interim payments-PARHM		090, 001	U	20.00
21. 00	Tentative settlement (for contractor use only)		0	0	21. 00
21. 01	Tentative settlement-PARHM (for contractor use only)			Ü	21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.02	2, 19.25, 20, and 21)	23, 612	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	39, 723	0	23. 00
	chapter 1, §115.2				
200 00	Rural Community Hospital Demonstration Project (§410A Demonstr	· · · · · · · · · · · · · · · · · · ·			200 00
200.00	Is this the first year of the current 5-year demonstration per Century Cures Act? Enter "Y" for yes or "N" for no.	riod under the Zist			200. 00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from V	Vkst. D-1. Pt. II. line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	е		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)	6. 1			204. 00
	Computation of Demonstration Target Amount Limitation (N/A in period)	Tirst year of the curre	nt 5-year demonst	ration	
205.00	Medicare swing-bed SNF target amount				205. 00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti	mes line 204)			206. 00
200.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				200.00
207.00	Program reimbursement under the §410A Demonstration (see instr				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2		1		208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210.00	Reserved for future use				210. 00
045 00	Comparision of PPS versus Cost Reimbursement	200 -1 11 212			015 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2 instructions)	209 plus line 210) (see			215. 00
	1 113 ti uc ti 0113)		1	l	I

