] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low.

[1] Cost Report Status
[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. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1

(5) Amended PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened

Contractor use only

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH JAY HOSPITAL (15-1320) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

JONATHAN VANATOR (Si gned)

Officer or Administrator of Provider(s)

number of times reopened = 0-9.

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1.00	2. 00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
Hospi tal	0	-416, 623	-312, 528	0	0	1. 00
Subprovi der - IPF	0	-1	4		0	2. 00
Subprovi der - I RF	0	0	0		0	3. 00
Swing Bed - SNF	0	-19, 151	0		0	5. 00
Swing Bed - NF	0				0	6.00
Total	0	-435, 775	-312, 524	0	0	200. 00
	PART III - SETTLEMENT SUMMARY Hospital Subprovider - IPF Subprovider - IRF Swing Bed - SNF	1.00	Cost Center Description	1.00 2.00 3.00	Cost Center Description	Cost Center Description

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents , please contact 1-800-MEDICARE.

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:10 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 500 W. VOTAW 1.00 1.00 PO Box: State: IN 2.00 City: PORTLAND Zip Code: 47371 County: JAY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)

/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 IU HEALTH JAY HOSPITAL 151320 99915 01/01/2004 Ν 0 3.00 Hospi tal Subprovider - IPF 0 IU HEALTH JAY HOSPITAL 99915 Р 4.00 15M320 4 10/01/2005 Ν 4.00 PSYCH UNIT 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF LUHP SWING BEDS 157320 99915 01/01/2004 N 7 00 7 00 N 0 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 21.00 2 1. 00 2. 00 3.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 N Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)

Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) 22.02 22.02 N N Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to 22.03 N Ν N rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost

	illetiloù useu ili tile piroi (,051			II.		
reporting period? In column 2, en	er "Y" for yes or "N" for r	10.					
	In-State	In-State	Out-of	Out-of	Medi cai	d Other	
	Medi cai d	Medicaid	State	State	HMO day	/s Medicaid	
	paid day	s eligible	Medi cai d	Medi cai d	1	days	
	'	unpai d	paid days	eligible			
		days		unpai d			
	1.00	2. 00	3.00	4. 00	5. 00	6.00	1
24.00 If this provider is an IPPS hospita	I, enter the	0 (0	C)	0 0	24.0
in-state Medicaid paid days in colu	ımn 1, in-state						
Medicaid eligible unpaid days in co	olumn 2,						
out-of-state Medicaid paid days in	column 3,						
out-of-state Medicaid eligible unpa	id days in column						
4, Medicaid HMO paid and eligible b	out unpaid days in						
column 5, and other Medicaid days i	n column 6		1				

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:10 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days eligible days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1.00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the 26. 00 cost reporting period. Enter "1" for urban or "2" for rural. Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37 01 37 01 instructions) 38.00 | If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39.00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 | Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν N 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1. 00 2. 00 3 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν Ν 45.00 with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances 46.00 Ν Ν Ν 46.00 pursuant to 42 CFR §412 348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν Ν 47.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. 48.00 N Ν 48.00 Ν Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, 59.00 Pt. NAHE 413.85 Pass-Through Worksheet A Y/N Line # Oual ification 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 adjustement? Enter "Y" for yes or "N" for no in column 2.

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 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:10 am Y/N IME Direct GME IME Direct GME 2.00 5.00 1.00 3. 00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0.00 Ν 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) Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 3.00 1.00 2.00 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) 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 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) N 63.00

		Unweighted	Unweighted	Ratio (col. 1/	
		FTEs	FTEs in	(col. 1 + col.	
		Nonprovi der	Hospi tal	2))	
		Si te			
		1. 00	2.00	3. 00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost r	eporting	
	period that begins on or after July 1, 2009 and before June 30, 2010.				
6	64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00
	in the base year period, the number of unweighted non-primary care				
	resident FTEs attributable to rotations occurring in all nonprovider				
	settings. Enter in column 2 the number of unweighted non-primary care				
	resident FTEs that trained in your hospital. Enter in column 3 the ratio				
	of (column 1 divided by (column 1 + column 2)). (see instructions)				

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8: 10 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most N O N 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems IU HEALTH JAY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	CN: 15-1320	Peri od: From 01/01/2019 To 12/31/2019	u of Form CMS Worksheet S- Part I Date/Time Pr 6/29/2020 8:	-2 repared:
				1. 00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
184 3.40(1)(1)(1)/ Enter 1 for yes and N for no.	cl assi fi ed ι	under section	ı	N	87. 00
1000(d)(1)(b)(v1): Litter 1 101 yes 01 N 101 110.			V 1. 00	XI X 2. 00	
Title V and XIX Services					
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through th			N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appli 22.00 Are title XIX NF patients occupying title XVIII SNF beds (dua				N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicab	ole column.				
23.00 Does this facility operate an ICF/IID facility for purposes o "Y" for yes or "N" for no in the applicable column.	of title V and	d XIX? Enter	N	N	93. 00
04.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for no	in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appl	icable column	٦.	0.00	0.00	95. 00
06.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96. 00
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the appl			0.00	0.00	97. 00
8.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo column 1 for title V, and in column 2 for title XIX.			N	Y	98. 00
8.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit				Y	98. 01
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or			N	Y	98. 02
for title V, and in column 2 for title XIX. 18.03 Does title V or XIX follow Medicare (title XVIII) for a critic reimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 03
for title V, and in column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH routpatient services cost? Enter "Y" for yes or "N" for no in			N	N	98. 04
in column 2 for title XIX. P8.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co	ck the RCE dis	sallowance o	n N	Y	98. 05
column 2 for title XIX. 18.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column	reimbursed for	~ Wkst. D,	N	Y	98. 06
column 2 for title XIX.	. 101 11110	, and III			
Rural Providers 05.00 Does this hospital qualify as a CAH?			Y		105. 00
06.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive meth	nod of payme			106. 00
for outpatient services? (see instructions) 07.00 Column 1: If line 105 is Y, is this facility eligible for cos training programs? Enter "Y" for yes or "N" for no in column			N		107. 00
Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF	ou train I&Rs and/or IRF o	s in an			
Enter "Y" for yes or "N" for no in column 2. (see instructio 08.00 st this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		dul e? See 4	2 N		108. 00
NIN SECTION 3412. 113(C). ENTEN 1 101 YES OF N 101 NO.	Physi cal	Occupation	al Speech	Respi ratory	
00 001 f this book to a guilting as a CALL	1.00	2.00	3.00	4. 00	100.00
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
			•	4.00	
				1.00	110.00

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

Health Financial Systems IU HEALTH JAY HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		ri od:	u of Form CMS Worksheet S-	
	Fr	om 01/01/2019 12/31/2019	Part I Date/Time Pr 6/29/2020 8:	
	-	1. 00	2. 00	-
111.00 If this facility qualifies as a CAH, did it participate in the Frontier Co Health Integration Project (FCHIP) demonstration for this cost reporting p "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, e integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	period? Enter enter the column 2.	N N	2.00	111.00
	1. 00	2. 00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Mi scell aneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0 115. 00
116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116. 00
117.00 s this facility legally-required to carry malpractice insurance? Enter	N			117. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	2			118. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:	1. 00 102, 143	2. 00	3. 00	0 118. 01
		1 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost center other t	than the	1. 00 N	2. 00	118. 02
Administrative and General? If yes, submit supporting schedule listing count and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless proving Sal21 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	vision in ACA ' for yes or ne Outpatient	N	N	119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantable devices	s charged to	Υ		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(Υ	5. 00	122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 134.00 If this is an organ procurement organization (0P0), enter the 0P0 number is and termination date, if applicable, in column 2.	cation date cation date cation date cation date in tification ertification cation date	N		125. 00 126. 00 127. 00 128. 00 129. 00 130. 00 131. 00 132. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as defined in CMS chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home		Y	15H059	140. 00

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA In Lieu of Form CMS-2552-10 IU HEALTH JAY HOSPITAL Worksheet S-2 Part I Date/Time Prepared: 6/29/2020 8:10 am Provider CCN: 15-1320 Peri od: From 01/01/2019 To 12/31/2019 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141.00 Name: INDIANA UNIVERSITY HEALTH | Contractor's Name: WISCONSIN PHYSICIAN | Contractor's Number: 08101 141. 00

OCity: I	40 WEST TENTH STREET		SERVI CES		tor 3 Num	nber: U810		141.
		PO Box:	JEKVI CES					142.
DAre provi	NDI ANAPOLI S	State:	I N	Zi p Cod	e:	4620	4	143.
)Are provi							1 00	-
	ider based physicians' cos	ts included in Works	sheet A2				1. 00 Y	144.
	ruci basca priysi ci aris cos	ts Ther daed The Works	nicet A:				1	177.
						1. 00	2. 00	
	for renal services are cl							145.
	t services only? Enter "Y" the dialysis facility inc							
	Enter "Y" for yes or "N"		_ation for this cost	. reporting				
	cost allocation methodolog		previously filed cos	st report?		N		146.
	" for yes or "N" for no in			40, §4020) I	f			
yes, ente	er the approval date (mm/d	d/yyyy) in column 2.						
							1. 00	+
OWas there	e a change in the statisti	cal basis? Enter "Y"	for ves or "N" for	no.			N N	147.
	e a change in the order of						N	148.
OWas there	e a change to the simplifi	ed cost finding meth	nod? Enter "Y" for y	es or "N" fo	r no.		N	149.
			Part A	Part B		tle V	Title XIX	
Doos thi	s facility contain a provi	dor that qualifies	1.00	2.00		3.00	4.00	
	s raciffly contain a provi es? Enter "Y" for yes or "							
O Hospi tal			N	N N	1	N N	N	155.
0 Subprovi o			N	N		N	N	156.
0 Subprovi o			N	N		N	N	157.
O SUBPROVI [O SNF	DER		N	N		N	N	158. 159.
	LTH AGENCY		N N	N N		N	N N	160.
OCMHC	ZIII NOENOT		**	l N		N	N	161.
			,	1	<u> </u>			
							1. 00	
Multicamp Ols this b	pus hospital part of a Multica	mnus hospital that h	as one or more camr	uses in diff	erent CR	SΔs2	N	165.
	" for yes or "N" for no.	iiipus nospi tai that i	ias one or more camp	ases in airi	or one ob.	57131		100.
		Name	County		ip Code	CBSA	FTE/Campus	
01.6.1:	1/5 : 6	0	1. 00	2. 00	3. 00	4. 00	5. 00	21//
	165 is yes, for each nter the name in column						0.00	166.
	y in column 1, state in							
	, zip code in column 3,							
column 2,	column 4, FTE/Campus in							
CBSA in o	(see instructions)							
CBSA in o	(555 111511 4511 5115)						1. 00	1
CBSA in o	(656 7 115 (1 45 (1 5 115)							
CBSA in c	nformation Technology (HIT) incentive in the A	American Recovery ar	nd Reinvestme	ent Act			
CBSA in column 5 Health In Ols this p	nformation Technology (HIT provider a meaningful user	under §1886(n)? Er	nter "Y" for yes or	"N" for no.			Υ	
CBSA in column 5 Health Ir Ols this polifithis p	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10	under §1886(n)? Er 5 is "Y") and is a m	nter "Y" for yes or neaningful user (lin	"N" for no.		the	Y	
CBSA in column 5 Health In Ols this preasonable	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H	under §1886(n)? Er 5 is "Y") and is a m IT assets (see instr	nter "Y" for yes or meaningful user (lin ructions)	"N" for no. ne 167 is "Y"), enter			168
CBSA in column 5 Health In Ols this preasonable of this preasonab	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n	under §1886(n)? Er 5 is "Y") and is a m IT assets (see instr ot a meaningful user	nter "Y" for yes or meaningful user (lin ructions) r, does this provide	"N" for no. ne 167 is "Y" er qualify fo), enter r a hards		Y N	168.
CBSA in a column 5 Health Ir Ols this preasonabl If this pexception	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H	under §1886(n)? Er 5 is "Y") and is a m IT assets (see instr ot a meaningful user Enter "Y" for yes o	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see	"N" for no. ne 167 is "Y" er qualify fo instructions), enter r a hards)	shi p	N	168. 168.
Health In Ols this preasonabl	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)?	under §1886(n)? Er 15 is "Y") and is a m IT assets (see instr ot a meaningful user Enter "Y" for yes c ser (line 167 is "Y"	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see	"N" for no. ne 167 is "Y" er qualify fo instructions), enter r a hards) "N"), en	ship nter the	N O. 00	168. 168.
Health In Ols this preasonabl	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)? provider is a meaningful u	under §1886(n)? Er 15 is "Y") and is a m IT assets (see instr ot a meaningful user Enter "Y" for yes c ser (line 167 is "Y"	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see	"N" for no. ne 167 is "Y" er qualify fo instructions), enter r a hards) "N"), en Beg	ship nter the ginning	N 0.00 Endi ng	167. 168. 168. 0169.
Health In Ols this preasonable of this pexception of this percent of the control	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)? provider is a meaningful u on factor. (see instructio	under §1886(n)? Er 15 is "Y") and is a m IT assets (see instr ot a meaningful user 'Enter "Y" for yes c ser (line 167 is "Y" ns)	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see ') and is not a CAH	"N" for no. ne 167 is "Y" er qualify fo instructions (line 105 is), enter r a hards) "N"), en Beg	ship nter the	N O. 00	168. 168. 0169.
Health In Ols this preasonable If this preaception of this preasonable If this preaception of the preaceptio	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)? provider is a meaningful u on factor. (see instructio	under §1886(n)? Er 15 is "Y") and is a m IT assets (see instr ot a meaningful user 'Enter "Y" for yes c ser (line 167 is "Y" ns)	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see ') and is not a CAH	"N" for no. ne 167 is "Y" er qualify fo instructions (line 105 is), enter r a hards) "N"), en Beg	ship nter the ginning	N 0.00 Endi ng	168. 168. 0169.
Health In Ols this preasonable If this preaception of this preasonable If this preaception of the preaceptio	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)? provider is a meaningful u on factor. (see instructio	under §1886(n)? Er 15 is "Y") and is a m IT assets (see instr ot a meaningful user 'Enter "Y" for yes c ser (line 167 is "Y" ns)	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see ') and is not a CAH	"N" for no. ne 167 is "Y" er qualify fo instructions (line 105 is), enter r a hards) "N"), en Beg	ship nter the ginning	N 0.00 Endi ng	168. 168. 0169.
Health In Ols this preasonable If this preaception of this preasonable If this preaception of the preaceptio	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)? provider is a meaningful u on factor. (see instructio	under §1886(n)? Er 15 is "Y") and is a m IT assets (see instr ot a meaningful user 'Enter "Y" for yes c ser (line 167 is "Y" ns)	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see ') and is not a CAH	"N" for no. ne 167 is "Y" er qualify fo instructions (line 105 is), enter r a hard:) "N"), en	ship nter the ginning	N 0.00 Endi ng	168. 168.
Health In Ols this preasonable of this perception of the period re	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n under §413.70(a)(6)(ii)? provider is a meaningful u on factor. (see instructio columns 1 and 2 the EHR b espectively (mm/dd/yyyy)	under §1886(n)? Er 5 is "Y") and is a m IT assets (see instr ot a meaningful user 'Enter "Y" for yes c ser (line 167 is "Y" ns) eginning date and er	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see ') and is not a CAH anding date for the r	"N" for no. ne 167 is "Y" er qualify fo instructions (line 105 is reporting), enter r a hard:) "N"), en	shi p nter the ginni ng 1.00	N 0. 00 Endi ng 2. 00	168. 168. 0169.
Health In Ols this preasonable of this preasonable of this preasonable of the preasonable	nformation Technology (HIT provider a meaningful user provider is a CAH (line 10 le cost incurred for the H provider is a CAH and is n n under §413.70(a)(6)(ii)? provider is a meaningful u on factor. (see instructio columns 1 and 2 the EHR b espectively (mm/dd/yyyy)	under §1886(n)? Er 15 is "Y") and is a m 11T assets (see instrot a meaningful user 12 Enter "Y" for yes of ser (line 167 is "Y" 15 ins) The seginning date and er 16 ider have any days freported on Wkst. S-3	nter "Y" for yes or meaningful user (lin ructions) r, does this provide or "N" for no. (see ') and is not a CAH anding date for the ruffer individuals enro 3, Pt. I, line 2, co	"N" for no. ne 167 is "Y" er qualify fo instructions (line 105 is reporting olled in ol. 6? Enter), enter r a hards) "N"), en	ship Inter the	N 0. 00 Endi ng 2. 00	168. 168. 0169.
CBSA in o	(656 7 115 (1 45 (1 5 115)							,,,

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 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/29/2020 8:10 am Date 1. 00 2.00 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 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date 1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2 00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 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 Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 03/20/2020 4.00 Υ Α 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 N 7.00 8.00 Were nursing school and/or allied health programs approved and/or renewed during the N 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9 00 N 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. 11.00 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 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, Ν 15.00 see instructions Part B Part A Y/N Date Y/N Date 1.00 3.00 PS&R Data Was the cost report prepared using $\overline{\text{the PS\&R Report onl y?}}$ 16.00 Ν 16.00 Ν 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 04/01/2020 04/01/2020 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν N 18.00 Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R 19.00 N Ν

Report data for corrections of other PS&R Report

information? If yes, see instructions.

SPI T	Financial Systems IU HEALTH JAY AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN	I: 15-1320	Peri od:	worksheet S	
				From 01/01/2019 To 12/31/2019	Date/Time P	repare
			ti on	Y/N	6/29/2020 8 Y/N	8: 10 am
		0	711 011	1. 00	3. 00	
. 00	If line 16 or 17 is yes, were adjustments made to PS&R	<u> </u>		N	N	20.
	Report data for Other? Describe the other adjustments:	V /N	Data	V /N	Doto	
		Y/N 1. 00	2.00	Y/N 3. 00	Date 4.00	
. 00	Was the cost report prepared only using the provider's	N	2.00	N N	4.00	21.
	records? If yes, see instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS HOS	SPI TALS)		1.00	
	Capital Related Cost		•			
00	Have assets been relifed for Medicare purposes? If yes, see				N	22
00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisa	Is made dur	ing the cost	Y	23
00	Were new leases and/or amendments to existing leases entered	d into durina tl	his cost re	portina period?	N	24
	If yes, see instructions	· ·				
00	Have there been new capitalized leases entered into during instructions.	the cost report	ing period?	If yes, see	N	25
00	Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost reportin	a period? L	f ves. see	N	26
	instructions.	· - · · · ·	9 1	, , , , , , , , , , , , , , , , , , , ,		
00	Has the provider's capitalization policy changed during the	cost reporting	period? If	yes, submit	N	27
	copy. Interest Expense					
00	Were new Loans, mortgage agreements or Letters of credit en	tered into duri	ng the cost	reporting	N	28
	period? If yes, see instructions.					
00	Did the provider have a funded depreciation account and/or l		t Service R	eserve Fund)	N	29
00	treated as a funded depreciation account? If yes, see instru Has existing debt been replaced prior to its scheduled matur		ebt? If ves	. see	N	30
00	instructions.		55t y55	, 300		
00	Has debt been recalled before scheduled maturity without is:	suance of new d	ebt? If yes	, see	N	31
	instructions. Purchased Services					
00	Have changes or new agreements occurred in patient care ser	vi ces furni shed	through co	ntractual	N	32
	arrangements with suppliers of services? If yes, see instru					
00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	lied pertaining	to competi	tive bidding? If		33
	Provi der-Based Physi ci ans					
00	Are services furnished at the provider facility under an ar	rangement with	provi der-ba	sed physi ci ans?	Υ	34
00	If yes, see instructions.				.,	0.5
00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in:		s with the	provi der-based	N	35
	personal during the esset reporting person in year see in	011 4011 01101		Y/N	Date	
				1. 00	2. 00	
	Home Office Costs Were home office costs claimed on the cost report?			Y		36
	If line 36 is yes, has a home office cost statement been pro	epared by the h	ome office?			37
	If yes, see instructions.					
00	If line 36 is yes, was the fiscal year end of the home off			N		38
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			. Y		39
55	see instructions.	. 3a compone	, , , , , ,	· · ·		"
00	If line 36 is yes, did the provider render services to the I	home office? I	f yes, see	N		40
	instructions.	_				
		1. 00	0	2.	00	
	Cost Report Preparer Contact Information					
		RHONDA		UTTER		41
	held by the cost report preparer in columns 1, 2, and 3,					
	respectively			i i		- 11
00	respectively. Enter the employer/company name of the cost report	INDIANA UNIVERSI	TY HEALTH			42
00	Enter the employer/company name of the cost report preparer.	I NDI ANA UNI VERSI 317-962-1093	TY HEALTH	RUTTER@I UHEALTI		42

Heal th Fi	inancial Systems	IU HEALTH JAY	HOSPI TAL			In Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	UESTI ONNAI RE	Provi der	CCN: 15-1320	Peri		Worksheet S-2	
					To	n 01/01/2019	Part II Date/Time Pre	parod:
					10	12/31/2019	6/29/2020 8: 1	0 am
				3. 00				
Co	ost Report Preparer Contact Information							
41. 00 En	nter the first name, last name and the tit	tle/position [I RECTOR					41.00
he	eld by the cost report preparer in columns	s 1, 2, and 3,						
re	especti vel y.							
42. 00 En	nter the employer/company name of the cost	t report						42. 00
	reparer.							
	nter the telephone number and email addres							43. 00
re	eport preparer in columns 1 and 2, respect	ti vel y.						

| Period: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1320

					-	To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
							I/P Days / O/P	<u> </u>
							Visits / Trips	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 12	5 48, 552. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
0.00	for the portion of LDP room available beds)							0.00
2.00	HMO and other (see instructions)							2. 00 3. 00
3. 00 4. 00	HMO I PF Subprovi der							4. 00
5.00	HMO IRF Subprovider 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			25	9, 12	5 48, 552. 00		7. 00
7.00	beds) (see instructions)			23	7, 12	40, 332. 00	ή	7.00
8.00	INTENSIVE CARE UNIT							8. 00
9. 00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			25	9, 12	5 48, 552. 00	0	14.00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF	40. 00		10	3, 65	O	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.)							23. 00
24. 00	HOSPI CE							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC	00.00						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		25			0	
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days			35			0	27. 00 28. 00
28.00	Ambul ance Tri ps						0	28.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see l'istruction)							31. 00
32. 00	Labor & delivery days (see instructions)			0		0		32. 00
32. 00	Total ancillary labor & delivery room			Ü				32. 00
JZ. 01	outpatient days (see instructions)							52.01
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges					1		33. 01
	,	'	•		'	10	•	'

Peri od: Worksheet S-3
From 01/01/2019
To 12/31/2019 Part I
Date/Time Prepared: 6/29/2020 8:10 am

					-	6/29/2020 8:1	0 am
		I/P Days	s / O/P Visits	/ Trips	Full Time	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	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	778	3	2, 023		10100	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)	256	471				2. 00
3.00	HMO I PF Subprovi der	24	439				3. 00
4.00	HMO IRF Subprovider	o	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	145	0	145	i		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	61			6. 00
7.00	Total Adults and Peds. (exclude observation	923	3	2, 229	1		7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00							10.00
11. 00							11. 00
12.00	, ,		_	4.5.0			12.00
13.00			7	152			13.00
14.00		923	10	2, 381	0.00	228. 25	
15.00		0 391	0	1 250	0.00	14.00	15.00
16. 00 17. 00		391	58	1, 250	0.00	14. 26	16. 00 17. 00
17.00							18.00
19. 00							19.00
20. 00							20.00
21. 00							21.00
22. 00							22. 00
23. 00							23. 00
24. 00	, ,						24. 00
24. 10				40)		24. 10
25. 00							25. 00
26. 00							26. 00
26. 25		o	0	C	0.00	0.00	26. 25
27. 00	Total (sum of lines 14-26)				0.00	242. 51	27. 00
28. 00	Observation Bed Days		11	842			28. 00
29. 00	Ambulance Trips	o					29. 00
30.00	Employee discount days (see instruction)			C			30.00
31.00	Employee discount days - IRF			C)		31. 00
32.00	Labor & delivery days (see instructions)	o	0	С			32. 00
32. 01				C			32. 01
	outpatient days (see instructions)						
33.00	1	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared:

				10	12/31/2019	6/29/2020 8:1	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	264	2	670	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)			7.1	10/		2 00
2.00	HMO and other (see instructions)			71	126		2.00
3.00	HMO IPF Subprovider				84		3.00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				Ч		4. 00 5. 00
6.00							6.00
7. 00	Hospital Adults & Peds. Swing Bed NF						7.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	264	2	670	
15. 00	CAH visits		_		-		15. 00
16. 00	SUBPROVI DER - I PF	0.00	0	43	7	203	•
17. 00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
	LTCH non-covered days			0			33.00
33. UT	LTCH site neutral days and discharges			0			33. 01

OSPL L	Financial Systems IU HEALTH JAY HOSF				u of Form CMS-2	
	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovi der CCI	N: 15-1320	Peri od: From 01/01/2019	Worksheet S-10	0
				To 12/31/2019	Date/Time Pre	pared
					6/29/2020 8: 10	0 am
					1. 00	
	Uncompensated and indigent care cost computation					
. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lin	e 202 columi	ו 8)	0. 351987	1. (
00	Medicaid (see instructions for each line)				0 000 750	
. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				2, 392, 759 Y	2. (3. (
. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental	l payments	from Medica	ai d?	Ϋ́	4.
. 00	If line 4 is no, then enter DSH and/or supplemental payments from				0	5.
. 00	Medicaid charges				21, 552, 190	•
. 00	Medicaid cost (line 1 times line 6)				7, 586, 091	7.
. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ine 7 minu	s sum of li	nes 2 and 5; if	5, 193, 332	8.
	Children's Health Insurance Program (CHIP) (see instructions for	each line)			
. 00	Net revenue from stand-alone CHIP		/		0	9.
0.00	Stand-alone CHIP charges				0	10.
1. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.
2. 00	Difference between net revenue and costs for stand-alone CHIP (li	ine 11 min	us line 9; i	f < zero then	0	12.
	<pre>enter zero) Other state or local government indigent care program (see instru</pre>	ructions fo	r each line`			
3. 00	Net revenue from state or local indigent care program (Not include				0	13.
1. 00	Charges for patients covered under state or local indigent care p	program (N	ot included	in lines 6 or	12, 145	14.
	10)					
5. 00 6. 00	State or local indigent care program cost (line 1 times line 14) Difference between net revenue and costs for state or local indices.		program (li	oo 15 minus lino	4, 275	•
6. 00	13; if < zero then enter zero)	gent care	program (TT	ie io illitius title	4, 275	10.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP	and state	/local indiç	gent care program	ns (see	
	instructions for each line)					l
7. 00	Private drants, donations, or endowment income restricted to fund	nding chari	tv care		0	 17.
	Private grants, donations, or endowment income restricted to fund Government grants, appropriations or transfers for support of hos				0	
8. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and Local i	spital ope	rati ons	s (sum of lines		18.
8. 00	Government grants, appropriations or transfers for support of hos	spital ope	rati ons	s (sum of lines	0	18.
8. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and Local i	spital ope	rations are programs Uninsured patients	I nsured pati ents	0 5, 197, 607 Total (col. 1 + col. 2)	18.
3. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16)	spital ope	rations are programs Uninsured	Insured	0 5, 197, 607 Total (col. 1	18.
3. 00 9. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)	ospital ope indigent c	rations are programs Uninsured patients 1.00	I nsured pati ents 2.00	0 5, 197, 607 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil	ospital ope indigent c	rations are programs Uninsured patients	I nsured pati ents 2.00	0 5, 197, 607 Total (col. 1 + col. 2) 3.00	18. 19.
3. 00 9. 00 0. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid , CHIP and state and local i 8, 12 and 16) Uncompensated Care (see instructions for each line)	ospital ope indigent c	rations are programs Uninsured patients 1.00	I nsured pati ents 2. 00 42, 165	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554	18. 19.
9. 00 9. 00 0. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local image is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions)	ospital ope indigent c	Uninsured patients 1.00 3,179,3	Insured patients 2.00 42,165 42,165	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269	18. 19. 20. 21.
9. 00 9. 00 0. 00	Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	ospital ope indigent c	Uninsured patients 1.00 3,179,3	I nsured pati ents 2. 00 42, 165	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269	18. 19. 20. 21.
8. 00 9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care	ospital ope indigent c	Uni nsured patients 1.00 3,179,3	Insured patients 2.00 39 42,165 04 42,165	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269	18. 19. 20. 21. 22.
9. 00 9. 00 0. 00 1. 00 2. 00	Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of	ospital ope indigent c	Uninsured patients 1.00 3,179,3	Insured pati ents 2.00 39 42,165 0 0	0 5, 197, 607 Total (col. 1 + col. 2) 3.00 3, 221, 554 1, 161, 269	18. 19. 20. 21. 22.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22)	Iity off as	Tations are programs Uninsured patients 1.00 3,179,33 1,119,10	Insured patients 2.00 39 42,165 04 42,165 0 0 04 42,165	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269 0 1, 161, 269	18. 19. 20. 21. 22. 23.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of host Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient	lity ts (see off as	Tations are programs Uninsured patients 1.00 3,179,33 1,119,10	Insured patients 2.00 39 42,165 04 42,165 0 0 04 42,165	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269 0 1, 161, 269	18. 19. 20. 21. 22. 23.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the charges for patient days beyond the	lity ts (see off as days beyour or a grant or a gran	Uni nsured patients 1.00 3,179,3 1,119,10 1,119,10 nd a Length	Insured patients 2.00 39 42,165 04 42,165 0 0 04 42,165 of stay limit	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269 0 1, 161, 269	20. 21. 22. 23.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care put line 24 is yes, enter the charges for patient days beyond the stay limit	lity ts (see off as days beyonorogram? e indigent	Uni nsured patients 1.00 3,179,3 1,119,10 1,119,10 nd a Length	Insured patients 2.00 39 42,165 04 42,165 0 0 04 42,165 of stay limit	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269 0 1, 161, 269 1. 00 N	20. 21. 22. 23.
3. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care put line 24 is yes, enter the charges for patient days beyond the stay limit Total bad debt expense for the entire hospital complex (see instructions)	lity ats (see off as days beyo program? e indigent cructions)	Uni nsured pati ents 1.00 3,179,3 1,119,10 1,119,10 nd a Length care program	Insured patients 2.00 39 42,165 04 42,165 0 0 04 42,165 of stay limit	0 5, 197, 607 Total (col. 1 + col. 2) 3.00 3, 221, 554 1, 161, 269 0 1, 161, 269 1.00 N	20. 21. 22. 23. 24. 25.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facil (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care put line 24 is yes, enter the charges for patient days beyond the stay limit	lity Its (see Off as days beyour orgram? e indigent cructions) (see instr	Uni nsured patients 1.00 3,179,3: 1,119,10 1,119,10 a length care program	Insured patients 2.00 39 42,165 04 42,165 0 0 04 42,165 of stay limit	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269 0 1, 161, 269 1. 00 N 0 3, 432, 226	20. 21. 22. 23. 24. 25. 26. 27.
8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 01 8. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discount instructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	lity ts (see days beyour orgram? e indigent cructions) (see instruct	Uni nsured patients 1.00 3,179,3 1,119,10 1,119,10 nd a length care programuctions)	Insured patients 2.00 39	0 5, 197, 607 Total (col. 1 + col. 2) 3.00 3, 221, 554 1, 161, 269 0 1, 161, 269 1.00 N 0 3, 432, 226 544, 186 837, 209 2, 595, 017	20. 21. 22. 23. 24. 25. 26. 27. 27. 28.
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Government grants, appropriations or transfers for support of hos Total unreimbursed cost for Medicaid, CHIP and state and local is 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facility (see instructions) Cost of patients approved for charity care and uninsured discountinstructions) Payments received from patients for amounts previously written of charity care Cost of charity care (line 21 minus line 22) Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care provided in the stay limit Total bad debt expense for the entire hospital complex (see instructions) Medicare reimbursable bad debts for the entire hospital complex (see	lity ts (see days beyour orgram? e indigent cructions) (see instruct	Uni nsured patients 1.00 3,179,3 1,119,10 1,119,10 nd a length care programuctions)	Insured patients 2.00 39	0 5, 197, 607 Total (col. 1 + col. 2) 3. 00 3, 221, 554 1, 161, 269 0 1, 161, 269 1. 00 N 0 3, 432, 226 544, 186 837, 209	20. 21. 22. 23. 24. 25. 26. 27. 27. 28. 29.

