Health Financial Systems	IU HEALTH JAY HOSPITAL	-	In Lieu	of Form CMS-2552-10
This report is required by law (42 USC 1395g;				ORM APPROVED
payments made since the beginning of the cost	reporting period being deemed	l overpayments (42 USC		MB NO. 0938-0050
				XPI RES 09-30-2025
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST	REPORT CERTIFICATION Provid			lorksheet S
AND SETTLEMENT SUMMARY		To		Parts I-III Date/Time Prepared:
				5/26/2023 12:02 pm
PART I - COST REPORT STATUS				· · · · ·
Provider 1. [X] Electronically prepared			Date: 5/26/2023	B Time: 12:02 pm
use only 2. [] Manually prepared cost r				
3.[0]If this is an amended re 4.[F]Medicare Utilization. Er	<pre>>port enter the number of time nter "F" for full, "L" for lo</pre>	es the provider resubr w, or "N" for no.	mitted this co	st report
Contractor 5. [1] Cost Report Status 6.		10. NPR Da		
use only (1) As Submitted 7.	Contractor No.	11. Contra	actor's Vendor	Code: 4
	[N] Initial Report for this [N] Final Report for this Pr	ovider CCN	n Time 5, Con number of time	s reopened = 0-9.
(3) Settled with Audit ^{9.} (4) Reopened	[]			s reopened = 0-9.
(4) Reopened (5) Amended				
PART II - CERTIFICATION BY A CHIEF FINANCIAL (
MISREPRESENTATION OR FALSIFICATION OF ANY INFO				
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMEN				
PROVIDED OR PROCURED THROUGH THE PAYMENT DIREC ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONME		ICK OR WERE UTHERWISE	ILLEGAL, CRIM	NAL, CIVIL AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONME	INT MAY RESULT.			
CERTIFICATION BY CHIEF FINANCIAL OFFIC	CER OR ADMINISTRATOR OF PROVID	JER(S)		
I HEREBY CERTIFY that I have read the	above certification statement	t and that I have exar	mined the acco	mpanyi ng
electronically filed or manually submi				
Statement of Revenue and Expenses prep				
beginning 01/01/2022 and ending 12/31				
			is cost report	were
are true, correct, complete and prepai applicable instructions, except as not regarding the provision of health care provided in compliance with such laws	red from the books and records ted. I further certify that I e services, and that the servi	s of the provider in a am familiar with the	accordance wit laws and regu	h Lations

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX		
		1	2	SI GNATURE STATEMENT	
1	Jor	n Vanator	т	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name	Jon Vanator			2
3	Signatory Title	CFO			3
4	Date	(Dated when report is electronica			4

			Title XVIII				
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	66, 537	386, 781	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	123, 817	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
200.00	TOTAL	0	190, 354	386, 781	0	0	200.00

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

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi d	er CCN	1	Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti	me Pre	epare
	1.00	2.00		3.00			1.00	5/26/20	123 12:	02 ρ
	Hospital and Hospital Health Care Co				I					
00	Street: 500 W. VOTAW	P0 Box:								1.
00	City: PORTLAND	State: IN	Zip Code	e: 4737	1 Count	y: JAY				2.
		Component Name	CCN	CBSA	A Provi der	Date	Payme	nt Syst	em (P,	
			Number	Numbe	er Type	Certified	Т,	0, or	N)	
							V	XVIII	XIX	1
		1.00	2.00	3.00) 4.00	5.00	6.00	7.00	8.00	1
	Hospital and Hospital-Based Componer	nt Identification:								
0	Hospi tal	IU HEALTH JAY HOSPITAL	151320	9991	5 1	01/01/2004	Ν	0	Р	3
0	Subprovider - IPF									4
0	Subprovider - IRF									5
0	Subprovider - (Other)									6
- C	Swing Beds - SNF	IU HEALTH JAY SWING BED	157320	9991	5	01/01/2004	N	0	N	7
с С	Swing Beds - NF	TO HEREIN SKI SKING DED	102020	,,,,,		017 017 2001				8
с С	Hospital -Based SNF									9
00	Hospital - Based NF									10
00	Hospital -Based OLTC									11
00	Hospital-Based HHA									12
00	Separately Certified ASC									13
00	Hospital-Based Hospice									14
00	Hospital-Based Health Clinic - RHC									15
0C	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
00	Renal Dialysis									18
00	Other									19
	1					From:		То	:	
						1.00		2.0	00	1
00	Cost Reporting Period (mm/dd/yyyy)					01/01/2	022	12/31/	/2022	20
00	Type of Control (see instructions)					2				21
					1.00	2.00		3. ()0	
	Inpatient PPS Information									
00	Does this facility qualify and is it	currently receiving pay	ments fo	r	N	N				22
	disproportionate share hospital adju	stment, in accordance wi	th 42 CFI	२						
	§412.106? In column 1, enter "Y" fo	or yes or "N" for no. Is	thi s							
	facility subject to 42 CFR Section §									
	hospital?) In column 2, enter "Y" fo	r ves or "N" for no.								
D1	Did this hospital receive interim UC		tal UCPs.	for	Ν	N				22
	this cost reporting period? Enter ir									
	for the portion of the cost reportir									
	1. Enter in column 2, "Y" for yes or	"N" for no for the port	tion of th							
	cost reporting period occurring on c									
		arter october 1. (see								
<u></u>	instructions)				N	N				1 22
52	Is this a newly merged hospital that				N	N				22
	determined at cost report settlement			umn						
	1, "Y" for yes or "N" for no, for th									
	period prior to October 1. Enter in			no,						
	for the portion of the cost reportir									
	Did this hospital receive a geograph				N	N		N		22
03	rural as a result of the OMB standar	5								
03	adopted by CMS in FY2015? Enter in c									1
23	for the portion of the cost reportir	g period prior to Octobe		er						1
03			no cost							
23	in column 2, "Y" for yes or "N" for									
03						1				1
03	in column 2, "Y" for yes or "N" for	er October 1. (see instr	ructions)	as						1
)3	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	er October 1. (see instr 100 but not more than 49	ructions) 99 beds (a							1
)3	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	er October 1. (see instr 100 but not more than 49	ructions) 99 beds (a							
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column	ructions) 99 beds (a 3, "Y" fo	or						22
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from	ructions) 99 beds (a 3, "Y" fo n urban to	or o						22
	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis	ructions) 99 beds (a 3, "Y" fo n urban to stical are	or o eas						22
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	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportin in column 2, "Y" for yes or "N" for	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th	ructions) 99 beds (a 3, "Y" fo n urban to stical are r "N" for er 1. Ente ne cost	or o eas no						22
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04	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column edicaid days on lines 24	ructions) 29 beds (a 3, "Y" for stical arc stical arc s	or beas no er as for 5		3 N				22
04	in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column ic reclassification from delineations for statis column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see instr 100 but not more than 49 2.105)? Enter in column edicaid days on lines 24 of admission, 2 if censu	ructions) 29 beds (a 3, "Y" for stical arc "N" for er 1. Entene cost ructions) 29 beds (a n 3, "Y" for and/or 29 us days, (a	or beas no er as for 5 or 3		3 N				
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	ALTH JAY HO				In Lieu			2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	CN: 15-1320	Period: From 01/0		Part I	eet S-2	
				To 12/3	1/2022	Date/T 5/26/2		
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO day	id 0 ys Meo	ither di cai d days	
24.00 If this provider is an LDDS baselitel, optar the	1.00	2.00	3.00	4.00	5.00		5.00	24.00
 24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 4, out-of-state Medicaid days in column 1, the in-state Medicaid eligible unpaid days in column 3, out-of-state Medicaid eligible unpaid 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. 	o			0		0	C	25.00
				Urban/R		Date of 2.		
26.00 Enter your standard geographic classification (not w		s at the be	gi nni ng of		2		-	26.00
cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for i ïcation in	rural. If a column 2.	ppl i cabl e,		2			27.00
35.00 If this is a sole community hospital (SCH), enter th effect in the cost reporting period.	e number of	periods S	UH STATUS I		U			35.00
36.00 Enter applicable beginning and ending dates of SCH s	tatus. Subs	script line	: 36 for num	Begi nr 1. (Endi 2.		36.00
of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), ente	es.	·			o			37.00
<pre>is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f instructions)</pre>								37.01
38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.								38.00
				Y/		Y/ 2.		-
39.00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), on the mileage ii)? Enter	r (iii)? En e requireme in column	ter in colu nts in 2 "Y" for y	mn es		Ν	J	39.00
40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for				N	J	40.00
					V 1.00	2.00		-
Prospective Payment System (PPS)-Capital	-+		the star of the					45.00
 45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc 	eption for	extraordi n	ary circums	tances	N N	N N	N N	45.00 46.00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS				0	N	N	N	47.00
48.00 Is the facility electing full federal capital paymen Teaching Hospitals					N	N	N	48.00
 56.00 Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to c involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2 57.00 For cost reporting periods beginning prior to Decemb is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no i "sidents start training in the first month of this "N" for no in column 2. If column 2 is "Y", complet 	"Y" for yes or 27, 2020, olumn 1 is ams in the CRs) MA din ber 27, 2020 n column 1. cost report	s or "N" fo under 42 "Y", or if prior year rect GME pa D, if line in approve If column ting period	r no in col CFR 413.78(this hospi or penulti yment reduc 56, column d GME progr 1 is "Y", ? Enter "Y	umn 1. For b)(2), see tal was mate year, tion? Enter 1, is yes, ams trained did " for yes o				56.00
complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not compl	`applicable R 413.77(e on duty, i	e. For cost)(1)(iv) a f the resp	reporting nd (v), reg onse to lin	periods ardless of e 56 is "Y"				