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/24/2024 9:43 am

Title XVIII				10 12/01/2020	5/24/2024 9: 4	3 am
Name   Name			Title XVIII	Hospi tal		
Name   Name						
1,00   Inpatient services   1,377,508   1.00   0.					1. 00	
Nursing and Allied Health Managed Care payment (see instructions)		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
Organ acquisition   0   3.00   Cell full art therapy acquisition cost (see instructions)   1, 377, 508   4.00   5.00   7   1   1   1   1   1   1   1   1   1	1.00	Inpatient services			1, 377, 508	1. 00
Cell ular 'therapy acquisition cost (see instructions)	2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3.00   Subtotal (sum of lines I through 3.01)	3.00	Organ acqui si ti on			0	3. 00
Primary payer payments	3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
Primary payer payments	4.00	Subtotal (sum of lines 1 through 3.01)			1, 377, 508	4. 00
Total Cost (Line 4 less line 5). For CAH (see instructions)   1,391,283   6.00	5.00					5. 00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable charges   Reasonable charges   Routine service charges   0	6.00	1 3 . 3 . 3			1, 391, 283	6. 00
7.00   Routine service charges   0   7.00   0   0   0   0   0   0   0   0   0						
7.00   Routine service charges   0   7.00   0   0   0   0   0   0   0   0   0		Reasonable charges				
Ancillary service charges   0	7.00				0	7. 00
0.00	8.00				0	8. 00
10. 00   Total reasonable charges	9.00	1			0	9. 00
11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11.00					0	10.00
11.00   Aggregate amount actually collected from patients liable for payment for services on a charge basis   0   11.00		Customary charges				
had such payment been made in accordance with 42 CFR 413.13(e)	11.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	11. 00
13.00	12.00	Amounts that would have been realized from patients liable fo	r payment for services o	n a charge basis	0	12. 00
14. 00   Total customary charges (see instructions)   0   14. 00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see   0   15. 00   15.		had such payment been made in accordance with 42 CFR 413.13(e	)	Ü		
15.00   Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)   16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00   19.0	13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
Instructions   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   16.00   16.00   17.	14.00	Total customary charges (see instructions)			0	14.00
16.00   Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see   16.00   16.00   18.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   19	15.00	Excess of customary charges over reasonable cost (complete on	ly if line 14 exceeds li	ne 6) (see	0	15.00
Instructions   Cost of physicians' services in a teaching hospital (see instructions)   0   17. 00		instructions)				
17.00	16.00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds line	e 14) (see	0	16.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT   0   18.00   18.00   19.00   10.00						
18. 00	17. 00		ructions)		0	17. 00
19.00   Cost of covered services (sum of lines 6, 17 and 18)   1, 391, 283   19.00						
20. 00   Deductibles (exclude professional component)   159, 912   20. 00		, , , ,	4, line 49)			
21.00   Excess reasonable cost (from line 16)   0   21.00   22.00   Subtotal (line 19 minus line 20 and 21)   1,231,371   22.00   23.00   20 coin surance   800   23.00   25.00   Allowable bad debts (exclude bad debts for professional services) (see instructions)   16,058   25.00   27.00   Allowable bad debts (see instructions)   16,058   25.00   27.00   Allowable bad debts for dual eligible beneficiaries (see instructions)   15,316   27.00						
22. 00       Subtotal (line 19 minus line 20 and 21)       1, 231, 371       22. 00         23. 00       Coinsurance       800       23. 00         24. 00       Subtotal (line 22 minus line 23)       1, 230, 571       24. 00         25. 00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       16, 058       25. 00         26. 00       Adjusted reimbursable bad debts (see instructions)       10, 438       26. 00         27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       15, 316       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 241, 009       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29. 90         29. 98       Recovery of accelerated depreciation.       0       29. 98         29. 99       Bemonstration payment adjustment amount before sequestration       0       29. 99         30. 01       Sequestration adjustment (see instructions)       24, 820       30. 01         30. 02       Demonstration payment adjustment amount after sequestration       24, 820       30. 01         31. 01       Interim payments-PARHM       1, 255						
23.00		·				
24.00       Subtotal (line 22 minus line 23)       1, 230, 571       24.00         25.00       Al I lowable bad debts (exclude bad debts for professional services) (see instructions)       16,058       25.00         26.00       Adjusted reimbursable bad debts (see instructions)       10,438       25.00         27.00       Al I lowable bad debts for dual eligible beneficiaries (see instructions)       15,316       27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,241,009       28.00         29.50       Ditter ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29.00         29.50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29.50         29.99       Recovery of accelerated depreciation.       0       29.99         29.99       Demonstration payment adjustment amount before sequestration       0       29.99         30.01       Sequestration adjustment (see instructions)       1,241,009       30.00         30.02       Demonstration payment adjustment amount after sequestration       0       29.99         31.01       Interim payments       1,245,000       30.02         31.01       Interim payments       1,255,497       31.00         32.00       Tentative settlement (for contractor use only)       32.01						