Heal th	Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der C	CN: 15-1320 F	'eri od:	Worksheet A	
					rom 01/01/2019 o 12/31/2019	Date/Time Pre	nared:
				'	0 12/31/201/	6/29/2020 8: 1	
	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 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		0		1, 209, 449	1, 209, 449	1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB		0	1		75, 227	1. 01
1. 02	00102 CAP REL COSTS-BLDG & FIXT-POB		0	d	35, 030		
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ		0) c	24, 153		1. 03
1.04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST		0) c	0	0	1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP		261, 330	261, 330			2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - MOB		0	C	6, 333	6, 333	2. 01
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB		0		0	0	2. 02
2. 03 4. 00	00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT	137, 375	28, 317	165, 692	2, 656, 631	0 2, 822, 323	2. 03 4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	425, 408	7, 862, 807				5. 00
7. 00	00700 OPERATION OF PLANT	310, 937	3, 064, 494				7. 00
7. 01	00701 OPERATION OF PLANT - MOB	0	152, 257				7. 01
7.02	00702 OPERATION OF PLANT - POB	0	83, 859	83, 859	-35, 030	48, 829	7. 02
7.03	00703 OPERATION OF PLANT - WJ	0	32, 790	32, 790	•		7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	44, 630	13, 933				8. 00
9.00	00900 HOUSEKEEPI NG	384, 987	256, 660				9. 00
10.00	01000 DI ETARY	322, 997	464, 366	1		234, 276	
11. 00 13. 00	01100 CAFETERIA 01300 NURSI NG ADMINI STRATI ON	1, 188, 820	0 315, 923	1	, .20		
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 188, 828	11, 636				
15. 00	01500 PHARMACY	480, 020	1, 472, 699				
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	,,,,,,,			16. 00
17.00	01700 SOCIAL SERVICE	0	0	C	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	1, 606, 372	1, 439, 807				
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	898, 072 0	504, 915 0				1
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		1	63, 467	03, 407	43.00
50.00	05000 OPERATING ROOM	1, 256, 143	2, 758, 734	4, 014, 877	-1, 009, 360	3, 005, 517	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	C	24, 867	24, 867	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	734, 829	1, 089, 722	1		954, 020	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	383, 727	1, 837, 470 159, 718				
66. 00	06600 PHYSI CAL THERAPY	476, 558	8, 601	i .			
67. 00	06700 OCCUPATI ONAL THERAPY	87, 175	646	i .		87, 548	
68.00	06800 SPEECH PATHOLOGY	17, 435	0	17, 435		17, 435	
69.00	06900 ELECTROCARDI OLOGY	0	22, 462	22, 462	-709	21, 753	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	240, 803		
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	1	/		
	07300 DRUGS CHARGED TO PATIENTS	109, 921	129, 850	239, 771	., 0.0, 2		
70.00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	107, 721	129, 630	237, 771	-01, 109	178, 582	70.00
90.00	09000 CLI NI C	0	0	C	0	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	581, 574	666, 433			839, 110	
90. 02	09002 JAY FAMILY MEDICINE	697, 161	1, 146, 132		-370, 976		
90. 03		38, 398	105, 747	1		137, 251	
90.04	09004 OP ORTHO CLINIC	207 724	102, 210			102, 213	
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	307, 734 85, 402	310, 712 23, 824			482, 307 93, 820	
91. 00	09100 EMERGENCY	989, 001	2, 267, 602	1			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	707,001	2,207,002	0, 200, 000	010,010	2, 711, 000	92.00
	04950 OUTPATIENT PSYCH	23, 691	25, 294	48, 985	-22, 330	26, 655	1
	SPECIAL PURPOSE COST CENTERS						
118.00	` ' '	11, 588, 527	26, 620, 950	38, 209, 477	204, 671	38, 414, 148	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	17	17	-17	0	190. 00
	19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN	109, 150	83, 921	l .			
	19300 NONPALD WORKERS	0	00, 721	1			193. 00
	07950 VACANT	o	0	1	_	0	194. 00
	07952 WEST JAY CLINIC	270, 464	140, 601				
	07953 JAY MERI DI AN URGENT CARE	183, 961	81, 589				
200.00	TOTAL (SUM OF LINES 118 through 199)	12, 152, 102	26, 927, 078	39, 079, 180	0	39, 079, 180	200.00

Peri od: Worksheet A From 01/01/2019 Date/Time Prepared: 4/29/2020 8:10 am

				6/29/2020	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	<u>1</u>	
	GENERAL SERVICE COST CENTERS	6. 00	7. 00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT	-351, 355	858, 094	1	1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB	-75, 227	000,071		1. 01
1.02	00102 CAP REL COSTS-BLDG & FIXT-POB	-35, 030	O		1. 02
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ	-24, 153	0		1. 03
1.04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP	194, 703	1, 810, 612	1	2. 00
2. 01	00201 CAP REL COSTS MVBLE EQUIP - MOB	17, 672	24, 005		2. 01
2. 02 2. 03	00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ	0	0		2. 02 2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-37, 784	2, 784, 539		4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	564, 200	8, 651, 616	l .	5. 00
7. 00	00700 OPERATION OF PLANT	234, 167	2, 284, 913	1	7. 00
7. 01	00701 OPERATION OF PLANT - MOB	0	70, 697		7. 01
7.02	00702 OPERATION OF PLANT - POB	-24, 364	24, 465	5	7. 02
7.03	00703 OPERATION OF PLANT - WJ	-18, 070	0		7. 03
8. 00	00800 LAUNDRY & LINEN SERVICE	0	89, 911	1	8. 00
9.00	00900 HOUSEKEEPI NG	0	490, 851	1	9.00
10.00	01000 DI ETARY 01100 CAFETERI A	-6, 063 -167, 054	228, 213 247, 366		10.00
11. 00 13. 00	01300 NURSING ADMINISTRATION	422, 626	1, 715, 903	1	11. 00
14. 00		-35	658, 441	1	14. 00
15. 00	01500 PHARMACY	345, 630	1, 076, 159	1	15. 00
16. 00	1 1	0	0		16. 00
17. 00	1 1	0	O		17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-629, 471	1, 683, 231	1	30. 00
40.00	04000 SUBPROVI DER - I PF	-254, 614	964, 398	1	40.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	63, 467		43. 00
50. 00		-1, 516, 361	1, 489, 156	5	50.00
52. 00	1 1	0	24, 867		52.00
53.00	1 1	0	0	1	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	178, 805	1, 132, 825	5	54.00
60.00	06000 LABORATORY	-12, 123	1, 793, 603	3	60.00
65. 00	06500 RESPI RATORY THERAPY	30, 242	446, 518	l .	65. 00
66.00	06600 PHYSI CAL THERAPY	38, 449	519, 172		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	87, 548	1	67. 00 68. 00
68. 00 69. 00	1 1	0	17, 435 21, 753	1	69.00
71. 00	1 1	o	240, 803	1	71.00
72. 00	1 1	o	28, 318	1	72. 00
73.00	1 1	0	1, 516, 241		73. 00
76.00	03160 CARDI OPULMONARY	99, 686	278, 268	3	76. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	1 1	0	(/2 112	1	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	-175, 997	663, 113		90. 01 90. 02
90. 02	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	-614, 207 -95, 975	858, 110 41, 276		90. 02
90. 03	09004 OP ORTHO CLINIC	-102, 213	41, 270		90.03
90. 05		-138, 560	343, 747		90. 05
90. 06		0	93, 820		90. 06
91.00	09100 EMERGENCY	-1, 510, 152	1, 401, 411	1	91.00
92.00					92. 00
93. 00	04950 OUTPATIENT PSYCH	0	26, 655	5	93. 00
110 0	SPECIAL PURPOSE COST CENTERS	2 ((2 (22	24 754 500		110.00
118. 00		-3, 662, 628	34, 751, 520	J	118. 00
190 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	O		190, 00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	135, 512		190.00
	19300 NONPALD WORKERS	o	133, 312	l .	193. 00
	07950 VACANT	0	O		194. 00
194. 02	2 07952 WEST JAY CLINIC	0	319, 034	4	194. 02
	3 07953 JAY MERIDIAN URGENT CARE	0	210, 486		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-3, 662, 628	35, 416, 552	2	200. 00

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					6/29/2020 8:	
		Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - CAFETERIA	3.00	4.00	3.00		
1.00	CAFETERI A	1100	206, 347	208, 073		1. 00
	0		206, 347	208, 073		
1. 00	B - DRUGS RECLASS PHARMACY	15. 00	O	41, 080		1.00
2.00	DRUGS CHARGED TO PATIENTS	73. 00	o	1, 516, 241		2.00
3.00		0.00	o	0		3. 00
4.00		0. 00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8.00		0.00	o	Ö		8. 00
9.00		0. 00	o	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	o	Ö		13. 00
14.00		0. 00	О	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	0	o		18. 00
	0		ō	1, 557, 321		
4 00	C - SUPPLIES/IMPLANTS	11.00	ما	(4/ (07		4 00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO	14. 00 71. 00	0	646, 687 240, 803		1. 00 2. 00
2.00	PATI ENTS	71.00	Ĭ	240,003		2.00
3.00	IMPL. DEV. CHARGED TO	72. 00	0	28, 318		3. 00
4. 00	PATIENTS NURSING ADMINISTRATION	13. 00	0	225		4. 00
5.00	LABORATORY	60. 00	0	1, 121		5. 00
6.00	OP ORTHO CLINIC	90. 04	o	. 3		6. 00
7.00	OUTPATIENT PSYCH	93.00	0	31		7. 00
8. 00 9. 00	JAY MERIDIAN URGENT CARE	194. 03 0. 00	0	131 0		8. 00 9. 00
10. 00		0.00	o	Ö		10.00
11. 00		0.00	ō	Ö		11. 00
12. 00		0. 00	0	0		12. 00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	o	Ö		16. 00
17. 00		0. 00	O	0		17. 00
18.00		0.00	0	0		18. 00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	o	o		21. 00
22. 00		0. 00	0	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00 25. 00		0. 00 0. 00	0	0		24. 00 25. 00
25.00			— — —	917, 319		25.00
	D - LAUNDRY					
1.00	LAUNDRY & LINEN SERVICE	8. 00 0. 00	0	41, 953		1.00
2. 00 3. 00		0.00	ol Ol	0		2. 00 3. 00
4. 00		0.00	o	Ö		4. 00
5.00		0.00	0	0		5. 00
	O DEDDECLATION		0	41, 953		-
1.00	E - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	ol	1, 154, 745		1.00
2.00	CAP REL COSTS-BLDG &	1. 01	ō	75, 227		2. 00
2 22	FIXT-MOB	4 6 6		25 222		2.00
3.00	CAP REL COSTS-BLDG & FLXT-POB	1. 02	0	35, 030		3. 00
4.00	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	О	24, 153		4. 00
5.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	1, 352, 337		5. 00
6.00	CAP REL COSTS-MVBLE EQUIP - MOB	2. 01	0	6, 333		6. 00
7. 00		0. 00	О	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
	1	0.00	Ч	٥١		1 11.00

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

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6
From 01/01/2019
To 12/31/2019 Date/Ti me Prepared: Provider CCN: 15-1320

					6/29/2020 8:	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
10.00	2. 00	3.00	4. 00	5. 00		10.00
12.00		0. 00 0. 00	0	0		12.00
13. 00 14. 00		0.00	0	0		13. 00 14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	Ö	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	O	0		20. 00
	0			2, 647, 825		
	F - PROPERTY TAXES					
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	•	3 <u>1, 7</u> 62		1. 00
	0		0	31, 762		_
1 00	G - PROPERTY INSURANCE	1 00	ما	22.042		1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	22, 942		1.00
2.00	O KEL COSTS-WVBLE EQUIP	— — -2. 00	0	<u>2, 2</u> 42 25, 184		2. 00
	H - HOUSEKEEPING SUPPLIES		O _I	23, 104		
1. 00	HOUSEKEEPI NG	9. 00	0	14, 380		1.00
2.00		0.00	O	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00 10. 00		0. 00 0. 00	0	0		9.00
11. 00		0.00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	o		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	o	0		16. 00
	0		0	14, 380		
	J - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 676, 657		1.00
2.00		0.00	0	0		2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	o	Ö		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16. 00 17. 00		0. 00 0. 00	0	0		16. 00 17. 00
17.00		0.00	0	0		18.00
19. 00		0.00	0	0		19. 00
20. 00		0.00	o	o		20.00
21. 00		0.00	ő	Ö		21. 00
22. 00		0.00	O	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	0	0		24. 00
	0	I	0	2, 676, 657		_
4 00	K - NURSERY AND LABOR AND DEL			,		
1.00	NURSERY	43.00	57, 106	6, 361		1. 00
2. 00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	2 <u>2, 3</u> 75 79, 481	<u>2, 492</u> 8, 853		2. 00
500 00	Grand Total: Increases		285, 828	8, 129, 327		500. 00
300.00	or and Total. Thereases	1	200, 020	0, 127, 327		1 300. 00

	Financial Systems		IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SI FI CATI ONS			Provi der (Period: From 01/01/2019	Worksheet A-6	1
						Γο 12/31/2019		
		Decreases					6/29/2020 8:1	0 am
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.			
	6. 00	7. 00	8. 00	9. 00	10. 00			
1. 00	A - CAFETERI A DI ETARY	10.00	206, 347	208, 073	0	I		1. 00
1.00	0		206, 347	20 <u>8, 073</u> 208, 073				1.00
	B - DRUGS RECLASS		200, 017	200, 0,0				
1.00	PHARMACY	15. 00	0	1, 087, 181		•		1. 00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	19, 783		1		2.00
3. 00 4. 00	ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00	0	117 33		1		3. 00 4. 00
5. 00	ADULTS & PEDIATRICS	30.00	ő	10, 396		1		5. 00
6.00	SUBPROVI DER - I PF	40.00	О	54		!		6.00
7.00	OPERATING ROOM	50.00	0	18, 531		1		7. 00
8. 00 9. 00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54. 00 65. 00	0	35, 345 126		•		8. 00 9. 00
10. 00	PHYSICAL THERAPY	66.00	o	150		•		10. 00
11. 00	CARDI OPULMONARY	76.00	O	2, 376				11. 00
12.00	FAMILY PRACTICE OF JAY	90. 01	0	193, 423	0			12.00
13. 00	COUNTY JAY FAMILY MEDICINE	90. 02	o	140 441	0			13. 00
14. 00	WOUND CLINIC	90.02	0	148, 441 290		•		14. 00
15. 00	JAY FAMILY FIRST HEALTH CARE	90. 05	ő	27, 954		•		15. 00
16. 00	INFUSION CLINIC	90. 06	0	1, 669		1		16. 00
17. 00	EMERGENCY	91.00	0	11, 418		1		17. 00
18. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	34 321				18. 00
	C - SUPPLIES/IMPLANTS		O _I	1, 337, 321				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	243	0			1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 598		•		2. 00
3. 00 4. 00	OPERATION OF PLANT	7.00	0	33, 228	0	•		3. 00 4. 00
4. 00 5. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8. 00 9. 00	0	4 397		•		5. 00
6. 00	DI ETARY	10.00	ő	1, 738				6. 00
7.00	PHARMACY	15. 00	O	16, 701				7. 00
8.00	ADULTS & PEDIATRICS	30. 00	0	132, 789				8. 00
9.00	SUBPROVI DER - I PF	40.00	0	4, 178		•		9.00
10. 00 11. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	511, 586 53, 230		•		10. 00 11. 00
12. 00	RESPIRATORY THERAPY	65.00	0	13, 561		•		12. 00
13. 00	PHYSI CAL THERAPY	66.00	Ö	2, 844		•		13. 00
14.00	OCCUPATI ONAL THERAPY	67. 00	0	273				14.00
15. 00	ELECTROCARDI OLOGY	69. 00	0	709		•		15. 00
16.00	CARDI OPULMONARY	76.00	0	1, 345				16.00
17. 00	FAMILY PRACTICE OF JAY COUNTY	90. 01	0	20, 567	0			17. 00
18. 00	JAY FAMILY MEDICINE	90. 02	О	9, 985	0			18.00
19. 00	WOUND CLINIC	90. 03	0	3, 732				19. 00
20. 00	JAY FAMILY FIRST HEALTH CARE	90.05	0	7, 788				20.00
21. 00 22. 00	INFUSION CLINIC EMERGENCY	90. 06 91. 00	0	9, 489 89, 629		•		21. 00 22. 00
23. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	69, 629 17				23. 00
20.00	CANTEEN CANTEE SHOT Q	170.00	Ĭ	.,				20.00
24. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	О	363		ł		24. 00
25. 00	WEST JAY CLINIC	194.02	0	1, 325				25. 00
	O D - LAUNDRY		0	917, 319				
1.00	HOUSEKEEPI NG	9.00	0	34, 561	0			1. 00
2.00	DI ETARY	10.00	O	176		l e		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	1, 359		•		3. 00
4.00	OPERATING ROOM	50.00	0	5, 385		•		4.00
5. 00	INFUSION CLINIC	<u>90.</u> 06	0					5. 00
	E - DEPRECIATION		O ₁	41, 700				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	51, 949	9			1.00
2.00	OPERATION OF PLANT	7. 00	0	1, 209, 379		l e		2. 00
3.00	OPERATION OF PLANT - MOB	7. 01	0	81, 560				3. 00
4. 00 5. 00	OPERATION OF PLANT - POB	7. 02 7. 03	0	35, 030 14, 720				4. 00 5. 00
6.00	OPERATION OF PLANT - WJ DIETARY	10. 00	0	14, 720 8, 934	-			6. 00
7. 00	PHARMACY	15. 00	0	69, 800				7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	131, 724	0			8.00
9.00	SUBPROVI DER - I PF	40.00	0	4, 734		•		9. 00
10.00	OPERATING ROOM	50.00	0	210, 638		1		10.00
11. 00 12. 00	RADI OLOGY-DI AGNOSTI C LABORATORY	54. 00 60. 00	0	644, 429 32, 865		ł .		11. 00 12. 00
13. 00	RESPIRATORY THERAPY	65.00	0	26, 753		ł .		13. 00
	<u>. '</u>		-1			•		

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1320

| Peri od: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

					'	o 12/31/2019 Date/lime P 6/29/2020 8	
		Decreases					
	Cost Center	Li ne #	Salary	0ther	Wkst. A-7 Ref.		
44.00	6.00	7. 00	8. 00	9.00	10. 00		11.00
14.00	PHYSI CAL THERAPY	66.00	0	1, 415	0		14. 00
15. 00 16. 00	CARDI OPULMONARY WOUND CLINIC	76. 00 90. 03	0	29, 941			15. 00 16. 00
17. 00	INFUSION CLINIC	90.03	0	1, 322 445	0		17. 00
18. 00	EMERGENCY	91.00	0	73, 038	١		18. 00
19. 00	OUTPATIENT PSYCH	93. 00	0	9, 716	l 1		19. 00
20. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	9, 433			20.00
20.00	0		— — ŏ	2, 647, 825			20.00
	F - PROPERTY TAXES	1	-1	=/ 0 / 0=0			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	31, 762	13		1.00
		T		31, 762			1
	G - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	25, 184	12		1. 00
2.00		0.00	0_	0	12		2. 00
	0		0	25, 184			
	H - HOUSEKEEPING SUPPLIES						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	53			1.00
2.00	OPERATION OF PLANT	7. 00	0	10, 817	0		2. 00
3. 00	PHARMACY	15. 00	0	9	0		3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	218	l .		4. 00
5.00	SUBPROVI DER - I PF	40.00	0	427	0		5. 00
6.00	OPERATING ROOM	50.00	0	1, 191	0		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	545	l 1		7. 00
8. 00 9. 00	RESPIRATORY THERAPY	65. 00 66. 00	0	48 27	0		8. 00 9. 00
9. 00 10. 00	PHYSI CAL THERAPY CARDI OPULMONARY	76.00	0	27 162			10.00
11. 00	FAMILY PRACTICE OF JAY	90. 01	0	344	l .		11. 00
11.00	COUNTY	90.01	9	344	٥		11.00
12. 00	JAY FAMILY MEDICINE	90. 02	0	388	o		12. 00
13. 00	JAY FAMILY FIRST HEALTH CARE	90. 05	0	21	0		13. 00
14. 00	EMERGENCY	91.00	o	62	o		14. 00
15. 00	OUTPATIENT PSYCH	93.00	o	10	· ·		15. 00
16.00	PHYSICIANS' PRIVATE OFFICES	192.00	O	58	l .		16. 00
				14, 380			
	J - EMPLOYEE BENEFITS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	90, 136	l .		1.00
2.00	OPERATION OF PLANT	7. 00	0	71, 261	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	0	10, 601	0		3. 00
4.00	HOUSEKEEPI NG	9. 00	0	130, 218			4. 00
5.00	DI ETARY	10.00	0	127, 786			5. 00
6. 00	NURSING ADMINISTRATION	13.00	0	211, 691	0		6. 00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	7	0		7. 00
8.00	PHARMACY	15.00	0	89, 579	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	368, 657	0		9.00
10.00	SUBPROVI DER - I PF	40.00	O O	174, 582	0		10.00
11.00	OPERATING ROOM	50. 00 54. 00	0	262, 029	l 1		11.00
12.00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	65.00	0	136, 982 86, 681			12.00
13. 00 14. 00	CARDI OPULMONARY	76. 00	ol Ol	27, 365			13. 00 14. 00
15. 00	FAMILY PRACTICE OF JAY	90. 01	0	194, 563	l .		15. 00
13.00	COUNTY	70.01	o o	174, 303	o o		13.00
16. 00	JAY FAMILY MEDICINE	90. 02	o	212, 162	o		16. 00
17. 00	WOUND CLINIC	90. 03	0	1, 550	l 1		17. 00
18. 00	JAY FAMILY FIRST HEALTH CARE	90. 05	o o	100, 376			18. 00
19. 00	INFUSION CLINIC	90.06	ol o	3, 331	ا		19. 00
20. 00	EMERGENCY	91.00	0	170, 893	o		20. 00
21. 00	OUTPATIENT PSYCH	93. 00	0	12, 635			21. 00
22. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	47, 671			22. 00
23. 00	WEST JAY CLINIC	194. 02	0	90, 706	o		23. 00
24. 00	JAY MERI DI AN URGENT CARE	194. 03	o	55, 195			24. 00
. ==	0	— — ·*†	— — o l	2, 676, 657			
	K - NURSERY AND LABOR AND DEL	I VERY_					
1.00	ADULTS & PEDIATRICS	30.00	79, 481	8, 853	0		1. 00
2.00		0.00	0	0			2. 00
	0		79, 481	8, 853			
	Grand Total: Decreases		285, 828	8, 129, 327	i l		500.00

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

Provi der CCN: 15-1320

					To 12/31/2019	Date/Time Prep 6/29/2020 8:10	pared: D am
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	1, 006, 948	0		0	0	1. 00
2.00	Land Improvements	0	0		0	0	2. 00
3.00	Buildings and Fixtures	19, 125, 052	0		0	0	3. 00
4.00	Building Improvements	0	0		0	0	4. 00
5.00	Fi xed Equipment	0	0		0	0	5. 00
6.00	Movable Equipment	7, 974, 055	752, 827		0 752, 827	64, 700	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	28, 106, 055	752, 827		0 752, 827	64, 700	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10.00	Total (line 8 minus line 9)	28, 106, 055	752, 827		0 752, 827	64, 700	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	1, 006, 948	0				1. 00
2.00	Land Improvements	0	0				2. 00
3.00	Buildings and Fixtures	19, 125, 052	0				3. 00
4.00	Building Improvements	0	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	8, 662, 182	0				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	28, 794, 182	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	28, 794, 182	0				10. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1320

					To 12/31/2019	Date/Time Prep 6/29/2020 8:10	
			SL	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		9.00	10.00	11.00	instructions) 12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK				12.00	13.00	
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT-MOB	o	0		0 0	ol	1. 01
1.02	CAP REL COSTS-BLDG & FLXT-POB	О	0		0 0	o	1. 02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0		0 0	0	1. 03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	O	0		0 0	0	1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	261, 330	0		0 0	0	2. 00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0		0	0	2. 01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0		0	0	2. 02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0		0	0	2. 03
3. 00	Total (sum of lines 1-2)	261, 330	0		0 0	0	3. 00
		SUMMARY OF	CAPITAL				
	Cost Center Description	Other T	otal (1) (sum				
	cost center bescription	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)	tili ougii 14)				
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMN	12, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
1. 01	CAP REL COSTS-BLDG & FIXT-MOB	0	0				1. 01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0				1. 02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0				1. 03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0				1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	0	261, 330				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 2/1 220				2. 03
3. 00	Total (sum of lines 1-2)	l O	261, 330	I		I	3. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 15-1320	From 01/01/2019	
		To 12/31/2019	Date/Time Prepared:

RECONC	CILIATION OF CAPITAL COSTS CENTERS				Period: Worksheet A-7		
					rom 01/01/2019 o 12/31/2019	Part III Date/Time Pre	oared:
		1			1	6/29/2020 8: 10	o am
		COMI	PUTATION OF RAT	1108	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col. 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	28, 794, 182		,,		0	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT-MOB	0		1		0	1. 01
1. 02	CAP REL COSTS-BLDG & FIXT-POB	0	0	C		0	1. 02
1.03	CAP REL COSTS-BLDG & FLXT-WJ	0	0		0.000000	0	1. 03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP	0	0	C		0	1. 04
2. 00 2. 01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0		0. 000000 0. 000000	0	2. 00 2. 01
2. 01	CAP REL COSTS-MVBLE EQUIP - MOB				0.000000	0	2. 01
2. 02	CAP REL COSTS-MVBLE EQUIP - WJ	0	0		0.00000	0	2. 02
3. 00	Total (sum of lines 1-2)	28, 794, 182	0	28, 794, 182		0	3. 00
0.00	Total (Sam et 111165 1 2)		TION OF OTHER (F CAPITAL	0.00
		_		I=			
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate d Costs	cols. 5 through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	0			803, 390	0	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT-MOB	0			0	0	1. 01
1. 02	CAP REL COSTS-BLDG & FIXT-POB	0		·	0	0	1. 02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	1		0	0	1. 03
1. 04 2. 00	CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP	0	0		1, 808, 370	0	1. 04 2. 00
2. 00	CAP REL COSTS-MVBLE EQUIP - MOB	0	0		24, 005	0	2. 00
2. 01	CAP REL COSTS-MVBLE EQUIP - MOB	0				0	2. 01
2. 03	CAP REL COSTS-MVBLE EQUIP - WJ	0	-			Ö	2. 02
3.00	Total (sum of lines 1-2)	0	-		2, 635, 765	0	3. 00
			Sl	JMMARY OF CAPIT		-	
	Cost Center Description	Interest	Insurance (see		Other	Total (2) (sum	
			instructions)	Instructions)	Capi tal -Rel ate d Costs (see	of cols. 9 through 14)	
					instructions)	tili ougii 14)	
		11.00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0		31, 762	0	858, 094	1. 00
1. 01	CAP REL COSTS-BLDG & FIXT-MOB	0	1	C	_	0	1. 01
1. 02	CAP REL COSTS-BLDG & FIXT-POB	0	1	C	0	0	1. 02
1.03	CAP REL COSTS-BLDG & FLXT-WJ	0]		0	0	1. 03
1.04	CAP REL COSTS-BLDG & FLXT-INTEREST	0	2 242		0	0	1. 04
2. 00 2. 01	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB	0	_,	0	0	1, 810, 612 24, 005	2. 00 2. 01
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0			0	24, 005	2. 01
2. 02	CAP REL COSTS-MVBLE EQUIP - WJ		0	"	0	n	2. 02
3. 00	Total (sum of lines 1-2)	0	25, 184	31, 762	_	2, 692, 711	

| Period: | Worksheet A-8 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared:

To 12/31/201				Date/Time Prep 6/29/2020 8:10	pared:		
				Expense Classification on	Worksheet A	0/29/2020 8. 10	Jaili
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - CAP REL	1. 00 B	2. 00 288, 997	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 9	1. 00
4 04	COSTS-BLDG & FIXT (chapter 2)				4 04		4 04
1. 01	Investment income - CAP REL COSTS-BLDG & FIXT-MOB (chapter 2)			CAP REL COSTS-BLDG & FIXT-MOB	1. 01	0	1. 01
1. 02	Investment income - CAP REL COSTS-BLDG & FIXT-POB (chapter			CAP REL COSTS-BLDG & FIXT-POB	1. 02	0	1. 02
1. 03	2) Investment income - CAP REL COSTS-BLDG & FIXT-WJ (chapter		0	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	0	1. 03
1. 04	2) Investment income - CAP REL			CAP REL COSTS-BLDG &	1. 04	0	1. 04
2. 00	COSTS-BLDG & FIXT-INTEREST (chapter 2) Investment income - CAP REL			FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)					U	
2. 01	Investment income - CAP REL COSTS-MVBLE EQUIP - MOB (chapter 2)			CAP REL COSTS-MVBLE EQUIP - MOB	2. 01	0	2. 01
2. 02	Investment income - CAP REL COSTS-MVBLE EQUIP - POB (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP - POB	2. 02	0	2. 02
2. 03	Investment income - CAP REL COSTS-MVBLE EQUIP - WJ			CAP REL COSTS-MVBLE EQUIP - WJ	2. 03	0	2. 03
3. 00	<pre>(chapter 2) Investment income - other (chapter 2)</pre>		0		0.00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5.00	di scounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by	В	-105, 661	CAP REL COSTS-BLDG & FIXT	1. 00	9	6. 00
	suppliers (chapter 8)	_				0	
7. 00	Tel ephone services (pay stations excluded) (chapter 21)		U		0.00	U	7. 00
8. 00	Tel evi si on and radi o servi ce (chapter 21)		0		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -3, 875, 945		0.00	0	9. 00 10. 00
11. 00	adjustment Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	1	A-8-1	6, 368, 007			0	12. 00
13.00	Laundry and linen service	В	1/7 054	CAFETERI A	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others	1	-107, 054	CAFETERIA	11. 00 0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0.00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0. 00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)		_				
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
		. '		· '	!	'	

Provider CCN: 15-1320 Peri od: Worksheet A-8 From 01/01/2019 | worksheet A-o | | To 12/31/2019 | Date/Time Prepared:

				To	12/31/2019	Date/Time Prep 6/29/2020 8:10	
				Expense Classification on	Worksheet A	0/29/2020 6. 10	Jaili
				To/From Which the Amount is t			
	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	
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114.00		25. 00
	physicians' compensation						
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-BLDG &	1. 01	0	26. 01
20.01	COSTS-BLDG & FIXT-MOB			FIXT-MOB	1.01	J	20.01
26. 02	Depreciation - CAP REL			CAP REL COSTS-BLDG &	1. 02	0	26. 02
0/ 00	COSTS-BLDG & FIXT-POB			FIXT-POB	4 00		04 00
26. 03	Depreciation - CAP REL COSTS-BLDG & FIXT-WJ		0	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	0	26. 03
26. 04	Depreciation - CAP REL		0	CAP REL COSTS-BLDG &	1. 04	0	26. 04
	COSTS-BLDG & FIXT-INTEREST			FIXT-INTEREST			
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
27 01	COSTS-MVBLE EQUIP		0	CAD DEL COSTS MADLE FOLLD	2 01	0	27 01
27. 01	Depreciation - CAP REL COSTS-MVBLE EQUIP - MOB			CAP REL COSTS-MVBLE EQUIP - MOB	2. 01	U	27. 01
27. 02	Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP -	2. 02	0	27. 02
	COSTS-MVBLE EQUIP - POB			POB			
27. 03	Depreciation - CAP REL			CAP REL COSTS-MVBLE EQUIP -	2. 03	0	27. 03
28. 00	COSTS-MVBLE EQUIP - WJ Non-physician Anesthetist			WJ *** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0	cost center bereted	0.00	0	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30. 00
	therapy costs in excess of						
20.00	limitation (chapter 14)			ABULLTO A REPLATRICO	22.00		00.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest EMPLOYEE BENEFITS	A	-2 674 783	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 00
33. 01	HOSPITAL ASSESSMENT FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT - POB	7. 02	9	33. 03
33. 04	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT - WJ	7. 03	9	33. 04
33. 05 33. 06	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	9	33. 05 33. 06
	MI SCELLANEOUS I NCOME	В		CENTRAL SERVICES & SUPPLY	14. 00	0	
33. 08	MI SCELLANEOUS I NCOME	В		PHARMACY	15. 00	0	
	MI SCELLANEOUS I NCOME	В		SUBPROVI DER - I PF	40.00	0	33. 09
33. 10	MI SCELLANEOUS I NCOME	В		LABORATORY	60.00	0	33. 10
33. 11 33. 12	MI SCELLANEOUS I NCOME ACCRUED PTO EXPENSE	B A	·	EMERGENCY EMPLOYEE BENEFITS DEPARTMENT	91. 00 4. 00	0	33. 11 33. 12
33. 12	MARKETING EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 14	CONTRACTED HOSPITALIST	A		ADULTS & PEDIATRICS	30.00	0	33. 14
33. 15	CONTRACTED CRNA	A	-578, 344	OPERATING ROOM	50.00	0	33. 15
33. 16	AMORTI ZED START UP COST	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 16
33. 17	MEDICARE DEPRECIATION EXPENSE	A A		CAP REL COSTS-BLDG & FIXT	1.00	9	33. 17
33. 18	MEDICARE DEPRECIATION EXPENSE	A		CAP REL COSTS-BLDG & FIXT-MOB	1. 01	9	33. 18
33. 19	MEDICARE DEPRECIATION EXPENSE	A		CAP REL COSTS-BLDG &	1. 02	9	33. 19
				FI XT-POB			
33. 20	MEDICARE DEPRECIATION EXPENSE	A		CAP REL COSTS-BLDG & FIXT-WJ	1. 03	9	
33. 21 33. 22	MEDICARE DEPRECIATION EXPENSE MEDICARE DEPRECIATION EXPENSE	A A		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP -	2. 00 2. 01	9	33. 21 33. 22
JJ. ZZ	WILDI GARE DEFRECIATION EXPENSE	"		MOB	2.01	9	JJ. ZZ
50.00	TOTAL (sum of lines 1 thru 49)		-3, 662, 628	1			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.
(2) Additional adjustments must be made and applicable and cubes into the seef.