Health Financial Systems IU HE	ALTH JAY	HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provider CC		Period: From 01/01/2022	Worksheet S-2 Part I	
				o 12/31/2022	Date/Time Pre	
				V	5/26/2023 12: XVIII XIX	02 pm
				1.00		50.00
58.00 If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' services	as		58.00
59.00 Are costs claimed on line 100 of Worksheet A? If ye				N		59.00
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification	
			17 1		Cri teri on	
			1.00	2.00	Code	
60.00 Are you claiming nursing and allied health education	n (NAHE)	costs for	1.00 N	2.00	3.00	60.00
any programs that meet the criteria under 42 CFR 413						
instructions) Enter "Y" for yes or "N" for no in co is "Y", are you impacted by CR 11642 (or subsequent						
adjustment? Enter "Y" for yes or "N" for no in colu	ımn 2.				51 1 0115	
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
column 1. (see instructions)						
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61.01
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,	-					01.02
and primary care FTEs added under section 5503 of						
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care						61.03
and/or general surgery residents, which is used for						
determining compliance with the 75% test. (see instructions)						
61.04 Enter the number of unweighted primary care/or						61.04
surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						
61.05 Enter the difference between the baseline primary						61.05
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line	2					
61.04 minus line 61.03). (see instructions)						
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.06
care or general surgery. (see instructions)						
	Pro	ogram Name	Program Code	Unweighted	Unweighted Direct GME	
					FTE Count	
61.10 Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00	61.10
specialty, if any, and the number of FTE residents				0.00	0.00	01.10
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,	ו					
the direct GME FTE unweighted count. Enter Th corumn 4,						
					1.00	
ACA Provisions Affecting the Health Resources and Se	ervi ces a	Administratior	n (HRSA)		1.00	
62.00 Enter the number of FTE residents that your hospital	traineo			riod for which	0.00	62.00
your hospital received HRSA PCRE funding (see instru 62.01 Enter the number of FTE residents that rotated from		ng Health Cen	ter (THC) into	o your hospital	0.00	62.01
during in this cost reporting period of HRSA THC pro	ogram. (s	see instructio		- ·		
Teaching Hospitals that Claim Residents in Nonprovid63.00Has your facility trained residents in nonprovider s	ettings	during this c	ost reportina	period? Enter	N	63.00
"Y" for yes or "N" for no in column 1. If yes, compl						

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPL		ALTH JAY HOSPITAL ATA Provide		Period:	u of Form CMS-2 Worksheet S-2	
				rom 01/01/2022 To 12/31/2022		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Yea period that begins on or after J			igsThis base yea	r is your cost	reporting	
4.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column	yes, or your facili ber of unweighted nou tations occurring in number of unweighted ur hospital. Enter in	ty trained reside n-primary care all nonprovider d non-primary car n column 3 the ra	e	0 0.00	0. 000000	64.00
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col.	
	-		FTEs Nonprovider	FTEs in Hospital	3/ (col . 3 + col . 4))	
	1.00	2.00	Si te 3.00	4.00	5.00	-
55.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to 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	0.0	0 0.00	0. 000000 Ratio (col.	65.00
			FTEs Nonprovider Site	FTEs in Hospital	1/ (col . 1 + col . 2))	
		. NI	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n wonprovider Set	tingsEffective	for cost report	ing periods	
6.00 Enter in column 1 the number of a FTEs attributable to rotations of Enter in column 2 the number of a FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.0	0 0.00	0. 000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
7.00 Estas is a literative for the	1.00	2.00	3.00	4.00	5.00	17.0-
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.0	0 0.00	0. 000000	

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu o	of Form CMS-2	552-10					
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Period: Wo	/orksheet S-2 Part I						
To 12/31/2022 Da	ate/Time Prep						
	5/26/2023 12:0	<u>J2 pm</u>					
	1.00						
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)68.00For a cost reporting period beginning prior to October 1, 2022, did you obtain permission from your MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 10, 2022)?	N	68.00					
Inpatient Psychiatric Facility PPS	2.00 3.00						
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? N		70.00					
Enter "Y" for yes or "N" for no. 71.00 fline 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most N	N O	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)							
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. 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most	0	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)							
	1.00						
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00					
81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter	N	80.00 81.00					
"Y" for yes and "N" for no.							
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00					
86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section		86.00					
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital an extended neoplastic disease care hospital classified under section	N	87.00					
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	Number of						
Approved for Permanent	Number of Approved						
	Permanent						
(Y/N) A 1.00	Adjustments 2.00						
88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target	0	88.00					
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions)							
Column 2: Enter the number of approved permanent adjustments.	Approved						
Wkst. A Line Effective No. Date	Approved Permanent						
	Adjustment						
	Amount Per Discharge						
1.00 2.00	3.00	00.00					
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 0.00 on which the per discharge permanent adjustment approval was based.	0	89.00					
Column 2: Enter the effective date (i.e., the cost reporting period							
beginning date) for the permanent adjustment to the TEFRA target amount per discharge.							
Column 3: Enter the amount of the approved permanent adjustment to the TEFRA target amount per discharge.							
V	XIX						
Title V and XIX Services	2.00						
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N	Y	90.00					
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in N	N	91.00					
full or in part? Enter "Y" for yes or "N" for no in the applicable column.							
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.	N	92.00					
93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter N "Y" for yes or "N" for no in the applicable column.	N	93.00					
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, 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 applicable column. 0.00	0.00	95.00					
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N applicable column.	N	96.00					
97.00 f line 96 is "Y", enter the reduction percentage in the applicable column. 0.00	0.00	97.00					

IUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CCN: 15-1320	Period:	u of Form CMS- Worksheet S-:	
				From 01/01/2022 To 12/31/2022		onaroc
				10 12/31/2022	5/26/2023 12	
				V	XI X	
	r			1.00	2.00	
	Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" column 1 for title V, and in column 2 for title XIX.	nterns and re for yes or "N	sidents post " for no in	N	Y	98. (
98. 01	Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for t title XIX.				Y	98.
98. 02	Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V, and in column 2 for title XIX.			N	Y	98.
98. 03	Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in column 2 for title XIX.				N	98.
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAP outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX.		N	Ν	98.	
8. 05	Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 2 for title XIX.	isallowance o title V, and	n N in	Y	98.	
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.	or Wkst. D, V, and in	N	Y	98.	
	Rural Providers			N/		105
06.00	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all	-inclusive me	thod of payme	nt N		105. 106.
07.00	for outpatient services? (see instructions) Column 1: If line 105 is Y, is this facility eligible for c training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, dc	N		107.		
08.00	approved medical education program in the CAH's excluded I Enter "Y" for yes or "N" for no in column 2. (see instruct Is this a rural hospital qualifying for an exception to the	i ons)	. ,	2 N		108
	CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati ona		Respi ratory	
00 00	If this hospital qualifies as a CAH or a cost provider, are	1.00	2.00 N	3.00 N	4.00 N	109.
	therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.				11	107.
					1.00	-
10.00		al Demonstrat "Y" for yes o	ion project (r "N" for no.	§410A Ifyes,		
10.00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	al Demonstrat "Y" for yes o	ion project (r "N" for no.	§410A Ifyes, ough 215, as	1. 00 N	110.
10. 00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating in	ion project (r "N" for no. lines 200 thr Community period? Ente enter the n column 2.	§410A If yes, ough 215, as 1.00 N	1.00	
10. 00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wc applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating in	ion project (r "N" for no. lines 200 thr Communi ty period? Ente enter the n column 2. s; and/or "C"	\$410A If yes, ough 215, as 1.00 N r	1.00 N	110.
10.00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wc applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services.	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed	ion project (r "N" for no. lines 200 thr Communi ty period? Ente enter the n column 2. s; and/or "C" 1.00	§410A If yes, ough 215, as 1.00 N	1. 00 N	110.
10. 00 11. 00 12. 00 13. 00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began particid demonstration. In column 3, enter the date the hospital ce. Did this hospital participate in the Community Health Access	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is pating in the cased as and Rural	ion project (r "N" for no. lines 200 thr Community period? Ente enter the n column 2. s; and/or "C" <u>1.00</u> N	\$410A If yes, ough 215, as 1.00 N r	1.00 N	110.
10. 00 11. 00 12. 00 13. 00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to con- integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If con- "Y", enter in column 2, the date the hospital began particing demonstration. In column 3, enter the date the hospital con- participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is pating in the passed ass and Rural c cost	ion project (r "N" for no. lines 200 thr Communi ty peri od? Ente enter the n column 2. s; and/or "C" 1.00 N	\$410A If yes, ough 215, as 1.00 N r	1.00 N 2.00	110. 1110. 1111. 1112. 1113.
10. 00 11. 00 12. 00 13. 00 15. 00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no.	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is pating in the eased ass and Rural cost pr "N" for no B, or E only) 93" percent (includes	ion project (r "N" for no. lines 200 thr Community period? Ente enter the n column 2. s; and/or "C" 1.00 N	\$410A If yes, ough 215, as 1.00 N r	1.00 N 2.00	110. 1110. 1111. 1112. 1113.
10.00 11.00 12.00 13.00 15.00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscel aneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes c in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y" "N" for no.	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is pating in the eased as and Rural cost or "N" for no B, or E only) '93" percent (includes ers) based on ' for yes or	i on project (r "N" for no. li nes 200 thr Communi ty peri od? Ente enter the n col umn 2. s; and/or "C" 1.00 N	\$410A If yes, ough 215, as 1.00 N r	1.00 N 2.00	1110. 1110. 1111. 1112. 1113. 1113.
10.00 11.00 12.00 13.00 15.00 16.00 17.00	for yes or "N" for no for each therapy. Did this hospital participate in the Rural Community Hospit Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, Lines 200 through 218, and Wo applicable. If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c "Y" for yes or "N" for no in column 1. If the response to c integration prong of the FCHIP demo in which this CAH is pa Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. Did this hospital participate in the Pennsylvania Rural Hea (PARHM) demonstration for any portion of the current cost r period? Enter "Y" for yes or "N" for no in column 1. If c "Y", enter in column 2, the date the hospital began particid demonstration. In column 3, enter the date the hospital ce participation in the demonstration, if applicable. Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current reporting period? Enter "Y" for yes or "N" for no. Miscel Laneous Cost Reporting Information Is this an all-inclusive rate provider? Enter "Y" for yes c in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either " for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208.1. Is this facility classified as a referral center? Enter "Y"	al Demonstrat "Y" for yes o prksheet E-2, the Frontier cost reporting column 1 is Y, articipating i additional bed alth Model reporting column 1 is pating in the cased as and Rural cost or "N" for no B, or E only) '93" percent (includes ers) based on for yes or urance? Enter	ion project (r "N" for no. lines 200 thr Communi ty peri od? Ente enter the n column 2. s; and/or "C" 1.00 N N N N	\$410A If yes, ough 215, as 1.00 N r	1.00 N 2.00 3.00	110. 1110. 1111. 1112. 1113.