25.00       Allowable bad debts (exclude bad debts for professional services) (see instructions)       16,058   25.00         26.00       Adjusted reimbursable bad debts (see instructions)       10,438   26.00         27.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       15,316   27.00         28.00       Subtotal (sum of lines 24 and 25, or line 26)       1,241,009   28.00         29.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0 29.00         29.50       Pioneer ACO demonstration payment adjustment (see instructions)       0 29.50         29.99       Recovery of accelerated depreciation.       0 29.98         29.99       Demonstration payment adjustment amount before sequestration       0 29.99         30.00       Subtotal (see instructions)       1,241,009   30.00         30.01       Sequestration adjustment (see instructions)       24,820   30.01         30.02       Sequestration adjustment amount after sequestration       0 30.02         31.00       Interim payments       1,255,497   31.00         31.01       Interim payments-PARHM       31.01         32.00       Tentative settlement (for contractor use only)       32.01         33.00       Balance due provi der/program (line 30 minus lines 30.01, 30.02, 31, and 32)       33.01         33.01       Balance due provider/						
26. 00 Adj usted reimbursable bad debts (see instructions)  27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions)  28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Demonstration payment adjustment amount after sequestration  31. 00 Interim payments  31. 01 Interim payments  11. 255, 497 31. 00  32. 01 Tentative settlement (for contractor use only)  33. 00 Bal ance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)  33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)  34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  10. 438 26. 00  15, 316 27. 00  15, 316 27. 00  1, 241, 009  29. 90  1, 241, 009  29. 99  1, 241, 009  29. 99  1, 241, 009  29. 99  1, 241, 009  29. 99  1, 241, 009  29. 90  29. 90  29. 90  29. 90  29. 90  1, 241, 009  29. 90  29. 90  1, 241, 009  29. 90  29. 90  1, 241, 009  29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 29. 90  10. 20. 00  10. 29. 90  10. 29		,				
27. 00       Allowable bad debts for dual eligible beneficiaries (see instructions)       15, 316       27. 00         28. 00       Subtotal (sum of lines 24 and 25, or line 26)       1, 241,009       28. 00         29. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       29. 00         29. 50       Pioneer ACO demonstration payment adjustment (see instructions)       0       29. 95         29. 98       Recovery of accelerated depreciation.       0       29. 99         30. 00       Subtotal (see instructions)       0       29. 99         30. 01       Sequestration adjustment (see instructions)       24, 820       30. 01         30. 02       Demonstration payment adjustment amount after sequestration       0       29. 99         30. 03       Sequestration adjustment (see instructions)       24, 820       30. 01         30. 03       Interim payments       0       30. 02         31. 01       Interim payments       1, 255, 497       31. 00         31. 01       Interim payments-PARHM       31. 01       31. 01         32. 01       Tentative settlement (for contractor use only)       32. 01         33. 01       Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)       -39, 308       33. 00         33. 01       Balance		,	ces) (see instructions)			
28. 00 Subtotal (sum of lines 24 and 25, or line 26)  29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  29. 50 Pioneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 02 Sequestration adjustment (see instructions)  31. 01 Interim payments  31. 01 Interim payments  31. 01 Interim payments (for contractor use only)  32. 01 Tentative settlement (for contractor use only)  33. 00 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  77, 176 34. 00						
29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. 29. 99 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 77, 176 34. 00			ructions)			
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions)  29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment after sequestration  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment amount after sequestration  31. 00 Interim payments  31. 01 Interim payments  31. 01 Interim payments-PARHM  32. 00 Tentative settlement (for contractor use only)  32. 01 Tentative settlement (for contractor use only)  33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  77, 176 34. 00		· · · · · · · · · · · · · · · · · · ·				
29. 98 Recovery of accelerated depreciation.  29. 99 Demonstration payment adjustment amount before sequestration  30. 00 Subtotal (see instructions)  30. 01 Sequestration adjustment (see instructions)  30. 02 Demonstration payment adjustment amount after sequestration  30. 03 Sequestration adjustment-PARHM  30. 03  31. 00 Interim payments  11. 255, 497 31. 00  31. 01 Interim payments-PARHM  32. 00 Tentative settlement (for contractor use only)  32. 01 Tentative settlement-PARHM (for contractor use only)  33. 01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)  34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  77, 176 34. 00						
29. 99 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30. 02 30. 02 30. 03			s)			
30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30. 00 30. 02 30. 02 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 30. 03 31. 01 32. 05 32. 06 32. 07 32. 07 33. 07 34. 00						
30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30. 01 30. 02 30. 02 30. 03 30. 03 30. 03 31. 01, and 32. 01 31. 00 32. 00 32. 00 32. 01 32. 00 33. 01 33. 00		, , , , , , , , , , , , , , , , , , , ,				
30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,  77, 176 34. 00		,				
30. 03   Sequestration adjustment-PARHM   30. 03   31. 00   Interim payments   1, 255, 497   31. 00   31. 01   Interim payments-PARHM   31. 01   32. 00   Tentative settlement (for contractor use only)   0   32. 00   32. 01   33. 00   Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32)   33. 01   Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)   33. 01   34. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   77, 176   34. 00		, ,			•	
31.00 Interim payments 31.01 Interim payments					0	
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, 31, and 32)   -39, 308   33. 00   33. 01   Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01)   33. 01   34. 00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,   77, 176   34. 00						
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 77, 176 34.00		, ,			1, 255, 497	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 77, 176 34.00						
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 77, 176 34.00		·			0	
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 77, 176 34.00						
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 77,176 34.00		, , , , , , , , , , , , , , , , , , , ,	•		-39, 308	
		, , ,				
9115. 2	34.00	· · · · · · · · · · · · · · · · · · ·	nce with CMS Pub. 15-2, (	cnapter 1,	77, 176	34.00
		3110. 2				