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

Health Financial Systems		IU HEALTH JA	Y HOSPI TAL	In Lie	eu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8			
				From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:1			
			Expense Classification or					
			To/From Which the Amount is	to be Adjusted				
				1				
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			

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 01/01/2019
To 12/31/2019

Provider CCN: 15-1320
Period:
From 01/01/2019
To 12/31/2019
Date/Time Prepared:
6/29/2020 8:10 am

				To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
1 00	HOME OFFICE COSTS:	CAD DEL COCTO DI DO 0 ELVE	LIONE OFFI CE	100 700	0	1 00
1.00		CAP REL COSTS-BLDG & FIXT	HOME OFFICE	-180, 739	0	1.00
2. 00 3. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	209, 179 2, 757, 524	0	2. 00 3. 00
3.00	1	ADMINISTRATIVE & GENERAL	HOME OFFICE		4, 857, 865	3. 00
3. 01	1	ADMINISTRATIVE & GENERAL	RELATED PARTY	6, 471, 608 696, 239	134, 216	3. 01
3. 02	1	OPERATION OF PLANT	RELATED PARTY	234, 167	134, 210	3. 02
3. 04	1	NURSING ADMINISTRATION	RELATED PARTY	423, 347		3. 04
3. 05	1	PHARMACY	RELATED PARTY	352, 771		3. 05
3. 06		OPERATING ROOM	RELATED PARTY	17, 186	Ö	3. 06
3. 07		RADI OLOGY-DI AGNOSTI C	RELATED PARTY	178, 805		3. 07
3. 08		RESPI RATORY THERAPY	RELATED PARTY	30, 242		3. 08
3. 09	I	PHYSI CAL THERAPY	RELATED PARTY	38, 449	Ö	3. 09
3. 10	I	CARDI OPULMONARY	RELATED PARTY	131, 310	Ö	3. 10
3. 11	I	EMPLOYEE BENEFITS DEPARTMENT	RELATED PARTY	9, 578	9, 578	3. 11
3. 12	I	ADMINISTRATIVE & GENERAL	RELATED PARTY	87, 678	87, 678	3. 12
3. 13	I	OPERATION OF PLANT	RELATED PARTY	125, 827	125, 827	3. 13
3. 14	I	DIETARY	RELATED PARTY	55, 295	55, 295	3. 14
3. 15	I	PHARMACY	RELATED PARTY	130, 436	130, 436	3. 15
3. 16	30.00	ADULTS & PEDIATRICS	RELATED PARTY	649, 428	649, 428	3. 16
3. 17	40.00	SUBPROVIDER - IPF	RELATED PARTY	244, 956	244, 956	3. 17
3. 18	50.00	OPERATING ROOM	RELATED PARTY	982, 244	982, 244	3. 18
3. 19	54. 00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	523	523	3. 19
3. 20	60.00	LABORATORY	RELATED PARTY	1, 699, 931	1, 699, 931	3. 20
3. 21	65. 00	RESPI RATORY THERAPY	RELATED PARTY	1, 438	1, 438	3. 21
3. 22	66.00	PHYSI CAL THERAPY	RELATED PARTY	477, 449	477, 449	3. 22
3. 23	67. 00	OCCUPATIONAL THERAPY	RELATED PARTY	87, 548	87, 548	3. 23
3. 24		SPEECH PATHOLOGY	RELATED PARTY	17, 435	17, 435	3. 24
3. 25		ELECTROCARDI OLOGY	RELATED PARTY	20, 564	20, 564	3. 25
3. 26	1	CARDI OPULMONARY	RELATED PARTY	58, 825	58, 825	3. 26
3. 27	1	FAMILY PRACTICE OF JAY COUNT		185, 837	185, 837	3. 27
3. 28		JAY FAMILY MEDICINE	RELATED PARTY	712, 741	712, 741	3. 28
3. 29		WOUND CLINIC	RELATED PARTY	95, 975	95, 975	3. 29
3. 30		JAY FAMILY FIRST HEALTH CARE		144, 457	144, 457	3. 30
3. 31		EMERGENCY	RELATED PARTY	1, 824, 308	1, 824, 308	3. 31
3. 32		OUTPATIENT PSYCH	RELATED PARTY	333	333	3. 32
3. 33		PHYSICIANS' PRIVATE OFFICES	RELATED PARTY	1, 429	1, 429	3. 33
3. 34		WEST JAY CLINIC	RELATED PARTY	23, 500	23, 500	3. 34
3. 35	I	JAY MERIDIAN URGENT CARE	RELATED PARTY	9, 560	9, 560	3. 35
4.00	0.00			0	0	4. 00
5.00	TOTALS (sum of lines 1-4).			19, 007, 383	12, 639, 376	5. 00
	Transfer column 6, line 5 to Worksheet A-8, column 2,					
	line 12.					
	JITHE IZ.			<u> </u>		

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

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

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

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

i Ci ilibui	Schicit 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
100.00	G. Other (financial or		100.00
	non-financial) specify:		

Health Financial Systems	IU HEALTH JAY	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM I	RELATED ORGANIZATIONS AND HOME	Provi der C	CCN: 15-1320	Peri od: From 01/01/2019	Worksheet A-8	1-1
OFFICE COSTS					Date/Time Pre 6/29/2020 8:1	
		·	Related Organ	nization(s) and/o	or Home Office	
Symbol (1)		Percentage of Ownership	N	Jame	Percentage of Ownership	

3.00

4. 00

5. 00

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

1. 00

- 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.

2.00

E. Individual is director, officer, administrator, or key person of provider and related organization.
F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

The 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.

	Crimbal Sometic and Critic Aviii.							
6.00	HOSPI TAL	6.00						
7.00	HOME OFFICE	7.00						
8.00		8.00						
9.00		9.00						
10.00		10.00						
100.00		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	Provider CCN: 15-1320	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2019 To 12/31/2019	Date/Time Prepared: 6/29/2020 8:10 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

WKST. A Line F Cost Center/Physician Identifier Remuneration Professional Provider Component Compo						7	To 12/31/2019	Date/Time Pre 6/29/2020 8:	epared: 10 am
1.00		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		
1.00				Remuneration	Component	Component			
1.00					·	·		Hours	
2.00 5.00 O OPERATING ROOM 955, 203 955, 203 0 0 0 2.00		1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
3.00 60. ODLABORATORY 40. 000 0 40. 000 0 0 3. 00	1.00			254, 214	254, 214	0	0	0	1. 00
1.00	2.00								
5. 00	3.00					40, 000	0	0	
COUNTY C	4.00	76. 00	CARDI OPULMONARY	31, 624	31, 624	0	0	0	4. 00
6.00 90. Q2 JAY FAMILY MEDICINE 614, 207 614, 207 0 0 0 0 0 0 0 0 0	5.00	90. 01	FAMILY PRACTICE OF JAY	175, 997	175, 997	0	0	0	5. 00
7. 00 90. 03			1						
8. 00 90. 04 0P ORTHO CLINIC 102, 213 102, 213 0 0 0 0 0 8, 00 0 0 0 0 0 0 0 0 0							0	1	
9.00 90.05 JAY FAMILY FIRST HEALTH CARE 1.38, 560 1.85.00 0 0 0 0 0 0 0 0 0		•			1		0	ı	
10.00		•					0	1	1
1.00							0	1	
Wkst. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Cost of Cost		91.00	EMERGENCY				-		1
Identifier	200.00							·	
1.00		Wkst. A Line #							
1.00			I denti fi er	Limit					
1.00					Limit			Insurance	
1.00		1 00	2.00	0.00	0.00			14.00	
2.00	1 00								1 00
3.00					_	_			
4.00									
5.00				1	1	_	0		
COUNTY						·	0	1	
7. 00 90. 03 WOUND CLINIC 0 0 0 0 0 0 0 7. 00 8. 00 90. 04 OP ORTHO CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3.00	70.01		Ĭ		,		Ĭ	3.00
8.00 90.04 OP ORTHO CLINIC 9.00 0 0 0 0 0 0 0 0 9.00 10.00 90.05 JAY FAMILY FIRST HEALTH CARE 10 0 0 0 0 0 0 0 0 0 0 10.00 200.00 91.00 EMERGENCY 0 0 0 0 0 0 0 0 0 0 0 0 10.00 200.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6.00	90. 02	JAY FAMILY MEDICINE	0	C	0	0	0	6. 00
9. 00 90. 05 JAY FAMILY FIRST HEALTH CARE 10. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	C	0	0	0	7. 00
10.00				0	C	0	0	0	
Wkst. A Line # Cost Center/Physician Identifier Component Share of Col. 14 Disallowance Disal				0	C	0	0	0	1
Wkst. A Line # Cost Center/Physician Identifier Component Share of col. Limit Disallowance Disallowance Limit Disallowance Disallowanc		91. 00	EMERGENCY	0	C	0	0	_	
Identifier Component Share of col. Li mi t Di sal I owance	200.00			0	C		0	0	200.00
Share of col . 14		Wkst. A Line #					Adjustment		
14 1.00 2.00 15.00 16.00 17.00 18.00 1.00 1.00 1.00 1.00 1.00 1.00			I denti fi er		Limit	Di sal I owance			
1.00									
1.00 40.00 SUBPROVI DER - I PF 0 0 254, 214 1.00 2.00 50.00 OPERATI NG ROOM 0 0 0 955, 203 2.00 3.00 60.00 LABORATORY 0 0 0 0 0 3.00 4.00 76.00 CARDI OPULMONARY 0 0 0 31,624 4.00 5.00 90.01 FAMI LY PRACTICE OF JAY 0 0 0 175,997 5.00 COUNTY 0 0 0 6.00 0 6.00 7.00 90.03 WOUND CLI NI C 0 0 6.00 95,975 7.00 8.00 90.04 OP ORTHO CLINI C 0 0 0 102,213 8.00 9.00 90.05 JAY FAMI LY FIRST HEALTH CARE 0 0 138,560 9.00 10.00 91.00 EMERGENCY 0 0 1,507,952 10.00		1 00	2 00		16.00	17.00	19 00	-	
2. 00 50. 00 OPERATING ROOM 0 0 0 955, 203 2. 00 3. 00 60. 00 LABORATORY 0 0 0 0 0 3. 00 4. 00 76. 00 CARDI OPULMONARY 0 0 0 0 31, 624 4. 00 5. 00 FAMI LY PRACTICE OF JAY 0 0 0 175, 997 5. 00 0 0 0 0 0 0 0 0 0	1 00								1 00
3. 00 60. 00 LABORATORY 0 0 0 0 3. 00 4. 00 76. 00 CARDI OPULMONARY 0 0 0 31, 624 5. 00 90. 01 FAMI LY PRACTI CE OF JAY 0 0 0 175, 997 6. 00 90. 02 JAY FAMI LY MEDI CI NE 0 0 0 614, 207 7. 00 90. 03 WOUND CLI NI C 0 0 95, 975 8. 00 90. 04 OP ORTHO CLI NI C 0 0 0 102, 213 8. 00 90. 05 JAY FAMI LY FIRST HEALTH CARE 0 0 138, 560 10. 00 91. 00 EMERGENCY 0 0 0 1, 507, 952 10. 00								•	
4. 00						_			
5. 00 90. 01 FAMI LY PRACTICE OF JAY COUNTY 0 0 175, 997 5. 00 6. 00 90. 02 JAY FAMI LY MEDICINE 0 0 0 614, 207 6. 00 7. 00 90. 03 WOUND CLINIC 0 0 0 95, 975 7. 00 8. 00 90. 04 OP ORTHO CLINIC 0 0 0 102, 213 8. 00 9. 00 90. 05 JAY FAMI LY FIRST HEALTH CARE 0 0 0 138, 560 9. 00 10. 00 91. 00 EMERGENCY 0 0 1, 507, 952 10. 00				1	1	1	Ĭ		
COUNTY 6. 00 90. 02 JAY FAMILY MEDICINE 0 0 0 614, 207 7. 00 90. 03 WOUND CLINIC 0 0 0 95, 975 8. 00 90. 04 OP ORTHO CLINIC 0 0 0 102, 213 9. 00 90. 05 JAY FAMILY FIRST HEALTH CARE 0 0 138, 560 10. 00 91. 00 EMERGENCY 0 0 0 1, 507, 952 10. 00		1		-	1	1			1
7. 00 90. 03 WOUND CLINIC 0 0 95, 975 7. 00 8. 00 90. 04 OP ORTHO CLINIC 0 0 0 102, 213 8. 00 9. 00 90. 05 JAY FAMILY FIRST HEALTH CARE 0 0 0 138, 560 9. 00 10. 00 91. 00 EMERGENCY 0 0 0 1, 507, 952 10. 00	5.00	70.01		٥		0	173, 447		3.00
8.00 90.04 OP ORTHO CLINIC 0 0 102, 213 8.00 9.00 90.05 JAY FAMILY FIRST HEALTH CARE 0 0 138, 560 9.00 10.00 91.00 EMERGENCY 0 0 0 1,507, 952 10.00	6.00	90. 02	JAY FAMILY MEDICINE	0	C	0	614, 207		6. 00
9. 00 90. 05 JAY FAMILY FIRST HEALTH CARE 0 0 0 138, 560 9. 00 10. 00 91. 00 EMERGENCY 0 0 0 1, 507, 952 10. 00	7.00	90. 03	WOUND CLINIC	0	C	0	95, 975		7. 00
10. 00 91. 00 EMERGENCY 0 0 1, 507, 952 10. 00				0	C	0			
				0	(ή		•	
200.00 0 0 3,875,945 200.00	10.00	91.00	EMERGENCY	0	(-			
	200.00			0	(C	0	3, 875, 945		200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

				To	12/31/2019	Date/Time Pre 6/29/2020 8:1	
				CAPITAL REL	ATED COSTS	0/24/2020 8. 1	O alli
	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)					
	GENERAL SERVICE COST CENTERS	0	1.00	1. 01	1. 02	1. 03	
1.00	00100 CAP REL COSTS-BLDG & FIXT	858, 094	858, 094				1. 00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB	0	0	0			1. 01
1. 02 1. 03	O0102 CAP REL COSTS-BLDG & FIXT-POB O0103 CAP REL COSTS-BLDG & FIXT-WJ	0	0	0	C	0	1. 02 1. 03
1. 04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	Ö	Ö	Ö	C	Ö	1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP	1, 810, 612					2.00
2. 01 2. 02	OO201 CAP REL COSTS-MVBLE EQUIP - MOB OO202 CAP REL COSTS-MVBLE EQUIP - POB	24, 005 0					2. 01 2. 02
2.03	00203 CAP REL COSTS-MVBLE EQUIP - WJ	0					2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	2, 784, 539	1, 182	0	C	0	4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT	8, 651, 616 2, 284, 913	112, 510 156, 329	0	C	0	5. 00 7. 00
7. 01	00701 OPERATION OF PLANT - MOB	70, 697	0	0	C	0	7. 01
7. 02 7. 03	OO7O2 OPERATION OF PLANT - POB OO7O3 OPERATION OF PLANT - WJ	24, 465	0	0	C	0	7. 02 7. 03
8. 00	00800 LAUNDRY & LINEN SERVICE	89, 911	6, 215	0	C	o o	8. 00
9. 00	00900 HOUSEKEEPI NG	490, 851	6, 278	0	C	0	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	228, 213 247, 366	16, 145 28, 554	0	C	0	10. 00 11. 00
	01300 NURSING ADMINISTRATION	1, 715, 903	11, 604	0	C	Ö	13. 00
	01400 CENTRAL SERVI CES & SUPPLY	658, 441	0	0	C	0	14. 00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 076, 159 0	10, 463 0	0	C	0	
	01700 SOCIAL SERVICE	0	Ö	Ö	C		•
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 683, 231	124 210	0		0	30.00
40. 00	04000 SUBPROVI DER - I PF	964, 398	124, 219 38, 201	0	C		
43. 00	04300 NURSERY	63, 467	5, 891	0	C	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1, 489, 156	41, 769	0	C	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	24, 867	2, 302	0	C	1	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 1, 132, 825	0 52, 253	0	C	0	
60.00	06000 LABORATORY	1, 793, 603	27, 361	0	C	0	60.00
	06500 RESPI RATORY THERAPY	446, 518	7, 649	0	C	0	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	519, 172 87, 548	34, 068 6, 027	0	C	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	17, 435	105	O	C	Ö	ı
69. 00	06900 ELECTROCARDI OLOGY	21, 753	0	0	C	0	69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	240, 803 28, 318	0	0	C	0	71. 00 72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 516, 241	Ö	0	C	o o	73. 00
76. 00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	278, 268	0	0	C	0	76. 00
90.00	09000 CLINIC	0	0	0	C	0	
	09001 FAMILY PRACTICE OF JAY COUNTY	663, 113	0	0	C		
	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	858, 110 41, 276	3, 568	0	C	0	
90. 04	09004 OP ORTHO CLINIC	0	0	0	C	Ö	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	343, 747 93, 820	40, 471	0	C	0	90. 05 90. 06
	09100 EMERGENCY	1, 401, 411	6, 466 49, 909	0	C	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 00	04950 OUTPATIENT PSYCH SPECIAL PURPOSE COST CENTERS	26, 655	16, 438	0	C) 0	93.00
118. 00		34, 751, 520	805, 977	0	C	0	118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0.047	0	C		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	135, 512	8, 067 0	0	C		190.00
193. 00	19300 NONPALD WORKERS	0	o	0	C	0	193. 00
	07950 VACANT 07952 WEST JAY CLINIC	0 319, 034	27, 257	0	C	•	194. 00 194. 02
	07953 JAY MERIDIAN URGENT CARE	210, 486	16, 793	0	C		194. 02
200.00	Cross Foot Adjustments		_	_	_		200. 00
201. 00 202. 00		35, 416, 552	0 858, 094	0	C		201. 00 202. 00
				-,			

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: | 6/29/2020 8:10 am

		CAP	TITAL RELATED CO	OSTS	6/29/2020 8: 1	0 am
Cost Center Description	BLDG &	MVBLE EQUIP	MVRLE FOLLE -	MVBLE EQUIP -	MVRLE FOLLE -	
cost center bescription	FIXT-INTEREST		MOB	POB	WJ	
GENERAL SERVI CE COST CENTERS	1. 04	2. 00	2. 01	2. 02	2. 03	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FIXT-MOB						1. 01
1.02 O0102 CAP REL COSTS-BLDG & FLXT-POB						1. 02
1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTERES	т					1. 03 1. 04
2. 00 00200 CAP REL COSTS-MVBLE EQUIP		1, 810, 612				2. 00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB		0	24, 005			2. 01
2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	2. 02 2. 03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 495	ő	Ö	ő	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	0	237, 401		0	0	5. 00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - MOB	0	329, 861	623	0	0	7. 00 7. 01
7. 02 00701 OPERATION OF PLANT - MOB	0		0		0	7. 01
7.03 OO703 OPERATION OF PLANT - WJ	0	0	0	0	0	7. 03
8. 00 00800 LAUNDRY & LINEN SERVICE	0	13, 114	1	0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	13, 247 34, 066	1	0	0	9. 00 10. 00
11. 00 01100 CAFETERI A	0	60, 250	1	0	ő	11. 00
13.00 01300 NURSING ADMINISTRATION	0	24, 484	0	0	0	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY	0	0	0	0	0	14. 00 15. 00
16. 00 01600 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	22, 078 0			0	16.00
17.00 01700 SOCIAL SERVICE	0	0	Ō	0		17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2/2 10/	1 0			20.00
30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER - 1 PF	0 0	262, 106 80, 606	1			30. 00 40. 00
43. 00 04300 NURSERY	0		1			43. 00
ANCILLARY SERVICE COST CENTERS		00.404	1 110			F0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	88, 134 4, 857			0	50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	Ö	0	ő	Ö	ő	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	110, 256	i	0	0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	57, 733 16, 139	i	0	0	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	0	71, 885	1	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	12, 717	1	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	221	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI EI	NTS 0		0	0	0	69. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	Ō	0	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	1, 903	0	0	76. 00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	7, 661			90. 01
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	0	0 7, 528	10, 713	0	0	90. 02 90. 03
90. 04 09004 OP ORTHO CLINIC	0	7, 320	Ö	0	0	90.03
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	85, 396	1	0	0	90. 05
90.06 09006 I NFUSION CLINIC 91.00 09100 EMERGENCY	0	13, 644	1	0	0	90. 06 91. 00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAI	-	105, 311		0	0	91.00
93. 00 04950 OUTPATIENT PSYCH	0	34, 684	0	0	0	93. 00
SPECIAL PURPOSE COST CENTERS	117)	1 700 / 42	24.005		1 0	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through NONREI MBURSABLE COST CENTERS	117) 0	1, 700, 643	24, 005	0	0	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTE	EN O	17, 022	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS 194. 00 07950 VACANT	0	0 57, 512	0	0		193. 00 194. 00
194. 02 07952 WEST JAY CLINIC		0,,512	Ö		l .	194. 00
194.03 07953 JAY MERIDIAN URGENT CARE	0	35, 435	0	0		194. 03
200.00 Cross Foot Adjustments			_		_	200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201)	0	1, 810, 612	24, 005	0		201.00
1 - (- (- (- (- (- (- (- (- (- (- (- (- (1	., ., ., .,		'	'	

			11	5 12/31/2019	6/29/2020 8:1	
Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	o diii
'	BENEFITS		& GENERAL	PLANT	PLANT - MOB	
	DEPARTMENT					
OFFICE ALL OFFICE COOT OFFITEDS	4. 00	4A	5. 00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1. 00 1. 01
1. 02 00102 CAP REL COSTS-BLDG & FLXT-NOB						1. 01
1. 03 O0103 CAP REL COSTS-BLDG & FIXT-WJ						1. 02
1. 04 O0104 CAP REL COSTS-BLDG & FIXT-INTEREST						1. 04
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2.02 O0202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2.03 O0203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 788, 216					4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	98, 723	9, 102, 031		0 007 5/4		5. 00
7. 00 00700 OPERATION OF PLANT	72, 158	2, 843, 884	983, 680	3, 827, 564	05 151	7.00
7.01 00701 0PERATI ON OF PLANT - MOB 7.02 00702 0PERATI ON OF PLANT - POB	0	70, 697 24, 465	24, 454 8, 462	U O	95, 151 0	7. 01 7. 02
7. 03 00703 OPERATION OF PLANT - POB 7. 03 00703 OPERATION OF PLANT - WJ		24, 400 0	0, 402	0	0	7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE	10, 357	119, 597	41, 368	25, 463	0	8. 00
9. 00 00900 HOUSEKEEPI NG	89, 343	599, 719		25, 720	0	9. 00
10. 00 01000 DI ETARY	27, 071	305, 495	105, 669	66, 143	0	10.00
11. 00 01100 CAFETERI A	47, 886	384, 056			0	11. 00
13.00 01300 NURSING ADMINISTRATION	275, 886	2, 027, 877		47, 539	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	37	658, 478	227, 764	0	0	14.00
15. 00 01500 PHARMACY	111, 397	1, 220, 097	422, 024	42, 866	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	254 222	0 400 004	000 440	500 005		00.00
30. 00 03000 ADULTS & PEDI ATRI CS	354, 338	2, 423, 894	838, 410	508, 905	0	30.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	208, 413 13, 252	1, 291, 618 95, 040	· ·		0	40. 00 43. 00
ANCILLARY SERVICE COST CENTERS	13, 232	73, 040	32,074	24, 134		43.00
50. 00 05000 OPERATI NG ROOM	291, 509	1, 911, 716	661, 251	484, 774	5, 059	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5, 192	37, 218		9, 431	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	170, 530	1, 465, 864	507, 034	214, 074	0	54.00
60. 00 06000 LABORATORY	0	1, 878, 697	649, 830	112, 095	0	60.00
65. 00 06500 RESPI RATORY THERAPY	89, 050	559, 356		31, 335	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	110, 593	735, 718		139, 572	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	20, 230	126, 522		24, 691	0	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	4, 046	21, 807	7, 543	429	0	68. 00 69. 00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		21, 753 240, 803		0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		28, 318		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 516, 241		ol	0	73. 00
76. 00 03160 CARDI OPULMONARY	25, 509	305, 680		64, 985	8, 381	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	_	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	134, 964	805, 738			33, 746	
90. 02 09002 JAY FAMI LY MEDI CI NE	161, 788	1, 030, 611	356, 482	365, 906	47, 191	
90. 03 09003 WOUND CLI NI C	8, 911	61, 283	21, 197	14, 617	0	90. 03
90. 04 09004 OP ORTHO CLINIC	71 415	U E41 20E	107 200	171 000	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE 90.06 09006 INFUSION CLINIC	71, 415 19, 819	541, 205 133, 749	187, 200 46, 263	171, 808 26, 491	774 0	90. 05 90. 06
91. 00 09100 EMERGENCY	229, 514	1, 786, 145	· ·	204, 472	0	90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	227, 314	1, 700, 143	017,017	204, 472	O	92. 00
93. 00 04950 OUTPATI ENT PSYCH	5, 498	83, 275	28, 804	67, 343	0	93. 00
SPECIAL PURPOSE COST CENTERS	0, 170	00, 270	20,001	07,010		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 657, 429	34, 458, 647	8, 770, 698	3, 207, 934	95, 151	118. 00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 089	8, 678	33, 050	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	25, 330	160, 842	55, 634	267, 871	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 VACANT	0	84, 769	· ·	111, 666		194. 00
194. 02 07952 WEST JAY CLINIC	62, 766	381, 800		138, 243		194. 02
194. 03 07953 JAY MERIDIAN URGENT CARE	42, 691	305, 405	105, 638	68, 800	0	194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	_	_	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 788, 216	35, 416, 552	9, 102, 031	3, 827, 564	95, 151	
	2,,00,210	55, 110, 552	,, 102, 001	3, 327, 304	70, 101	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:10 am

						6/29/2020 8: 1	0 am
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT - POB	PLANT - WJ	LINEN SERVICE	0.00	40.00	
	GENERAL SERVICE COST CENTERS	7. 02	7. 03	8. 00	9. 00	10. 00	
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	DO101 CAP REL COSTS-BLDG & FIXT-MOB						1. 01
1	00102 CAP REL COSTS-BLDG & FIXT-POB						1. 02
	00103 CAP REL COSTS-BLDG & FIXT-WJ						1. 02
	DO104 CAP REL COSTS-BLDG & FIXT-INTEREST						1. 03
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
	00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 02
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
1	00500 ADMINISTRATIVE & GENERAL						5. 00
1	00700 OPERATION OF PLANT						7. 00
1	00701 OPERATION OF PLANT - MOB						7. 01
	00702 OPERATION OF PLANT - POB	32, 927					7. 02
	00703 OPERATION OF PLANT - WJ	02,727	0				7. 03
1	00800 LAUNDRY & LINEN SERVICE	0	0	186, 428			8. 00
	00900 HOUSEKEEPI NG	0	0	22, 575	l .		9. 00
	01000 DI ETARY	0	0	5, 826		498, 685	10.00
	01100 CAFETERI A	0	0	0	27, 506	0	11. 00
1	01300 NURSING ADMINISTRATION	0	0	0	11, 178	0	13.00
- 1	01400 CENTRAL SERVICES & SUPPLY	0	0	l o	o	0	14. 00
1	01500 PHARMACY	0	0	0	10, 079	0	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	0	0	o	0	16. 00
1	01700 SOCIAL SERVICE	0	0	0	o	0	17. 00
-	NPATIENT ROUTINE SERVICE COST CENTERS				-1		
30.00	03000 ADULTS & PEDIATRICS	0	0	85, 467	119, 664	354, 423	30.00
40.00	04000 SUBPROVIDER - IPF	0	0	4, 612	36, 800	144, 262	40. 00
43.00	04300 NURSERY	0	0	3, 378	5, 675	0	43.00
Α	ANCILLARY SERVICE COST CENTERS						
50.00	D5000 OPERATING ROOM	23, 624	0	19, 420	113, 987	0	50.00
52.00	D5200 DELIVERY ROOM & LABOR ROOM	0	0	0	2, 217	0	52.00
53.00	D5300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	D5400 RADI OLOGY-DI AGNOSTI C	0	0	14, 807	50, 336	0	54.00
60.00	D6000 LABORATORY	0	0	0	26, 357	0	60.00
65.00	D6500 RESPIRATORY THERAPY	0	0	0	7, 368	0	65. 00
66.00	D6600 PHYSI CAL THERAPY	0	0	1, 214	32, 818	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	5, 806	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	101	0	68. 00
1	06900 ELECTROCARDI OLOGY	0	0	3, 884	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
1	D7300 DRUGS CHARGED TO PATIENTS	0	0	0		0	73. 00
	03160 CARDI OPULMONARY	0	0	0	15, 280	0	76. 00
-	OUTPATIENT SERVICE COST CENTERS			I			
	09000 CLINIC	0	0	0	· ·	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	_		0	90. 01
1	09002 JAY FAMILY MEDICINE	0	0			0	90. 02
	D9003 WOUND CLINIC	0	0		3, 437	0	90. 03
1	09004 OP ORTHO CLINIC	0	0		0	0	90. 04
	09005 JAY FAMILY FIRST HEALTH CARE	0	0	0	40, 398	0	90. 05
	09006 I NFUSI ON CLI NI C	0	0	0	6, 229	0	90.06
	09100 EMERGENCY	0	0	25, 245	48, 078	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				45.005		92.00
	04950 OUTPATIENT PSYCH	0	0	0	15, 835	0	93. 00
_	SPECIAL PURPOSE COST CENTERS	00.704		10/ 400	740.040	100 (05	440.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	23, 624	0	186, 428	742, 262	498, 685	118.00
	NONREI MBURSABLE COST CENTERS				7 774		400 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	9, 303	0	0	62, 986		192.00
1	19300 NONPALD WORKERS	0	0		0 0		193. 00
	D7950 VACANT	0	0	0	26, 257		194. 00
1	07952 WEST JAY CLINIC	0	0		0		194. 02
	07953 JAY MERIDIAN URGENT CARE	0	0	0	16, 177	0	194. 03
200.00	Cross Foot Adjustments		^	_		^	200.00
201.00	Negative Cost Centers	0	0		055 453		201.00
202. 00	TOTAL (sum lines 118 through 201)	32, 927	0	186, 428	855, 453	498, 685	2U2. UU

			10	12/31/2019	Date/IIme Pre 6/29/2020 8:1	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	- Cam
, , , , , , , , , , , , , , , , , , ,		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	T					
1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FLXT-MOB						1. 01
1. 02 O0102 CAP REL COSTS-BLDG & FLXT-POB						1. 02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04 O0104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 O0200 CAP REL COSTS-MVBLE EQUIP						1.04
2. 01 00200 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 EQUIP - WJ						2. 02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 00701 OPERATION OF PLANT - MOB						7. 01
7.02 00702 OPERATION OF PLANT - POB						7. 02
7.03 OO703 OPERATION OF PLANT - WJ						7. 03
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	661, 387					11.00
13. 00 01300 NURSI NG ADMINI STRATI ON	53, 118	2, 841, 142	201 210			13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	886, 242	1 700 410		14.00
15. 00 01500 PHARMACY	21, 775	0	6, 577	1, 723, 418	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	U	U	U	U _I	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	89, 331	607, 049	94, 757	11, 323	0	30.00
40. 00 04000 SUBPROVI DER - 1 PF	48, 900	357, 995	4, 303	10	0	40. 00
43. 00 04300 NURSERY	2, 743	18, 639	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	72, 699	469, 185	324, 623	6, 655	0	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 063	7, 391	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0 35, 904	0	35, 697	4, 128	0	53. 00 54. 00
60. 00 06000 LABORATORY	40, 224	0	33, 047 O	4, 120	0	60.00
65. 00 06500 RESPIRATORY THERAPY	21, 021	0	14, 169	90	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	18, 175	o	2, 893	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	4, 252	o	273	o	0	67. 00
68.00 06800 SPEECH PATHOLOGY	617	o	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	697	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	236, 068	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	27, 761	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 678, 033	0	73. 00
76. 00 03160 CARDI OPULMONARY	6, 413	1, 607	1, 392	0	0	76. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	0	O	0	ol	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	59, 325	351, 889		9, 015	0	
90. 02 09002 JAY FAMILY MEDICINE	70, 127	448, 297	10, 626	227	0	90. 02
90. 03 09003 WOUND CLINIC	2, 366	22, 174	3, 528	0	0	90. 03
90. 04 09004 OP ORTHO CLINIC	0	0	0	0	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	28, 359	150, 396	7, 458	0	0	90. 05
90.06 09006 INFUSION CLINIC	3, 429	32, 136	9, 187	1, 847	0	90. 06
91. 00 09100 EMERGENCY	50, 203	374, 384	84, 569	12, 052	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.044		4.0			92.00
93. 00 04950 OUTPATIENT PSYCH	3, 361	0	12	O ₁	0	93. 00
SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	633, 405	2, 841, 142	884, 522	1, 723, 380	0	118. 00
NONREI MBURSABLE COST CENTERS	000, 100	2,011,112	001, 022	1, 720, 000		1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	10, 596	0	394	38	0	192. 00
193.00 19300 NONPALD WORKERS	0	O	0	0		193. 00
194. 00 07950 VACANT	0	0	0	0		194. 00
194. 02 07952 WEST JAY CLINIC	17 204	0	1, 309	0		194. 02
194.03 07953 JAY MERIDIAN URGENT CARE 200.00 Cross Foot Adjustments	17, 386	O	0	o	0	194. 03 200. 00
201.00 Negative Cost Centers	0	n	Λ	n	n	200.00
202.00 TOTAL (sum lines 118 through 201)	661, 387	2, 841, 142	886, 242	1, 723, 418		202.00
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COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320 Peri od: Worksheet B From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:10 am Cost Center Description SOCIAL SERVICE Total Subtotal Intern & Residents Cost & Post Stepdown Adjustments 17.00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.02 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.03 1.03 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 1.04 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 00203 CAP REL COSTS-MVBLE EQUIP - WJ 2 03 2 03 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT - MOB 7 01 7 01 7.02 00702 OPERATION OF PLANT - POB 7.02 00703 OPERATION OF PLANT - WJ 7.03 7.03 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 5, 133, 223 5. 133. 223 30.00 04000 SUBPROVIDER - IPF 2, 491, 767 2, 491, 767 40.00 40.00 0 0 04300 NURSERY 0 0 43.00 182, 483 182.483 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 4, 092, 993 50 00 4 092 993 50 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 00000000 0 52.00 70, 193 70, 193 05300 ANESTHESI OLOGY 0 53 00 53 00 2, 327, 844 05400 RADI OLOGY-DI AGNOSTI C 2, 327, 844 54.00 54.00 06000 LABORATORY 0 60.00 2, 707, 203 2, 707, 203 60.00 0 06500 RESPIRATORY THERAPY 65.00 826, 817 826, 817 65.00 66.00 06600 PHYSI CAL THERAPY 1, 184, 870 1, 184, 870 66.00 67.00 06700 OCCUPATIONAL THERAPY 205, 307 0 205, 307 67.00 06800 SPEECH PATHOLOGY 30, 497 0 30, 497 68.00 68.00 06900 ELECTROCARDI OLOGY 33, 858 0 33, 858 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 560, 163 0 560, 163 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 65, 874 0 65, 874 72.00 0 0 07300 DRUGS CHARGED TO PATIENTS 3, 718, 733 73.00 3, 718, 733 73.00 03160 CARDI OPULMONARY 0 76.00 509, 471 509, 471 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 0 09001 FAMILY PRACTICE OF JAY COUNTY 00000 90.01 1, 881, 524 1, 881, 524 90.01 90.02 09002 JAY FAMILY MEDICINE 2, 415, 504 2, 415, 504 90.02 09003 WOUND CLINIC 0 90.03 128, 602 128, 602 90.03 09004 OP ORTHO CLINIC 0 90.04 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 90.05 1, 127, 598 1, 127, 598 90.05 90.06 09006 INFUSION CLINIC 259, 331 0 259, 331 90.06 0 91.00 09100 EMERGENCY 3, 202, 965 0 3, 202, 965 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92 00 04950 OUTPATIENT PSYCH 93.00 0 198, 630 0 198, 630 93.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 0 33, 355, 450 0 33, 355, 450 118.00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 74.605 0 74.605 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 567, 664 567, 664 0 193. 00 19300 NONPALD WORKERS 0 193.00 οĺ 194. 00 07950 VACANT 252, 013 252, 013 194 00 0 194. 02 07952 WEST JAY CLINIC 653, 414 0 653, 414 194.02 194. 03 07953 JAY MERIDIAN URGENT CARE 0 194. 03 513, 406 513, 406 200.00 Cross Foot Adjustments C 0 200.00 0 0 201.00 Negative Cost Centers 201.00 35, 416, 552 TOTAL (sum lines 118 through 201) 202.00 35, 416, 552 202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:10 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