Ith Financial Systems IU HEALTH JAY HOSPIT SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Prov		: 15-1320		riod: om 01/01/2022	Worksheet S Part I	Prepared
		Premi ums		Losses	Insurance	
	-	1.00	_	2.00	3.00	
3.01 List amounts of malpractice premiums and paid losses:		53, 1	130	0		0118.0
			+	1.00	2.00	
3.02 Are malpractice premiums and paid losses reported in a cost center	other t	han the		N	2.00	118.0
Administrative and General? If yes, submit supporting schedule lis and amounts contained therein. 2.00D0 NOT USE THIS LINE	sting co	st centers				119.0
0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmle §3121 and applicable amendments? (see instructions) Enter in column "N" for no. Is this a rural hospital with < 100 beds that qualifies Hold Harmless provision in ACA §3121 and applicable amendments? (see Enter in column 2, "Y" for yes or "N" for no.	n 1, "Y" s for th	for yes or e Outpatier	-	Ν	Ν	120. (
0.00 Did this facility incur and report costs for high cost implantable	devi ces	charged to		Y		121.
patients? Enter "Y" for yes or "N" for no. 2.00Does the cost report contain healthcare related taxes as defined in	n §1903()	w)(3) of th	ne	Y	5.00	122.
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y"						
the Worksheet A line number where these taxes are included. 3.00Did the facility and/or its subproviders (if applicable) purchase p	orofessi	onal				123.
services, e.g., legal, accounting, tax preparation, bookkeeping, pa						
management/consulting services, from an unrelated organization? In for yes or "N" for no.	column	1, enter "				
If column 1 is "Y", were the majority of the expenses, i.e., greate			al			
professional services expenses, for services purchased from unrelat located in a CBSA outside of the main hospital CBSA? In column 2, e			or			
"N" for no.						
Certified Transplant Center Information 5. 00Does this facility operate a Medicare-certified transplant center?	Enter "	V" for ves		N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) be		i itti yes		IN		125.
5.00 If this is a Medicare-certified kidney transplant program, enter th	ne certi	fication da	ite			126.
in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare-certified heart transplant program, enter the	e certif	ication dat	e			127.
in column 1 and termination date, if applicable, in column 2.						
3.00 If this is a Medicare-certified liver transplant program, enter the in column 1 and termination date, if applicable, in column 2.	e certif	ication dat	e			128.
9.00 If this is a Medicare-certified lung transplant program, enter the	certi fi	cation date	9			129.
in column 1 and termination date, if applicable, in column 2. 0.00 f this is a Medicare-certified pancreas transplant program, enter	the cor	tification				130.
date in column 1 and termination date, if applicable, in column 2.	the cer	tincation				130.
1.00 If this is a Medicare-certified intestinal transplant program, ente	er the c	erti fi cati d	on			131.
date in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare-certified islet transplant program, enter the in column 1 and termination date, if applicable, in column 2.	e certif	ication dat	e			132.
8.00 Removed and reserved 4.00 If this is a hospital-based organ procurement organization (OPO), @	ontor th		n l			133.
in column 1 and termination date, if applicable, in column 2.	sinter th		21			134.
All Providers	in CMC	Dub 1E 1		Y	1511050	140
0.00 Are there any related organization or home office costs as defined chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, ar are claimed, enter in column 2 the home office chain number. (see i	nd home	office cost	s	-	15H059	140.
1.00 2.00 If this facility is part of a chain organization, enter on lines 14	41 throu	ah 143 the	nar	<u>3.00</u> and address	of the home	2
office and enter the home office contractor name and contractor num	mber.					
I. OOName: INDIANA UNIVERSITY HEALTH Contractor's Name: WI SCONSIN SERVICES	PHYSI CI /	AN Contrac	tor'	s Number: 0810	1	141.
2. OOStreet: 340 WEST TENTH STREET PO Box:						142.
3.00 City: INDIANAPOLIS State: IN		Zip Code	e:	4620	4	143.
					1.00	_
1.00 Are provider based physicians' costs included in Worksheet A?					Y	144.
			-	1.00	2.00	
5.00 If costs for renal services are claimed on Wkst. A, line 74, are th	ne costs	for		1.00	2.00	145.
inpatient services only? Enter "Y" for yes or "N" for no in column no, does the dialysis facility include Medicare utilization for thi period? Enter "Y" for yes or "N" for no in column 2.	1. If c	olumn 1 is				
		roport2		Ν		146.
5.00Has the cost allocation methodology changed from the previously fil	ed cost	report				

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	١	Provider CC	N: 15-1320		eriod:		Worksheet S-	2
					Fi Te		01/2022 31/2022		
								1.00	
47.00Was there a change in the statist	cal basis? Enter "Y"	for ye	s or "N" for	no.				N 1.00	147.0
48.00Was there a change in the order o	f allocation? Enter "۱	Y" for	yes or "N" f	or no.				N	148.0
19.00Was there a change to the simplif	ed cost finding metho	od? Ent						N	149.0
			Part A 1.00	Part 2.00			le V 00	Title XIX 4.00	-
Does this facility contain a prov	ider that qualifies fo	or an e				-			
or charges? Enter "Y" for yes or									
55. 00 Hospi tal			N	Ν			Ν	N	155. C
56.00 Subprovider - IPF			N	N			N	N	156.0
57.00 Subprovi der – IRF 58.00 SUBPROVI DER			N	N			N	N	157. C
59. 00 S0BPROVI DER 59. 00 SNF			N	N			N	N	159.0
50. OOHOME HEALTH AGENCY			N	N			N	N	160.0
51.00 CMHC				Ν			N	N	161.0
								1.00	-
Mul ti campus									
55.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more camp	uses in di	ffer	ent CBS	As?	N	165. C
	Name		County	State	Zip	Code	CBSA	FTE/Campus	
	0		1.00	2.00	3.	00	4.00	5.00	
56.00 If line 165 is yes, for each								0.0	0166.0
campus enter the name in column 0, county in column 1, state in									
column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1.00	_
Health Information Technology (HI	T) incentive in the Ar	meri can	n Recovery an	d Rei nves	tment	Act			
57.00 Is this provider a meaningful use								Y	167.0
58.00 f this provider is a CAH (line 1 reasonable cost incurred for the				e 16/ IS '	Υ),	enter	the		168.0
58.01 If this provider is a CAH and is				r qualify	for	a hards	hin	N	168.0
exception under §413.70(a)(6)(ii)						a naras	inβ		100.0
59.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")					N"), en	ter the	0. C	0169.0
						Begi	nni ng	Endi ng	
						1.	00	2.00	
70.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and end	ding da	te for the r	eporti ng					170.0
						1	00	2.00	_
71.00 fline 167 is "Y", does this pro	vider have any days fo	or indi	viduals enro	lledin			<u>00</u> Y		3171.0
							•	7	9171.0
section 1876 Medicare cost plans	reported on Wkst. S-3.	ΡΤ. Ι	, line 2, co	I. 6? Ente	er:				

OSPI T	Financial Systems IU HEALTH JA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet S- Part II Date/Time Pr 5/26/2023 12	epared:
		·		Y/N	Date	
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSI					_
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format.	N for all NU re	esponses. Ent	er all dates in	the	
	COMPLETED BY ALL HOSPITALS					-
	Provider Organization and Operation					-
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	Ν		1.0
	reporting period? If yes, enter the date of the change in	column 2. (see	instructions			
			Y/N	Date	V/I	
. 00	Has the provider terminated participation in the Medicare	Drogram2 lf	1.00 N	2.00	3.00	2.0
. 00	yes, enter in column 2 the date of termination and in colum voluntary or "1" for involuntary.	mn 3, "V" for				2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					_
. 00	Column 1: Were the financial statements prepared by a Cer- Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe	for Compiled, ailable in	Y	A		4.0
. 00	those on the filed financial statements? If yes, submit re-					5.0
			•	Y/N	Legal Oper.	
				1.00	2.00	
~~	Approved Educational Activities	<u> </u>				
. 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: IT yes, I	s the provide	r N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions		Ν		7.0
. 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.		wed during th			8.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	ns.				9.0
0. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	the current	N		10.0
1. 00	Are GME cost directly assigned to cost centers other than	I& Rin an An	proved	Ν		11.0
1.00	Teaching Program on Worksheet A? If yes, see instructions.		proved			
					Y/N	
					1.00	
	Bad Debts		11			1 1 0 0
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection			act reporting	Y N	12. C
5.00	period? If yes, submit copy.	poincy change	uuring this c	lost reporting	IN	13.0
4. 00	If line 12 is yes, were patient deductibles and/or coinsur- instructions.	ance amounts w	aived? If yes	, see	Ν	14. C
	Bed Complement					
5.00	Did total beds available change from the prior cost report			tructions.	• P	15.0
		Y/N	t A Date	Y/N	t B Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
6. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		Ν		16.0
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/04/2023	Y	04/04/2022	17.0
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19. (