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

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: 15-1320 Pr

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 9:43 am

OH y)					5/24/2024 9:4	3 am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1			1	
1.00	Cash on hand in banks	-10, 843, 539		_	_	1.00
2. 00 3. 00	Temporary i nvestments Notes receivable	0	0		0	2. 00 3. 00
4.00	Accounts recei vable	3, 073, 221	1	0	0	4.00
5.00	Other recei vable	891, 842		0	o o	5.00
6. 00	Allowances for uncollectible notes and accounts receivable	0	Ö	0	Ō	6. 00
7.00	Inventory	409, 205	0	0	0	7. 00
8.00	Prepai d expenses	78, 689	0	0	0	8. 00
9.00	Other current assets	0	0	_	0	9.00
10.00	Due from other funds	( 200 502	0	_	0	10.00
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	-6, 390, 582	2 0	0	0	11. 00
12. 00	Land	989, 148	0	0	0	12. 00
13. 00	Land improvements	0	o o		_	13. 00
14.00	Accumulated depreciation	0	0	0	0	14.00
15. 00	Bui I di ngs	19, 337, 833	0	0	0	15. 00
16. 00	Accumulated depreciation	-7, 606, 012	1	0	0	16. 00
17. 00	Leasehold improvements	0	0	_	0	17. 00
18.00	Accumulated depreciation	0	0	_	0	18.00
19. 00 20. 00	Fixed equipment Accumulated depreciation	0	0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks	42, 146		0	0	21.00
22. 00	Accumulated depreciation	-39, 512	1	0	ő	22. 00
23. 00	Major movable equipment	12, 940, 233	1	0	ō	23. 00
24.00	Accumulated depreciation	-8, 156, 803	0	0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00 29. 00	Accumulated depreciation	0	0	_	0	28. 00 29. 00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	17, 507, 033	1	_		30.00
30.00	OTHER ASSETS	17, 307, 033	,, 0		0	30.00
31.00	Investments	0	0	0	0	31.00
32. 00	Deposits on Leases	0	0	0	_	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34. 00	Other assets	0	0		0	34.00
35. 00	Total other assets (sum of lines 31-34)	0	0	_	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	11, 116, 451	] 0	0	0	36. 00
37. 00	Accounts payable	2, 633, 060	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	741, 018	1	0		38. 00
39. 00	Payrol I taxes payable	67, 831	1	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	458, 332				42.00
43. 00 44. 00	Due to other funds Other current liabilities	3, 978, 863	0	0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	7, 879, 104		_		45. 00
10.00	LONG TERM LIABILITIES	1,0,,,,0,				10.00
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0	0	0	0	47. 00
48. 00	Unsecured Loans	0	0			48. 00
49. 00	Other long term liabilities	0	0		_	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	7 070 104	0		_	50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	7, 879, 104	. 0	0	0	51.00
52. 00	General fund balance	3, 237, 347	,			52. 00
53. 00	Specific purpose fund	0,20,,01,	0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	3, 237, 347	,	_	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	11, 116, 451			0	60.00
_0.00	59)	1.,.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				- 3. 55
			•	•	•	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES IU HEALTH JAY HOSPITAL

HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 15-1320 Period: From 01/01/2023 Worksheet G-1

					From 01/01/2023 To 12/31/2023		
		General	Fund	Speci al F	Purpose Fund	Endowment Fund	
		1.00			1	5.00	
1 00	Fund balances at beginning of period	1.00	2. 00 9, 041, 056	3. 00	4. 00	5. 00	1. 00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)	1	-5, 803, 710			1	2. 00
3.00	Total (sum of line 1 and line 2)		3, 237, 346		(		3. 00
4. 00	ROUNDI NG	1	0, 207, 010		0	l ol	4. 00
5.00		0			0	0	5. 00
6.00		0			0	0	6.00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9. 00		0	_		0	0	9. 00
10.00	Total additions (sum of line 4-9)		7				10.00
11. 00 12. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)		3, 237, 347		0	)	11. 00 12. 00
12.00	beductions (debit adjustments) (specify)				0	0	12.00
14. 00					0		14. 00
15. 00		0			o	l ol	15. 00
16. 00		0			0	0	16.00
17.00		0			0	0	17.00
18. 00	Total deductions (sum of lines 12-17)		0		(	1	18.00
19. 00	Fund balance at end of period per balance		3, 237, 347		(		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Eriadimetre Faria		1 4114			
	I <del>-</del>	6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00 2. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0		3. 00
4. 00	ROUNDI NG		0		٩		4. 00
5. 00			0				5. 00
6.00		1	0				6.00
7.00			0				7. 00
8. 00			0				8. 00
9.00	T + 1 - 11111 ( C + 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1		0				9. 00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)		0		٥		12. 00
13. 00	beddetrons (debrt adjustments) (specify)		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 sheet (line 11 minus line 18)	0			0		19. 00
	Isheer (Time II IIII lus II lie 10)	I I		I	ı	l	