						12/31/2019	6/29/2020 8:1	
					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					
	OENED	AL CERVI OF COCT OFNITERS	0	1. 00	1. 01	1. 02	1. 03	
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		CAP REL COSTS BLDG & FLXT LATEREST						1. 03
1. 04 2. 00		CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP						1. 04 2. 00
2. 01	1	CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2.02		CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2.03	1	CAP REL COSTS-MVBLE EQUIP - WJ				_		2. 03
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0	1, 182 112, 510	1	(0 0	
7. 00		OPERATION OF PLANT		156, 329	1	(
7. 01		OPERATION OF PLANT - MOB	0	0		C	0	1
7. 02		OPERATION OF PLANT - POB	0	0	· ·	(0	
7. 03 8. 00		OPERATION OF PLANT - WJ	0	0		(0 0	7. 03 8. 00
9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	6, 215 6, 278	1	(
10.00	1	DI ETARY	i o	16, 145	1	Č	o o	
11. 00	1	CAFETERI A	o	28, 554	i I	(0	
13.00	1	NURSI NG ADMI NI STRATI ON	0	11, 604	i I	(0	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	0 10, 463	· ·	(0 0	
16. 00		MEDICAL RECORDS & LIBRARY	Ö	0	1	(1	16. 00
17. 00		SOCIAL SERVICE	0	0	0	(0	17. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS		124 210			ol o	20.00
30. 00 40. 00		ADULTS & PEDIATRICS SUBPROVIDER - IPF	0	124, 219 38, 201	l l	(•	
43. 00		NURSERY	0			Ċ		
50.00		LARY SERVICE COST CENTERS	1		l al			
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0	41, 769 2, 302		(•	
53. 00		ANESTHESI OLOGY		2, 302		(53.00
54.00	05400	RADI OLOGY-DI AGNOSTI C	0	52, 253	0	(0	54.00
60.00	1	LABORATORY	0	27, 361	1	(0	60.00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	7, 649 34, 068	1	(0 0	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY		6, 027	1	(67. 00
68. 00	1	SPEECH PATHOLOGY	0	105	1	Ċ	o o	1
69. 00		ELECTROCARDI OLOGY	0	0	1	(0	69. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	(0 0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATTENTS		0		(
76. 00	1	CARDI OPULMONARY	0	0	0	(0	76. 00
00.00		TIENT SERVICE COST CENTERS		0	J ol			00.00
90. 00 90. 01		CLINIC FAMILY PRACTICE OF JAY COUNTY	0		0	(0 0	1
90. 02		JAY FAMILY MEDICINE	O	0		Ć	o o	
90. 03		WOUND CLINIC	o	3, 568	1	(0	
90. 04 90. 05		OP ORTHO CLINIC JAY FAMILY FIRST HEALTH CARE	0	0	0	(0	1
90.05	1	INFUSION CLINIC	0	40, 471 6, 466	1	(0 0	1
91. 00		EMERGENCY	O	49, 909	1	Ć	1	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93. 00		OUTPATIENT PSYCH AL PURPOSE COST CENTERS	0	16, 438	0	(0	93. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	O	805, 977	0	(0	118. 00
	NONRE	IMBURSABLE COST CENTERS						
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	0	8, 067 0	1	(190. 00 192. 00
		NONPALD WORKERS		0		(192.00
194.00	07950	VACANT		27, 257	O	C	0	194. 00
		WEST JAY CLINIC	0	0	0	(•	194. 02
194. 03 200. 00		JAY MERIDIAN URGENT CARE Cross Foot Adjustments	0	16, 793	0	(٥	194. 03 200. 00
200.00		Negative Cost Centers		0	О	(0	200.00
202.00	1	TOTAL (sum lines 118 through 201)	o	858, 094	.l o	C		202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1320

Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

6/29/2020 8:10 am CAPITAL RELATED COSTS MVBLE EQUIP -Cost Center Description BLDG & MVBLE EQUIP MVBLE EQUIP - MVBLE EQUIP -FLXT-LNTEREST MOB POB 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-INTEREST 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 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 2, 495 4.00 Λ 5.00 00500 ADMINISTRATIVE & GENERAL 237, 401 1, 781 0 5.00 7.00 00700 OPERATION OF PLANT 0000000000 329, 861 623 0 0 0 0 0 0 0 0 0 7.00 00701 OPERATION OF PLANT - MOB 0 7.01 7.01 0 C 00702 OPERATION OF PLANT - POB 7.02 C 0 0 7.02 7.03 00703 OPERATION OF PLANT - WJ 0 0 7.03 00800 LAUNDRY & LINEN SERVICE 8.00 13, 114 0 8.00 00900 HOUSEKEEPI NG 9 00 13 247 0 0 9 00 10.00 01000 DI ETARY 34,066 0 10.00 01100 CAFETERI A 60, 250 0 0 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 24, 484 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 14 00 0 0 0 15.00 01500 PHARMACY 22,078 0 0 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 0 0 16.00 01700 SOCIAL SERVICE 17 00 0 0 0 0 17 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 30.00 262, 106 04000 SUBPROVIDER - IPF 0 ol 40.00 80, 606 0 0 40.00 04300 NURSERY 0 43.00 12, 430 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 88, 134 1, 148 0 0 50.00 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 4, 857 C 0 0 0 0 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 110, 256 0 0 54.00 06000 LABORATORY 57, 733 60.00 60.00 65.00 06500 RESPIRATORY THERAPY 00000000 16, 139 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 71.885 0 66.00 12, 717 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 68 00 06800 SPEECH PATHOLOGY 221 0 Ω 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 C 03160 CARDI OPULMONARY 0 0 76.00 0 0 1,903 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0 90. 01 0 7,661 0 0 90.01 0 09002 JAY FAMILY MEDICINE 90 02 90 02 r 10, 713 0 09003 WOUND CLINIC 0 90.03 90.03 7,528 0 0 90.04 09004 OP ORTHO CLINIC 0 0 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 90.05 85.396 176 0 90.05 90.06 09006 INFUSION CLINIC 13, 644 C 0 0 90.06 91.00 09100 EMERGENCY 0 105, 311 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 OUTPATIENT PSYCH 93.00 34, 684 Ω 0 93.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 118. 00 0 1, 700, 643 24,005 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 190, 00 0 17, 022 0 0 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 193.00 0 0 0 0 194. 00 07950 VACANT 57, 512 0 0 194, 00 194. 02 07952 WEST JAY CLINIC 0 194. 02 0 194. 03 07953 JAY MERIDIAN URGENT CARE 0 0 0 0 194. 03 35, 435 200.00 Cross Foot Adjustments 200.00 201 00 0 0 201 00 Negative Cost Centers C 0 202.00 TOTAL (sum lines 118 through 201) 1, 810, 612 24,005 0 202.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:10 am

			''	3 12/31/2019	6/29/2020 8: 1	
Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
	2A	DEPARTMENT 4. 00	5. 00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS	271		0.00	7, 00	7.01	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01 O0101 CAP REL COSTS-BLDG & FIXT-MOB					I	1. 01
1.02 O0102 CAP REL COSTS-BLDG & FIXT-POB					I	1. 02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ					I	1. 03
1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST					l	1. 04
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB					I	2. 00 2. 01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB					I	2. 02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ					I	2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 677	3, 677			I	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	351, 692	130			I	5. 00
7.00 OO700 OPERATION OF PLANT	486, 813	95		524, 926		7. 00
7. 01 00701 OPERATION OF PLANT - MOB	0	0	945	0	945	7. 01
7.02 00702 OPERATION OF PLANT - POB 7.03 00703 OPERATION OF PLANT - WJ	0	0	327	0	0 0	7. 02 7. 03
8. 00 00800 LAUNDRY & LINEN SERVICE	19, 329	14	1, 599	3, 492	0	
9. 00 00900 HOUSEKEEPI NG	19, 525	118		3, 527	Ö	
10. 00 01000 DI ETARY	50, 211	36	4, 084	9, 071	0	10.00
11. 00 01100 CAFETERI A	88, 804	63		16, 043	0	11. 00
13. 00 O1300 NURSI NG ADMINI STRATI ON	36, 088	364	27, 113	6, 520	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	22 541	0 147	8, 804	0 5 070	0 0	14. 00 15. 00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	32, 541 0	147	16, 313 0	5, 879 0	0	16. 00
17. 00 01700 SOCI AL SERVI CE	0	0	_	ő	Ö	1
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	386, 325	468		69, 793	0	
40. 00 04000 SUBPROVI DER - PF	118, 807	275		21, 464	0	40.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	18, 321	17	1, 271	3, 310	0	43. 00
50. 00 05000 OPERATING ROOM	131, 051	384	25, 560	66, 484	50	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	7, 159	7	498	1, 293	0	1
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	162, 509	225		29, 359	0	54.00
60. 00 06000 LABORATORY	85, 094	0		15, 373	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	23, 788	117	7, 479	4, 297	0	65. 00 66. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	105, 953 18, 744	146 27	9, 837 1, 692	19, 141 3, 386	1 0	67. 00
68. 00 06800 SPEECH PATHOLOGY	326	5	292	59	Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	291	o	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	-,	0	0	71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATLENTS 76.00 O3160 CARDLOPULMONARY	0 1, 903	0 34		0 8, 912	0 83	73. 00 76. 00
OUTPATIENT SERVICE COST CENTERS	1, 703		4,007	0, 712	- 03	70.00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	7, 661	178	10, 773			90. 01
90. 02 09002 JAY FAMILY MEDICINE	10, 713	213		50, 182		1
90. 03 09003 WOUND CLINIC 90. 04 09004 OP ORTHO CLINIC	11, 096	12		2, 005	0	90. 03 90. 04
90.04 09004 0P ORTHO CLINIC 90.05 09005 JAY FAMILY FIRST HEALTH CARE	126, 043	0 94		23, 562	0 8	
90. 06 09006 NFUSION CLINIC	20, 110	26		3, 633	0	90.06
91. 00 09100 EMERGENCY	155, 220	303		28, 042	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				I	92.00
93. 00 04950 OUTPATIENT PSYCH	51, 122	7	1, 113	9, 236	0	93. 00
SPECIAL PURPOSE COST CENTERS	0 500 (05	2 505	222.047	400 047	0.45	440.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 530, 625	3, 505	339, 016	439, 947	945	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	25, 089	0	335	4, 533	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	33		36, 737		192. 00
193. 00 19300 NONPALD WORKERS	0	0		O	0	193. 00
194. 00 07950 VACANT	84, 769	0	, , , , ,	15, 314		194. 00
194.02 07952 WEST JAY CLINIC	0	83 54		18, 959		194. 02 194. 03
194.03 07953 JAY MERIDIAN URGENT CARE 200.00 Cross Foot Adjustments	52, 228 0	56	4, 083	9, 436	1	200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 692, 711	3, 677	351, 822	524, 926		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:10 am

						6/29/2020 8: 1	0 am
	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		PLANT - POB	PLANT - WJ	LINEN SERVICE	0.00	40.00	
	GENERAL SERVICE COST CENTERS	7. 02	7. 03	8.00	9. 00	10. 00	
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. 02	00103 CAP REL COSTS-BLDG & FIXT-WJ			•			1. 02
1. 03	00103 CAP REL COSTS-BLDG & FIXT-INTEREST			•			1. 03
2.00	00200 CAP REL COSTS-MVBLE EQUI P			•			2. 00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2. 02	00201 CAF REL COSTS-MVBLE EQUIP - MOB			•			2. 01
2. 02	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 02
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - MOB						7. 01
7. 02	00702 OPERATION OF PLANT - POB	327					7. 02
7. 03	00703 OPERATION OF PLANT - WJ	0	0	i			7. 03
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	24, 434			8. 00
9. 00	00900 HOUSEKEEPI NG	0	0	2, 959	l .		9. 00
10. 00	01000 DI ETARY	0	0	764	l	64, 787	10.00
11. 00	01100 CAFETERI A	0	0	0	1, 098	0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	446	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	Ö	0	0	14. 00
15. 00	01500 PHARMACY	0	0	0	402	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	i o	0	0	0	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
.,,	INPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		17.00
30.00	03000 ADULTS & PEDIATRICS	0	0	11, 201	4, 776	46, 045	30. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	1	l	18, 742	40. 00
43. 00	04300 NURSERY	0	0		· · ·	0	43. 00
	ANCILLARY SERVICE COST CENTERS		_				
50.00	05000 OPERATING ROOM	235	0	2, 545	4, 550	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	Ó	o	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	1, 941	2, 009	0	54.00
60.00	06000 LABORATORY	0	0	0	1, 052	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	294	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	159	1, 310	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	232	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	4	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	509	o	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	0	73. 00
76.00	03160 CARDI OPULMONARY	0	0	0	610	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0	2, 456	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0	0	3, 434	0	90. 02
90. 03	09003 WOUND CLINIC	0	0	0	137	0	90. 03
90. 04	09004 OP ORTHO CLINIC	0	0	0	0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	0	0	0	1, 613	0	90. 05
90.06	09006 INFUSION CLINIC	0	0	0	249	0	90. 06
91.00	09100 EMERGENCY	0	0	3, 309	1, 919	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
93.00	04950 OUTPATIENT PSYCH	0	0	0	632	0	93. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	235	0	24, 434	29, 629	64, 787	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	310	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	92	0	0	2, 514	0	192. 00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00	07950 VACANT	0	0	0	1, 048	0	194. 00
194. 02	2 07952 WEST JAY CLINIC	0	0	0	O	0	194. 02
194. 03	3 07953 JAY MERIDIAN URGENT CARE	0	0	0	646	0	194. 03
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	327	0	24, 434	34, 147	64, 787	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:10 am

COST Center Description					12/01/201/	6/29/2020 8: 1	0 am
CHIESTAL SERVICE COST ENTERS	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
SENERAL SERVICE COST CERTERS			ADMI NI STRATI ON				
SHINMAL STROYLE COST CINTIES							
1.00		11. 00	13. 00	14. 00	15. 00	16. 00	
1.01 0.010 CAP REL COSTS-BLOG & FIXT-NOB 1.02 1.03 0.010 CAP REL COSTS-BLOG & FIXT-AU 1.03							
1.02 0.102 CAP REL COSTS-BLD & FIXT-POR 1.03 0.103 0.104 CAP REL COSTS-BLD & FIXT-INTEREST 1.04 1.03 1.04 1.05 1.04 1.05 1.04 1.05							1
1.03 0.0103 CAP REL COSTS-BLO & FIXT-WJ 1.04 0.0146 CAP REL COSTS-BLO & FIXT-WJ 1.04 0.0146 CAP REL COSTS-DWILE EQUIP 1.08 2.0 0.020 CAP REL COSTS-DWILE EQUIP 1.00 0.0000 0.0000 0.000 0.0000 0.0000 0.0000							
1.04 0.0104 CAP REL COSTS-BLD & FIXT-INTEREST	1.02 O0102 CAP REL COSTS-BLDG & FIXT-POB						1. 02
2.00	1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ						1. 03
2.00	1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1. 04
2 02 0202 CAP REL COSTS-MINGLE EQUIP F - 708 4 0.0 03000 (JAPEL COSTS-MINGLE EQUIP F - 708 4 0.0 03000 (JAPEL COSTS-MINGLE EQUIP F - 708 5 0.0 03000 (JAPEL COSTS-MINGLE EQUIP F - 708 7 0.0 03000 (JAPEL COSTS-MINGLE EQUIP F - 708 7 0.0 03000 (JAPEL COSTS-MINGLE EQUIP F - 708 7 0.0 03000 (JAPEL COSTS-MINGLE EQUIP F - 708 7 0.0 03000 (JAPEL COSTS - 708 7 0.0 03000 (JAPEL C	2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
2, 03 0.0203 CAP PEL COSTS-MYBLE EQUIP P W 4.00 0.0400 (DELTOYE BERREIT S) EPRARTENT 4.00 0.0500 (DELTOYE BERREIT S) EPRARTENT 5.00 7.00 0.0500 (DEPARTION OF PLANT 0.00	2.01 OO201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
4, 00 00400 EMPLOYEE BENEFI IS DEPARTIKENT	2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
4. 00 00400 EMPLOYEE BEREFITS DEPARTWENT	2.03 O0203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
5,00							4.00
7.00							5. 00
7. 0. 00703 (DERENTI NO OF PLANT - MOB 7. 0. 00703 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENT NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (DERENTI NO OF PLANT - WJ 8. 0. 00 (7.00
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8.00 00800 LAINDRY & LINEN SERVICE							
9.00 00000 HOUSEKEPING							
10.00 01000 DIETRY							1
11. 00 01100 CAPETERIA							
13.00 01300 JULISIN CADMINISTRATION 8,926 79,457		111 1/13					
14. 00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 5 59.006 15.00 16.00 01600 PHARMACY 3, 669 0 0 0 0 0 0 0 0 0			70 457				
15.00 O1500 PHARMACY 3,659 0 65 59,006 15.00 17.00 17.00 17.00 NOLLA SERVICE 0 0 0 0 0 0 0 17.00 17.00 NOLLA SERVICE OST CENTERS				0 004			1
16. 00 O1600 MEDICAL RECORDS & LIBRARY O O O O O O O O O			0		FO 004		
17.00			0		59, 006	0	
IMPATI ENT ROUTINE SERVICE COST CENTERS			0	_	0		
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ANCILLARY SERVICE COST CENTERS					-1		
50.00		461	521	0	0	0	43.00
179 207 0 0 0 0 0 0 0 0 0		10.017	40.400		000		
53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 64.00 05400 RADIOLOGY-DI AGNOSTIC 6.033 0 3555 141 0 54.00 66.00 06600 LABORATORY 6.760 0 0 0 0 0 60.00 65.00 06500 RABORATORY 3.532 0 141 3 3 0 65.00 66.00 06600 PHYSI CAL THERAPY 3.504 0 29 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 715 0 3 0 0 67.00 68.00 06600 PHYSI CAL THERAPY 715 0 3 0 0 67.00 69.00 06600 SPECEH PATHOLOGY 104 0 0 0 0 0 68.00 69.00 06900 SELECTROCARDI OLOGY 104 0 0 0 0 0 0 69.00 06900 SELECTROCARDI OLOGY 104 0 0 0 0 0 0 69.00 0700 0700 0700 0700 0700 0700 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 2.345 0 0 71.00 72.00 07200 INPL. DEV. CHARGED TO PATI ENTS 0 0 0 2.766 0 0 72.00 73.00 07300 ORIGOS CHARGED TO PATI ENTS 0 0 0 0 57.452 0 73.00 76.00 03160 CARDI OPULLMONARY 1,078 45 14 0 0 76.00 79.01 09000 CLINIC 0 0 0 0 0 0 0 79.01 09000 CLINIC 0 0 0 0 0 0 79.02 09000 OLINIC 0 0 0 0 0 0 79.03 09003 MOUND CLINIC 398 620 35 0 0 0 0 79.04 09004 PORTHO CLINIC 0 0 0 0 0 0 79.05 09005 JAY FAMILLY FIRST HEALTH CARE 4,766 4,206 74 0 0 0 0 79.06 09005 ANY FAMILLY FIRST HEALTH CARE 4,766 4,206 74 0 0 0 0 79.00 09006 INFUSIO NO CLINIC 576 899 91 63 0 0 79.00 09006 INFUSIO NO CLINIC 576 899 91 63 0 0 79.00 09006 INFUSIO NO CLINIC 576 899 91 63 0 0 79.00 09006 INFUSIO NO CLINIC 576 899 91 63 0 0 79.00 09000 09000 00 00 00 00					ı		1
54.00 05400 RADIO LOCY-DI ARMOSTIC 6, 0.03 0 355 141 0 54.00 0.00 06000 LABORATORY 6, 760 0 0 0 0 0 0.00				=	0		
60.00 06.000 LABORATORY 6, 76.0 0 0 0 0 0 0 0 0 0			0		0		1
65.00 06500 RESPI RATORY THERAPY 3, 552 0 141 3 0 65.00 66.00 06600 PHYSI CAL THERAPY 715 0 3 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 715 0 3 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 104 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 2.345 0 0 71.00 72.00 072.00 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 2.76 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 57.452 0 73.00 76.00 03160 CARDI OPULMONARY 1,078 45 14 0 0 76.00 03160 CARDI OPULMONARY 1,078 45 14 0 0 76.00 00.01 09000 CLI NIC 0 0 0 0 0 0 0 00.01 09000 15MI LY PRACTICE OF JAY COUNTY 9,969 9,841 198 309 0 0 0 00.02 09002 JAY FAMILY MEDI CI NE 11,784 12,537 106 8 0 90.02 00.03 09003 WOUND CLINIC 0 0 0 0 0 0 0 0 0 00.04 09004 0P ORTHO CLINIC 0 0 0 0 0 0 0 0 0 00.05 09005 JAY FAMILY IFIRST HEALTH CARE 4,766 4,206 74 0 0 0 0 0 00.01 09000 0 0 0 0 0 0 0 0			0		141		1
66.00 06600 PHYSI CAL THERAPY 3,054 0 29 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 715 0 3 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 104 0 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 7 0 0 69.00 71.00 707100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 276 0 0 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 276 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 57.452 0 73.00 76.00 03160 CARDI OPULMONARY 1,078 45 14 0 0 76.00 79.01 09000 CINIT C 0 0 0 0 0 0 0 79.01 09000 CINIT C 0 0 0 0 0 0 79.02 09002 JAY FAMILY MEDI CINE 11,784 12,537 106 8 0 90.02 79.03 09003 WOUND CLINIC 0 0 0 0 0 0 0 0 79.05 09005 JAY FAMILY FIRST HEALTH CARE 4,766 4,206 74 0 0 0 0 79.04 09005 JAY FAMILY FIRST HEALTH CARE 4,766 4,206 74 0 0 0 79.05 09005 JAY FAMILY FIRST HEALTH CARE 576 899 91 63 0 90.00 79.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 565 0 0 0 0 0 0 79.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 565 0 0 0 0 0 79.00 09200 0FFIRST HEALTH CARE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 4 1 0 192.00 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 0 0 0 0 0 79.00 09200 0FFIRST HEALTH CAPE 1,781 0 0 0 0 0 79.00 09200 09200			0		0		1
67. 00 06700 0CCUPATI ONAL THERAPY 715 0 3 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 104 0 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 2,345 0 0 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 276 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 57, 452 0 73. 00 74. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 57, 452 0 73. 00 75. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 57, 452 0 73. 00 76. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 76. 00 07000 CLINIC 0 0 0 0 0 0 76. 00 07000 CLINIC 0 0 0 0 0 0 77. 00 07000 CLINIC 0 0 0 0 0 0 78. 00 07000 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 79. 02 09002 JAY FAMILY PRACTICE OF JAY COUNTY 9, 969 9, 841 198 309 0 90. 01 79. 02 09002 JAY FAMILY PRACTICE OF JAY COUNTY 9, 969 9, 841 198 309 0 90. 02 79. 03 09003 WOUND CLINIC 398 620 35 0 0 90. 02 79. 04 09004 0P ORTHO CLINIC 0 0 0 0 0 0 0 79. 05 09005 JAY FAMILY FIRST HEALTH CARE 4, 766 4, 206 74 0 0 90. 05 79. 06 09006 IAY FAMILY FIRST HEALTH CARE 4, 766 4, 206 74 0 0 90. 05 79. 00 09200 08SERVATION BEDS (NON-DISTINCT PART 8, 436 10, 470 840 413 0 91. 00 79. 00 09200 08SERVATION BEDS (NON-DISTINCT PART 8, 436 10, 470 840 413 0 91. 00 79. 00 09200 095ERVATION BEDS (NON-DISTINCT PART 9, 457 8, 787 59, 005 0 79. 00 09200 095ERVATION BEDS (NON-DISTINCT PART 9, 457 8, 787 59, 005 0 79. 00 09200 09005 00005 0000			0		3		
68.00 06800 SPECH PATHOLOGY			0	29	0		1
69,00 06900 ELECTROCARDIOLOGY	67. 00 06700 OCCUPATI ONAL THERAPY	715	0	3	0		67. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 2,345 0 0 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73.	68.00 06800 SPEECH PATHOLOGY	104	0	0	0	0	68. 00
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 276 0 0 72.00	69. 00 06900 ELECTROCARDI OLOGY	0	0	7	0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 57,452 0 73. 00 76. 00 03160 CARDI OPULMONARY 1,078 45 14 0 0 76. 00 0UTPATIENT SERVICE COST CENTERS	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2, 345	0	0	71.00
76. 00 03160 CARDI OPULMONARY 1, 078 45 14 0 0 76. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	276	0	0	72.00
90. 00 09000 CLINIC 0	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	57, 452	0	73.00
90. 00	76. 00 03160 CARDI OPULMONARY	1, 078	45	14	0	0	76.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 9, 969 9, 841 198 309 0 90. 01 90. 02 09002 JAY FAMILY MEDICINE 11, 784 12, 537 106 8 0 90. 02 90. 03 09003 WOUND CLINIC 398 620 35 0 0 90. 03 90. 04 09004 0P ORTHO CLINIC 0 0 0 0 0 0 90. 05 09005 JAY FAMILY FIRST HEALTH CARE 4, 766 4, 206 74 0 0 90. 05 90. 06 09006 INFUSION CLINIC 576 899 91 63 0 90. 06 91. 00 09100 EMERGENCY 8, 436 10, 470 840 413 0 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 92. 00 93. 00 04950 OUTPATIENT PSYCH 565 0 0 0 0 0 91. 00 SUBTOTALS (SUM OF LINES 1 through 117) 106, 440 79, 457 8, 787 59, 005 0 192. 00 19200 PHYSI CIANS' PRI VATE OFFICES 1, 781 0 4 1 0 192. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 194. 02 194. 00 07952 WEST JAY CLINIC 0 0 0 0 0 194. 02 194. 03 07953 JAY MERIDIAN URGENT CARE 2, 922 0 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 201. 00 Nogative Cost Centers 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 201. 00 0 0 0 0 200. 00 0 0 0 201. 00 0 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 200. 00 0 0 0 200. 00 0 0 0 200. 00 0 0 200. 00	OUTPATIENT SERVICE COST CENTERS						
90. 02	90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 03	90.01 09001 FAMILY PRACTICE OF JAY COUNTY	9, 969	9, 841	198	309	0	90. 01
90. 04	90.02 09002 JAY FAMILY MEDICINE	11, 784	12, 537	106	8	0	90. 02
90. 05	90. 03 09003 WOUND CLINIC	398	620	35	0	0	90. 03
90. 06 09006 INFUSION CLINIC 576 899 91 63 0 90. 06 91. 00 09100 EMERGENCY 8,436 10,470 840 413 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 04950 OUTPATIENT PSYCH 565 0 0 0 0 0 93. 00 93. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 106,440 79,457 8,787 59,005 0 118. 00 NONREI MBURSABLE COST CENTERS 1,781 0 4 1 0 192. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1,781 0 4 1 0 192. 00 193. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 0 194. 00 194. 00 194. 02 07952 WEST JAY CLINIC 0 0 0 0 0 194. 02 194. 03 079953 JAY MERIDIAN URGENT CARE 2,922 0 0 0 0 0 0 194. 02 200. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0	90. 04 09004 OP ORTHO CLINIC	0	0		0	0	90. 04
90. 06 09006 INFUSION CLINIC 576 899 91 63 0 90. 06 91. 00 09100 EMERGENCY 8, 436 10, 470 840 413 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 04950 OUTPATIENT PSYCH 565 0 0 0 0 0 93. 00 93. 00 94. 00 04950 OUTPATIENT PSYCH 565 0 0 0 0 0 0 0 0 0	90.05 09005 JAY FAMILY FIRST HEALTH CARE	4, 766	4, 206	74	0	0	90.05
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92. 00							
93. 00		.,					92.00
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 106,440 79,457 8,787 59,005 0 118.00	,	565	0	0	0	0	93.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 106, 440 79, 457 8, 787 59, 005 0 118. 00		000	<u> </u>	<u> </u>	۹۱		70.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1,781 0 4 1 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 VACANT 0 0 0 0 0 194. 00 194. 02 07952 WEST JAY CLINI C 0 0 13 0 0 194. 00 194. 03 07953 JAY MERI DI AN URGENT CARE 2,922 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00 201. 00 0 0 0 0 0 0 190. 00 0 0 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 0 190. 00 0 190. 00 0 0 190. 00 0 190. 00 0 0 190. 00 0 190. 00 0 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 0 190. 00 190. 00 0 190. 00 190. 00 0 190. 00 190.		106 440	79 457	8 787	59 005	0	118 00
190. 00 1900 1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 192. 00 192. 00 1920 1920 1920 1930 194		1007 110	, , , , , , ,	0, , 0, 1	07,000		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 1, 781 0 4 1 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 194. 00 194. 02 194. 02 194. 03 194. 03 194. 04 194. 05 194. 0		n	n	n	n	Ω	190.00
193. 00 19300 NONPAI D WORKERS			n	ا م	1		
194. 00 07950 VACANT		1,,,01	n	n	,		
194. 02 07952 WEST JAY CLINIC 0 0 13 0 0 194. 02 194. 03 07953 JAY MERIDIAN URGENT CARE 2, 922 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00		n	n	=	n		
194. 03 07953 JAY MERIDIAN URGENT CARE 2,922 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0			n	_	n		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	13	0		
201.00 Negative Cost Centers 0 0 0 0 201.00		2, 722	U I		٩	U	
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202.00 1017.2 (3011 111103 110 till 00gli 201) 111, 173 17, 407 0, 004 37, 000 0 202.00		111 1/2	70 157	2 201	59 006		
		111, 145	, , , , , , , ,	3, 304	07,000	O	,_02. 00