	inancial Systems IU HEALTH JA AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE	Provi der CC	N: 15-1320	Peri od:	Worksheet S	-2
			10 1020	From 01/01/2022 To 12/31/2022	Part II	repared:
		Descri	ption	Y/N	Y/N	
		0		1.00	3.00	
	f line 16 or 17 is yes, were adjustments made to PS&R			Ν	N	20.0
R	eport data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	as the cost report prepared only using the provider's ecords? If yes, see instructions.	N		N		21.0
					1.00	
	DMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC apital Related Cost	EPT CHILDRENS H	OSPI TALS)			
	ave assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.0
. 00 Ha	ave changes occurred in the Medicare depreciation expense eporting period? If yes, see instructions.		als made du	ring the cost	Y	23.0
.OO ₩€	ere new leases and/or amendments to existing leases enter f yes, see instructions	ed into during	this cost re	eporting period?	N	24.0
. 00 Ha	ave there been new capitalized leases entered into during	?lfyes, see	Ν	25.0		
. 00 We	nstructions. ere assets subject to Sec.2314 of DEFRA acquired during t	he cost reporti	ng period? I	f yes, see	N	26.0
. 00 Ha	nstructions. as the provider's capitalization policy changed during th opy.	fyes, submit	Ν	27.0		
In	opy. nterest Expense ere new Loans, mortgage agreements or Letters of credit e	untorod into dur	ing the cost	t coporting	N	28.0
pe	eriod? If yes, see instructions.		-			
tr	id the provider have a funded depreciation account and/or reated as a funded depreciation account? If yes, see inst	ructions		,	N	29.0
	as existing debt been replaced prior to its scheduled mat nstructions.	urity with new	debt? If yes	s, see	N	30.0
ir	as debt been recalled before scheduled maturity without i nstructions.	ssuance of new	debt? If yes	s, see	N	31.0
. 00 Ha	urchased Services ave changes or new agreements occurred in patient care se		d through co	ontractual	N	32.0
	rrangements with suppliers of services? If yes, see instr f line 32 is yes, were the requirements of Sec. 2135.2 ap		g to competi	tive bidding? If	Ē	33.0
	o, see instructions.	· · ·				_
	rovider-Based Physicians ere services furnished at the provider facility under an	arrangomont wit	h providor l	asod physicians?	ł Y	34.0
111111111	f yes, see instructions.	arrangement wrt	n provider-i	baseu priysi crans:		54.0
	fline 34 is yes, were there new agreements or amended ex		ts with the	provi der-based	N	35.0
. 00 I f	hysicians during the cost reporting period? If yes see i	nstructions		Y/N		
 00 1	hysicians during the cost reporting period? If yes, see i	nstructions.		1711	Date	
00 f ph		nstructions.		1.00	Date 2.00	
If 00 If ph	ome Office Costs	nstructi ons.		1.00		
00 1 f pt 00 1 f pt 00 00	ome Office Costs ere home office costs claimed on the cost report?		home officer	1.00 Y		
. 00 1 f ph . 00 1 . 00 1 . 00 1 . 1 f	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions.	prepared by the		1.00 ? Y Y		37.0
. 00 1 f ph . 00 Ho . 00 1 f . 00 1 f . 00 1 f t f	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes , was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en	prepared by the fice different d of the home o	from that of ffice.	1.00 ? Y F N		37. (38. (
. 00 11 ph . 00 Ho . 00 11 . 00 11 th . 00 11 th . 00 11 th . 00 11 th . 00 11	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions.	prepared by the fice different d of the home o er chain compon	from that of ffice. ents? If yes	1.00 Y Y F N S,		37. (38. (39. (
. 00 11 ph . 00 We . 00 11 . 00 11 . 00 11 th . 00 11 se . 00 11	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth	prepared by the fice different d of the home o er chain compon	from that of ffice. ents? If yes	1.00 ? Y F N		37. 0 38. 0 39. 0
11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11 11	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the	prepared by the fice different d of the home o er chain compon	from that of ffice. ents? If yes If yes, see	1.00 Y Y F N S, Y N		36. C 37. C 38. C 39. C 40. C
. 00 11 . 00 11 . 00 We . 00 11 . 00 11	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the	Frepared by the fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y F N S, Y N	2.00	37. 0 38. 0 39. 0
. 00 11 pt . 00 We . 00 11 . 00 11 tt . 00 11 se . 00 11 se . 00 11 se . 00 11 tt . 00 11 t	ome Office Costs ere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the nstructions. <u>ost Report Preparer Contact Information</u> nter the first name, last name and the title/position eld by the cost report preparer in columns 1, 2, and 3,	Frepared by the fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y F N S, Y N	2.00	37. 0 38. 0 39. 0
. 00 11 . 00 11	pme Office Costs lere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the nstructions. <u>post Report Preparer Contact Information</u> nter the first name, last name and the title/position eld by the cost report preparer in columns 1, 2, and 3, espectively. nter the employer/company name of the cost report	Fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y F N S, Y N 2.	2.00	37. (38. (39. (40. (41. (
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 <td>ome Office Costs lere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the nstructions. f line 36 is yes, did the provider render services to the nstructions. f line 36 is yes, did the provider render services to the nstructions.</td> <td>Prepared by the fice different d of the home o er chain compon home office?</td> <td>from that of ffice. ents? If yes If yes, see</td> <td>1.00 Y Y F N S, Y N 2.</td> <td>2.00</td> <td>37. (38. (39. (40. (</td>	ome Office Costs lere home office costs claimed on the cost report? f line 36 is yes, has a home office cost statement been p f yes, see instructions. f line 36 is yes, was the fiscal year end of the home of he provider? If yes, enter in column 2 the fiscal year en f line 36 is yes, did the provider render services to oth ee instructions. f line 36 is yes, did the provider render services to the nstructions. f line 36 is yes, did the provider render services to the nstructions. f line 36 is yes, did the provider render services to the nstructions.	Prepared by the fice different d of the home o er chain compon home office?	from that of ffice. ents? If yes If yes, see	1.00 Y Y F N S, Y N 2.	2.00	37. (38. (39. (40. (

Health Financial Systems IU HEALTH	JAY HOSPI TAL	In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der CCN: 15-1320	Period:	Worksheet S-2	
		From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	pared:
			5/26/2023 12:	02 pm
	3.00			
Cost Report Preparer Contact Information				
41.00 Enter the first name, last name and the title/position	DI RECTOR			41.00
held by the cost report preparer in columns 1, 2, and 3				
respecti vel y.				
42.00 Enter the employer/company name of the cost report				42.00
preparer.				
43.00 Enter the telephone number and email address of the cos	t			43.00
report preparer in columns 1 and 2, respectively.				

10SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022		pared:
						5/26/2023 12: I/P Days / O/P Visits / Trips	02 pm
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	21	7,66	33, 096. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						2.00
2.00	HMO and other (see instructions)						2.00
3.00 4.00	HMO IPF Subprovider HMO IRF Subprovider						3.00 4.00
f. 00 5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
5.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		21	7,66	33, 096. 00	0	7.00
	beds) (see instructions)			,,			
3. 00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	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)		21	7,66	33, 096. 00	0	14.00
15.00	CAH visits	10.00				0	15.00
16.00	SUBPROVIDER - IPF	40.00	0		0	0	16.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						17.0 18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPICE						24.0
4.10	HOSPICE (non-distinct part)	30.00					24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
7.00	Total (sum of lines 14-26)		21				27.0
8.00	Observation Bed Days					0	28.0
9.00	Ambul ance Trips						29.0
0.00	Employee discount days (see instruction) Employee discount days - IRF						30.0 31.0
31.00 32.00	Labor & delivery days (see instructions)		0		0		31.0
32.00	Total ancillary labor & delivery room		0				32.0
	outpatient days (see instructions)						02.0
33.00	LTCH non-covered days						33.0
33.01	LTCH site neutral days and discharges						33.0
	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	1	0	0	

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2022 To 12/31/2022		
						5/26/2023 12:	
		I/P Days	/ O/P Visits	/ Irips	Full Time E	qui val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns		
		6.00	7.00	Patients 8.00	& Residents 9.00	Payrol I 10. 00	
	PART I – STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	576	17	1, 37	9		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)	425	127				2.00
3.00	HMO I PF Subprovider	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	266	0	26			5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF	0.10	0	25			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	842	17	1, 89	/		7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN I NTENSI VE CARE UNI T						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0		0		13.00
14.00	Total (see instructions)	842	17	1, 89	7 0.00	193.02	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	0	0		0.00	0.00	16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00 24.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPICE HOSPICE (non-distinct part)			1	0		24.00
25.00	CMHC - CMHC			I I	0		24.10
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0.00	193.02	
28.00	Observation Bed Days		13	60			28.00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32.00	Labor & delivery days (see instructions)	0	0		0		32.00
32.01	Total ancillary labor & delivery room				0		32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0	_				33.01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0		0		34.00

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/26/2023 12:	parec
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	component	Workers	nue v		II LIE AIA	Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA	I					
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	17	73 4	400	1.(
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
~~	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)			10			2.
. 00	HMO I PF Subprovi der				0		3. 4.
. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				0		4. 5.
. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						6.
. 00	Total Adults and Peds. (exclude observation						7.
. 00	beds) (see instructions)						/ .
. 00	INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY						13.
4.00	Total (see instructions)	0.00	0	17	73 4	400	14.
5.00	CAH visits						15.
6.00	SUBPROVIDER - IPF	0.00	0		0 0	0	16.
7.00	SUBPROVIDER - IRF						17.
8.00 9.00	SUBPROVIDER						18. 19.
9.00 0.00	SKILLED NURSING FACILITY NURSING FACILITY						20.
1.00	OTHER LONG TERM CARE						20.
2.00	HOME HEALTH AGENCY						21.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
4.00	HOSPI CE						24.
4.10	HOSPICE (non-distinct part)						24.
5.00	CMHC - CMHC						25
5.00	RURAL HEALTH CLINIC						26
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
7.00	Total (sum of lines 14-26)	0.00					27
3.00	Observation Bed Days						28.
9.00	Ambul ance Trips						29.
0.00	Employee discount days (see instruction)						30.
1.00	Employee discount days - IRF						31.
2.00	Labor & delivery days (see instructions)						32.
2.01	Total ancillary labor & delivery room						32.
3.00	outpatient days (see instructions) LTCH non-covered days				0		33.
3.00	LTCH non-covered days LTCH site neutral days and discharges				0		33.
	Temporary Expansion COVID-19 PHE Acute Care				0		33. 34.