Health Financial Systems
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: 15-1320

			To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
	Cost Center Description	Inpatient	Outpati ent	Total	J dill
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	2, 360, 81	4	2, 360, 814	1. 00
2.00	SUBPROVI DER - I PF		0	0	2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	461, 61	6	461, 616	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	2, 822, 43	0	2, 822, 430	10. 00
	Intensive Care Type Inpatient Hospital Services		1		
11.00	INTENSIVE CARE UNIT				11. 00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)			0	15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16. 00
17. 00	11-15)   Total inpatient routine care services (sum of lines 10 and 16)	2, 822, 43	0	2, 822, 430	17. 00
18. 00	Ancillary services	3, 480, 59		54, 288, 618	
19. 00	Outpatient services	367, 11		32, 099, 994	
20. 00	RURAL HEALTH CLINIC (RHC)		0 1, 697, 771	1, 697, 771	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	•	0 1, 047, 771	1, 047, 771	21. 00
22. 00	HOME HEALTH AGENCY		o o	U	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	6, 670, 13	3 84, 238, 680		28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES	•			
29.00	Operating expenses (per Wkst. A, column 3, line 200)		41, 974, 207		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34. 00
35. 00			0		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40.00
41. 00	7		0		41.00
42. 00	Total deductions (sum of lines 37-41)		41 074 207		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	ei	41, 974, 207		43. 00
	to Wkst. G-3, line 4)	I	1		

	Financial Systems	IU HEALTH JAY HOSPITAL		u of Form CMS-2	2552-1
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Peri od: From 01/01/2023	Worksheet G-3	
			To 12/31/2023	Date/Time Prep 5/24/2024 9:43	
				0,21,2021 7. 10	J dill
				1. 00	
. 00	Total patient revenues (from Wkst. G-2, Part I	, column 3, line 28)		90, 908, 813	1. 0
2. 00	Less contractual allowances and discounts on p	atients' accounts		54, 681, 848	2.0
3. 00	Net patient revenues (line 1 minus line 2)			36, 226, 965	3. 0
. 00	Less total operating expenses (from Wkst. G-2,			41, 974, 207	4. C
. 00	Net income from service to patients (line 3 mi	nus line 4)		-5, 747, 242	5. 0
	OTHER I NCOME				
. 00	Contributions, donations, bequests, etc			0	6. 0
. 00	Income from investments			0	7. (
. 00	Revenues from telephone and other miscellaneou	s communication services		0	8. (
. 00	Revenue from television and radio service			0	9. (
0. 00	Purchase di scounts			0	10. (
	Rebates and refunds of expenses			0	11. (
2. 00	Parking lot receipts			0	12. (
	Revenue from laundry and linen service			0	13.
	Revenue from meals sold to employees and guest	S		0	14.
5.00	Revenue from rental of living quarters	1: 446 464:4-		0	15. 16.
	Revenue from sale of medical and surgical supp			0	17.
	Revenue from sale of drugs to other than patie Revenue from sale of medical records and abstr			0	17.
	Tuition (fees, sale of textbooks, uniforms, et			0	19.
	Revenue from gifts, flowers, coffee shops, and	,		0	20.
	Rental of vending machines	Carreen		0	20.
2. 00	Rental of hospital space			0	21.
3. 00	Governmental appropriations			0	23.
4. 00	MI SCELLANEOUS I NCOME			-56, 468	23. 24.
	COVI D-19 PHE Fundi ng			-30, 400	24.
	Total other income (sum of lines 6-24)			-56, 468	
	Total (line 5 plus line 25)			-5, 803, 710	
	OTHER EXPENSES (SPECIFY)			-5, 803, 710	27.
	Total other expenses (sum of line 27 and subsc	rints)		0	28.
	Net income (or loss) for the period (line 26 m	1 /		-5, 803, 710	-