ALLOCAT	Cost Center Description		Provider C		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B Part II Date/Time Pre	nared
	Cost Center Description					6/29/2020 8: 1	O am
		SOCIAL SERVICE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
- In		17. 00	24. 00	25. 00	26.00		
-	GENERAL SERVICE COST CENTERS						1 00
1. 01 0 1. 02 0 1. 03 0 1. 04 0 2. 00 0 2. 01 0 2. 02 0 2. 03 0 4. 00 0 5. 00 0 7. 01 0 7. 01 0 7. 01 0 7. 03 0 8. 00 0 10. 00 0 11. 00 0 14. 00 0 15. 00 0 16. 00 0 17. 00 0 17. 00 0 17. 00 0 18. 00 0 19. 00 0 19. 00 0 10. 00 0 10. 00 0 11. 00 0 11. 00 0 12. 00 0 13. 00 0 14. 00 0 15. 00 0 16. 00 0 17. 00 0 17. 00 0 17. 00 0 17. 00 0 18. 00 0 19. 00 0 19. 00 0 19. 00 0 10. 00 0 11. 00 0 11. 00 0 12. 00 0 13. 00 0 14. 00 0 15. 00 0 16. 00 0 17. 00 0 17. 00 0 17. 00 0 17. 00 0 18. 00 0 19. 00 0 1	DO1001 CAP REL COSTS-BLDG & FIXT DO1011 CAP REL COSTS-BLDG & FIXT-MOB DO1002 CAP REL COSTS-BLDG & FIXT-MOB DO1003 CAP REL COSTS-BLDG & FIXT-POB DO1004 CAP REL COSTS-BLDG & FIXT-INTEREST DO2000 CAP REL COSTS-MVBLE EQUIP DO2001 CAP REL COSTS-MVBLE EQUIP - MOB DO2002 CAP REL COSTS-MVBLE EQUIP - POB DO2003 CAP REL COSTS-MVBLE EQUIP - WJ DO2000 CAPTATION OF PLANT DO2001 OPERATION OF PLANT DO2001 OPERATION OF PLANT - MOB DO2000 CAPETATION OF PLANT - WJ DO2000 CAPETATION OF PLANT - WJ DO2000 DIETARY DO2000 DIETARY DO2000 DIETARY DO2000 CAPETERIA DO2000 NURSING ADMINISTRATION DO2000 CAPETERIA DO2000 PHARMACY DO2000 MEDICAL RECORDS & LIBRARY DO2000 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	0					1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 2. 03 4. 00 5. 00 7. 00 7. 01 7. 02 7. 03 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
	03000 ADULTS & PEDIATRICS	0	584, 332	2 0	584, 332		30.00
1	04000 SUBPROVI DER - I PF	0	196, 902	1			40. 00
	04300 NURSERY	0	24, 571	0	24, 571		43. 00
50. 00 0 52. 00 0 53. 00 0 54. 00 0 65. 00 0 65. 00 0 66. 00 0 67. 00 0 68. 00 0 69. 00 0 71. 00 0 72. 00 0 73. 00 0	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESI OLOGY D5400 RADI OLOGY-DI AGNOSTIC D6000 LABORATORY D6500 RESPIRATORY THERAPY D6700 OCCUPATIONAL THERAPY D6700 OCCUPATIONAL THERAPY D6800 SPEECH PATHOLOGY D6900 ELECTROCARDI OLOGY D7100 MEDI CAL SUPPLIES CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS D7300 DRUGS CHARGED TO PATIENTS D3160 CARDI OPULMONARY	0 0 0 0 0 0 0 0 0 0	259, 650 9, 432 0 222, 171 133, 397 39, 651 139, 629 24, 799 790 807 5, 565 77, 724 16, 766		259, 650 9, 432 0 222, 171 133, 397 39, 651 139, 629 24, 799 790 807 5, 565 655 77, 724		50. 00 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
1	09000 CLINIC	0	0	0	0		90.00
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0	77, 604 103, 225		77, 604 103, 225		90. 01 90. 02
	09003 WOUND CLINIC		15, 122	1	15, 122		90. 03
	09004 OP ORTHO CLINIC		0	0	o		90. 04
	09005 JAY FAMILY FIRST HEALTH CARE	0	167, 602	1	167, 602		90.05
1	D9006 INFUSION CLINIC D9100 EMERGENCY		27, 435 232, 833	1	27, 435 232, 833		90. 06 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		232, 033) o	232, 033		92.00
1	04950 OUTPATIENT PSYCH	O	62, 675	1	62, 675		93.00
S	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 423, 337	0	2, 423, 337		118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30, 267	7 0	30, 267		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	43, 312		43, 312		192. 00
193. 00 1	19300 NONPALD WORKERS		0	O	0		193. 00
	07950 VACANT	0	102, 264		102, 264		194. 00
	07952 WEST JAY CLINIC	0	24, 160		24, 160		194. 02
	D7953 JAY MERIDIAN URGENT CARE	0	69, 371		69, 371		194. 03
200.00	Cross Foot Adjustments		0	0	0		200.00
201.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 0	0 2, 692, 711	0	0 2, 692, 711		201. 00 202. 00
202.00				. ()	۷, ۵۶۷, ۱۱۱۱		12U2. UU

						6/29/2020 8:1	0 am
			CAP	ITAL RELATED CO	OSTS		
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ	BLDG &	
	Cost Center Description	(SQUARE FEET)	FIXT-MOB	FIXT-POB	DLDG & FIXI-WJ	FIXT-INTEREST	
		(040/11/2 / 22/)	(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)	
			FÈET-MOB)	FÈET-POB)	FEET-WJ)	,	
	T	1.00	1. 01	1. 02	1. 03	1. 04	
4 00	GENERAL SERVICE COST CENTERS	00.044					1 4 00
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 CAP REL COSTS-BLDG & FIXT-MOB	82, 011 0	10 124				1. 00 1. 01
1.01	00101 CAP REL COSTS-BLDG & FIXT-WOB	0	19, 126	9, 538			1.01
1. 02	00103 CAP REL COSTS-BLDG & FIXT-WJ		0	7, 330	6, 953		1. 02
1. 04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	l o	0	Ö	0,755	82, 011	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 EQUIP - WJ						2. 03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	113	0	0	0	113	4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	10, 753	1, 419 496	0 615	0	10, 753	5. 00 7. 00
7. 00 7. 01	00700 OPERATION OF PLANT - MOB	14, 941	490	013	0	14, 941 0	7.00
7. 02	00702 OPERATION OF PLANT - POB		0	0	0	Ö	7. 02
7. 03	00703 OPERATION OF PLANT - WJ	l o	0	Ö	0	Ö	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	594	0	0	0	594	8. 00
9.00	00900 HOUSEKEEPI NG	600	0	0	0	600	9. 00
10.00	01000 DI ETARY	1, 543	0	0	0	1, 543	10.00
11. 00	01100 CAFETERI A	2, 729	0	0	0	2, 729	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 109	0	0	0	1, 109	
14. 00 15. 00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY	1,000	0	0	0	0 1, 000	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1,000	0	0	0	1,000	16.00
17. 00	01700 SOCIAL SERVICE	l o	0	Ö	0	Ö	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	11, 872	0	0	0	11, 872	30. 00
40. 00	04000 SUBPROVI DER - I PF	3, 651	0	0			40. 00
43. 00	04300 NURSERY	563	0	0	0	563	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	3, 992	915	6, 402	0	3, 992	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	220	913	0, 402	0	220	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	Ö	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 994	0	0	0	4, 994	54.00
60.00	06000 LABORATORY	2, 615	0	0	0	2, 615	60.00
65.00	06500 RESPI RATORY THERAPY	731	0	0	0	731	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 256	0	0	0	3, 256	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	576 10	0	0	0	576 10	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	10	0	0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0	Ö	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 00	03160 CARDI OPULMONARY	0	1, 516	0	0	0	76. 00
90. 00	OUTPATIENT SERVICE COST CENTERS		0		0	0	90.00
90.00	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY		6, 104		0	0	90.00
90. 02	09002 JAY FAMILY MEDICINE		8, 536	Ö	0	ő	90. 02
90. 03	09003 WOUND CLINIC	341	0	0	0	341	90. 03
90. 04	09004 OP ORTHO CLINIC	0	0	0	0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	3, 868	140	0	0	3, 868	1
90.06	09006 I NFUSI ON CLINI C	618	0	0	0	618	90.06
91. 00 92. 00	09100 EMERGENCY	4, 770	O	0	O	4, 770	91. 00 92. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	1, 571	0	0	0	1, 571	1
70.00	SPECIAL PURPOSE COST CENTERS	1,071	<u> </u>		<u> </u>	1,071	70.00
118.00		77, 030	19, 126	7, 017	0	77, 030	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0	0	_		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	0	0	2, 521 0			192. 00 193. 00
	07950 VACANT	2, 605	0				194. 00
	07952 WEST JAY CLINIC	0	0	Ö	3, 225		194. 02
	07953 JAY MERIDIAN URGENT CARE	1, 605	0	0	0		194. 03
200.00	1 1						200. 00
201.00		055					201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	858, 094	0	0	0	0	202. 00
203.00	1 /	10. 463157	0. 000000	0. 000000	0. 000000	0. 000000	203. 00
	, , , , , , , , , , , , , , , , , , ,			, , , , , , , , , , , , , , , , , , , ,	,		

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-1			
COST ALLOCATION - STATISTICAL BASIS	Provider CCN: 15-1320	Period: From 01/01/2019	Worksheet B-1		
			Date/Time Prepared: 6/29/2020 8:10 am		
	CAPITAL PELATED	COSTS			

						6/29/2020 8:1	<u>u am</u>
			CAP	ITAL RELATED (COSTS		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB	BLDG & FLXT-POB	BLDG & FIXT-WJ	BLDG & FIXT-INTEREST	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)	
			FÈET-MOB)	FÈET-POB)	FEET-WJ)	, ,	
		1.00	1. 01	1. 02	1. 03	1. 04	
204.00	Cost to be allocated (per Wkst. B, Part II)						204. 00
205.00	Unit cost multiplier (Wkst. B, Part						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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1320 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:10 am CAPITAL RELATED COSTS MVBLE EQUIP Cost Center Description MVBLE EQUIP -MVBLE EQUIP - MVBLE EQUIP -**EMPLOYEE** (SOUARE FEET) MOB POB **BENEFITS** W.J (SQUARE (SQUARE (SQUARE DEPARTMENT FEET-MOB) FEET-POB) FEET-WJ) (GROSS SALARI ES) 2.00 2. 01 2.02 2. 03 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.02 00103 CAP REL COSTS-BLDG & FIXT-WJ 1 03 1 03 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 1.04 1.04 2.00 00200 CAP REL COSTS-MVBLE EQUIP 82,011 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.01 0 19.126 00202 CAP REL COSTS-MVBLE EQUIP - POB 2 02 9.538 0 2 02 2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 6, 953 2.03 00400 EMPLOYEE BENEFITS DEPARTMENT 12, 014, 727 4.00 113 0 4.00 00500 ADMINISTRATIVE & GENERAL 10, 753 425, 408 5.00 1.419 5.00 0 0 00700 OPERATION OF PLANT 14, 941 7 00 496 615 0 310, 937 7.00 7.01 00701 OPERATION OF PLANT - MOB 7.01 0 C C 0 00702 OPERATION OF PLANT - POB 7.02 0 0 0 7.02 0 00703 OPERATION OF PLANT - WJ 7.03 0 0 7.03 0 0 8.00 00800 LAUNDRY & LINEN SERVICE 594 C 0 44.630 8 00 o 9.00 00900 HOUSEKEEPI NG 600 384, 987 9.00 10.00 01000 DI ETARY 1,543 0 116, 650 10.00 0 01100 CAFETERI A 11.00 0 206, 347 2,729 0 11.00 01300 NURSING ADMINISTRATION 0 13.00 1, 109 Ω 1, 188, 820 13.00 0 01400 CENTRAL SERVICES & SUPPLY 0 14.00 160 14.00 15.00 01500 PHARMACY 1,000 0 480, 020 15.00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 16, 00 0 C 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 11, 872 0 0 0 1, 526, 891 30.00 04000 SUBPROVIDER - IPF 0 0 40.00 3,651 Ω 898, 072 40.00 04300 NURSERY 43.00 57, 106 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 1, 256, 143 50.00 3.992 915 6, 402 52.00 05200 DELIVERY ROOM & LABOR ROOM 220 0 22, 375 52.00 C 05300 ANESTHESI OLOGY 53.00 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 4, 994 54.00 0 0 734.829 54.00 06000 LABORATORY 0 0 60.00 2,615 Ω 60.00 0 65.00 06500 RESPIRATORY THERAPY 731 0 0 383, 727 65.00 66.00 06600 PHYSI CAL THERAPY 3, 256 0 476, 558 66.00 67 00 06700 OCCUPATIONAL THERAPY 0 0 576 87, 175 67 00 06800 SPEECH PATHOLOGY 68.00 10 C 0 17, 435 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 O 72 00 72 00 C 0 |07300| DRUGS CHARGED TO PATIENTS 73.00 0 0 0 0 73.00 03160 CARDI OPULMONARY 109, 921 76.00 1.516 0 0 76.00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 O 0 0 90 00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0 6, 104 0 0 581, 574 90.01 09002 JAY FAMILY MEDICINE 0 90.02 8,536 697, 161 90.02 0 09003 WOUND CLINIC 0 90.03 90.03 341 C 38, 398 09004 OP ORTHO CLINIC 0 90 04 90 04 0 C 0 90.05 09005 JAY FAMILY FIRST HEALTH CARE 3,868 140 0 0 307, 734 90.05 09006 INFUSION CLINIC 0 0 90 06 618 C 85, 402 90.06 91 00 09100 EMERGENCY 0 0 989, 001 91 00 4.770 C 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 04950 OUTPATIENT PSYCH 93.00 1,571 0 0 23, 691 93.00 SPECIAL PURPOSE COST CENTERS 19, 126 7,017 11, 451, 152 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 77.030 0 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 771 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 2, 521 3, 728 109, 150 192, 00 0 0 193. 00 19300 NONPALD WORKERS Λ C 0 193.00 C 194. 00 07950 VACANT 0 194. 00 2,605 0 194.02 07952 WEST JAY CLINIC C 0 3, 225 270, 464 194. 02 194. 03 07953 JAY MERIDIAN URGENT CARE 183, 961 194. 03 1,605 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 2, 788, 216 202. 00 202.00 Cost to be allocated (per Wkst. B, 1, 810, 612 24,005 Part I)

1. 255098

0.000000

0.000000

22.077673

0. 232067 203. 00

Unit cost multiplier (Wkst. B, Part I)

203.00

Health Financial Systems		IU HEALTH JA	IU HEALTH JAY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLO	OCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1			
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:1			
			CAPI TAL REI	LATED COSTS					
	Cost Center Description	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE	MVBLE EQUIP POB (SQUARE	- MVBLE EQUIP - WJ (SQUARE	EMPLOYEE BENEFITS DEPARTMENT			
			FEET-MOB)	FEET-POB)	FEET-WJ)	(GROSS SALARI ES)			
		2.00	2. 01	2. 02	2. 03	4. 00			
204. 00	Cost to be allocated (per Wkst. B, Part II)					3, 677	204. 00		
205. 00	Unit cost multiplier (Wkst. B, Part					0. 000306	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		

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1320

					10	12/31/2019	Date/lime Pre 6/29/2020 8:1	
		Cost Center Description	Reconciliation	ADMI NI STRATI VE		OPERATION OF	OPERATION OF	
				& GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	PLANT - MOB (SQUARE	PLANT - POB (SQUARE	
					· ·	FEET-MOB)	FEET-POB)	
	CENED	AL CERVICE COCT CENTERS	5A	5. 00	7. 00	7. 01	7. 02	
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	1	CAP REL COSTS-BLDG & FIXT-WJ						1. 03
1.04		CAP REL COSTS-BLDG & FIXT-INTEREST						1. 04
2. 00 2. 01		CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB						2. 00 2. 01
2.01	1	CAP REL COSTS-MVBLE EQUIP - MOB						2.01
2. 03		CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00		ADMINISTRATIVE & GENERAL	-9, 102, 031	26, 314, 521				5. 00
7.00	1	OPERATION OF PLANT	0	2, 843, 884		17 211		7.00
7. 01 7. 02		OPERATION OF PLANT - MOB OPERATION OF PLANT - POB	0	70, 697 24, 465		17, 211 0	8, 923	7. 01 7. 02
7. 03		OPERATION OF PLANT - WJ	Ö	0		o	0, 720	7. 03
8.00		LAUNDRY & LINEN SERVICE	0	119, 597	594	o	0	8. 00
9.00	1	HOUSEKEEPI NG	0	599, 719		0	0	9. 00
10.00	1	DI ETARY	0	305, 495		0	0	10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	0	384, 056 2, 027, 877		0	0	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	0	658, 478		0	0	14. 00
15. 00		PHARMACY	o	1, 220, 097		o	0	15. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	0	0		О	0	16. 00
17. 00		SOCI AL SERVI CE	0	0	0	0	0	17. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	0	2 422 004	11 070	ما	0	20.00
30. 00 40. 00		ADULTS & PEDIATRICS SUBPROVIDER - IPF	0	_,, .	· ·	0	0	30. 00 40. 00
43. 00	1	NURSERY	Ö	., ,		o	0	43. 00
		LARY SERVICE COST CENTERS				1		
50.00	1	OPERATING ROOM	0	1, 911, 716		915	6, 402	50.00
52.00		DELIVERY ROOM & LABOR ROOM	0	37, 218		0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0 1, 465, 864	1	ol Ol	0	53. 00 54. 00
60.00	1	LABORATORY	0	1, 878, 697		o	0	60.00
65. 00	1	RESPI RATORY THERAPY	0	559, 356		o	0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	735, 718		0	0	66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	126, 522		0	0	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	21, 807 21, 753		0	0	68. 00 69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	240, 803		0	0	71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	28, 318		ō	0	72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	1, 516, 241		0	0	73. 00
76. 00		CARDI OPULMONARY	0	305, 680	1, 516	1, 516	0	76. 00
00 00		TIENT SERVICE COST CENTERS CLINIC	0	0	0	ol	0	90. 00
90. 00	1	FAMILY PRACTICE OF JAY COUNTY	0	805, 738		6, 104	0	
90. 02	1	JAY FAMILY MEDICINE	0	1, 030, 611		8, 536	0	90. 02
90. 03		WOUND CLINIC	0	61, 283	341	О	0	90. 03
90. 04	1	OP ORTHO CLINIC	0	0	0	0	0	90. 04
90. 05	1	JAY FAMILY FIRST HEALTH CARE	0	541, 205		140 0	0	90. 05
90. 06 91. 00		INFUSION CLINIC EMERGENCY	0	133, 749 1, 786, 145		0	0	90. 06 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART		1, 700, 143	4,770	Ĭ	O	92. 00
93. 00		OUTPATIENT PSYCH	0	83, 275	1, 571	0	0	•
		AL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	-9, 102, 031	25, 356, 616	74, 836	17, 211	6, 402	118. 00
190 00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	25, 089	771	ol	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	Ö	160, 842		Ö		192. 00
193.00	19300	NONPALD WORKERS	0	0		ō	0	193. 00
		VACANT	0	84, 769		0		194. 00
	1	WEST JAY CLINIC	0	381, 800		0		194. 02
194. 03 200. 00		JAY MERIDIAN URGENT CARE Cross Foot Adjustments		305, 405	1, 605	O	0	194. 03 200. 00
200.00		Negative Cost Centers						200.00
202.00		Cost to be allocated (per Wkst. B,		9, 102, 031	3, 827, 564	95, 151	32, 927	
		Part I)				_		
203.00	1	Unit cost multiplier (Wkst. B, Part I)		0. 345894		5. 528499	3. 690127	
204.00	,	Cost to be allocated (per Wkst. B, Part II)		351, 822	524, 926	945	327	204. 00
	I	1	ı	ı	1	ı		ı

Health Fina	ncial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	
			& GENERAL	PLANT	PLANT - MOB	PLANT - POB	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE	(SQUARE	
					FEET-MOB)	FEET-POB)	
		5A	5. 00	7. 00	7. 01	7. 02	
205. 00	Unit cost multiplier (Wkst. B, Part		0. 013370	5. 87882	0. 054907	0. 036647	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	IU HEALTH JA		ON 45 4000 D		u of Form CMS-2	<u> 2552-10</u>
COST	ALLOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Pre 6/29/2020 8:1	
	Cost Center Description	OPERATION OF PLANT - WJ (SQUARE FEET-WJ)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
		7. 03	8.00	9. 00	10.00	11. 00	
14. 00 15. 00 16. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-MOB 00103 CAP REL COSTS-BLDG & FIXT-MOB 00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP - MOB 00201 CAP REL COSTS-MVBLE EQUIP - POB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 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 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	6, 953 0 0 0 0 0 0	46, 080 5, 580 1, 440 0 0 0 0	84, 872 1, 543 2, 729 1, 109 0 1, 000	12, 963	19, 287 1, 549 0 635 0	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 2. 03 4. 00 5. 00 7. 01 7. 02 7. 03 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
30. 00 40. 00 43. 00	03000 ADULTS & PEDIATRICS 04000 SUBPROVIDER - IPF 04300 NURSERY	0 0 0	21, 125 1, 140 835	3, 651	9, 213 3, 750 0	2, 605 1, 426 80	30. 00 40. 00 43. 00
72. 00 73. 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	0 0 0 0 0 0 0 0	4, 800 0 0 3, 660 0 300 0 960 0 0	220 0 4, 994 2, 615 731 3, 256 576 10 0 0	0 0 0 0 0	2, 120 311 0 1, 047 1, 173 613 530 124 18 0 0 0	50. 00 52. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 71. 00 72. 00 73. 00 76. 00
90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH SPECIAL PURPOSE COST CENTERS	0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 6, 240	6, 104 8, 536 341 0 4, 008 618 4, 770	0 0 0 0 0 0 0	0 1, 730 2, 045 69 0 827 100 1, 464	92. 00 93. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	46, 080	73, 642	12, 963	18, 471	118. 00
192.00 193.00 194.00 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPALD WORKERS 07950 VACANT 207952 WEST JAY CLINIC 807953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments Negative Cost Centers	0 3, 728 0 0 3, 225 0	0 0 0 0 0 0 0	771 6, 249 0 2, 605 0 1, 605	0 0 0 0	309 0 0	190. 00 192. 00 193. 00 194. 00 194. 02 194. 03 200. 00 201. 00 202. 00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)	0. 000000	4. 045747 24, 434	10. 079331	38. 469876 64, 787	34. 291855 111, 143	203. 00

Health Fina	ncial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2019	Worksheet B-1	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT - WJ	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MAN HOURS)	
		(SQUARE	(POUNDS OF				
		FEET-WJ)	LAUNDRY)				
		7. 03	8. 00	9. 00	10.00	11. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 530252	0. 40233	5 4. 997840	5. 762586	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

Health Financial Systems	IU HEALTH JAY				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provi der CC		eriod: com 01/01/2019 o 12/31/2019	Worksheet B-1 Date/Time Pre 6/29/2020 8:1	pared:
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUIS.)	RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	
	(DI RECT NRSI NG HRS)	(COSTED REQUIS.)		(GROSS CHARGES)		
	13.00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVI CE COST CENTERS						
1.00	8, 841 0 0 0	904, 019 6, 709 0 0	1, 557, 249 0 0	94, 763, 214 0	0	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 2. 03 4. 00 5. 00 7. 01 7. 02 7. 03 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	1, 889	96, 658	10, 231	8, 907, 287	0	30.00
40. 00 04000 SUBPROVI DER - I PF	1, 114	4, 389	9	2, 212, 200	0	
43. 00 04300 NURSERY	58	0	0	207, 215	0	43. 00
ANCI LLARY SERVI CE COST CENTERS	1 4/0	221 127	4 013	20. 7/0. 122	0	F0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 460 23	331, 136 0	6, 013 0	20, 769, 132 1, 339, 572	0	
53. 00 05300 ANESTHESI OLOGY	0	ő	Ö	1, 337, 372	0	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	36, 413	3, 730	11, 346, 101	0	1
60. 00 06000 LABORATORY	0	0	0	8, 927, 999	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	14, 453	81	1, 178, 512	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 951	0	1, 417, 082	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	278	0	300, 745	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	14, 646	0	
69. 00 06900 ELECTROCARDI OLOGY	0	711	0	880, 483 1, 208, 669	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	240, 803 28, 318	0	437, 550		
73. 00 07300 DRUGS CHARGED TO PATIENTS		20, 310	1, 516, 241	10, 726, 684	0	1
76. 00 03160 CARDI OPULMONARY	5	1, 420	0	2, 253, 308	0	1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	1, 095 1, 395	20, 332 10, 839	8, 146 205	1, 258, 334 1, 068, 471	0	
90. 03 09003 WOUND CLINIC	69	3, 599	203	115, 619	0	1
90. 04 09004 OP ORTHO CLINIC	0	0	0	50, 563	0	1
90.05 09005 JAY FAMILY FIRST HEALTH CARE	468	7, 608	0	243, 853	0	90. 05
90. 06 09006 INFUSION CLINIC	100	9, 371	1, 669	1, 951, 392	0	
91. 00 09100 EMERGENCY	1, 165	86, 265	10, 890	17, 740, 970	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 OUTPATIENT PSYCH	0	12	0	206, 827	0	92. 00 93. 00
SPECIAL PURPOSE COST CENTERS		12	<u> </u>	200, 021	0	75.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 841	902, 265	1, 557, 215	94, 763, 214	0	118. 00
NONREI MBURSABLE COST CENTERS		4.7	al	ام		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	17 402	0 34	0		190. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	402	0	0		193. 00
194. 00 07950 VACANT	0	o	0	0		194. 00
194.02 07952 WEST JAY CLINIC	0	1, 335	0	0		194. 02
194. 03 07953 JAY MERIDIAN URGENT CARE	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00
202.00 Regative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	2, 841, 142	886, 242	1, 723, 418	n	n	201.00
Part I)		550, 2 72	., .20, 110	Ĭ		
203.00 Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	321. 359801 79, 457	0. 980336 8, 804	1. 106707 59, 006	0. 000000 0	0. 000000 0	203. 00 204. 00
	<u> </u>	<u> </u>	<u> </u>			

Heal th Finar	ncial Systems	IU HEALTH JAY	/ HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY	(TIME SPENT)	
		(DIRECT NRSING	(COSTED		(GROSS		
		HRS)	REQUIS.)		CHARGES)		
		13. 00	14.00	15. 00	16. 00	17. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	8. 987332	0. 009739	0. 03789	0. 000000	0. 000000	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

From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/29/2020 8:10 am Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 5, 133, 223 30 00 5, 133, 223 5, 133, 223 40.00 04000 SUBPROVIDER - IPF 2, 491, 767 2, 491, 767 0 2, 491, 767 40.00 04300 NURSERY 43.00 182, 483 182, 483 0 182, 483 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 092, 993 4, 092, 993 4, 092, 993 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 70, 193 70, 193 0 70, 193 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53.00 2, 327, 844 2, 327, 844 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 327, 844 54 00 60.00 06000 LABORATORY 2, 707, 203 2, 707, 203 2, 707, 203 60.00 65.00 06500 RESPIRATORY THERAPY 826, 817 826, 817 826, 817 65.00 06600 PHYSI CAL THERAPY 1, 184, 870 0 1, 184, 870 1, 184, 870 66.00 66.00 06700 OCCUPATIONAL THERAPY 205, 307 205, 307 0 205, 307 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 30, 497 30, 497 30, 497 68.00 06900 ELECTROCARDI OLOGY 33, 858 69.00 33, 858 0 33, 858 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 560 163 560 163 560 163 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 65,874 65, 874 65, 874 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 718, 733 3, 718, 733 0 3, 718, 733 73.00 03160 CARDI OPULMONARY 76.00 509, 471 509, 471 0 509, 471 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 1, 881, 524 1, 881, 524 1, 881, 524 90. 01 0 0 0 90.01 90 02 09002 JAY FAMILY MEDICINE 2.415.504 2, 415, 504 2, 415, 504 90 02 09003 WOUND CLINIC 90.03 128, 602 128, 602 128, 602 90.03 90.04 09004 OP ORTHO CLINIC 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 90.05 1, 127, 598 1, 127, 598 0 1, 127, 598 90.05 09006 INFUSION CLINIC 90 06 259, 331 259, 331 259, 331 90.06 91.00 09100 EMERGENCY 3, 202, 965 3, 202, 965 3, 202, 965 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 433, 909 1, 433, 909 1, 433, 909 92.00 93. 00 | 04950 | OUTPATIENT PSYCH 198, 630 198, 630 198, 630 93.00

34, 789, 359

1, 433, 909

33, 355, 450

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33, 355, 450

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0

34, 789, 359 200. 00

1, 433, 909 201. 00

33, 355, 450 202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

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

From 01/01/2019 To 12/31/2019 Part I Date/Time Prepared: 6/29/2020 8:10 am Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 970, 129 03000 ADULTS & PEDIATRICS 3, 970, 129 30.00 30.00 40.00 04000 SUBPROVIDER - IPF 2, 212, 200 2, 212, 200 40.00 04300 NURSERY 207, 215 207, 215 43.00 43.00 ANCILLARY SERVICE COST CENTERS 4, 415, 696 0.000000 50.00 16, 353, 436 20, 769, 132 0.197071 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 910, 635 428, 937 1, 339, 572 0.052400 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.205167 54.00 660,056 10, 686, 045 0.000000 11, 346, 101 54.00 8, 927, 999 0.000000 60.00 06000 LABORATORY 1, 632, 941 7, 295, 058 0. 303226 60 00 65.00 06500 RESPIRATORY THERAPY 641, 167 537, 345 1, 178, 512 0.701577 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 195, 861 1, 221, 221 1, 417, 082 0.836134 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 300, 745 0.682661 0.000000 67.00 128, 434 172, 311 67.00 68.00 06800 SPEECH PATHOLOGY 2, 936 11, 710 14, 646 2.082275 0.000000 68.00 06900 ELECTROCARDI OLOGY 91, 892 788, 591 880, 483 0.038454 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 600, 234 608, 435 1, 208, 669 0.463454 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 389, 704 0.150552 0.000000 72 00 72 00 47.846 437, 550 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 407, 622 8, 319, 062 10, 726, 684 0.346681 0.000000 73.00 03160 CARDI OPULMONARY 0.000000 76.00 271,015 1, 982, 293 2, 253, 308 0.226099 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 590 1, 257, 744 1, 258, 334 1.495250 0.000000 90.01 09002 JAY FAMILY MEDICINE 1,067,703 90. 02 768 1,068,471 2. 260711 0.000000 90.02 90.03 09003 WOUND CLINIC 0 115, 619 115, 619 1 112291 0 000000 90 03 90.04 09004 OP ORTHO CLINIC 0 50, 563 50, 563 0.000000 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 141 243, 712 243, 853 4. 624089 0.000000 90.05 90.06 09006 INFUSION CLINIC 1, 951, 392 1, 951, 392 0.132895 0.000000 90.06 0 09100 EMERGENCY 17, 740, 970 0.180541 0.000000 91.00 875, 139 16, 865, 831 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 350 4, 926, 808 4, 937, 158 0.290432 0.000000 92.00 04950 OUTPATIENT PSYCH 0.960368 93.00 250 206, 577 206, 827 0.000000 93.00 200 00 Subtotal (see instructions) 19, 283, 117 75, 480, 097 94, 763, 214 200 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 19, 283, 117 75, 480, 097 94, 763, 214 202.00

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 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

				To 12/31/2019	Date/Time Prepared: 6/29/2020 8:10 am
			Title XVIII	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
	·	Ratio			
		11. 00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS				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. 197071			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 052400			52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 205167			54.00
60.00	06000 LABORATORY	0. 303226			60.00
65.00	06500 RESPIRATORY THERAPY	0. 701577			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 836134			66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 682661			67. 00
68.00	06800 SPEECH PATHOLOGY	2. 082275			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 038454			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 463454			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 150552			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 346681			73. 00
76.00	03160 CARDI OPULMONARY	0. 226099			76. 00
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0. 000000			90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1. 495250			90. 01
90. 02	09002 JAY FAMILY MEDICINE	2. 260711			90. 02
90. 03	09003 WOUND CLINIC	1. 112291			90. 03
90. 04	09004 OP ORTHO CLINIC	0. 000000			90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	4. 624089			90. 05
90.06	09006 INFUSION CLINIC	0. 132895			90.06
91.00	09100 EMERGENCY	0. 180541			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 290432			92. 00
	04950 OUTPATI ENT PSYCH	0. 960368			93. 00
200.00					200. 00
201.00					201. 00
202.00	Total (see instructions)				202. 00

From 01/01/2019 Part I 12/31/2019 Date/Time Prepared: 6/29/2020 8:10 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 5, 133, 223 30 00 5, 133, 223 5, 133, 223 40.00 04000 SUBPROVIDER - IPF 2, 491, 767 2, 491, 767 0 2, 491, 767 40.00 04300 NURSERY 43.00 182, 483 182, 483 0 182, 483 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 092, 993 4, 092, 993 4, 092, 993 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 70, 193 70, 193 0 70, 193 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 53.00 2, 327, 844 2, 327, 844 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 327, 844 54 00 60.00 06000 LABORATORY 2, 707, 203 2, 707, 203 2, 707, 203 60.00 65.00 06500 RESPIRATORY THERAPY 826, 817 826, 817 826, 817 65.00 06600 PHYSI CAL THERAPY 1, 184, 870 0 1, 184, 870 1, 184, 870 66.00 66.00 06700 OCCUPATIONAL THERAPY 205, 307 0 205, 307 205, 307 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 30, 497 30, 497 30, 497 68.00 06900 ELECTROCARDI OLOGY 33, 858 69.00 33, 858 0 33, 858 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 560 163 560 163 560 163 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 65,874 65, 874 65, 874 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 718, 733 3, 718, 733 0 3, 718, 733 73.00 03160 CARDI OPULMONARY 76.00 509, 471 509, 471 0 509, 471 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 1, 881, 524 1, 881, 524 1, 881, 524 90. 01 0 0 0 90.01 90 02 09002 JAY FAMILY MEDICINE 2.415.504 2, 415, 504 2, 415, 504 90 02 09003 WOUND CLINIC 90.03 128, 602 128, 602 128, 602 90.03 90.04 09004 OP ORTHO CLINIC 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 90.05 1, 127, 598 1, 127, 598 0 1, 127, 598 90.05 09006 INFUSION CLINIC 90 06 259, 331 259, 331 259, 331 90.06 91.00 09100 EMERGENCY 3, 202, 965 3, 202, 965 3, 202, 965 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 433, 909 1, 433, 909 1, 433, 909 92.00 93. 00 | 04950 | OUTPATIENT PSYCH 198, 630 198, 630 198, 630 93.00 34, 789, 359 34, 789, 359 0 34, 789, 359 200. 00 200.00 Subtotal (see instructions) Ω