Heal th	n Financial Systems IU HEAL	TH JAY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI 7	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-1320	Peri od:	Worksheet S-1	0
				From 01/01/2022 To 12/31/2022		pared
				10 12/01/2022	5/26/2023 12:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 col	lumn 3 divided by Li	ine 202 colum	1.8)	0. 424025	1.00
1.00	Medicaid (see instructions for each line)			1.0)	0. 424025	1.00
2.00	Net revenue from Medicaid				3, 267, 120	2.00
3.00	Did you receive DSH or supplemental payments from Medi	i cai d?			N	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or s	supplemental paymen ⁻	ts from Medic	ai d?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental pa	ayments from Medical	id		0	5.00
6.00	Medicaid charges				19, 959, 436	
7.00	Medicaid cost (line 1 times line 6)	(1) 7			8, 463, 300	
8.00	Difference between net revenue and costs for Medicaid < zero then enter zero)			nes 2 and 5; IT	5, 196, 180	8.00
0.00	Children's Health Insurance Program (CHIP) (see instru	uctions for each lin	ne)			0.00
9.00	Net revenue from stand-alone CHIP				0	
10.00 11.00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)					
12.00	Difference between net revenue and costs for stand-al	one CHIP (line 11 mi	inus line 9 [.]	f < zero then	0	
12.00	enter zero)				Ŭ	12.00
	Other state or local government indigent care program	(see instructions	for each line)	1	
13.00	Net revenue from state or local indigent care program	(Not included on li	ines 2, 5 or	9)	4,606	13.00
14.00	Charges for patients covered under state or local indi	igent care program	(Not included	in lines 6 or	95, 172	14.00
	10)					
15.00	State or local indigent care program cost (line 1 time				40, 355	
16.00	Difference between net revenue and costs for state or 13; if < zero then enter zero)	local indigent car	e program (II	ne 15 minus line	35, 749	16.00
	Grants, donations and total unreimbursed cost for Medi	icaid CHIP and sta	te/local indi	pent care progra	ams (see	
	instructions for each line)			gent our e progre		
17.00	Private grants, donations, or endowment income restric	cted to funding cha	rity care		0	17.00
18.00	Government grants, appropriations or transfers for su				0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state 8, 12 and 16)	and local indigent	care program	s (sum of lines	5, 231, 929	19.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the	entire facility	1, 884, 95	0 69, 999	1, 954, 949	20.00
20100	(see instructions)		.,	0,,,,,		201.00
21.00	Cost of patients approved for charity care and uninsu	red discounts (see	799, 26	6 69, 999	869, 265	21.00
	instructions)					
22.00	Payments received from patients for amounts previously	y written off as		0 0	0	22.00
22.00	charity care		700.04	((0,000	0(0, 2)(5	22.00
23.00	Cost of charity care (line 21 minus line 22)		799, 26	6 69, 999	869, 265	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges t	for patient days be	yond a length	of stay limit	N	24.00
	imposed on patients covered by Medicaid or other indig	gent care program?		-		
25.00	If line 24 is yes, enter the charges for patient days	beyond the indigen	t care progra	m's length of	0	25.00
0/ 27	stay limit	(、 、		1 074 5	0/ 0-
26.00	Total bad debt expense for the entire hospital complex				1, 974, 535	
27.00	Medicare reimbursable bad debts for the entire hospital				322, 973	1
27.01 28.00	Medicare allowable bad debts for the entire hospital of Non-Medicare bad debt expense (see instructions)	complex (see instru	5110115/		496, 882	1
28.00	Cost of non-Medicare and non-reimbursable Medicare bac	d deht exnense (soo	instructions	`	1, 477, 653 800, 471	
30.00				/	1, 669, 736	
	Total unreimbursed and uncompensated care cost (line				6, 901, 665	

				T	rom 01/01/2022 o 12/31/2022	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Recl assi fi cat i ons (See A-6)	5/26/2023 12: Recl assi fi ed Tri al Bal ance (col. 3 +- col. 4)	02 pm
	_	1.00	2.00	3.00	4.00	5. 00	
	GENERAL SERVICE COST CENTERS				4 405 000	1 105 000	1
. 00 . 01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MOB		0				1.00 1.01
. 02	00102 CAP REL COSTS-BLDG & FIXT-POB		0	0			1
	00103 CAP REL COSTS-BLDG & FIXT-WJ		0	0	9, 433	9, 433	1.03
	00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP		0	0	-	0	1.04
. 00 . 01	00200 CAP REL COSTS-MVBLE EQUIP - MOB		0	0		1, 389, 472 29, 787	2.00
. 02	00202 CAP REL COSTS-MVBLE EQUIP - POB		0	0	0	0	2.02
. 03	00203 CAP REL COSTS-MVBLE EQUIP - WJ	10,100	0	0	0	0	2.03
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	10, 428 967, 492	21, 990 9, 870, 807				4.00
. 00	00700 OPERATION OF PLANT	539, 413	3, 679, 416				
. 01	00701 OPERATION OF PLANT - MOB	0	118, 573				7.01
	00702 OPERATION OF PLANT - POB	0	86, 271				7.02
	00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE	0 37,607	0 -25, 368	-	-	0 76, 763	7.03
	00900 HOUSEKEEPI NG	444, 751	503, 076				
	01000 DI ETARY	364, 028	446, 015				
		0	0				
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 319, 378	628, 651 2, 417			1, 579, 011 133, 918	13.00
	01500 PHARMACY	554, 662	1, 786, 381			993, 036	
6.00	01600 MEDICAL RECORDS & LIBRARY	0	0			0	16.00
7.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
0.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 741, 250	1, 461, 689	3, 202, 939	- 205, 905	2, 997, 034	30.00
	04000 SUBPROVI DER – I PF	0	0				40.00
	04300 NURSERY	0	0	0	0	0	43.00
	ANCI LLARY SERVI CE COST CENTERS	893, 141	1, 469, 179	2, 362, 320	-617, 851	1, 744, 469	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0/3, 141	0				52.00
	05300 ANESTHESI OLOGY	0	0	0	-	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1,034,417	1, 141, 733				
	06000 LABORATORY 06500 RESPI RATORY THERAPY	630 471, 592	2, 357, 816 219, 701			2, 357, 926 619, 042	
	06600 PHYSI CAL THERAPY	513, 525	64, 193				
	06700 OCCUPATI ONAL THERAPY	93, 938	0			93, 938	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	18, 788	0	18, 788		18, 788	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	3, 885 0				69.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	Ő	0				
3.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0			
	03160 CARDI OPULMONARY 07700 ALLOGENEI C HSCT ACQUI SI TI ON	151, 108 0	165, 811 0				1
	OUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	0	0	177.00
	09000 CLI NI C	0	0				90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	692, 816 831, 355	662, 920				
	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	831, 355	660, 885 668			1, 056, 145 1	90.02
	09004 OP ORTHO CLINIC	Ő	627			627	
	09005 JAY FAMILY FIRST HEALTH CARE	338, 101	277, 563				
	09006 I NFUSI ON CLINIC 09007 HEALTH BEGI NNI NGS PROGRAM	94, 046 286, 345	34, 323 145, 695				
	09007 HEALTH BEGINNINGS PROGRAM	286, 345 1, 394, 565	2, 047, 036				90.07
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	, ,	, , ,			2, 120, 001	92.00
	04950 OUTPATIENT PSYCH	92, 012	61, 146	153, 158	-44, 069	109, 089	93.00
	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	0	0		102.00
	SPECIAL PURPOSE COST CENTERS					0	1.52.00
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 885, 388	27, 893, 099	40, 778, 487	64, 187	40, 842, 674	118.00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	124, 399	92, 440				
93.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
	07950 VACANT	0	-30				194.00
	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE	0	0	0	0		194.02 194.03
94.03		13,009,787	0 27, 985, 509	, °			

.00110	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IF EXPENSES	Provider CCN: 15-1	From 01/01/2022	eet A
				To 12/31/2022 Date/Ti	ime Prepare 023 12:02 p
	Cost Center Description	Adjustments	Net Expenses		20 12.02
		(See A-8)	For		
		6.00	Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	7.00		
00	00100 CAP REL COSTS-BLDG & FIXT	-369, 550	816, 353		1.
01	00101 CAP REL COSTS-BLDG & FIXT-MOB	-75, 227	0		1.
02	00102 CAP REL COSTS-BLDG & FIXT-POB	-62, 070			1
03	00103 CAP REL COSTS-BLDG & FIXT-WJ	-9, 433	0		1
04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP	0 321, 000	0 1, 710, 472		1
00 01	00200 CAP REL COSTS-MVBLE EQUIP	321,000	29, 787		2
02	00202 CAP REL COSTS-MVBLE EQUIP - POB	0	0		2
03	00203 CAP REL COSTS-MVBLE EQUIP - WJ	0	0		2
00	00400 EMPLOYEE BENEFITS DEPARTMENT	-961, 181	2,047,123		4
00	00500 ADMINI STRATI VE & GENERAL	-1, 277, 813			5
00	00700 OPERATION OF PLANT	-88, 495	2, 812, 070		7
01 02	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0	43, 244 51, 211		7
02	00702 OPERATION OF PLANT - POB	0	0		7
00	00800 LAUNDRY & LINEN SERVICE	0	76, 763		8
00	00900 HOUSEKEEPI NG	0	831, 899		9
	01000 DI ETARY	9, 012	320, 442		10
	01100 CAFETERI A	-105	337, 120		11
	01300 NURSI NG ADMI NI STRATI ON	142, 927	1, 721, 938		13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 49, 465	133, 918 1, 042, 501		14
	01600 MEDICAL RECORDS & LIBRARY	49,400	0		16
	01700 SOCIAL SERVICE	0			17
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS	-751, 671	2, 245, 363		30
0.00	04000 SUBPROVIDER - IPF	0	0		40
. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		43
. 00	05000 OPERATING ROOM	-319, 269	1, 425, 200		50
	05200 DELIVERY ROOM & LABOR ROOM	0	0		52
	05300 ANESTHESI OLOGY	0	0		53
	05400 RADI OLOGY-DI AGNOSTI C	58, 116			54
	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 15, 663	2, 357, 926 634, 705		60 65
. 00	06600 PHYSI CAL THERAPY	-10, 370	566, 614		66
	06700 OCCUPATI ONAL THERAPY	0	93, 938		67
	06800 SPEECH PATHOLOGY	0	18, 788		68
	06900 ELECTROCARDI OLOGY	0	1, 197		69
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	65,063		71
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	23, 421 1, 693, 462		72
	03160 CARDI OPULMONARY	28, 813			76
	07700 ALLOGENEIC HSCT ACQUISITION	20, 013			77
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	0	0		90
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	-33, 180			90
	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	-88, 479 0	967, 666 1		90 90
	09004 OP ORTHO CLINIC	0	627		90
	09005 JAY FAMILY FIRST HEALTH CARE	-16, 590	1		90
	09006 INFUSION CLINIC	0	120, 285		90
	09007 HEALTH BEGI NNI NGS PROGRAM	0	336, 482		90
	09100 EMERGENCY	-8, 884	3, 149, 477		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	0	109, 089		92
. 55	OTHER REIMBURSABLE COST CENTERS	0	107,007		
2.00	10200 OPI OI D TREATMENT PROGRAM	0	0		102
. ·	SPECIAL PURPOSE COST CENTERS		07.077.077		
8.00		-3, 447, 321	37, 395, 353		118
0 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190
	19200 PHYSI CLANS' PRI VATE OFFI CES	-130			190
	19300 NONPAI D WORKERS	0	0		193
	07950 VACANT	0	-30		194
		-	ı _		100
4. 02	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE	0	0		194 194