	Financial Systems	IU HEALTH JA				eu of Form CMS-	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1320	Peri od: From 01/01/2023	Worksheet M-1	
			Component	CCN: 15-8558	To 12/31/2023		nared:
			Component	0014. 10 0000	10 12/01/2020	5/24/2024 9: 4	
				_	RHC I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	133, 839	3, 350	137, 18	-129		1. 00
2.00	Physician Assistant	0	C	)	0 0	0	2. 00
3.00	Nurse Practitioner	74, 743	12, 464	87, 20	07 -6, 129		
4.00	Visiting Nurse	0	C	)	0	0	4. 00
5.00	Other Nurse	0	C		0	0	5. 00
6.00	Clinical Psychologist	0	C		0	0	6. 00
7. 00	Clinical Social Worker	0	C		0	0	7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	C	)	0	0	8. 00
9.00	Other Facility Health Care Staff Costs	82, 938					
10.00	Subtotal (sum of lines 1 through 9)	291, 520	34, 404	325, 9	24 -18, 599		
11. 00	Physician Services Under Agreement	0	C		0 0	0	11. 00
	Physician Supervision Under Agreement	0	C		0	0	12. 00
	Other Costs Under Agreement	0	C	)	0 0	0	10.00
	Subtotal (sum of lines 11 through 13)	0	C	)	0 0	0	14. 00
	Medical Supplies	0	C	)	0 0	0	15. 00
	Transportation (Health Care Staff)	0	C	)	0 0	0	
17 00	Demonstration Medical Facilians	1	2 200	N 2 0/	00 000	l	17 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Period: Worksheet M-1 From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

			Component	CCN: 1!	5-8558	То	12/31/2023	Date/Time Pro 5/24/2024 9:4	epared: 43 am
							RHC I	Cost	
		Adjustments	Net Expenses						
		1	for Allocation	n					
			(col. 5 + col.	.					
			6)						
		6. 00	7. 00						
	FACILITY HEALTH CARE STAFF COSTS								
1. 00	Physi ci an	371, 527	508, 587	1					1. 00
2.00	Physician Assistant	0		0					2. 00
3.00	Nurse Practitioner	102, 904	183, 982	1					3. 00
4.00	Visiting Nurse	0		0					4.00
5.00	Other Nurse	0	(	0					5. 00
6.00	Clinical Psychologist	U <sub>I</sub>	(						6.00
7.00	Clinical Social Worker	٩	(	٩					7.00
7. 10 7. 11	Marriage and Family Therapist								7. 10 7. 11
7. TT 8. 00	Mental Health Counselor	0	(						8.00
9.00	Laboratory Technician Other Facility Health Care Staff Costs	443, 466	532, 653	2					9.00
10.00	Subtotal (sum of lines 1 through 9)	917, 897	1, 225, 222						10.00
11. 00	Physician Services Under Agreement	917, 697	1, 223, 222	2					11.00
12. 00	Physician Supervision Under Agreement	0	(	0					12.00
13. 00	Other Costs Under Agreement	0	(						13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	(	0					14. 00
15. 00	Medical Supplies	0	-	0					15. 00
16. 00	Transportation (Health Care Staff)	0	(						16. 00
17. 00	Depreciation-Medical Equipment	9, 999	9, 999	9					17. 00
18. 00	Professional Liability Insurance	0	2, 888						18. 00
19. 00	Other Health Care Costs	-945, 216	104, 61						19. 00
20. 00	Allowable GME Costs		,						20.00
21. 00	Subtotal (sum of lines 15 through 20)	-935, 217	117, 498	8					21. 00
22. 00	Total Cost of Health Care Services (sum of	-17, 320	1, 342, 720	1					22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES	·							
23.00	Pharmacy	0	(	0					23. 00
24.00	Dental	0	(	0					24. 00
25.00	Optometry	0	(	0					25. 00
25. 01	Tel eheal th	0	(	0					25. 01
25. 02	Chronic Care Management	0	(	0					25. 02
26. 00	All other nonreimbursable costs	0	(	0					26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	(	0					28. 00
	through 27) FACILITY OVERHEAD								
29. 00	FACILITY OVERHEAD Facility Costs	79, 606	79, 606	6					29. 00
30.00	Administrative Costs	77,000		0					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	79, 606	79, 606	-					31.00
31.00	30)	77,000	77,000	٦					31.00
32. 00	Total facility costs (sum of lines 22, 28	62, 286	1, 422, 326	6					32. 00
32.00	and 31)	52, 200	., .22,020	-					52.55
		'							1