1, 433, 909

33, 355, 450

1, 433, 909

33, 355, 450

1, 433, 909 201. 00

33, 355, 450 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

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 12/31/2019 Date/Time Prepared: 6/29/2020 8:10 am Title XIX Hospi tal PPS 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 3, 970, 129 03000 ADULTS & PEDIATRICS 3, 970, 129 30.00 30.00 40.00 04000 SUBPROVIDER - IPF 2, 212, 200 2, 212, 200 40.00 04300 NURSERY 207, 215 207, 215 43.00 43.00 ANCILLARY SERVICE COST CENTERS 4, 415, 696 0.000000 50.00 16, 353, 436 20, 769, 132 0.197071 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 910, 635 428, 937 1, 339, 572 0.052400 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.205167 54.00 660,056 10, 686, 045 0.000000 11, 346, 101 54.00 8, 927, 999 0.000000 60.00 06000 LABORATORY 1, 632, 941 7, 295, 058 0. 303226 60 00 65.00 06500 RESPIRATORY THERAPY 641, 167 537, 345 1, 178, 512 0.701577 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 195, 861 1, 221, 221 1, 417, 082 0.836134 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 300, 745 0.682661 0.000000 67.00 128, 434 172, 311 67.00 68.00 06800 SPEECH PATHOLOGY 2, 936 11, 710 14, 646 2.082275 0.000000 68.00 06900 ELECTROCARDI OLOGY 91, 892 788, 591 880, 483 0.038454 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 600, 234 608, 435 1, 208, 669 0.463454 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.150552 389, 704 0.000000 72 00 72 00 47.846 437, 550 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 407, 622 8, 319, 062 10, 726, 684 0.346681 0.000000 73.00 03160 CARDI OPULMONARY 0.000000 76.00 271,015 1, 982, 293 2, 253, 308 0.226099 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 590 1, 257, 744 1, 258, 334 1.495250 0.000000 90.01 09002 JAY FAMILY MEDICINE 1,067,703 90. 02 768 1,068,471 2. 260711 0.000000 90.02 90.03 09003 WOUND CLINIC 0 115, 619 115, 619 1 112291 0 000000 90 03 90.04 09004 OP ORTHO CLINIC 0 50, 563 50, 563 0.000000 0.000000 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 141 243, 712 243, 853 4. 624089 0.000000 90.05 90.06 09006 INFUSION CLINIC 1, 951, 392 1, 951, 392 0.132895 0.000000 90.06 0 09100 EMERGENCY 17, 740, 970 0.180541 0.000000 91.00 875, 139 16, 865, 831 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 350 4, 926, 808 4, 937, 158 0.290432 0.000000 92.00 04950 OUTPATIENT PSYCH 0.960368 93.00 250 206, 577 206, 827 0.000000 93.00 200 00 Subtotal (see instructions) 19, 283, 117 75, 480, 097 94, 763, 214 200 00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 19, 283, 117 75, 480, 097 94, 763, 214 202.00

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: Worksheet C From 01/01/2019 Part I
		To 12/31/2019 Date/Time Prepared:

				To 12/31/2019	Date/Time Prepared 6/29/2020 8:10 am	
			Title XIX	Hospi tal	PPS	_
	Cost Center Description	PPS Inpatient		<u> </u>		
	'	Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.	00
40.00	04000 SUBPROVI DER - I PF				40.	00
43.00	04300 NURSERY				43.	00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	0. 197071			50.	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 052400			52.	
53.00	05300 ANESTHESI OLOGY	0. 000000			53.	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 205167			54.	
60.00	06000 LABORATORY	0. 303226			60.	00
65.00	06500 RESPI RATORY THERAPY	0. 701577			65.	00
66.00	06600 PHYSI CAL THERAPY	0. 836134			66.	00
67.00	06700 OCCUPATI ONAL THERAPY	0. 682661			67.	00
68. 00	06800 SPEECH PATHOLOGY	2. 082275			68.	00
69. 00	06900 ELECTROCARDI OLOGY	0. 038454			69.	00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 463454			71.	00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 150552			72.	00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 346681			73.	00
76.00	03160 CARDI OPULMONARY	0. 226099			76.	00
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0. 000000			90.	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1. 495250			90.	01
	09002 JAY FAMILY MEDICINE	2. 260711			90.	
	09003 WOUND CLINIC	1. 112291			90.	
	09004 OP ORTHO CLINIC	0. 000000			90.	
	09005 JAY FAMILY FIRST HEALTH CARE	4. 624089			90.	
	09006 INFUSION CLINIC	0. 132895			90.	
	09100 EMERGENCY	0. 180541			91.	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 290432			92.	
	04950 OUTPATI ENT PSYCH	0. 960368			93.	
200.00					200.	
201.00	l l				201.	
202.00	Total (see instructions)				202.	00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10

| Period: | Worksheet C |
| From 01/01/2019 | Part II |
| To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:10 am | Provider CCN: 15-1320

						6/29/2020 8: 10	o am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos	t Capi tal	Operating Cost	
		(Wkst. B, Part	(Wkst. B, Part	Net of Capita	I 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	4, 092, 993	259, 650	3, 833, 34	3 0	0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	70, 193	9, 432	60, 76	1 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0)	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 327, 844	222, 171	2, 105, 67	3 0	0	54.00
60.00	06000 LABORATORY	2, 707, 203	133, 397	2, 573, 80	6 0	0	60. 00
65.00	06500 RESPI RATORY THERAPY	826, 817	39, 651	787, 16	6 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 184, 870	139, 629	1, 045, 24	1 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	205, 307	24, 799	180, 50	8 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	30, 497	790	29, 70	7 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	33, 858	807	33, 05	1 0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	560, 163	5, 565	554, 59	8 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	65, 874	655	65, 21	9 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 718, 733	77, 724	3, 641, 00	9 0	0	73. 00
76.00	03160 CARDI OPULMONARY	509, 471	16, 766	492, 70	5 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0		0 0	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 881, 524	77, 604	1, 803, 92	0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	2, 415, 504	103, 225	2, 312, 27	9 0	0	90. 02
90. 03	09003 WOUND CLINIC	128, 602	15, 122	113, 48	0	0	90. 03
90. 04	09004 OP ORTHO CLINIC	0	0)	0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	1, 127, 598	167, 602	959, 99	6 0	0	90. 05
90.06	09006 INFUSION CLINIC	259, 331	27, 435	231, 89	6 0	0	90. 06
91.00	09100 EMERGENCY	3, 202, 965	232, 833	2, 970, 13	2 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 433, 909	163, 226	1, 270, 68	3 0	0	92.00
93.00	04950 OUTPATIENT PSYCH	198, 630	62, 675	135, 95	5 0	0	93. 00
200.00	Subtotal (sum of lines 50 thru 199)	26, 981, 886	1, 780, 758	25, 201, 12	8 0	0	200. 00
201.00		1, 433, 909	163, 226	1, 270, 68	3 0		201. 00
202.00	Total (line 200 minus line 201)	25, 547, 977	1, 617, 532	23, 930, 44	5 0	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

IN Lieu of Form CMS-2552-10
Provider CCN: 15-1320
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared:

	. 0.10 . 0.1. 11.2. 0.1.2.			T	o 12/31/2019	Date/Time Pre 6/29/2020 8:1	
			Ti tI	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	·	Capital and		Cost to Charge			
		Operating Cost	Part I, column	Ratio (col. 6			
		Reducti on	8)	/ col . 7)			
		6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	4, 092, 993	20, 769, 132	0. 197071			50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	70, 193	1, 339, 572	0.052400			52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 327, 844	11, 346, 101	0. 205167			54.00
60.00	06000 LABORATORY	2, 707, 203	8, 927, 999	0. 303226			60.00
65.00	06500 RESPIRATORY THERAPY	826, 817	1, 178, 512	0. 701577			65.00
66.00	06600 PHYSI CAL THERAPY	1, 184, 870	1, 417, 082	0. 836134			66.00
67.00	06700 OCCUPATI ONAL THERAPY	205, 307	300, 745	0. 682661			67.00
68.00	06800 SPEECH PATHOLOGY	30, 497	14, 646	2. 082275			68. 00
69. 00	06900 ELECTROCARDI OLOGY	33, 858	880, 483	0. 038454			69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	560, 163	1, 208, 669	0. 463454			71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	65, 874	437, 550	0. 150552			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 718, 733	10, 726, 684	0. 346681			73. 00
76.00	03160 CARDI OPULMONARY	509, 471	2, 253, 308	0. 226099			76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0.000000			90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 881, 524	1, 258, 334	1. 495250			90. 01
90. 02	09002 JAY FAMILY MEDICINE	2, 415, 504	1, 068, 471	2. 260711			90. 02
90. 03	09003 WOUND CLINIC	128, 602	115, 619	1. 112291			90. 03
90.04	09004 OP ORTHO CLINIC	0	50, 563	0.000000			90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	1, 127, 598	243, 853	4. 624089			90. 05
90.06	09006 INFUSION CLINIC	259, 331	1, 951, 392	0. 132895			90.06
91.00	09100 EMERGENCY	3, 202, 965	17, 740, 970	0. 180541			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 433, 909	4, 937, 158	0. 290432			92.00
93.00	04950 OUTPATIENT PSYCH	198, 630	206, 827	0. 960368			93.00
200.00	Subtotal (sum of lines 50 thru 199)	26, 981, 886	l ·				200.00
201.00		1, 433, 909					201.00
202.00	Total (line 200 minus line 201)	25, 547, 977	88, 373, 670				202. 00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE C	APITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	6/29/2020 8: 10	pareu. O am
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col .	Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00		4.00	5.00	
ANCILLARY CERVICE COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	259, 650	20, 769, 132	0. 01250	750 402	9, 383	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	9, 432		•		9, 383	52.00
52. 00 05200 DELT VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	9, 432		•		0	52.00
54. 00 05400 RADI OLOGY	222, 171	ļ			- 1	54. 00
60. 00 06000 LABORATORY	133, 397				6, 857	60.00
65. 00 06500 RESPI RATORY THERAPY	39, 651					1
66. 00 06600 PHYSI CAL THERAPY	139, 629				·	1
67. 00 06700 OCCUPATI ONAL THERAPY	24, 799				·	1
68. 00 06800 SPEECH PATHOLOGY	790					1
69. 00 06900 ELECTROCARDI OLOGY	807					69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN						71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	655				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 724				4, 289	l
76. 00 03160 CARDI OPULMONARY	16, 766			1 157, 240	1, 170	76. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>		•	<u> </u>		
90. 00 09000 CLI NI C	0	C	0.00000		0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	77, 604	1, 258, 334	0. 06167	2 0	0	90. 01
90.02 09002 JAY FAMILY MEDICINE	103, 225		0. 096610	0 0	0	90. 02
90. 03 09003 WOUND CLINIC	15, 122				0	90. 03
90. 04 09004 OP ORTHO CLINIC	0	00,000			0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	167, 602				0	90. 05
90.06 09006 INFUSION CLINIC	27, 435		•		0	90. 06
91. 00 09100 EMERGENCY	232, 833					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR					0	92.00
93. 00 04950 OUTPATIENT PSYCH	62, 675		•		0	93. 00
200.00 Total (lines 50 through 199)	1, 780, 758	88, 373, 670	1	2, 671, 698	47, 355	200. OO

Health Financial Systems IU HEALTH JAY

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS IU HEALTH JAY HOSPITAL Provi der CCN: 15-1320

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS

					10 12/31/2017	6/29/2020 8: 1	
				XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
			Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	1	0	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	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	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76.00	03160 CARDI OPULMONARY	0	0		0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS				_		
90.00	09000 CLI NI C	0	0		0	0	, , , , , ,
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0		0	0	90. 02
90. 03	09003 WOUND CLINIC	0	0		0	0	90. 03
90. 04	09004 OP ORTHO CLINIC	0	0		0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	0	0		0	0	90. 05
90. 06	09006 INFUSION CLINIC	0	0		0	0	90. 06
91. 00	09100 EMERGENCY	0	0		0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	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	stems IU HEALTH JAY HOSPI		OSPI TAL In Li		
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS	Provider CCN: 15-1320	Dari ad:	Worksheet D	

From 01/01/2019 | Part IV To 12/31/2019 | Date/Ti THROUGH COSTS Date/Time Prepared: 6/29/2020 8:10 am Title XVIII Hospi tal Cost All Other Total Charges Ratio of Cost Cost Center Description Total Cost Total to Charges Medi cal (sum of cols. (from Wkst. C, Outpati ent 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 20, 769, 132 0.00000050.00 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 339, 572 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 11, 346, 101 0.000000 54 00 0 60.00 06000 LABORATORY 0 8, 927, 999 0.000000 60.00 65. 00 06500 RESPIRATORY THERAPY 1, 178, 512 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 1, 417, 082 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 300, 745 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 14, 646 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 0 880, 483 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 208, 669 0 0.000000 71 00 71 00 Ω 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 437, 550 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 10, 726, 684 0.000000 73.00 03160 CARDI OPULMONARY 0 0 2, 253, 308 0.000000 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0.000000 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0000000000 0 1, 258, 334 0.000000 90. 01 90.01 09002 JAY FAMILY MEDICINE 0 0 1, 068, 471 0.000000 90.02 90.02 90.03 09003 WOUND CLINIC 0 0 115, 619 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0 50, 563 0.000000 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 243, 853 0.000000 90.05 90.05 90.06 09006 INFUSION CLINIC 0 1, 951, 392 0 0.000000 90.06 0 91. 00 09100 EMERGENCY 0 17, 740, 970 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 4, 937, 158 0.000000 92.00 93. 00 04950 OUTPATIENT PSYCH 206, 827 93.00 0.000000

88, 373, 670

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH JAY HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LANDATIENT (OUTDATIENT A	NOTITION CERVICOS OTHER DACC D 1 1 CON 45 4000	D . I	

Period: From 01/01/2019 To 12/31/2019 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1320 THROUGH COSTS Date/Time Prepared: 6/29/2020 8:10 am Title XVIII Hospi tal Cost Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges 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 750, 493 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 189, 265 0 54.00 0 0 06000 LABORATORY 60.00 0.000000 458, 941 60.00 0 0 65.00 06500 RESPIRATORY THERAPY 0.000000 254, 893 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 83, 635 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.000000 53, 410 67.00 0 0 06800 SPEECH PATHOLOGY 68.00 0.000000 2, 028 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 18, 396 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.000000 100,883 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 591, 932 0 73.00 03160 CARDI OPULMONARY 0 0 76.00 76.00 0.000000 157, 240 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 0 0 0 0 90.01 09002 JAY FAMILY MEDICINE 0 90. 02 0.000000 0 0 0 0 0 0 0 0 0 90.02 09003 WOUND CLINIC 0 90. 03 90.03 0.000000 Ω 0 0 90.04 09004 OP ORTHO CLINIC 0.000000 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 0 90.05 0 90.06 09006 INFUSION CLINIC 0.000000 0 0 90.06 91. 00 09100 EMERGENCY 0 0.000000 10, 582 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 92.00 93. 00 | 04950 | OUTPATIENT PSYCH 0.000000 0 0 93.00 Total (lines 50 through 199) 0 200. 00 200.00 2, 671, 698

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1320	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/29/2020 8:1	pared: O am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			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			
	4.00	0.00	(see inst.)	(see inst.)	F 00	
ANOULL ARV. CERVILOE, COST, CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0.107071	1 0	4 452 00	70	0	F0 00
50. 00 05000 OPERATING ROOM	0. 197071	l .	.,,		ū	00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0. 052400		5, 65	0 0	0	52. 00 53. 00
	0. 000000		2 040 24	۷۱ ۷۱	0	54.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 205167 0. 303226		2, 849, 21		0	60.00
		l .	1, 945, 97		-	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 701577 0. 836134		162, 38		0	65. 00 66. 00
		0	446, 59		0	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 682661	0	41, 34		0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	2. 082275 0. 038454		6, 40		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 038454		229, 32 99, 40		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 150552	l .	1		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 130332		1		0	73.00
75. 00 07500 DRUGS CHARGED TO PATTENTS 76. 00 03160 CARDI OPULMONARY	0. 226099				0	
OUTPATIENT SERVICE COST CENTERS	0. 220077		000, 70	o _l	0	70.00
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 495250		•		0	90.00
90. 02 09002 JAY FAMILY MEDICINE	2. 260711		472, 17		0	90.01
90. 03 09003 WOUND CLI NI C	1. 112291		39, 93		0	90. 03
90. 04 09004 0P ORTHO CLINIC	0. 000000		25, 98		0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	4. 624089	l .	87, 04		0	90.05
90. 06 09006 I NFUSI ON CLINI C	0. 132895		855, 91		0	90.06
91. 00 09100 EMERGENCY	0. 180541				0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 290432				0	92.00
93. 00 04950 OUTPATIENT PSYCH	0. 960368		18, 70		0	1
200.00 Subtotal (see instructions)	0.70000				_	200.00
201. 00 Less PBP Clinic Lab. Services-Program			25, 555, 6	0 0		201. 00
Only Charges				آ ا		
202.00 Net Charges (line 200 - line 201)		0	20, 088, 39	325, 865	0	202. 00

| Peri od: | Worksheet D | From 01/01/2019 | Part V | To 12/31/2019 | Date/Time Prepared:

					To 12/31/2019	Date/Time Prepar 6/29/2020 8:10 a	
			Titl∈	e XVIII	Hospi tal	Cost	
		Cos	sts				
(Cost Center Description	Cost	Cost				
		Reimbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)	-			
ANCLLL	ARY SERVICE COST CENTERS	6. 00	7. 00				
	OPERATING ROOM	877, 736	15	:		EC	0. 00
	DELIVERY ROOM & LABOR ROOM	296	0	•			2. 00
1 1	ANESTHESI OLOGY	270	0				2. 00 3. 00
	RADI OLOGY-DI AGNOSTI C	584, 566	0				4. 00
	LABORATORY	590, 070	0			l l	0. 00
	RESPI RATORY THERAPY	113, 928	0			l l	5. 00
	PHYSI CAL THERAPY	373, 409	0			•	6. 00
	OCCUPATIONAL THERAPY	28, 225	0				7. 00
	SPEECH PATHOLOGY	13, 335	0				8. 00
	ELECTROCARDI OLOGY	8, 819	Ö				9. 00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	46, 070	0				1. 00
	IMPL. DEV. CHARGED TO PATIENTS	15, 011	0				2. 00
	DRUGS CHARGED TO PATIENTS	708, 255	83, 238				3. 00
	CARDI OPULMONARY	194, 603	0	1		•	6. 00
OUTPATI	IENT SERVICE COST CENTERS			•			
90.00 09000 0	CLI NI C	0	0			90	0. 00
90. 01 09001 F	FAMILY PRACTICE OF JAY COUNTY	461, 769	48, 262	2		90	0. 01
90. 02 09002	JAY FAMILY MEDICINE	1, 067, 440	97, 066)		90	0. 02
90. 03 09003 V		44, 420	0)			0. 03
	OP ORTHO CLINIC	0	0)			0. 04
	JAY FAMILY FIRST HEALTH CARE	402, 522	23, 574				0. 05
	INFUSION CLINIC	113, 747	31	1			0. 06
	EMERGENCY	608, 745	663			l I	1. 00
	OBSERVATION BEDS (NON-DISTINCT PART	483, 409	427	•			2. 00
	OUTPATIENT PSYCH	17, 965	0	1			3. 00
	Subtotal (see instructions)	6, 754, 340	253, 276	p			0. 00
	Less PBP Clinic Lab. Services-Program	0				201	1. 00
	Only Charges	. 754 040	050 07/			200	0.00
202.00	Net Charges (line 200 - line 201)	6, 754, 340	253, 276	9		202	2. 00

		V 1100D1 TA1			6.5	
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	TU HEALTH JA AL COSTS	Provi der C	CN: 15-1320 CCN: 15-M320	Peri od: From 01/01/2019 To 12/31/2019		pared:
		Title	· XVIII	Subprovi der - I PF	6/29/2020 8: 1 PPS	<u>0 am</u>
Cost Center Description	(from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	t Inpatient Program	Capital Costs (column 3 x column 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	259, 650				0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	9, 432				0	52. 00
53. 00 05300 ANESTHESI OLOGY	0		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	222, 171					
60. 00 06000 LABORATORY	133, 397		l .			
65. 00 06500 RESPI RATORY THERAPY	39, 651					
66. 00 06600 PHYSI CAL THERAPY	139, 629				433	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	24, 799				425	
68. 00 06800 SPEECH PATHOLOGY	790				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	807				10	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 565				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	655				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	77, 724		l .		1, 126	
76. 00 O3160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	16, 766	2, 253, 308	0. 0074	+1 0	0	76. 00
90. 00 09000 CLINIC		0	0.0000	00	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	77, 604	_			14	90.00
90. 02 09002 JAY FAMILY MEDICINE	103, 225				66	90. 01
90. 03 09003 WOUND CLINIC	15, 122		l .		0	
90. 04 09004 OP ORTHO CLINIC	13, 122				Ö	90. 04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	167, 602				0	90. 05
90. 06 09006 NFUSI ON CLINI C	27, 435		l .		0	90.06
91. 00 09100 EMERGENCY	232, 833				523	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	232,033				0	1
93. 00 04950 OUTPATI ENT PSYCH	62, 675				0	93. 00
200.00 Total (lines 50 through 199)	1, 617, 532			296, 328		200. 00

Health Financial Systems	IU HEALTH JAY H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1320 Component CCN: 15-M320	Peri od: From 01/01/2019	
		Component con. 13-w320	10 12/31/2019	6/29/2020 8: 10 am
		Title XVIII	Subprovi der -	PPS

			· ·			6/29/2020 8:1	O am
			Title	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	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	68. 00
	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73. 00
76. 00	03160 CARDI OPULMONARY	0	0) (0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0)	0	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0)	0	0	90. 01
	09002 JAY FAMILY MEDICINE	0	0)	0	0	90. 02
	09003 WOUND CLINIC	0	0		0	0	90. 03
	09004 OP ORTHO CLINIC	0	0		0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	0	0		0	0	90. 05
90.06	09006 I NFUSI ON CLI NI C	0			0	0	90. 06
	09100 EMERGENCY	0))	0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0]			0	92.00
	04950 OUTPATIENT PSYCH	0			0	0	, 0. 00
200.00	Total (lines 50 through 199)		ol C) () 0	0	200. 00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER			CN: 15-1320	Peri od:	Worksheet D	2002 10
	H COSTS	02 0111211 17100			From 01/01/2019	Part IV	
			Component	CCN: 15-M320	To 12/31/2019		pared:
-			Ti +Lo	: XVIII	Subprovi der -	6/29/2020 8: 10 PPS	<u>o am</u>
			11 (16	: AVIII	I PF	PF3	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	5551 551151 25551 Pt 1511	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	1		0 20, 769, 132		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 1, 339, 572		
53.00	05300 ANESTHESI OLOGY	0	0		0		
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 11, 346, 101		
60.00	06000 LABORATORY	0	0		0 8, 927, 999		
65.00	06500 RESPI RATORY THERAPY	0	0		0 1, 178, 512		
66. 00	06600 PHYSI CAL THERAPY	0	0		0 1, 417, 082		
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 300, 745		
68. 00	06800 SPEECH PATHOLOGY	0	0		0 14, 646		
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 880, 483		
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 208, 669		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 437, 550		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 726, 684		
76. 00	03160 CARDI OPULMONARY	0	0		0 2, 253, 308	0.000000	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC			1		0.000000	00.00
		0			0 0		
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0			0 1, 258, 334		
90. 02	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	0			0 1, 068, 471		
90. 03		0			0 115, 619		
90. 04	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	0			0 50, 563		
90. 05	09006 INFUSION CLINIC	0			0 243, 853		
90. 06 91. 00	109000 INFOSTON CETNIC	0			0 1, 951, 392		
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0 17, 740, 970 0 4, 937, 158		
	04950 OUTPATIENT PSYCH				0 4, 937, 158		
200.00		0	1		0 88, 373, 670		200.00
200.00	Tiotal (Titles so through 177))	1	I	00, 373, 070	ı	1200.00

	5		LIOCOL TAL			C.F. OHC	0550 40
	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	IU HEALTH JAY	Provi der CO	N. 1E 1220	Period:	eu of Form CMS-2 Worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SER SH COSTS	VICE OTHER PASS		CCN: 15-1320 CCN: 15-M320	From 01/01/2019 To 12/31/2019	Part IV	pared:
			·			6/29/2020 8:1	
			Title	XVIII	Subprovi der -	PPS	
					IPF		
	Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
		7)	40.00	x col. 10)	40.00	x col . 12)	
	ANOLLI ADV. CEDVI OF COCT OFNITEDO	9. 00	10. 00	11. 00	12. 00	13. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	0				F0 00
50.00	05000 OPERATING ROOM	0. 000000	0		0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	- 000		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 939		0	0	
60. 00	06000 LABORATORY	0. 000000	67, 733		0	0	60.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	6, 230		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	4, 398		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	5, 152		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	10, 731		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	155, 369		0	0	73. 00
76. 00	03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0	_	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	227		0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0. 000000	682		0	0	90. 02
90. 03	09003 WOUND CLINIC	0. 000000	0		0	0	
90. 04	09004 OP ORTHO CLINIC	0. 000000	0		0	0	
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	0. 000000	0		0	0	90. 05
90. 06	09006 INFUSION CLINIC	0. 000000	0		0	0	90. 06
91. 00	09100 EMERGENCY	0. 000000	39, 867		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0	0	
93.00	04950 OUTPATI ENT PSYCH	0. 000000	0		0	0	
200.00	Total (lines 50 through 199)		296, 328		0 0	0	200. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der Co		Peri od: From 01/01/2019	Worksheet D Part V	
		Component	CCN: 15-M320	To 12/31/2019	Date/Time Pre 6/29/2020 8:1	pared: O am
		Title	XVIII	Subprovi der -	PPS	
				I PF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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	. Ded. & Coins.		

				TPF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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.	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. 197071		[C	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 052400		[C	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000		[C	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 205167		[C	0	0	
60. 00 06000 LABORATORY	0. 303226	0	[C	0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 701577	0	C	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 836134	0	C	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 682661	0	C	0	0	
68. 00 06800 SPEECH PATHOLOGY	2. 082275	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 038454	0	C	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 463454	0	C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 150552	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 346681	0	C	26	0	73. 00
76. 00 03160 CARDI OPULMONARY	0. 226099	0	C	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0	C	0	0	1
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 495250	0	C	0	0	90. 01
90.02 09002 JAY FAMILY MEDICINE	2. 260711	0	C	0	0	90. 02
90. 03 09003 WOUND CLINIC	1. 112291	0	C	0	0	90. 03
90.04 09004 OP ORTHO CLINIC	0. 000000	0	C	0	0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	4. 624089	0	C	0	0	90. 05
90.06 09006 INFUSION CLINIC	0. 132895	0	C	0	0	90.06
91. 00 09100 EMERGENCY	0. 180541	0	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 290432	0	C	0	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0. 960368	0	C	0	0	93. 00
200.00 Subtotal (see instructions)		0	C	26	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program			C	0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	(c	26	0	202. 00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-1320	Peri od: From 01/01/2019	Worksheet D Part V	
			Component	CCN: 15-M320	To 12/31/2019		
			Titl∈	× XVIII	Subprovi der - I PF	PPS	_
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
_	ANGLEL ADV. CEDVI CE. COCT. CENTEDO	6. 00	7. 00				
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0	ı			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	_				52. 00
	05300 ANESTHESI OLOGY	1 0	_				53. 00
	05400 RADI OLOGY-DI AGNOSTI C						54.00
60.00	06000 LABORATORY						60.00
	06500 RESPIRATORY THERAPY						65. 00
	06600 PHYSI CAL THERAPY						66. 00
	06700 OCCUPATI ONAL THERAPY						67. 00
	06800 SPEECH PATHOLOGY						68. 00
	06900 ELECTROCARDI OLOGY						69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS						71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		_				72.00
	07300 DRUGS CHARGED TO PATIENTS		_	1			73.00
	03160 CARDI OPULMONARY			1			76.00
70.00	OUTPATIENT SERVICE COST CENTERS			1			70.00
90 00	09000 CLI NI C	0	0	1			90.00
	09001 FAMILY PRACTICE OF JAY COUNTY						90. 01
	09002 JAY FAMILY MEDICINE	0	i o	,			90. 02
	09003 WOUND CLINIC		i o	,			90. 03
	09004 OP ORTHO CLINIC						90. 04
	09005 JAY FAMILY FIRST HEALTH CARE						90. 05
	09006 INFUSION CLINIC	0					90. 06
	09100 EMERGENCY						91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		O				92.00
	04950 OUTPATI ENT PSYCH		O				93. 00
200.00	l I	0	9				200.00
201.00		0					201.00
	Only Charges		1				

202. 00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

202.00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1320 Peri od: Worksheet D From 01/01/2019 Part V Component CCN: 15-Z320 12/31/2019 Date/Time Prepared: To 6/29/2020 8:10 am Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From 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.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 197071 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.052400 0 0 05300 ANESTHESI OLOGY 0.000000 0 53 00 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.205167 0 0 60. 00 | 06000 | LABORATORY 0. 303226 0 0 65.00 06500 RESPIRATORY THERAPY 0.701577 0 0

Health Financial Systems

I U HEALTH JAY HOSPITAL

In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-1320
Component CCN: 15-2320
Period:
From 01/01/2019
To 12/31/2019
Part V
Date/Time Prepared:
6/29/2020 8: 10 am

		Component C	CCN: 15-Z320	To 12/31/2019		epared: 10 am
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	0				50. 00
52.00 05200 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	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	o				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	o				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o				73. 00
76. 00 03160 CARDI OPULMONARY	0	o				76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	o				90. 01
90.02 09002 JAY FAMILY MEDICINE	0	o				90. 02
90. 03 09003 WOUND CLINIC	0	o				90. 03
90. 04 09004 OP ORTHO CLINIC	0	o				90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	l ol				90. 05
90.06 09006 INFUSION CLINIC	0	l ol				90. 06
91. 00 09100 EMERGENCY	0	l ol				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	ol				92. 00
93. 00 04950 OUTPATI ENT PSYCH	0	l ol				93. 00
200.00 Subtotal (see instructions)	0	ol				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	o				202. 00
	*					

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	6/29/2020 8: 10	pareu. O am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	584, 332	28, 935	555, 39	7 2, 865	193. 86	30. 00
40. 00 SUBPROVI DER - I PF	196, 902	0	196, 90	2 1, 250	157. 52	40.00
43. 00 NURSERY	24, 571		24, 57	1 152	161. 65	43.00
200.00 Total (lines 30 through 199)	805, 805		776, 87	0 4, 267		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 & PEDI ATRI CS	3	582				30. 00
40. 00 SUBPROVI DER - I PF	58	9, 136	,		ļ	40.00
43. 00 NURSERY	7	1, 132			ļ	43.00
200.00 Total (lines 30 through 199)	68	10, 850)			200. 00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE	CAPITAL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		nared·
				10 12/01/2017	6/29/2020 8: 10	0 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(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	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	259, 650	20, 769, 132	0. 01250	2 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	9, 432		•			
53. 00 05300 ANESTHESI OLOGY	7, 102		1		0	ı
54. 00 05400 RADI OLOGY-DI AGNOSTI C	222, 171	11, 346, 101	l .		-	54.00
60. 00 06000 LABORATORY	133, 397					60.00
65. 00 06500 RESPIRATORY THERAPY	39, 651					65.00
66. 00 06600 PHYSI CAL THERAPY	139, 629			3 494	49	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	24, 799	300, 745	0. 08245	9 263	22	67. 00
68.00 06800 SPEECH PATHOLOGY	790	14, 646	0. 05394	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	807	880, 483	0. 00091	7 657	ı 1 ¹	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NTS 5, 565	1, 208, 669	0.00460	4 576	3	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	655	437, 550	0. 00149	7 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 724	10, 726, 684	0.00724	6 9, 100	66	73. 00
76. 00 03160 CARDI OPULMONARY	16, 766	2, 253, 308	0.00744	1 2, 589	19	76. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		0.0000		0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	77, 604				0	90. 01
90.02 09002 JAY FAMILY MEDICINE	103, 225				0	90. 02
90. 03 09003 WOUND CLINIC	15, 122		•		0	90. 03
90. 04 09004 OP ORTHO CLINIC	0	00,000			0	90. 04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	167, 602				0	90. 05
90. 06 09006 INFUSION CLINIC	27, 435		•		0	90. 06
91. 00 09100 EMERGENCY	232, 833				69	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PA					0	92.00
93. 00 04950 OUTPATIENT PSYCH	62, 675		•		0	93. 00
200.00 Total (lines 50 through 199)	1, 780, 758	88, 373, 670	1	61, 369	714	200. 00