	Financial Systems SFFICATIONS		IU HEALTH J		CN: 15-1320	l n Peri od:	Lieu of Form CM	
RECENS					011. 10 1020	From 01/01/2 To 12/31/2	022 022 Date/Time	Prepared:
		Increases	Caller	011			5/26/2023	12:02 pm
	Cost Center 2.00	Line # 3.00	Sal ary 4.00	0ther 5.00				
	A – CAFETERIA							
1.00	CAFETERI A	<u>11.00</u>	<u>190, 5</u> 22 190, 522	<u>146, 703</u> 146, 703				1.00
	B - DRUGS RECLASS		L					
1.00 2.00	PHARMACY DRUGS CHARGED TO PATIENTS	15.00 73.00	0 0	82, 012 1, 693, 462				1.00 2.00
3.00	DROUG CHARGED TO TATTENTS	0.00	0	0				3.00
4.00 5.00		0. 00 0. 00	0 0	0				4.00 5.00
6.00		0.00	0	0				6.00
7.00 8.00		0. 00 0. 00	0 0	0 0				7.00 8.00
9.00		0.00	0	0				9.00
10.00		0.00	0 0	0 0				10.00
11. 00 12. 00		0. 00 0. 00	0	0				11.00 12.00
13.00		0.00	0	0				13.00
14.00 15.00		0.00 0.00	0 0	0 0				14.00 15.00
16.00		0.00	0	0				16.00
17.00	<u> </u>		0	00000000				17.00
1 00	C - SUPPLIES/IMPLANTS	1						
1.00 2.00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO	14.00 71.00	0 0	131, 504 65, 063				1.00 2.00
	PATIENTS							
3.00	I MPL. DEV. CHARGED TO PATI ENTS	72.00	0	23, 421				3.00
4.00	ADMI NI STRATI VE & GENERAL	5.00	0	12, 711				4.00
5.00 6.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0 0	1, 208 94				5.00 6.00
7.00	NURSING ADMINISTRATION	13.00	0	50				7.00
8.00 9.00	RADI OLOGY-DI AGNOSTI C CARDI OPULMONARY	54.00 76.00	0 0	614 118				8.00 9.00
10.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	28				10.00
11. 00 12. 00		0. 00 0. 00	0 0	0 0				11.00 12.00
13.00		0.00	0	0				13.00
14.00 15.00		0. 00 0. 00	0 0	0 0				14.00 15.00
16.00		0.00	0	0				16.00
17.00		0.00	0 0	0 0				17.00
18. 00 19. 00		0.00	0	0				18.00 19.00
	0 D - LAUNDRY		0	234, 811				_
1.00	LAUNDRY & LINEN SERVICE	8.00	0	75, 076				1.00
2.00		0.00	0 0	0 0				2.00
3.00 4.00		0. 00 0. 00	0	0				3.00 4.00
5.00		0.00	0	0 0				5.00
6.00 7.00		0.00 0.00	0	0				6.00 7.00
8.00		0.00	0	0				8.00
9. 00 10. 00		0.00 0.00	0 0	0 0				9.00 10.00
			0	75,076				_
1.00	E - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	0	1, 154, 745				1.00
2.00	CAP REL COSTS-BLDG &	1. 01	0	75, 227				2.00
3.00	FIXT-MOB CAP REL COSTS-BLDG &	1. 02	0	35, 030				3.00
	FI XT-POB		-					
4.00 5.00	CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-MVBLE EQUIP	1.03 2.00	0 0	9, 433 1, 383, 944				4.00 5.00
6.00	CAP REL COSTS-MVBLE EQUIP -	2.01	Ö	29, 787				6.00
7.00	МОВ	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 10.00
11.00		0.00	0	0				11.00
12.00 13.00		0.00 0.00	0 0	0 0				12.00 13.00
	1I	0.00	9	0				1

From 01/01/2 To 12/31/2	Lieu of Form CMS-2552-7 Worksheet A-6
	2022 2022 Date/Time Prepared 5/26/2023 12:02 pm
Cost Contor Line # Salary Other	572672023 12:02 pm
Cost Center Line # Salary Other 2.00 3.00 4.00 5.00	
4. 00 0. 00 0 0	14. C
5. 00 0. 00 0 0 5. 00 0. 00 0 0	15. C 16. C
	17.0
	18.0
00 0.00 0 0 00 0.00 0 0 0	19.0 20.0
0 0 2,688,166	
G - PROPERTY INSURANCE 10 CAP REL COSTS-BLDG & FIXT 1.00 0 31, 158	1. (
00 <u>CAP REL COSTS-MVBLE EQUIP</u> 2.00 0 5,528 0 36,686	2.0
0 0 36, 686 H - HOUSEKEEPI NG SUPPLI ES	
0 HOUSEKEEPI NG 9. 00 0 2, 755	1. (
0 0.00 0 0 0 0.00 0 0	2.0
	4. (
	5.0
0 0.00 0 0 0 0.00 0 0	6.0
0.00 0 0	8.
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0.00 0 0	11.
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	13.
00 0.00 0 0	15.
00 0.00 0 0 00 0.00 0 0	16. 17.
	18.
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	19.
J - EMPLOYEE BENEFITS	
0 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 2,987,374 0 0 0 0 0 0	1.0
	3.
0 0.00 0 0 0 0.00 0 0	4. 5.
	5.
	7.
0 0.00 0 0 0 0.00 0 0	8.
00 0.00 0 0	10.
00 0.00 0 0 00 0.00 0 0	11.
	13.
00 0.00 0 0	14.
00 0.00 0 0 00 0.00 0 0	15. 16.
00 0.00 0 0	17.
00 0.00 0 0 00 0.00 0 0	18. 19.
	20.
$\begin{array}{cccccccccccccccccccccccccccccccccccc$	21.
0 0 2,987,374 0 - PREMIUM WAGES	
	1.0
	2.
0 RESPIRATORY_THERAPY65.0021,4851,638	
RESPIRATORY THERAPY 65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS	1.
RESPIRATORY_THERAPY 65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 30.00 127,000 9,716	3.0
RESPIRATORY THERAPY 65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 127,000 9,716 0 0 129,000 9,869	
0 RESPIRATORY_THERAPY65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 127,000 9,716 0 0 127,000 9,716 0 0 129,000 9,869 0 RESPI RATORY_THERAPY 65.00 48,000 3,672 0 FAMI LY PRACTI CE OF JAY 90.01 16,000 1,224	
0 RESPIRATORY_THERAPY65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 127,000 9,716 0 0 127,000 9,716 0 0 129,000 9,869 0 0 163.00 129,000 0 0 129,000 9,869 0 0 142,948 10,900 0 0 127,000 9,869 0 0 129,000 129,000 0 RSPI RATORY THERAPY 65.00 48,000 0 FAMI LY PRACTICE OF JAY 90.01 16,000 1,224 0 COUNTY 12,24 10,000 1,224	4.
D RESPIRATORY_THERAPY65.00 21,485 1,638 D 142,948 10,900 P - EMPLOYEE BONUS 142,948 10,900 D ADULTS & PEDI ATRI CS 30.00 127,000 9,716 D OPERATI NG ROOM 50.00 129,000 9,869 D RESPI RATORY_THERAPY 65.00 48,000 3,672 D FAMI LY_PRACTI CE OF JAY 90.01 16,000 1,224 COUNTY D JAY_FAMI LY_MEDI CI NE 90.02 38,000 2,907 D JAY_FAMI LY_FIRST HEALTH_CARE 90.05 10,000 765	4. 1 5. 1 6. 1
D RESPIRATORY_THERAPY65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 142,948 10,900 0 ADULTS & PEDI ATRI CS 30.00 127,000 9,716 0 OPERATI NG ROOM 50.00 129,000 9,869 0 RESPI RATORY_THERAPY 65.00 48,000 3,672 0 FAMI LY_PRACTI CE OF JAY 90.01 16,000 1,224 0 JAY_FAMI LY_MEDI CI NE 90.02 38,000 2,907 0 JAY_FAMI LY_FI RST HEALTH_CARE 90.05 10,000 765 0 INFUSI ON CLI NI C 90.06 16,000 1,224	4. (5. (6. (7. (
0 RESPIRATORY_THERAPY65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 10,900 9,716 0 ADULTS & PEDI ATRI CS 30.00 127,000 9,716 0 OPERATI NG ROOM 50.00 129,000 9,869 0 RESPI RATORY THERAPY 65.00 48,000 3,672 0 FAMI LY PRACTI CE OF JAY 90.01 16,000 1,224 COUNTY 0 JAY FAMI LY MEDI CI NE 90.02 38,000 2,907 0 JAY FAMI LY MEDI CI NE 90.05 10,000 765 0 INFUSI ON CLI NI C 90.06 16,000 1,224 0 HEALTH BEGI NNI NGS PROGRAM 90.07 28,000 2,142	4. 1 5. 1 6. 1
.00 RESPIRATORY_THERAPY65.00 21,485 1,638 0 142,948 10,900 P - EMPLOYEE BONUS 142,948 10,900 0 ADULTS & PEDI ATRI CS 30.00 127,000 9,716 00 OPERATI NG ROM 50.00 129,000 9,869 00 RESPI RATORY_THERAPY 65.00 48,000 3,672 00 FAMI LY_PRACTI CE OF JAY 90.01 16,000 1,224 00 JAY_FAMI LY_MEDI CI NE 90.02 38,000 2,907 00 JAY_FAMI LY_FIRST HEALTH_CARE 90.05 10,000 765 00 INFUSI ON_CLI NI C 90.06 16,000 1,224 00 HEALTH_BEGI NNI NGS_PROGRAM 90.07 28,000 2,142	