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	IU HEALTH JA		ON 45 4000		u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provider CO		Peri od: From 01/01/2023	Worksheet M-2	
			Component (		To 12/31/2023	Date/Time Pre 5/24/2024 9:4	
					RHC I	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		. ,	(col. 1 x col. 3)	4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 01					1. 00
2.00	Physician Assistant	0.00		2, 10			2. 00
3.00	Nurse Practitioner	0. 84					3. 00
4.00	Subtotal (sum of lines 1 through 3)	1. 85			6, 006	8, 884	4. 00
5.00	Visiting Nurse	0. 00				0	5. 00
6. 00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0. 00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00				0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0. 00	0			0	7. 02
7. 03	only) Marriage and Family Therapist						7. 03
7. 03 7. 04	Mental Health Counselor						7.03
8. 00	Total FTEs and Visits (sum of lines 4	1. 85	8, 884			8, 884	8.00
8.00	through 7)	1.00	0,004			0, 004	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWARD F OCCUPANCE TO BE A SECURITION OF ALLOWARD F. CO. O. A. D. L. CARLETTE OCCUPANCE TO BE A SECURITION OF ALLOWARD F. CO. O. A. D. L. CARLETTE OCCUPANCE TO BE A SECURITION OF ALLOWARD F. CO. O. A. D. C. CARLETTE OCCUPANCE TO BE A SECURITION OF ALLOWARD F. CO. O. C.					1. 00	
40.00	DETERMINATION OF ALLOWABLE COST APPLICABLE T			VICES		4 040 700	10.00
10.00	Total costs of health care services (from Wk					1, 342, 720	1
11. 00 12. 00	Total nonreimbursable costs (from Wkst. M-1,					1 242 720	
12.00	Cost of all services (excluding overhead) (s Ratio of hospital-based RHC/FQHC services (I					1, 342, 720 1, 000000	
14. 00	Total hospital-based RHC/FQHC services (I			no 21)		79, 606	
15. 00	Parent provider overhead allocated to facili			110 31)		79, 606 764, 292	
16. 00		ty (see Ilistiuc	LI UIIS)			843, 898	
17. 00	Allowable GME overhead (see instructions)					043, 090	17. 00
18. 00	Enter the amount from line 16					843, 898	
19 00	Overhead applicable to hospital-based RHC/FC	NHC services (li	ne 13 x line 1	8)		843, 898	19.00

	Financial Systems IU HEALTH JAY H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1320	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI C	ES	Component CCN: 15-8558	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 9:4:	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			2, 186, 618	
2. 00 3. 00	Cost of injections/infusions and their administration (from WI Total allowable cost excluding injections/infusions (line 1 mi			108, 551 2, 078, 067	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)	Thus Time 2)		8, 884	4.00
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	5. 00
6.00	Total adjusted visits (line 4 plus line 5)			8, 884	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	233.91 of Limit (1)	7.00
			Rate Period N/A	Rate Period 1 (01/01/2023	
			IN/ A	through	
				12/31/2023)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1. 00	2. 00 290. 32	8. 00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	0.00	233. 91	9.00
	CALCULATION OF SETTLEMENT				1
10.00	Program covered visits excluding mental health services (from		0	2, 018	
11. 00 12. 00	Program cost excluding costs for mental health services (line Program covered visits for mental health services (from contra	•	0	472, 030 0	1
13. 00	Program covered cost from mental health services (line 9 x lin		0	0	
14. 00	Limit adjustment for mental health services (see instructions)		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	472, 030	15. 00 16. 00
16. 01	Total program charges (see instructions)(from contractor's rea			367, 105	
16. 02	Total program preventive charges (see instructions)(from provi	ider's records)		23, 376	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		30, 057	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0) (Titles V and XIX see instructions.)	3 and 18) times .80)		344, 466	16. 04
16. 05	Total program cost (see instructions)		0	374, 523	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		11, 391	18.00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		66, 468	19. 00
20.00	Net program cost excluding injections/infusions (see instructions)			374, 523	
21. 00 21. 50	Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions)	M-4, line 16)		1, 308	21. 00 21. 50
21. 55	Total program IOP Costs (see instructions)				21. 55
21. 60	Program IOP deductible and coinsurance (see instructions)				21. 60
22.00	Total reimbursable Program cost (sum of lines 20, 21, 21.50, r	minus line 21.60)		375, 831	
23. 00 23. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
24. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		0	
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	s)		0	
25. <del>99</del> 26. 00	Net reimbursable amount (see instructions)			375, 831	
26. 01	Sequestration adjustment (see instructions)			7, 517	26. 01
26. 02	Demonstration payment adjustment amount after sequestration			0	
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			299, 504	27. 00 28. 00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		68, 810	
30.00	Protested amounts (nonallowable cost report items) in accordan			20, 673	