Health Financial Systems	IU HEALTH JAY			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COSTS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School No Post-Stepdown Adjustments	ursing School	Allied Health Post-Stepdown Adjustments 2A		All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	IA	1.00	ZA	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS 40. 00 04000 SUBPROVIDER - IPF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	0 0 0	0 0 0 0		0 0 0 0 0 0	0 0 0 0	40. 00
Cost Center Description	Adjustment (Amount (see instructions) m	Total Costs sum of cols. 1 through 3, ninus col. 4)	Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 40.00 04000 SUBPROVIDER - IPF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0	0 0	2, 86 1, 25 15 4, 26	0.00 2 0.00	58 7	30. 00 40. 00 43. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	· ·	7, 20	*1	30	200.00
30. 00	0 0 0					30. 00 40. 00 43. 00 200. 00

Health Financial Systems IU HEALTH JAY

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS IU HEALTH JAY HOSPITAL

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: Provi der CCN: 15-1320 THROUGH COSTS

					12, 01, 201,	6/29/2020 8: 1	
				e XIX	Hospi tal	PPS	
	Cost Center Description			Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0	(0	0	1 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	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 00	03160 CARDI OPULMONARY	0	0	(0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(0	0	70.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	(0	0	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0	(0	0	90. 02
90. 03	09003 WOUND CLINIC	0	0	(0	0	90. 03
90. 04	09004 OP ORTHO CLINIC	0	0	(0	0	90. 04
90. 05	09005 JAY FAMILY FIRST HEALTH CARE	0	0	(0	0	90. 05
90. 06	09006 INFUSION CLINIC	0	0	(0	0	90. 06
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(0	92. 00
93.00		0	0	(0	0	
200.00	Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	IU HEALTH JAY H	IOSPI TAL		In Lieu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS	Provider CCN: 15-1320	Pari ad:	Worksheet D

From 01/01/2019 | Part IV To 12/31/2019 | Date/Ti THROUGH COSTS Date/Time Prepared: 6/29/2020 8:10 am Title XIX Hospi tal All Other Total Charges Ratio of Cost Cost Center Description Total Cost Total to Charges Medi cal (sum of cols. (from Wkst. C, Outpati ent 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 20, 769, 132 0.00000050.00 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 1, 339, 572 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 11, 346, 101 0.000000 54 00 0 60.00 06000 LABORATORY 0 8, 927, 999 0.000000 60.00 65. 00 06500 RESPIRATORY THERAPY 1, 178, 512 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 1, 417, 082 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0 0 67.00 300, 745 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 14, 646 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 0 880, 483 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 208, 669 0 0.000000 71 00 71 00 Ω 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 437, 550 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 10, 726, 684 0.000000 73.00 03160 CARDI OPULMONARY 0 0 2, 253, 308 0.000000 76.00 76.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0.000000 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0000000000 0 1, 258, 334 0.000000 90. 01 90.01 09002 JAY FAMILY MEDICINE 0 0 1, 068, 471 0.000000 90.02 90.02 90.03 09003 WOUND CLINIC 0 0 115, 619 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0 50, 563 0.000000 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 243, 853 0.000000 90.05 90.05 90.06 09006 INFUSION CLINIC 0 1, 951, 392 0 0.000000 90.06 0 91. 00 09100 EMERGENCY 0 17, 740, 970 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 4, 937, 158 0.000000 92.00 93. 00 04950 OUTPATIENT PSYCH 206, 827 93.00 0.000000

88, 373, 670

200.00

200.00

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH JAY HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LANDATIENT (OUTDATIENT A	NOTITION CERVICOS OTHER DACC D 1 1 CON 45 4000	D . I	W 1 1 5

Period: From 01/01/2019 To 12/31/2019 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1320 THROUGH COSTS Date/Time Prepared: 6/29/2020 8:10 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 Pass-Through to Charges 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 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 21, 592 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 4, 804 0 54.00 0 0 06000 LABORATORY 60.00 0.000000 60.00 16, 022 0 65.00 06500 RESPIRATORY THERAPY 0.000000 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 494 0 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.000000 67.00 263 0 0 06800 SPEECH PATHOLOGY 68.00 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 657 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0.000000 576 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 9, 100 0 73.00 03160 CARDI OPULMONARY 2, 589 0 0 76.00 76.00 0.000000 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 0 0 0 90.01 0 0 0 0 0 0 0 09002 JAY FAMILY MEDICINE 0 90. 02 0.000000 0 90.02 0 09003 WOUND CLINIC 90. 03 90.03 0.000000 Ω 0 90.04 09004 OP ORTHO CLINIC 0.000000 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 0 90.05 0 90.06 09006 INFUSION CLINIC 0.000000 0 90.06 0 91. 00 09100 EMERGENCY 0.000000 5, 272 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.000000 0 92.00 93. 00 | 04950 | OUTPATIENT PSYCH 0.000000 0 0 93.00 0 Total (lines 50 through 199) 0 200. 00 200.00 61, 369

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 01/01/2019	Worksheet D-1
			Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Hospi tal	Cost

			10 12,01,201,	6/29/2020 8: 10	oan oan
		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			3, 071	1.00
2.00	Inpatient days (including private room days, excluding swing-b			2, 865	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	ed days)		2, 023	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	145	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	61	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
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	778	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	145	10. 00
	through December 31 of the cost reporting period (see instruct			ا	44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	confy (including privat	e room days)	0	12. 00
12 00	through December 31 of the cost reporting period	/! (!!			12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar ye			0	14 00
14. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	alli (excluding swing-bed	uays)		14. 00 15. 00
15. 00				0	
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT	+b	C +1+		17 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	r the cost		17. 00
10 00	reporting period	o often December 21 of	the cost		10 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es arter becember 31 or	the cost		18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	through Docombon 21 of	the cost	118. 90	10 00
19.00	reporting period	s till dugit becelliber 31 of	the cost	110. 90	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services	after December 31 of t	ha cost	0.00	20. 00
20.00	reporting period	arter becomber 31 or t	10 0031	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	:)		5, 133, 223	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0, 100, 220	
22.00	5 x line 17)	or or the cost report	ing period (ine	Ĭ	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	a 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	na period (line	7. 253	24.00
	7 x line 19)		5		
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)			254, 185	26.00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		4, 879, 038	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x lir	ne 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 879, 038	37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	,		1, 702. 98	
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 324, 918	
40.00	Medically necessary private room cost applicable to the Progra	,		0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 324, 918	41. 00

Private COL. 15-130 Private COL. 25-130	Heal th	Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:		
Title XVIII Respitat Cost Program Days Cost Co							Date/Time Pre	pared:
Total Note Program Brown				Ti +l e	YVIII	Hospi tal		0 am
1,00 2,00 3,00 4,00 5,00 4,00 5,00 4,00 5,00 4,00 6,00 4,00 6,00 4,00 6,00		Cost Center Description	Total			<u> </u>		
1.00 2.00 3.00 4.00 5.00 4.20 3.00 4.00 0 0 4.20 4.20 0 0 0 0 4.20 4.20 0 0 0 0 0 4.20		·	Inpatient Cost	npatient Days		÷		
			1 00	2 00		4 00		
	42. 00		0					42. 00
44.00	42.00				T.			42.00
45.00 BIRNS INTENSIVE CARE UNIT 46.00 SMRCIAL INTENSIVE CARE UNIT 46.00 SMRCIAL INTENSIVE CARE UNIT 46.00 SMRCIAL INTENSIVE CARE UNIT 46.00 47.00 Total Program inpatient acoust (sum of lines 4 through 48) (sue instructions) 40.00 Total Program inpatient costs (sum of lines 4 through 48) (sue instructions) 2, 230, 389 49.00 MSSS INBOURS COST AULISTIMENTS 2, 230, 389 49.00 Total Program inpatient costs (sum of lines 4 through 48) (sue instructions) 2, 230, 389 49.00 MSSS INBOURS COST AULISTIMENTS 2, 230, 389 49.00 Total Program excludable cost (sum of lines 50 and 51) 51.00 and 1/9 52.00 Total Program excludable cost (sum of lines 50 and 51) 52.00 Total Program excludable cost (sum of lines 50 and 51) 53.00 and 1/9 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 and 1/9 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 53.00 53.00 Total Program inpatient operating cost and target amount (line 54 k line 55) 50.00 Total Program inpatient operating cost and target amount (line 56 minus line 59) 53.00								
47.00								
1.00 1.00		1						
1.00	47.00							47.00
49.00 Prost Program inpatient costs (sum of lines 41 through 48) (see instructions) 2,230,389 49.00		<u>, </u>						
PASS TINDUGH COST ADJUSTMENTS					unc)			
50.00 Pass through costs applicable to Program inpatient routine services (From West. D., sum of Parts II and III 151.00	49.00		41 (111 Ough 46) (S	see mstructro	115)		2, 230, 369	49.00
51.00 Pass through costs applicable to Program inpatient ancillarly services (From Wist. D., sum of Parts II 0 51.00 online 1.00	50.00	Pass through costs applicable to Program inp	atient routine s	services (from	n Wkst. D, sum	of Parts I and	0	50. 00
and IV) 152.00 Total Program excludable cost (sum of lines 50 and 51) 153.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and operating cost excluding capital related, non-physician anesthetist, and operating cost sex cluding capital related, non-physician anesthetist, and operating costs, operating period (scharge) 154.00 Program discharge 155.00 Target amount (line 54 x line 55) 156.00 Discret amount (line 54 x line 55) 157.00 Discret amount (line 54 x line 55) 159.00 Discret amount (line 55 rom the cost reporting period ending 1996, updated and compounded by the market basket 159.00 Discret of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 159.00 Discret of lines 53/54 or 55 from prior year cost report, updated by the market basket 159.00 Discret of lines 53/54 or 55 from prior year cost report, updated by the market basket 159.00 Relief payment (see instructions) 169.00 Discret of lines 53/54 or 55 from prior year cost report, updated by the market basket 169.00 Relief payment (see instructions) 169.01 Discret payment (see instructions) 169.02 Discret payment (see instructions) 169.03 Discret payment (see instructions) 169.04 Discret payment (see instructions) 169.05 Discret payment (see instructions) 169.06 Discret payment (see instructions) 169.07 Discret payment (see instructions) 169.08 Discret payment (see instructions) 169.09 Discret payment (see instructions) 169.00 Discret payment (see instruction	51 00	1 '	atient ancillary	, services (fr	om Wkst D si	ım of Parts II	0	51 00
10 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) S4, 00 Program discharge	31.00		attent and train	Scrvices (II	om wkst. b, s	am or rarts ii		31.00
medical education costs (line 49 minus line 52)							_	
FARCET MOUNT AND LIMIT COMPUTATION 54.00 55.00 1arget amount per discharge 0.00 55.00 1arget amount per discharge 0.00 55.00 1arget amount per discharge 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00 55.00 0.00	53.00		9 1	ated, non-pny	sician anestn	etist, and	0	53.00
		TARGET AMOUNT AND LIMIT COMPUTATION	-					
56.00 Target amount (line 54 x line 55) 0 56.00 0 57.00 0 58.0								
57. 00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0 57. 00								
Section Lesser of Tines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the more thanker basket 0.00 60.00	57. 00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus l	line 53)	_	57. 00
market basket			porting ported o	anding 1006 u	indated and co	mpounded by the	_	
1.00 If line 53/54 is less than the lower of lines 55, 50 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	39.00		portring period e	ilulily 1996, u	ipuateu anu coi	iipourided by the	0.00	39.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) 82.00 82.00 82.00 82.00 83.00 84.00 84.00 84.00 84.00 84.00 85.00 86.00 87.00 88.00								
amount (line 56), otherwise enter zero (see instructions) 62.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 67.00 Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 68.00 Total title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 69.00 Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 37) 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 70.00 Adjusted general inpatient routine service costs per diem (line 70 + line 2) 71.00 Total Program general inpatient routine service costs (line 72 + line 73) 72.00 Total Program general inpatient routine service costs (fire 72 + line 73) 73.00 Total Program general inpatient routine service costs (fire 77 + line 78) 74.00 Program capital -related costs (line 75 + line 2) 75.00 Per diem capital -related costs (line 75 + line 2) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 75 + line 2) 78.00 Pagregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program inpatient routine service costs (see instructions) 81.00	61.00						0	61.00
Allowable Inpatient cost plus incentive payment (see instructions) 0 63.00		amount (line 56), otherwise enter zero (see		, (ee e. x	00), 0. 1.0 0.	the talget		
BROGRAM INPATIENT ROUTINE SWING BED COST			ont (soo instrus	stions)				
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0 69.00 PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 71.00 Program routine service cost (line 9 x line 71) 72.00 72.00 Program general inpatient routine service costs (line 14 x line 25) 73.00 74.00 75	03.00		ent (see mstruc	ti ons)			0	03.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only) 06.00 07.00	64. 00		ts through Decem	ber 31 of the	cost reporti	ng period (See	246, 932	64. 00
Instructions) (itle XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions) CAH (see i	65 00		ts after Decembe	er 31 of the c	nst renorting	neriod (See	0	65 00
CAH (see instructions) 77.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 88.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 88.00 Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICP/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICP/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ± line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Addically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Per diem capital-related costs (line 75 ± line 2) 77.00 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program inpatient service cost for excess costs (imine 78 minus line 79) 81.00 Rasonable inpatient routine service cost (see instructions) 82.00 Rasonable inpatient routine service cost (see instructions) 84.00 PORTITION OF DESERVATION BED PASS THROUGH COST 87.00 Total Observation bed days (see instructions) 84.00 85.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 77.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF DESERVATION BED PASS THROUGH COST		instructions) (title XVIII only)						
67. 00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 DART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 SKIlled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Total Program general inpatient routine service costs (line 72 + line 73) 74.00 Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Total Program service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 11.00 11.00 11.00 11.00 11.00 12.00 11.00 11.00 12.00 11.00 12.00 12.00 13.00 13.00 13.00 14.00 14.00 15.00 16.00 17.0	66. 00		ne costs (line 6	4 plus line 6	5)(title XVII	l only). For	246, 932	66. 00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period ((line 13 x line 20)	67. 00		e costs through	December 31 o	of the cost re	porting period	0	67. 00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 + line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 + line 2) 77.00 Program capital -related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service cost per diem limitation 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	40.00	,	t£t D-	21 -6				40.00
Total title V or XÍX swing-bed NF inpatient routine costs (line 67 + line 68) 069.00	68.00		e costs after be	ecember 31 or	the cost repo	rting period	0	68.00
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital -related costs (line 75 ÷ line 2) 77.00 Program capital -related costs (line 75 * line 2) 78.00 Inpatient routine service cost (line 77) 78.00 Inpatient routine service cost (line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost (see instructions) 82.00 Reasonable inpatient routine services (see instructions) 83.00 Utilization review - physician compensation (see instructions) 84.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 84.00 Adjusted general inpatient routine routine routine cost per diem (line 27 * line 2) 75.00 Total Program inpatient routine cost per diem (line 27 * line 2) 76.00 Total Program inpatient routine service cost see instructions) 84.00 Adjusted general inpatient routine cost per diem (line 27 * line 2) 85.00 Adjusted general inpatient routine cost per diem (line 27 * line 2)	69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2) 72.00 Program routine service cost (line 9 x line 71) 73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost (see instructions) 83.00 Reasonable inpatient routine service (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 78.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 79.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	70 00							70.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35) 74.00 Total Program general inpatient routine service costs (line 72 + line 73) 75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 74 minus line 77) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine services (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)			-					
Total Program general inpatient routine service costs (line 72 + line 73) 75.00 75.00 76.00 76.00 76.00 77.00 78.00 79.00 79.00 79.00 70.0		,	•		05)			
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 1 Inpatient routine service cost (line 74 minus line 77) 80.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Aggregate charges to beneficiaries for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 84.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Inpatient routine service cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)								
76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 86.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00			•	,		art II, column		
77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 78.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 80.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00	7/ 00	1 .	2)					7/ 00
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost per diem limitation 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		1						
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00	78. 00	Inpatient routine service cost (line 74 minu	s line 77)					78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00		00 0			· .	us Lino 70)		
82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 85.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00				oc minitati ON	. (1116 /0 1111111	us IIIIC /7)		
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)		Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				5)				
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 88.00		, ,		ıs)				
87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 1,702.98 88.00	86. 00	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,702.98 88.00	87. NN						842	87. 00
89.00 Observation bed cost (line 87 x line 88) (see instructions) 1,433,909 89.00	88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 702. 98	88. 00
	89. 00	Ubservation bed cost (line 87 x line 88) (se	e instructions)				1, 433, 909	89. 00

Health Financial Systems	IU HEALTH JA	Y 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 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	584, 332	5, 133, 223	0. 11383	3 1, 433, 909	163, 226	90.00
91.00 Nursing School cost	0	5, 133, 223	0.00000	0 1, 433, 909	0	91.00
92.00 Allied health cost	0	5, 133, 223	0.00000	0 1, 433, 909	0	92.00
93.00 All other Medical Education	0	5, 133, 223	0. 00000	1, 433, 909	0	93. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Peri od: From 01/01/2019	Worksheet D-1
	Component CCN: 15-M320	To 12/31/2019	Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		1, 250	1.00
2.00	Inpatient days (including private room days, excluding swing-			1, 250	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		1, 250	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period		24 6 11		, ,,,
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after December .	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 3°	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	391	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	Join days) arter	G	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	/ only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			U	13.00
14.00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	f the cost		17. 00
	reporting period	9			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	o till dagi. December e. e.		0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	(2)		2, 491, 767	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	na period (line	0	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
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 491, 767	
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		, ,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed cha	arges)	0	28. 00 29. 00
30. 00	Semi - pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	aus lino 22)(soo instrust	tions)	0.00	
34. 00 35. 00	Average per diem private room cost differential (line 34 x line)	, ,	LI OIIS)	0. 00 0. 00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	· · · · /		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	2, 491, 767	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 993. 41	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			779, 423	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 20)	•		770 422	
41. 00	Total Program general inpatient routine service cost (line 39	+ IIIIE 40)	ļ	779, 423	41.00

MPUI	ATION OF INPATIENT OPERATING COST		Provider CCN:	Fi	eriod: rom 01/01/2019		
			Component CCN:		o 12/31/2019		
			Title XV	111	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Costl	Total Av	verage Per m (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
. 00	NURSERY (title V & XIX only)	0	0	0.00			42.
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.
. 00	CORONARY CARE UNIT						44.
. 00	BURN INTENSIVE CARE UNIT						45.
. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				İ		46
. 00	Cost Center Description						47
						1.00	1.0
. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines					96, 676 876, 099	
. 00	PASS THROUGH COST ADJUSTMENTS	+1 till ough +0) (3	see matractrons)			070,077	7
. 00	Pass through costs applicable to Program inp	atient routine s	services (from Wk	st. D, sum o	of Parts I and	0	50
. 00		atient ancillary	/ services (from	Wkst. D. sur	m of Parts II	3, 935	51
	and IV)	,	(11 200				
. 00	Total Program excludable cost (sum of lines		atad nan nhucia	ion onootho	+: a+ and	3, 935	
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-physic	an anestne	tist, and	872, 164	33
	TARGET AMOUNT AND LIMIT COMPUTATION	-					
. 00 . 00	Program discharges Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0.00	
00	Difference between adjusted inpatient operat	ing cost and tar	get amount (line	56 minus li	ne 53)	Ö	
00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	endi ng 1996, upda	ted and comp	oounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the mark	et basket		0.00	60
. 00	If line 53/54 is less than the lower of line	es 55, 59 or 60 e	enter the Lesser	of 50% of th		0	61
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x 60)	, or 1% of	the target		
. 00	Relief payment (see instructions)	riisti ucti olis)				0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instruc	ctions)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docom	phor 21 of the co	st roportin	a ported (See		64
. 00	instructions) (title XVIII only)	its through becen	iber 31 of the co	at Tebol tillé	j period (see	١	04
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the cost	reporting p	period (See	0	65
. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	64 plus line 65)(title XVIII	onLv). For	0	66
	CAH (see instructions)		•				
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 of t	ne cost repo	orting period	0	67
. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing</pre>	e costs after De	ecember 31 of the	cost repor	ting period	0	68
	(line 13 x line 20)						١,,
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
. 00	Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service of		ne 70 ÷ line 2)				71
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	(line 14 v line	35)			72
. 00	Total Program general inpatient routine serv		•	33)			74
. 00	Capital -related cost allocated to inpatient	•	,	sheet B, Par	rt II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76
. 00	Program capital -related costs (line 9 x line						77
	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces			ino 70! -	cline 70)		79
. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation (I	ne /8 minus	s iine 79)		80
. 00	Inpatient routine service cost per drem from						82
. 00	Reasonable inpatient routine service costs (83
	Program inpatient ancillary services (see in						84
. 00	Utilization review - physician compensation						85
. 00							1 00
. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ough 65)				
. 00		S THROUGH COST				0 0.00	87

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (CCN: 15-M320	From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	C	2, 491, 767	0.00000	00	0	90.00
91.00 Nursing School cost	C	2, 491, 767	0.00000	00	0	91.00
92.00 Allied health cost	C	2, 491, 767	0.00000	00	0	92.00
93.00 All other Medical Education	c	2, 491, 767	0. 00000	00 0	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 01/01/2019	Worksheet D-1
		To 12/31/2019	Date/Time Prepared: 6/29/2020 8:10 am
	Title XIX	Hospi tal	PPS

				6/29/2020 8: 10	0 am
		Title XIX	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				1
4 00	I NPATI ENT DAYS			0.074	1
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-be			3, 071	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivata room dave	2, 865 0	1
3.00	do not complete this line.	(s). If you have only pr	i vate i ooni days,	J	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 023	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	145	1
	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	61	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)	+h- D (0.00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)	the Program (excluding	swing-bed and	3	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	alv (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruct		Join days)	١	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, er			- 1	
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	12.00
	through December 31 of the cost reporting period				
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15.00	Total nursery days (title V or XIX only)			152	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			7	16. 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	es through becember 51 0	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	118. 90	19.00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20.00
21 00	reporting period	- >		F 122 222	21 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing ported (line	5, 133, 223	1
22.00	5 x line 17)	er 31 of the cost report	ing period (inte	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	n period (line 6	0	23. 00
20.00	x line 18)	or or the cost reporting	g perrou (rine o	١	20.00
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	7, 253	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: 21 -: 1: 2:		254, 185	
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		4, 879, 038	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Caparal i pratient routing service charges (excluding swing-ber	d and observation had ab	arges)	0	28. 00
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed CD	ai yes <i>)</i>	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	
31. 00	General inpatient routine service cost/charge ratio (line 27 -	: line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	20,		0.00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	4, 879, 038	37. 00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTUENTO			1
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 700 00	30 00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 702. 98 5, 109	
39. 00 40. 00		•		5, 109	
	Total Program general inpatient routine service cost (line 39	,			41.00
55	1.112g. a gonerapat. a routino sorvico dost (1110 07			5, 107	

Heal th	Financial Systems	IU HEALTH JA	Y HOSPITAL			In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				CN: 15-1320	Peri od: From 01/01/2019	Worksheet D-1	
						To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
	Cost Center Description	Total	Total	Ti tl	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	cost center bescription	Inpatient Cost		Days			(col. 3 x col.	
		1.00	2.00		col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1. 00 182, 483	2.00	152	3. 00 1, 200. 5	4. 00	5. 00 8, 404	42. 00
12.00	Intensive Care Type Inpatient Hospital Units	102/100		.02	1,72001	,	37.101	12.00
43.00	INTENSIVE CARE UNIT							43. 00
44. 00	CORONARY CARE UNIT							44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200))			12, 552	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instru	<u>ıcti o</u>	ns)		26, 065	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine	servi ces (from	Wkst. D, sur	n of Parts I and	1, 714	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services	(fr	om Wkst. D, s	sum of Parts II	714	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					2. 428	52.00
53. 00	Total Program inpatient operating cost exclu		lated, nor	n-phy	sician anesth	netist, and	23, 637	
	medical education costs (line 49 minus line	52)						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges						0	54.00
55. 00	Target amount per discharge						_	55. 00
56. 00	Target amount (line 54 x line 55)						0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amour	nt (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 199	96. u	ndated and co	ompounded by the		59.00
	market basket	parating parate		-, -	,			
60.00	Lesser of lines 53/54 or 55 from prior year					the emount by		60.00
61.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha					-	0	61. 00
	amount (line 56), otherwise enter zero (see		- (,,	J		
62.00	Relief payment (see instructions)	(!+	-4!>				0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ictions)				0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	the	cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of t	he c	ost reportino	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus li	ne 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December	31 n	f the cost re	enorting period	n	67. 00
	(line 12 x line 19)	· ·						
	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)					orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	69. 00
70.00	Skilled nursing facility/other nursing facil							70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I						71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		ı(lin⊵ 1/	x Ii	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv				110 30)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (fr	om W	orksheet B, F	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital -related costs (line 9 x line							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovider ro	cord	s)			78. 00 79. 00
80. 00	Total Program routine service costs for comp					nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on				•		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I		* .					82. 00 83. 00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)					84.00
85. 00	Utilization review - physician compensation		ns)					85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th						86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions						QΛΩ	87. 00
88. 00	Adjusted general inpatient routine cost per	•	line 2)				1, 702. 98	1
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)					1, 433, 909	89. 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 01/01/2019 To 12/31/2019		
		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	584, 332	5, 133, 223	0. 11383	3 1, 433, 909	163, 226	90.00
91.00 Nursing School cost	0	5, 133, 223	0.00000	0 1, 433, 909	0	91.00
92.00 Allied health cost	0	5, 133, 223	0.00000	0 1, 433, 909	0	92.00
93.00 All other Medical Education	0	5, 133, 223	0. 00000	1, 433, 909	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 01/01/2019	Worksheet D-1
	Component CCN: 15-M320		
	Title XIX	Subprovi der -	Cost

		litle XIX	Subprovider - IPF	Cost	
	Cost Center Description			1.00	
PAF	RT I - ALL PROVIDER COMPONENTS			1. 00	
	PATIENT DAYS				
	patient days (including private room days and swing-bed days			1, 250	1. 00
	patient days (including private room days, excluding swing-	<i>y</i> ,		1, 250	2.00
	ivate room days (excluding swing-bed and observation bed day not complete this line.	ys). If you have only pr	vate room days,	0	3. 00
	mi-private room days (excluding swing-bed and observation be	ed days)		1, 250	4. 00
	tal swing-bed SNF type inpatient days (including private roo		r 31 of the cost	0	5. 00
	porting period				
	tal swing-bed SNF type inpatient days (including private rooporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
	tal swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	o	7. 00
	porting period	days) till sagit besomber	0. 0. 1 0001	Ĭ	7.00
	tal swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
	porting period (if calendar year, enter 0 on this line)	- +b - D (ldi		F0	0.00
	tal inpatient days including private room days applicable to wborn days) (see instructions)	the Program (excluding	swing-bed and	58	9. 00
	ing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
th	rough December 31 of the cost reporting period (see instruc-	ti ons)			
	ing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	cember 31 of the cost reporting period (if calendar year, en ing-bed NF type inpatient days applicable to titles V or XI)		e room days)	o	12. 00
	rough December 31 of the cost reporting period	Comy (merdaring private	e room days)	٥	12.00
13. 00 Sw	ing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
	ter December 31 of the cost reporting period (if calendar ye				
	dically necessary private room days applicable to the Progratal nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 152	14. 00 15. 00
	rsery days (title V or XIX only)			7	16.00
	ING BED ADJUSTMENT		l.	,	
	dicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
1	porting period				10.00
	dicare rate for swing-bed SNF services applicable to service porting period	es after becember 31 of	the cost		18. 00
	dicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	118. 90	19. 00
	porting period	-			
	dicaid rate for swing-bed NF services applicable to services	s after December 31 of t	ne cost	0. 00	20. 00
	porting period tal general inpatient routine service cost (see instruction:	s)		2, 491, 767	21. 00
	ing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
4	x line 17)	·			
	ing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	line 18) ing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	o	24. 00
	x line 19)	or or the cost reporting	ig perrou (irine	ĭ	21.00
	ing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
1	line 20)			o	24 00
1	tal swing-bed cost (see instructions) neral inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 491, 767	26. 00 27. 00
	I VATE ROOM DIFFERENTIAL ADJUSTMENT	(Title 21 milles Title 20)		2, 171, 707	27.00
	neral inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
1	ivate room charges (excluding swing-bed charges)			0	
	mi -pri vate room charges (excluding swing-bed charges)	1: 20)		0	30.00
	neral inpatient routine service cost/charge ratio (line 27 - erage private room per diem charge (line 29 ÷ line 3)	÷ 11 ne 28)		0. 000000 0. 00	31. 00 32. 00
	erage semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.00
	erage per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00	
	erage per diem private room cost differential (line 34 x li	ne 31)		0.00	
	ivate room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	2 401 767	36.00
	neral inpatient routine service cost net of swing-bed cost a minus line 36)	and private room cost dr	rierential (Tine	2, 491, 767	37. 00
	RT II - HOSPITAL AND SUBPROVIDERS ONLY				
PRO	OGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
1 .	justed general inpatient routine service cost per diem (see			1, 993. 41	
	ogram general inpatient routine service cost (line 9 x line			115, 618	
1	dically necessary private room cost applicable to the Progratal Program general inpatient routine service cost (line 39	•		0 115, 618	
55 176	12 13. 2. golden inpational routine service cost (Time of		ļ	710,010	

	Financial Systems FATION OF INPATIENT OPERATING COST	IU HEALTH JAY	HOSPITAL Provider CCN:	15_1320	In Peri od:	Lieu of Form CMS- Worksheet D-1	
JOINIFUI	ATTON OF THEATTENT OFERATING COST		Component CCN		From 01/01/20 To 12/31/20)19	
			Title		Subprovi der	6/29/2020 8:1	
	Cost Center Description	Total		verage Per	. I PF		
	cost center bescription	Inpatient Cost In				(col. 3 x col.	
12.00	MUDSERV (+i +l o V & VI V onl v)	1.00	2.00	3.00	4. 00	5.00) 42.0
2. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		υ	0.1	JU	OJ C	42.0
13.00	INTENSIVE CARE UNIT						43.0
4. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 0 45. 0
6. 00	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
0.00	<u> </u>		11 000)			1.00	10.0
8. 00 9. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines					3, 295 118, 913	
0 00	PASS THROUGH COST ADJUSTMENTS	y , ,	,				
0. 00	Pass through costs applicable to Program inp	atient routine se	ervices (from Wk	(St. D, Sur	n of Parts I a	nd C	50.0
1. 00	Pass through costs applicable to Program inp	atient ancillary	services (from	Wkst. D, s	sum of Parts I	1 0	51. C
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52.0
3. 00	Total Program inpatient operating cost exclu		ited, non-physic	cian anesth	netist, and	C	53.0
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					•	54. C
5. 00 6. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	
7. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (line	56 minus	line 53)		1
8. 00 9. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	portina period er	ndi na 1996, upda	ated and co	ompounded by t	he 0.00	
	market basket				, , , , , , , , , , , , ,		
0.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less tha	n expected costs					
2. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					62.0
3. 00		ent (see instruct	i ons)				63.0
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the co	st reporti	ng period (Se	e C	64.0
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after December	31 of the cost	reportino	a period (See		65.0
, 00	instructions)(title XVIII only)			. ,			
6. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Tine 64	prus rine os)(title xvii	i only). For	C	66.0
7. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through D	ecember 31 of t	the cost re	eporting perio	d C	67.0
8. 00	Title V or XIX swing-bed NF inpatient routin	e costs after Dec	ember 31 of the	cost repo	orting period	C	68.0
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line 68	3)			69.0
, oo	PART III - SKILLED NURSING FACILITY, OTHER N						70.6
0. 00 1. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c			. (TITIE 37,)		70.0
2. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	lino 14 v lino	25)			72. 0 73. 0
4. 00	Total Program general inpatient routine serv			33)			74. (
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service o	costs (from Work	sheet B, F	Part II, colum	n	75. 0
6. 00	Per diem capital-related costs (line 75 ÷ li						76.0
7. 00 8. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 0
9. 00	Aggregate charges to beneficiaries for exces	s costs (from pro					79. 0
0. 00 1. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st limitation (I	ine 78 mir	nus line 79)		80. (81. (
2. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 0
3.00							83. (
4. 00 5. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		5)				84. 0 85. 0
6. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 0
	PART IV - COMPUTATION OF OBSERVATION BED PAST Total observation bed days (see instructions						87. (
7.00		,					88. 0