	Financial Systems		IU HEALTH JAY		01 45 4000		u of Form CMS-2	
RECLAS	SI FI CATI ONS			Provi der C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet A-6 Date/Time Prep	pared:
		Decreases					5/26/2023 12:0	JZ pili
	Cost Center	Line #	Salary		Wkst. A-7 Ref			
	6.00 A - CAFETERIA	7.00	8.00	9.00	10.00			
1.00	DI ETARY	10.00	190, 522	146, 703		0		1.00
	0		190, 522	146, 703		1		
1 00	B - DRUGS RECLASS	15 00	ol	1 200 005				1 00
1.00 2.00	PHARMACY EMPLOYEE BENEFITS DEPARTMENT	15.00 4.00	0	1, 208, 085 9, 046		0		1.00 2.00
3.00	HOUSEKEEPI NG	9.00	0	7		0		3.00
4.00	DI ETARY	10. 00	0	6		0		4.00
5.00	NURSING ADMINISTRATION	13.00	0	79 17 020		0		5.00
6.00 7.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	17, 929 22, 994		0		6.00 7.00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	84, 857		0		8.00
9.00	RESPI RATORY THERAPY	65.00	0	156		0		9.00
10.00	PHYSI CAL THERAPY	66.00	0	33		0		10.00
11.00 12.00	CARDI OPULMONARY FAMILY PRACTICE OF JAY	76.00 90.01	0	6, 344 147, 584				11. 00 12. 00
12.00	COUNTY	70.01	Ű	117,001				12.00
13.00	JAY FAMILY MEDICINE	90.02	0	136, 043		0		13.00
14.00 15.00	JAY FAMILY FIRST HEALTH CARE	90. 05 90. 06	0	76, 093 7, 889		0		14.00 15.00
16.00	HEALTH BEGINNINGS PROGRAM	90.00	0	407		0		16.00
17.00	EMERGENCY	91.00	0	57, 922		0		17.00
	0		0	1, 775, 474		1		
1.00	C - SUPPLIES/IMPLANTS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	134		0		1.00
2.00	OPERATION OF PLANT	7.00	0	4, 207		0		2.00
3.00	OPERATION OF PLANT - MOB	7.01	Ő	102		0		3.00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	39		0		4.00
5.00		15.00	0	898		0		5.00
6.00 7.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	39, 519 92, 399		0		6.00 7.00
8.00	LABORATORY	60.00	0	418		0		8.00
9.00	RESPI RATORY THERAPY	65.00	0	13, 392		0		9.00
10.00	PHYSICAL THERAPY	66.00	0	63		0		10.00
11.00 12.00	ELECTROCARDI OLOGY FAMILY PRACTICE OF JAY	69.00 90.01	0	2, 688 7, 792		0		11. 00 12. 00
12.00	COUNTY	70.01	Ű	1,172				12.00
13.00	JAY FAMILY MEDICINE	90.02	0	3, 578		0		13.00
14.00 15.00	WOUND CLINIC JAY FAMILY FIRST HEALTH CARE	90. 03 90. 05	0	76 6, 813		0		14.00 15.00
16.00	INFUSION CLINIC	90.05	0	3, 490		0		16.00
17.00	HEALTH BEGINNINGS PROGRAM	90.07	0	230		0		17.00
18.00	EMERGENCY	91.00	0	58, 945		0		18.00
19.00	OUTPATIENT_PSYCH	<u> </u>	0	28 234, 811		0		19.00
	D - LAUNDRY			234,011				
1.00	OPERATION OF PLANT - POB	7.02	0	30		0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	24, 524		0		2.00
3.00 4.00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50.00 54.00	0	16, 993 10, 615		0		3.00 4.00
5.00	PHYSI CAL THERAPY	66.00	0	624		0		5.00
6.00	FAMILY PRACTICE OF JAY	90. 01	0	1, 260		0		6.00
7 00		00.00	0	207				7 00
7.00 8.00	JAY FAMILY MEDICINE JAY FAMILY FIRST HEALTH CARE	90. 02 90. 05	0	297 443		0		7.00 8.00
9.00	EMERGENCY	91.00	0	20, 032		0		9.00
10.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	258		0		10.00
			0	75, 076				
1.00	E - DEPRECIATION EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 308		9		1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	Ő	66, 456		9		2.00
3.00	OPERATION OF PLANT	7.00	0	1, 173, 403		9		3.00
4.00	OPERATION OF PLANT - MOB	7.01	0	75, 227		9		4.00
5.00 6.00	OPERATION OF PLANT – POB DIETARY	7. 02 10. 00	0	35, 030 17, 362		9		5.00 6.00
7.00	PHARMACY	15.00	0	86, 023		0		7.00
8.00	ADULTS & PEDIATRICS	30. 00	0	85, 772		0		8.00
9.00	OPERATING ROOM	50.00	0	373, 694		0		9.00
10. 00 11. 00	RADI OLOGY-DI AGNOSTI C RESPI RATORY THERAPY	54.00 65.00	0	600, 666 21, 889		0		10. 00 11. 00
12.00	CARDI OPULMONARY	76.00	0	21, 889		0		12.00
13.00	FAMILY PRACTICE OF JAY	90. 01	Ö	6, 275		0		13.00
14 00		00.00		501				14 00
14.00	WOUND CLINIC	90. 03	0	591		0		14.00

JLA3	SI FI CATI ONS			Provider (Fr	om 01/01/2022	orksheet A-6
		D			То		ate/Time Prepare /26/2023 12:02 p
	Cost Center	Decreases Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
00 00	JAY FAMILY FIRST HEALTH CARE	90. 05 90. 06	0	1, 579 445			15.
00	HEALTH BEGINNINGS PROGRAM	90.00	0	28, 978			17.
00	EMERGENCY	91.00	О	66, 366			18.
00	OUTPATIENT PSYCH	93.00	0	13, 158			19.
00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.00</u>	0	<u>9, 432</u> 2, 688, 166			20.
	G - PROPERTY INSURANCE						
00	ADMI NI STRATI VE & GENERAL	5.00	0	36, 686			1.
00		0.00	0	<u>0</u>			2.
	H - HOUSEKEEPING SUPPLIES						
00	ADMI NI STRATI VE & GENERAL	5.00	0	43			1.
)0)0	OPERATION OF PLANT DIETARY	7.00 10.00	0	7 18	0		2.
0	NURSING ADMINISTRATION	13.00	0	2			4
0	CENTRAL SERVICES & SUPPLY	14.00	0	3	0		5
0	PHARMACY	15.00	0	403			6
0 0	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	797 391	0		8
0	RADI OLOGY-DI AGNOSTI C	54.00	0	51	0		9
00	LABORATORY	60.00	0	5			10
00	RESPI RATORY THERAPY	65.00	0	4	0		11
00	PHYSI CAL THERAPY	66.00 76.00	0	14			12
00 00	CARDIOPULMONARY FAMILY PRACTICE OF JAY	76.00 90.01	0	9 118			13
00	COUNTY	,0.01	0	110			
00	JAY FAMILY MEDICINE	90. 02	0	217	0		15
00 00	JAY FAMILY FIRST HEALTH CARE	90. 05 90. 06	0	36 34	0		16
00	HEALTH BEGINNINGS PROGRAM	90.08 90.07	0	2			18
00	EMERGENCY	91.00	0	<u> 601 </u>	0		19
	O J - EMPLOYEE BENEFITS		0	2, 755			
00	ADMI NI STRATI VE & GENERAL	5.00	0	112, 697	0		1
00	OPERATION OF PLANT	7.00	0	140, 647	0		2
00	LAUNDRY & LINEN SERVICE	8.00	0	10, 513			3
)0)0	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	119, 884 144, 096			4
00	NURSING ADMINISTRATION	13.00	Ö	215, 139			6
00	PHARMACY	15.00	0	134, 610			7
00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	304,805			8
)0 00	RADI OLOGY-DI AGNOSTI C	54.00	0	250, 249 226, 220			9
00	LABORATORY	60.00	0	97	0		11
00	RESPI RATORY THERAPY	65.00	0	111, 605			12
00 00	CARDIOPULMONARY FAMILY PRACTICE OF JAY	76. 00 90. 01	0	44, 031 258, 868	0		13
00	COUNTY	90.01	0	250,000	0		14
00	JAY FAMILY MEDICINE	90.02	0	336, 867	0		15
00	JAY FAMILY FIRST HEALTH CARE	90.05	0	136, 951	0		16
00 00	INFUSION CLINIC HEALTH BEGINNINGS PROGRAM	90. 06 90. 07	U O	13, 450 96, 083			17
00	EMERGENCY	91.00	0	245, 154			19
00	OUTPATI ENT PSYCH	93.00	0	30, 883	0		20
00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	<u>54, 525</u> 2, 987, 374			21
	0 - PREMIUM WAGES		U	2, 707, 374			
00	NURSING ADMINISTRATION	13.00	142, 948	10, 900			1
0		0.00	0		0		2
	U P - EMPLOYEE BONUS		142, 948	10, 900			
0	ADMI NI STRATI VE & GENERAL	5.00	566, 000	43, 299	0		1
0		0.00	0	0	0		2
0		0.00	0	0			3
0		0. 00 0. 00	U O	0	0		4
0		0.00	0	0			6
0		0.00	0	0	0		7
00		0.00	0	0	0		8
0		0.00					9