	Financial Systems IU HEALTH JA ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Period: From 01/01/2023	worksheet M-4	
		Component (	CCN: 15-8558	To 12/31/2023	Date/Time Pre 5/24/2024 9:4	pared: 3 am
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 225, 222	1, 225, 22	22 1, 225, 222	1, 225, 222	1. 00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 008440	0. 02785	0. 000000	0. 000000	2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	10, 341	34, 12	27 0	0	3. 00
1. 00	Injections/infusions and related medical supplies costs (from your records)	8, 900	·		0	4. 00
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	19, 241	47, 41	16 0	0	5.00
5. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 342, 720	1, 342, 72	1, 342, 720	1, 342, 720	6. 00
7. 00	Total overhead (from Wkst. M-2, line 19)	843, 898	843, 89	843, 898	843, 898	7. 00
3. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 014330			0.000000	8. 00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	12, 093			0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	31, 334	·		0	10.00
11. 00	Total number of injections/infusions (from your records)	251			0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	124. 84				
13. 00	Number of injection/infusion administered to Program beneficiaries	3	<u></u>	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	375	93	0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI ON	
				1. 00	2. 00	

108, 551 15. 00 1, 308 16. 00

15.00 Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2)

16.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Health Financial Systems	IU HEALTH JAY H	OSPI TAL	In Lie	eu of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-13	From 01/01/2023	
		Component CCN: 15-8	558 To 12/31/2023	Date/Time Prepared:

		Component CCN: 15-8558	10 12/31/2023	5/24/2024 9: 43	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC		299, 504	1. (	
2. 00	Interim payments payable on individual bills, either submitthe contractor for services rendered in the cost reporting   "NONE" or enter a zero	period. If none, write		0	2. (
. 00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3. (
	Program to Provider			_	_
. 01				0	3.
. 02				0	3.
03				0	3.
04				0	3.
05				0	3.
F-0	Provider to Program				_
50				0	3.
51				0	3.
52				0	3
53				0	3
54			0	3	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4		0	3.	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	ter to Worksheet M-3, line	!	299, 504	4
	TO BE COMPLETED BY CONTRACTOR				
00		k novi ou. Al oo obou doto o	£		5.
00	List separately each tentative settlement payment after desleach payment. If none, write "NONE" or enter a zero. (1)	K review. Also show date o			Э
01	Program to Provider			0	_
01 02				0	5. 5.
02 03				0	5 5
J3	Provider to Program			0	Э
50	Provider to Program			0	5
50 51					5 5
51 52					5 5
99		00)			5 5
99 00	Determined net settlement amount (balance due) based on the	,		ا	5 6
30 31	SETTLEMENT TO PROVIDER	cost report. (1)		68, 810	6
	SETTLEMENT TO PROGRAM			08, 810	6
$\cap$ 2				368, 314	7.
					/
	Total Medicare program liability (see instructions)		Contractor		
	lotal Medicare program liability (see instructions)		Contractor	NPR Date	
02	lotal Medicare program liability (see instructions)	0	Contractor Number 1.00		