Health Financial Systems	Y HOSPITAL	HOSPI TAL		In Lieu of Form CMS-2		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2019 To 12/31/2019		pared: 0 am
		Titl	e XIX	Subprovi der – I PF	Cost	
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	196, 902	2, 491, 767	0. 07902	1 0	0	90.00
91.00 Nursing School cost	O	2, 491, 767	0. 00000	0	0	91.00
92.00 Allied health cost	O	2, 491, 767	0. 00000	0	0	92.00
93.00 All other Medical Education	0	2, 491, 767	0.00000	0 0	0	93. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	nared:
			10 12/31/2017	6/29/2020 8: 1	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 1/0 050		
30. 00 03000 ADULTS & PEDI ATRI CS			1, 468, 059		30.00
40. 00 04000 SUBPROVI DER - PF			0		40.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		0.4070	750 400	447.000	
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 19707		147, 900	1
52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY		0. 05240		0	
		0.00000		_	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 20516		38, 831	
65. 00 06500 RESPI RATORY THERAPY		0. 30322 0. 70157		139, 163 178, 827	
66. 00 06600 PHYSI CAL THERAPY		0. 83613		69, 930	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 68266		36, 461	
68. 00 06800 SPEECH PATHOLOGY		2. 08227		4, 223	
69. 00 06900 ELECTROCARDI OLOGY		0. 03845		707	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46345		46, 755	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 40343		40, 733	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 13033		205, 212	
76. 00 03160 CARDI OPULMONARY		0. 22609		35, 552	
OUTPATIENT SERVICE COST CENTERS		0. 22007	137, 240	33, 332	70.00
90. 00 09000 CLINIC		0.00000	00	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 49525		0	
90. 02 09002 JAY FAMILY MEDICINE		2. 26071		0	
90. 03 09003 WOUND CLINIC		1. 11229		0	
90. 04 09004 OP ORTHO CLINIC		0. 00000		0	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		4. 62408		0	
90. 06 09006 NFUSI ON CLINI C		0. 13289		0	
91. 00 09100 EMERGENCY		0. 18054		1, 910	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 29043		0	1
93. 00 04950 0UTPATI ENT PSYCH		0. 96036		0	

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

Net charges (line 200 minus line 201)

0. 960368

2, 671, 698

93.00

905, 471 200. 00 201. 00 202. 00

93. 00 | 04950 | OUTPATI ENT PSYCH

200. 00 201. 00

202.00

	nancial Systems I U HEALTH JAY HO ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1320	Peri od:	worksheet D-3	
		Component	CCN: 15-M320	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
		Ti tl e	: XVIII	Subprovi der – I PF	PPS	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	-
	ATIENT ROUTINE SERVICE COST CENTERS		T			
	000 ADULTS & PEDI ATRI CS			701 422		30.0
	000 SUBPROVI DER - I PF 800 NURSERY			701, 422		40. 43.
	ILLARY SERVICE COST CENTERS					43.
	OOO OPERATI NG ROOM		0. 1970	71 0	0	50.
	200 DELIVERY ROOM & LABOR ROOM		0. 05240		Ö	1
	BOO ANESTHESI OLOGY		0.00000		0	
	100 RADI OLOGY-DI AGNOSTI C		0. 2051		1, 218	54.
0.00 060	DOO LABORATORY		0. 30322	26 67, 733	20, 538	60.
	RESPI RATORY THERAPY		0. 7015			65.
	000 PHYSI CAL THERAPY		0. 83613	4, 398	3, 677	66.
	OO OCCUPATI ONAL THERAPY		0. 68266		3, 517	
	SOO SPEECH PATHOLOGY		2. 0822		0	1
	200 ELECTROCARDI OLOGY		0. 03845		413	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46345		0	
	200 IMPL. DEV. CHARGED TO PATIENTS		0. 1505		0	1
	800 DRUGS CHARGED TO PATIENTS 60 CARDI OPULMONARY		0. 34668 0. 22609		53, 863 0	1
	PATIENT SERVICE COST CENTERS		0. 2200	99 0	0	76.
	DOO CLINIC		0.0000	00 0	0	90.
	001 FAMILY PRACTICE OF JAY COUNTY		1. 4952		339	
	002 JAY FAMILY MEDICINE		2. 2607		1, 542	
	003 WOUND CLINIC		1. 11229		0	1
0.04	004 OP ORTHO CLINIC		0.00000	00	0	90.
0.05 090	005 JAY FAMILY FIRST HEALTH CARE		4. 62408	39 0	0	90.
	006 INFUSION CLINIC		0. 13289	95 0	0	90.
	00 EMERGENCY		0. 18054		7, 198	
	OOO OBSERVATION BEDS (NON-DISTINCT PART		0. 29043		0	
	OUTPATIENT PSYCH		0. 96036		0	
00.00	Total (sum of lines 50 through 94 and 96 through 98)			296, 328	96, 676	
01.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
02.00	Net charges (line 200 minus line 201)			296, 328		202

	Financial Systems IU HEALTH JAY	_			eu of Form CMS-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1320	Peri od:	Worksheet D-3	
		Component	CCN: 15-Z320	From 01/01/2019 To 12/31/2019		
		Ti tl e		Swing Beds - SNF	Cost	
	Cost Center Description		Ratio of Cos		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					
	03000 ADULTS & PEDI ATRI CS			0	l	30.00
	04000 SUBPROVI DER - I PF			0		40.00
43. 00	04300 NURSERY					43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		0. 1970	71 0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 1970		1	
	05300 ANESTHESI OLOGY		0.05240		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 2051		1	
	06000 LABORATORY		0. 30322			
	06500 RESPIRATORY THERAPY		0. 30322			
	06600 PHYSI CAL THERAPY		0. 7013			1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 6826	· ·		
	06800 SPEECH PATHOLOGY		2. 0822	· ·	17, 342	1
	06900 ELECTROCARDI OLOGY		0. 03845		1	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46345		0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1505!		o n	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 34668		24, 862	1
	03160 CARDI OPULMONARY		0. 2260			1
70.00	OUTPATIENT SERVICE COST CENTERS		0.2200	0,001	3,0	1
90.00	09000 CLI NI C		0.00000	00	0	90.00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY		1. 4952		0	90. 01
	09002 JAY FAMILY MEDICINE		2. 2607		0	1
	09003 WOUND CLINIC		1. 11229		0	
90. 04	09004 OP ORTHO CLINIC		0. 00000		0	90. 04
	09005 JAY FAMILY FIRST HEALTH CARE		4. 62408		0	90. 05
	09006 INFUSION CLINIC		0. 13289		Ō	1
	09100 EMERGENCY		0. 18054		0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 29043		0	1
93.00	04950 OUTPATIENT PSYCH		0. 96036	58 0	0	93.00

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

Net charges (line 200 minus line 201)

0. 960368

221, 318

0 93.00

115, 298 200. 00 201. 00

93. 00 | 04950 | OUTPATI ENT PSYCH

200.00

201.00 202.00

Heal th	Financial Systems	IU HEALTH JAY HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
				From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cost		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1, 00	2, 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDIATRICS			5, 424		30.00
40.00	04000 SUBPROVI DER - I PF			57, 240		40.00
43.00	04300 NURSERY			10, 175		43. 00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATI NG ROOM		0. 19707		0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM		0. 05240			1
	05300 ANESTHESI OLOGY		0. 00000		0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C		0. 20516	.,	l	
	06000 LABORATORY		0. 30322			
	06500 RESPI RATORY THERAPY		0. 70157		0	65. 00
	06600 PHYSI CAL THERAPY		0. 83613			
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0. 68266 2. 08227		180	67. 00 68. 00
	06900 ELECTROCARDI OLOGY		0. 03845		25	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 03645			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46343		0	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 34668			
	03160 CARDI OPULMONARY		0. 22609			
	OUTPATIENT SERVICE COST CENTERS		3, 22007	2,007		1 2 3 00
90.00	09000 CLI NI C		0.00000	0 0	0	90.00
00 01	00001 FAMILY DRACTICE OF IAV COUNTY		1 40505	0		00 01

0

0

0

0 90.05

0

0 93.00 12, 552 200. 00

952

90.01

90.02 90. 03

90.04

90.06

91.00

92.00 0

201. 00

202. 00

1.495250

2. 260711

1.112291

0.000000

4. 624089

0.132895

0. 180541

0. 290432

0.960368

61, 369

61, 369

09001 FAMILY PRACTICE OF JAY COUNTY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

Net charges (line 200 minus line 201)

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

09002 JAY FAMILY MEDICINE

90. 05 09005 JAY FAMILY FIRST HEALTH CARE

09003 WOUND CLINIC

93. 00 | 04950 | OUTPATIENT PSYCH

91. 00 09100 EMERGENCY

09004 OP ORTHO CLINIC

09006 INFUSION CLINIC

90. 01

90.02

90.03

90.04

90.06

200.00

201.00

202.00

	Financial Systems IU HEALTH JAY HENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1320	Peri od:	worksheet D-3	
			CCN: 15-M320	From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Subprovi der - I PF	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	LABOTA ENT. DOUTANE OFFICE OF COOT, OFFITEDO		1.00	2. 00	3. 00	
00 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		ı	1 ,, ,
30. 00 40. 00	03000 ADULTS & PEDI ATRI CS 04000 SUBPROVI DER - I PF			46, 744		30. C
	04300 NURSERY			40, 744		43. (
0.00	ANCILLARY SERVICE COST CENTERS					10. \
0. 00	05000 OPERATI NG ROOM		0. 1970	71 C	0	50.
2. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 0524	00 0	0	52.
3. 00	05300 ANESTHESI OLOGY		0.0000		_	53.
4. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 2051			
0. 00	06000 LABORATORY		0. 3032			1
5. 00	06500 RESPI RATORY THERAPY		0. 7015			
6.00	06600 PHYSI CAL THERAPY		0. 8361		0	
7. 00 8. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0. 6826 2. 0822		0	
9. 00	06900 ELECTROCARDI OLOGY		0. 0384		_	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4634		0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 1505		0	1
	07300 DRUGS CHARGED TO PATIENTS		0. 3466		_	1
	03160 CARDI OPULMONARY		0. 2260			
	OUTPATIENT SERVICE COST CENTERS					
0.00	09000 CLI NI C		0.0000			
0. 01	09001 FAMILY PRACTICE OF JAY COUNTY		1. 4952		_	
	09002 JAY FAMILY MEDICINE		2. 2607		0	
	09003 WOUND CLINIC		1. 1122		0	1
0. 04	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE		0.0000		0	
). US). 06	09006 INFUSION CLINIC		4. 6240 0. 1328		0	
1. 00	09100 EMERGENCY		0. 1326		0	
2. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2904		0	
	04950 OUTPATIENT PSYCH		0. 9603		ő	
00.00				11, 029		
201. 00		(line 61)		, , , , , , , , , , , , , , , , , , ,	.,	201.
202. 00				11, 029		202.

		6/29/2020 8: 10	o am
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES	1.00	
1.00	Medical and other services (see instructions)	7, 007, 616	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3. 00
4.00	Outlier payment (see instructions)	0	4.00
4. 01	Outlier reconciliation amount (see instructions)	0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0. 000	5. 00
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6	0 0. 00	6. 00 7. 00
8.00	Transitional corridor payment (see instructions)	0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9. 00
10.00	Organ acqui si ti ons	Ö	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	7, 007, 616	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonabl e charges		
12. 00	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 Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	o o	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	19. 00
	instructions)		
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)	7, 077, 692	21. 00
22. 00	Interns and residents (see instructions)	7,077,042	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)	Ö	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	Ö	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	137, 802	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	3, 534, 739	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	3, 405, 151	27. 00
00.00	instructions)		00.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00 29. 00
30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	3, 405, 151	30.00
31. 00	Primary payer payments	1, 763	31. 00
32. 00	Subtotal (line 30 minus line 31)	3, 403, 388	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34. 00	Allowable bad debts (see instructions)	800, 507	34.00
35. 00	, , ,	520, 330	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	570, 929 3, 923, 718	
38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	3, 923, 710	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	0	39. 99
40.00	Subtotal (see instructions)	3, 923, 718	40.00
40. 01	Sequestration adjustment (see instructions)	78, 474	
40. 02	Demonstration payment adjustment amount after sequestration	0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs	4 157 770	40. 03
41. 00 41. 01	Interim payments Interim payments-PARHM	4, 157, 772	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)	0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)		42. 01
43. 00	Balance due provider/program (see instructions)	-312, 528	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)	·	43.01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	379, 102	44. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		00 5-
90.00	Original outlier amount (see instructions)	0	90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money	0 0. 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)	0.00	93.00
	Total (sum of lines 91 and 93)		94. 00
20		•	

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 01/01/2019	Worksheet E Part B
	Component CCN: 15-M320	To 12/31/2019	Date/Time Prepared: 6/29/2020 8:10 am
	Title XVIII	Subprovi der -	PPS

		II tie Aviii	I PF	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			9	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions))		0	2. 00
3.00	OPPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00 4. 01
4. 01 5. 00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instructions	s)		0. 000	5. 00
6. 00	Line 2 times line 5	<i>'</i> /		0.000	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 from Wkst. D, Pt. IV, co	ol. 13, line 200		0	9. 00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			9	11.00
	Reasonable charges				
12. 00	Ancillary service charges			26	
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)			26	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for paymen	nt for services on a	charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for payment			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)		G		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)	1: 10	- 11) (26	18.00
19. 00	Excess of customary charges over reasonable cost (complete only if instructions)	Tine 18 exceeds fin	ie II) (See	17	19. 00
20.00	Excess of reasonable cost over customary charges (complete only if	line 11 exceeds lir	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (see instructions)			9	21. 00
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instruction	anc)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	JIIS)		0	24. 00
200	COMPUTATION OF REIMBURSEMENT SETTLEMENT				2 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus t instructions)	the sum of lines 22	and 23] (see	9	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50))		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			9	30.00
31. 00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			9	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			Ö	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			0	35.00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		0	36. 00
37. 00	,			9	37. 00
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)			Ü	39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced de	evices (see instruct	i ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			9	40. 00 40. 01
40. 01	Demonstration payment adjustment amount after sequestration			0	40. 01
40. 03	Sequestration adjustment-PARHM pass-throughs			_	40. 03
41. 00	Interim payments			5	41. 00
41. 01	Interim payments-PARHM				41. 01
42. 00 42. 01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 00 42. 01
43. 00	Balance due provider/program (see instructions)			4	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)			'	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2, c	chapter 1,	0	44. 00
	§115. 2				
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	90.00
92. 00	The rate used to calculate the Time Value of Money			0.00	92. 00
93. 00	1			0	93. 00
94. 00	Total (sum of lines 91 and 93)			0	94. 00

| Peri od: | Worksheet E-1 | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: Health Financial Systems IU

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1320

		T: +1 o			6/29/2020 8: 10	
		ii tie	XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 959, 40		2, 197, 172	1. 00
	Interim payments payable on individual bills, either			O	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
Ī	Program to Provider					
	ADJUSTMENTS TO PROVIDER	08/14/2019	381, 10	0 08/14/2019	1, 960, 600	3. 01
3.02				o	0	3. 02
3. 03				0	0	3. 03
3.04				0	0	3. 04
3. 05				0	0	3. 05
	Provi der to Program					
3. 50 3. 51	ADJUSTMENTS TO PROGRAM			0	0	3. 50 3. 51
3. 51				0		3. 51
3. 52				0		3. 52
3. 54				0		3. 54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines		381, 10	-	1, 960, 600	3. 99
	3. 50-3. 98)		, ,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 340, 50	8	4, 157, 772	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
Ī	Program to Provider			-		
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
	Provider to Program TENTATIVE TO PROGRAM			ما	1 0	F F0
5. 50 5. 51	TENTATIVE TO PROGRAM			0		5. 50 5. 51
5. 52				0		5. 52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
	SETTLEMENT TO PROVIDER			0	0	6. 01
	SETTLEMENT TO PROGRAM		416, 62		312, 528	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 923, 88		3, 845, 244	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor				2.00	8. 00

Health Financial Systems IU

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1320 Component CCN: 15-M320

		Title	XVIII	Subprovider -	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		564, 03	9	5 0	1. 00 2. 00
3. 00	services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
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)					3.00
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3.02				o	0	3. 02
3.03				0	0	3. 03
3.04				0	0	3. 04
3.05				0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 50	ADJUSTMENTS TO PROGRAM			0		3. 50
3. 52				0	0	3. 52
3. 53				Ö	l ol	3. 53
3.54				O	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)		F/4 00		_	4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		564, 03	9	5	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5. 03	Provider to Program			U	0	5. 03
5. 50	TENTATI VE TO PROGRAM			ol	0	5. 50
5. 51				Ö	Ö	5. 51
5.52				o	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			o	4	6. 01
6. 02	SETTLEMENT TO PROGRAM			1	0	6. 02
7.00	Total Medicare program liability (see instructions)		564, 03		9	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
8. 00	Name of Contractor	(J	1. 00	2. 00	8. 00
0.00	INAME OF COTTACTOR			1		0.00

Health Financial Systems IU

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	CON: 15-Z320 I	0 12/31/2019	6/29/2020 8:	
		Title	XVIII S	ving Beds - SNF		ro um
		I npati en	t Part A	Par	t B	
					1	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	<u></u>	1.00	2.00	3. 00	4. 00	1 00
1.00	Total interim payments paid to provider		336, 538 0			1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		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	08/14/2019	51, 600			3. 01
3. 02			0			3. 02
3.03			0			3. 03
3. 04 3. 05			0		l .	3. 04
3.05	Drawider to Draggem					3.05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		1 (3. 50
3. 51	ADSOSTWEIVIS TO TROOTONWI				l .	3.50
3. 52			ĺ			3. 52
3. 53			l o		l .	3.53
3.54			0			3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		51, 600			3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		388, 138			4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider	'			'	
5. 01	TENTATI VE TO PROVI DER		0		(5. 01
5.02			0		l .	5. 02
5.03			0		(5. 03
	Provider to Program			I	1	
5. 50	TENTATI VE TO PROGRAM		0		l .	5. 50
5. 51			0		l .	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 52 5. 99
5. 99	5. 50-5. 98)		0			5. 99
6.00	Determined net settlement amount (balance due) based on					6, 00
5. 00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		0			6. 01
6. 02	SETTLEMENT TO PROGRAM		19, 151			6. 02
7. 00	Total Medicare program liability (see instructions)		368, 987			7.00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	Name of Contractor)	1. 00	2. 00	8. 00
8.00						

Heal th	Financial Systems IU HEALTH JAY	HOSPI TAL	In Lie	u of Form CMS-	2552-10	
CALCUL					epared: O am	
		Title XVIII	Hospi tal	Cost		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				1	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_	
1.00	OO Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12			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 I	ine 20			6. 00	
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	,				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
	20 O Balance due provider (line 9 (or line 10) minus line 20 and line 21) (see instructions)					

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

30. 00 31. 00 32. 00

		Component CCN: 15-Z320	10 12/31/2019	6/29/2020 8:1	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COCT OF COMPDED CERVILORS		1. 00	2. 00	
1. 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		249, 401	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)		249, 401	Ü	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A. and sum of Wkst. D.	116, 451	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing				
	instructions)				
3.01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4. 00
5. 00	instructions) Program days		145	0	5. 00
6. 00	Interns and residents not in approved teaching program (see in:	structions)	145	0	
7. 00	Utilization review - physician compensation - SNF optional met	,	0	O	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		365, 852	0	
9. 00	Primary payer payments (see instructions)		0	0	9.00
10. 00	Subtotal (line 8 minus line 9)		365, 852	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applications)	able to physician	0	0	11.00
	professi onal servi ces)			_	
12.00	Subtotal (line 10 minus line 11)	(ld	365, 852	0	
13. 00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude coinsurance	1, 364	0	13.00
14. 00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (see instructions)		364, 488	0	
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions))			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstra	ation) payment	0		16. 5!
	adjustment (see instructions)				
6. 99	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions)		18, 506	0	17. 0
	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	12, 029 18, 506	0	
9. 00	Total (see instructions)	uctions)	376, 517	0	
	Sequestration adjustment (see instructions)		7, 530	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
9. 03	Sequestration adjustment-PARHM pass-throughs				19. 03
20. 00	Interim payments		388, 138	0	20.00
	Interim payments-PARHM				20. 0°
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)	21)	10 151	0	21. 0
22. 00 22. 01	Balance due provider/program (line 19 minus lines 19.01, 20, and Balance due provider/program-PARHM (see instructions)	nd 21)	-19, 151	0	22. 00 22. 0
23. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	19, 569	0	l l
23. 00	chapter 1, §115.2	ce with own rab. 13 2,	17, 307	O	25.00
	Rural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			1
200.00	Is this the first year of the current 5-year demonstration per	od under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				ļ
.04 00	Cost Reimbursement				004 0
.01.00	Medicare swing-bed SNF inpatient routine service costs (from W	KSt. D-1, Pt. II, line			201. 00
002 00	66 (title XVIII hospital)) Medicare swing-bed SNF inpatient ancillary service costs (from	Wkst D_3 col 3 lin			202. 00
.02.00	200 (title XVIII swing-bed SNF))	WKSt. D-3, COI. 3, IIII	6		202.00
03. 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demonst	rati on	1
	peri od)				
	Medicare swing-bed SNF target amount	11 004)			205. 00
06. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 til				206. 00
07 00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse 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)	, cor. i, sum or rilles	'		200.00
09. 00	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	tions)			209. 00
	Reserved for future use	,			210.00
	Comparision of PPS versus Cost Reimbursement]
15. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	09 plus line 210) (see			215. 00
	instructions)				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	From 01/01/2019	Worksheet E-3 Part V Date/Time Prepared: 6/29/2020 8:10 am

				6/29/2020 8: 10	o am
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpati ent servi ces			2, 230, 389	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3.00	Organ acqui si ti on	,		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			2, 230, 389	4. 00
5. 00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 252, 693	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2,202,070	0.00
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			Ö	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			Ö	10.00
10.00	Customary charges			Ü	10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			Ö	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	1 3	a onargo baoro	Ü	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	,		0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0	14. 00
15. 00	Excess of customary charges over reasonable cost (complete on	lv if line 14 exceeds li	ne 6) (see	Ö	15. 00
10.00	instructions)	.ye exceeds	0) (000	Ü	10.00
16. 00	Excess of reasonable cost over customary charges (complete on	lv if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)	,			
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,			
18.00	Direct graduate medical education payments (from Worksheet E-	4, line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 252, 693	19. 00
20.00	Deductibles (exclude professional component)			301, 372	
21.00	Excess reasonable cost (from line 16)			0	21. 00
22.00	Subtotal (line 19 minus line 20 and 21)			1, 951, 321	22. 00
23.00	Coinsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			1, 951, 321	24.00
25.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		18, 196	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)			11, 827	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		16, 832	27. 00
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 963, 148	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	29. 50
29, 99	Demonstration payment adjustment amount before sequestration	,		0	29. 99
30.00	Subtotal (see instructions)			1, 963, 148	30.00
30. 01	Sequestration adjustment (see instructions)			39, 263	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31. 00	Interim payments			2, 340, 508	
31. 01	Interim payments-PARHM			, ,	31. 01
32. 00	Tentative settlement (for contractor use only)			0	32. 00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.0)	2. 31. and 32)		-416, 623	33. 00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m)		and 32, 01)	, 520	33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordan			120, 560	34. 00
	§115. 2		, , ,	.,	
	•			. '	•

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320 Component CCN: 15-M320	From 01/01/2019	
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I PF	PPS	
		'			
	T			1. 00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS	i aal adugati aa naymanta	\ \ \	274 002	1 00
1. 00 2. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and med Net IPF PPS Outlier Payments	icai education payments)	374, 803 253, 942	1. 00 2. 00
3.00	Net IPF PPS ECT Payments			253, 742	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent co	ost report filed on or l	hefore November	0. 00	4. 00
4.00	15, 2004. (see instructions)	ost report fired on or i	berore November	0.00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE coun program or hospital closure, that would not be counted withou CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0. 00	4. 01	
5.00	New Teaching program adjustment. (see instructions)			0. 00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0. 00	6. 00
7. 00	teaching program" (see instuctions) Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0. 00	7. 00
	teaching program" (see instuctions)				
8.00	Intern and resident count for IPF PPS medical education adjus	tment (see instructions)	0. 00	
9.00	Average Daily Census (see instructions)			3. 424658	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to	the power of .5150 -1}.		0. 000000	
11. 00 12. 00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			620 745	11. 00 12. 00
13. 00	Nursing and Allied Health Managed Care payment (see instruction	on)		628, 745 0	13. 00
14. 00	Organ acquisition (DO NOT USE THIS LINE)	OII)		٥	14. 00
15. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	15. 00
16. 00	Subtotal (see instructions)	. 401. 55)		628, 745	
17. 00					17. 00
18.00					18. 00
19.00	Deducti bl es			53, 196	19. 00
20.00	Subtotal (line 18 minus line 19)			575, 549	20.00
21. 00	Coi nsurance			0	
22. 00	Subtotal (line 20 minus line 21)			575, 549	
23. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		0	23. 00
24. 00	Adjusted reimbursable bad debts (see instructions)			0	24. 00
25. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	25. 00
26. 00	Subtotal (sum of lines 22 and 24)			575, 549	
27. 00 28. 00	Direct graduate medical education payments (see instructions) Other pass through costs (see instructions)			0	27. 00 28. 00
29. 00	Outlier payments reconciliation			0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			o l	
30. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		ő	30. 50
30. 99	Demonstration payment adjustment amount before sequestration	-,		o	30. 99
31. 00	Total amount payable to the provider (see instructions)			575, 549	
31. 01	Sequestration adjustment (see instructions)			11, 511	31. 01
31. 02	Demonstration payment adjustment amount after sequestration			0	
32. 00	Interim payments			564, 039	
33. 00	Tentative settlement (for contractor use only)			0	
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.0			-1	
35. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	35. 00
	§115. 2				
50. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2			253, 942	50 00
51. 00	Outlier reconciliation adjustment amount (see instructions)			253, 942	51. 00
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	
			'	- 1	

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

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/29/2020 8:10 am

OH y)					6/29/2020 8:1	O am
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1.00	Cash on hand in banks	4, 122, 773	0	0	0	1.00
2.00	Temporary investments	0	Ö	0	1	
3.00	Notes recei vabl e	0	0	0	0	1
4.00	Accounts receivable	3, 417, 610	0	0	0	4. 00
5.00	Other recei vable	-1, 504, 147	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	422, 405		0	0	
8.00	Prepai d expenses	177, 617		0	0	
9.00	Other current assets	1, 524, 082		0	0	
10.00	Due from other funds	0	0	0	0	
11. 00	Total current assets (sum of lines 1-10)	8, 160, 340	0	0	0	11. 00
12. 00	FI XED ASSETS Land	1 004 049	0	0	0	12 00
13. 00	Land improvements	1, 006, 948		0		12. 00 13. 00
14. 00	Accumulated depreciation	0	0	0		1
15. 00	Buildings	19, 125, 052	0	0	ol ő	15. 00
	Accumulated depreciation	-2, 361, 267	0	0		1
17. 00	Leasehold improvements	0	Ö	0	o o	1
18.00	Accumulated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	0	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	0	0	20. 00
21.00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
	Major movable equipment	8, 658, 980		0	0	
	Accumulated depreciation	-2, 815, 301	0	0	0	
	Minor equipment depreciable	0	0	0	0	
	Accumulated depreciation	0	0	0	0	
28. 00	HIT designated Assets	0	0	0	0 0	27. 00 28. 00
29. 00	Accumulated depreciation Minor equipment-nondepreciable		0	0		29.00
	Total fixed assets (sum of lines 12-29)	23, 614, 412	1	0	1	1
30.00	OTHER ASSETS	25, 014, 412				30.00
31.00	Investments	0	0	0	0	31. 00
32.00	Deposits on Leases	0	0	0	0	32. 00
33.00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	31, 774, 752	0	0	0	36. 00
	CURRENT LI ABI LI TI ES	1				
	Accounts payable	10, 452, 000		0		
38. 00	Salaries, wages, and fees payable	1, 236, 430	0	0	1	
	Payroll taxes payable	0	0	0	0	
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	0	0	0	0	
41.00	Accel erated payments		0	U	ή	42.00
43. 00	Due to other funds	0	0	0	0	1
44. 00	Other current liabilities	4, 744, 167	l ő	0		1
	Total current liabilities (sum of lines 37 thru 44)	16, 432, 597		0		
	LONG TERM LIABILITIES			_		
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	0	0	48. 00
49.00	Other long term liabilities	0	0	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0		1
51.00	Total liabilities (sum of lines 45 and 50)	16, 432, 597	0	0	0	51.00
	CAPITAL ACCOUNTS	1				
52. 00	General fund balance	15, 342, 155				52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0	1	54.00
55. 00	Donor created - endowment fund balance - unrestricted			0	1	55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0) 0	56.00
57.00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	15, 342, 155	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	31, 774, 752		0	1	
	59)			Ö		
			-		-	•

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

Provi der CCN: 15-1320

General Fund Special Purpose Fund Endowment Fund Special Purpose Fund	1. 00 2. 00 3. 00 0 4. 00 0 5. 00 0 6. 00
1.00 Fund balances at beginning of period 23,031,789 0 2.00 Net income (loss) (from Wkst. G-3, line 29) -7,689,634 3.00 Total (sum of line 1 and line 2) 15,342,155 0	2. 00 3. 00 0 4. 00 0 5. 00 0 6. 00
1.00 Fund balances at beginning of period 23,031,789 0 2.00 Net income (loss) (from Wkst. G-3, line 29) -7,689,634 3.00 Total (sum of line 1 and line 2) 15,342,155 0	2. 00 3. 00 0 4. 00 0 5. 00 0 6. 00
2.00 Net income (loss) (from Wkst. G-3, line 29)	2. 00 3. 00 0 4. 00 0 5. 00 0 6. 00
3.00 Total (sum of line 1 and line 2) 15,342,155 0	3. 00 0 4. 00 0 5. 00 0 6. 00
	0 4.00 0 5.00 0 6.00
	0 5. 00 0 6. 00
4. 00 ROUNDING	0 6.00
6.00	
7.00	0 7.00
8.00	0 8.00
9.00	0 9.00
10.00 Total additions (sum of line 4-9)	10.00
11. 00 Subtotal (line 3 plus line 10) 15, 342, 155 0	11. 00
12.00 Deductions (debit adjustments) (specify) 0 0	0 12.00
13.00	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)	19. 00
Endowment Fund Plant Fund	
6.00 7.00 8.00	
1.00 Fund balances at beginning of period 0	1.00
2.00 Net income (loss) (from Wkst. G-3, line 29) 3.00 Total (sum of line 1 and line 2) 0	2. 00 3. 00
4. 00 ROUNDING 0	4.00
5. 00 0	5.00
6.00	6. 00
7.00	7. 00
8.00	8. 00
9.00	9. 00
10.00 Total additions (sum of line 4-9) 0 0	10. 00
11.00 Subtotal (line 3 plus line 10) 0 0	11. 00
12.00 Deductions (debit adjustments) (specify) 0	12. 00
13. 00	13.00
14. 00 0 15. 00 0	14. 00 15. 00
16.00	16.00
17.00	17.00
18.00 Total deductions (sum of lines 12-17)	18.00
19.00 Fund balance at end of period per balance 0 0	19. 00
sheet (line 11 minus line 18)	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1320

			10	12/31/2019	Date/IIme Prep 6/29/2020 8:10	
	Cost Center Description	Inpati er	t	Outpati ent	Total	, am
		1.00		2.00	3. 00	
	PART I - PATIENT REVENUES	·				
	General Inpatient Routine Services					
1.00	Hospi tal	3, 981	427		3, 981, 427	1.00
2.00	SUBPROVI DER - I PF	2, 212	200		2, 212, 200	2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF	195	917		195, 917	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8. 00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	6, 389	544		6, 389, 544	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT					11. 00
12.00	CORONARY CARE UNIT					12.00
13. 00	BURN INTENSIVE CARE UNIT					13.00
14. 00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes	0		0	16. 00
17 00	11-15)	6, 389	E 4 4		6, 389, 544	17. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services	12, 006		48, 794, 148	60, 800, 483	17.00
18. 00 19. 00	Outpatient services		238	26, 685, 949	27, 573, 187	19. 00
20. 00	RURAL HEALTH CLINIC	887	0	20, 003, 949	27, 573, 167	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		U	٥	٥	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	o	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst. 19,283	117	75, 480, 097	94, 763, 214	28. 00
	G-3, line 1)	,			.,,	
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			39, 079, 180		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	T + 1 + 1 + 1 · · · · · · · · · · · · · ·		0			41. 00
42.00	Total deductions (sum of lines 37-41)	(+nonofor		20 070 100		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		39, 079, 180		43. 00
	to Wkst. G-3, line 4)	I			ļ	

Heal th	Financial Systems	IU HEALTH JAY HOSPITAL	In lie	eu of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1320	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:1	
				0/27/2020 0. 1	o aiii
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I,	column 3, line 28)		94, 763, 214	1. 00
2.00	Less contractual allowances and discounts on pa	itients' accounts		64, 386, 557	2. 00
3.00	Net patient revenues (line 1 minus line 2)			30, 376, 657	3. 00
4.00	Less total operating expenses (from Wkst. G-2,	Part II, line 43)		39, 079, 180	4. 00
5.00	Net income from service to patients (line 3 min	us line 4)		-8, 702, 523	5. 00
	OTHER INCOME				
6.00	6.00 Contributions, donations, bequests, etc				6. 00
7.00					7. 00
8.00	8.00 Revenues from telephone and other miscellaneous communication services				8. 00
9.00	9.00 Revenue from television and radio service				9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests	;		0	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical suppl	ies to other than patients		0	16. 00
17.00	Revenue from sale of drugs to other than patien	its		0	17. 00
18.00	Revenue from sale of medical records and abstra	icts		0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc	c.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and	canteen		0	20. 00
21.00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MI SCELLANEOUS I NCOME			1, 012, 884	24. 00
25.00	Total other income (sum of lines 6-24)			1, 012, 884	25. 00
26.00	Total (line 5 plus line 25)			-7, 689, 639	26. 00
27 00	OO OTHER EVERNSES (POUNDLINGV)				27 00

27.00

28.00

-5

-7, 689, 634 29. 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

27. 00 OTHER EXPENSES (ROUNDINGY)