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022		Worksheet A-7 Part I Date/Time Prepared 5/26/2023 12:02 pm	
			Acqui si ti on	s			
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	989, 148	0		0	0	0	1.00
2.00 Land Improvements	0	0		0	0	0	2.00
3.00 Buildings and Fixtures	18, 977, 852	0		0	0	0	3.00
4.00 Building Improvements	0	0		0	0	0	4.00
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	9, 871, 745	109, 271		0	109, 271	157, 785	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	29, 838, 745	109, 271		0	109, 271	157, 785	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	29, 838, 745	109, 271		0	109, 271	157, 785	10.00
	Endi ng	Ful I y					
	Bal ance	Depreciated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00 Land	989, 148	0					1.00
2.00 Land Improvements	0	0					2.00
3.00 Buildings and Fixtures	18, 977, 852	0					3.00
4.00 Building Improvements	0	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	9, 823, 231	1, 519, 909					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	29, 790, 231	1, 519, 909					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	29, 790, 231	1, 519, 909					10.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2022 To 12/31/2022		pared:
			SL	IMMARY OF CAF	PITAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOF	KSHEET A, COLU	MN 2, LINES 1 a	and 2		-	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0		0 0	0	
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0		0 0	0	
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0		0 0	0	
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		0 0	0	1.04
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0		0 0	0	2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0		0 0	0	2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0		0 0	0	2.03
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPI TAL				
	Cost Center Description	Other	Total (1)				
	· ·	Capital - Relat	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOF	KSHEET A, COLU	MN 2, LINES 1 a	and 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	0				2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0				2.01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0				2.02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0				2.03
3.00	Total (sum of lines 1-2)	0	0				3.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2022 To 12/31/2022		pared:
		COME	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	I nsurance	
		1.00	2.00	3.00	4.00	5.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C			20 700 22	1 000000		1 00
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST	29, 790, 231 0 0 0 0			1 1.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0 0 0	1.00 1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ	0 0 0			0 0.000000 0 0.000000 0 0.000000 0 0.000000 0 0.000000	0 0 0	2.00 2.01 2.02 2.03
3.00	Total (sum of lines 1-2)	29, 790, 231	0	29, 790, 23			3.00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		r r				
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST	0 0 0 0 0	0		0 785, 195 0 0 0 -27, 040 0 0 0 0	0	1.00 1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03 3.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0 0 0 0	, s		0 1, 704, 944 0 29, 787 0 0 0 0 0 0 2, 492, 886	0 0 0	2.00 2.01 2.02 2.03 3.00
0.00			-	JMMARY OF CAPI			0.00
	Cost Center Description	Interest	Insurance (see instructions)	Taxes (see instructions)		Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00 1.01 1.02 1.03 1.04	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-VJ CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-BLDG & FIXT-INTEREST	0 0 0 0				0 -27, 040 0 0	1.00 1.01 1.02 1.03 1.04
2.00 2.01 2.02 2.03 3.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0 0 0 0			0 0 0 0 0 0 0 0 0 0	29, 787 0 0	2.00 2.01 2.02 2.03 3.00

	Financial Systems MENTS TO EXPENSES		IU HEALTH JA	Provider CCN: 15-1320 Pe	eri od:	u of Form CMS-2 Worksheet A-8	
				Fi To	rom 01/01/2022 0 12/31/2022	Date/Time Prep 5/26/2023 12:0	pared
			-	Expense Classification on To/From Which the Amount is		072072020 12.	02 01
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	-	(2) 1.00	2.00	3.00	4.00	5.00	
. 00	Investment income - CAP REL	В	50, 422	CAP REL COSTS-BLDG & FIXT	1.00	9	1. (
01	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL COSTS-BLDG & FIXT-MOB (chapter 2)			CAP REL COSTS-BLDG & FIXT-MOB	1. 01	О	1. (
02	2) Investment income - CAP REL COSTS-BLDG & FIXT-POB (chapter 2)			CAP REL COSTS-BLDG & FIXT-POB	1. 02	О	1. (
03	Investment income - CAP REL COSTS-BLDG & FIXT-WJ (chapter		0	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	1.
04	2) Investment income - CAP REL COSTS-BLDG & FIXT-INTEREST (chapter 2)			CAP REL COSTS-BLDG & FLXT-INTEREST	1.04	О	1.
00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
01	COSTS-MVBLE EQUIP (chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - MOB			CAP REL COSTS-MVBLE EQUIP - MOB	2. 01	0	2.
02	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - POB			CAP REL COSTS-MVBLE EQUIP - POB	2. 02	0	2.
03	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - WJ			CAP REL COSTS-MVBLE EQUIP - NJ	2. 03	0	2.
00	(chapter 2) Investment income - other		0		0.00	0	3.
00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.
00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.
00	expenses (chapter 8) Rental of provider space by	В	-35, 315	CAP REL COSTS-BLDG & FIXT	1.00	9	6.
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7.
00	21) Tel evision and radio service		0		0.00	0	8.
00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	
. 00	Provider-based physician adjustment	A-8-2	-143, 416			0	
00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	
00	Related organization transactions (chapter 10)	A-8-1	2, 682, 543			0	
00	Laundry and linen service Cafeteria-employees and guests	В	0 - 105	CAFETERIA	0.00 11.00	0	
00	Rental of quarters to employee and others		0		0.00	0	
00	Sale of medical and surgical supplies to other than		0		0.00	0	16
00	patients Sale of drugs to other than		0		0.00	0	17
00	patients Sale of medical records and		0		0.00	0	18
00	abstracts Nursing and allied health education (tuition, fees,		0		0.00	0	19
00	books, etc.) Vendi ng machi nes		0		0.00	0	
00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.
00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.

Heal th	Fi nanc	ci al	Systems
AD JUST	MENTS	TO F	XPENSES

Health Financial Systems		IU HEALTH JA	AY HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1320 F	Period:	Worksheet A-8	
				rom 01/01/2022 o 12/31/2022		
			Evenence Classification on	Waskahaat A	5/26/2023 12:	02 pm
			Expense Classification on To/From Which the Amount is			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	(2)				Ref.	pared: 02 pm 23.00 24.00 25.00 26.00 26.01 26.02 26.03 26.04 27.00 27.01 27.02 27.03 28.00 27.01 27.02 27.03 28.00 29.00 30.09 31.00 32.00 33.00 33.01 33.02 33.04 33.05 33.06 33.07 33.08 33.07 33.08 33.07 33.11 33.12 33.14 33.15 33.16
	1.00	2.00	3.00	4.00	5.00	
23.00 Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
therapy costs in excess of limitation (chapter 14)						
24.00 Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24 00
therapy costs in excess of				00100		21100
limitation (chapter 14)						
25.00 Utilization review -		0	*** Cost Center Deleted ***	114.00		25.00
physicians' compensation						
(chapter 21) 26.00 Depreciation - CAP REL			CAP REL COSTS-BLDG & FIXT	1.00	0	26 00
COSTS-BLDG & FIXT				1.00	Ĭ	20.00
26.01 Depreciation - CAP REL		0	CAP REL COSTS-BLDG &	1.01	0	26.01
COSTS-BLDG & FIXT-MOB			FI XT-MOB			
26.02 Depreciation - CAP REL		0	CAP REL COSTS-BLDG &	1.02	0	26.02
COSTS-BLDG & FIXT-POB 26.03 Depreciation - CAP REL			FIXT-POB CAP REL COSTS-BLDG & FIXT-W.	1. 03	0	24 02
26.03 Depreciation - CAP REL COSTS-BLDG & FIXT-WJ			CAP REL CUSIS-BEDG & FIXI-W.	1.03	U	20.03
26.04 Depreciation - CAP REL		0	CAP REL COSTS-BLDG &	1.04	0	26.04
COSTS-BLDG & FIXT-INTEREST			FI XT-I NTEREST			
27.00 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
COSTS-MVBLE EQUIP				0.01		
27.01 Depreciation - CAP REL COSTS-MVBLE EQUIP - MOB		0	CAP REL COSTS-MVBLE EQUIP -	2. 01	0	27.01
27.02 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP -	2.02	0	27 02
COSTS-MVBLE EQUIP - POB			POB	2.02	Ŭ	27.02
27.03 Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP -	2.03	0	27.03
COSTS-MVBLE EQUIP - WJ			LM			
28.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		
29.00 Physicians' assistant 30.00 Adjustment for occupational	A-8-3		OCCUPATIONAL THERAPY	0.00 67.00		
30.00 Adjustment for occupational therapy costs in excess of	A-0-3		OCCOPATIONAL THERAPT	67.00		30.00
limitation (chapter 14)						
30.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.99
instructions)					l I	
31.00 Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
pathology costs in excess of limitation (chapter 14)						
32.00 CAH HIT Adjustment for		0		0.00	0	32 00
Depreciation and Interest				0.00		02.00
33.00 EMPLOYEE BENEFITS	A	-2, 987, 461	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
33.01 HOSPITAL ASSESSMENT FEES	A		ADMI NI STRATI VE & GENERAL	5.00		
33. 02 MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5.00		
33. 03 MI SCELLANEOUS I NCOME 33. 04 CONTRACTED HOSPI TALI ST	B A		PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	
33. 05 CONTRACTED CRNA	A		OPERATING ROOM	50.00	0	
33.06 MEDICARE DEPRECIATION EXPENSE	A		CAP REL COSTS-BLDG & FIXT	1.00	9	
33. 07 MEDI CARE DEPRECIATION EXPENSE	A		CAP REL COSTS-BLDG &	1.01	9	
			FIXT-MOB			
33.08 MEDICARE DEPRECIATION EXPENSE	A	-35, 030	CAP REL COSTS-BLDG &	1. 02	9	33.08
	Δ	0 400	FIXT-POB	1 00	9	22.00
33. 09 MEDI CARE DEPRECIATION EXPENSE 33. 10 MEDI CARE DEPRECIATION EXPENSE	A A		CAP REL COSTS-BLDG & FIXT-W. CAP REL COSTS-MVBLE EQUIP	J 1. 03 2. 00		
33. 11 MEDI CARE DEPRECIATION EXPENSE	A		CAP REL COSTS-MVBLE EQUIP -	2.00	9	
			MOB	2.01		
33. 12 MI SCELLANEOUS I NCOME	В	-976	EMERGENCY	91.00	0	33.12
33. 13 MI SCELLANEOUS I NCOME	В		LABORATORY	60.00		
33. 14 MI SCELLANEOUS I NCOME	В	-27, 040	CAP REL COSTS-BLDG & FIXT-POB	1.02	9	33.14
33.15 MISC NON-ALLOWABLE	А	_197	PHYSICAL THERAPY	66.00	0	33 15
33. 16 MISC NON-ALLOWABLE	A		PHYSICIANS' PRIVATE OFFICES	192.00	0	
33. 17 MISC NON-ALLOWABLE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.18 MISC NON-ALLOWABLE	A		DI ETARY	10.00	0	
33. 19 MI SCELLANEOUS I NCOME	В		OUTPATIENT PSYCH	93.00	0	
33. 20 MI SCELLANEOUS I NCOME	B		EMPLOYEE BENEFITS DEPARTMENT		0	
33. 21 MI SCELLANEOUS I NCOME 33. 22 MI SC NON-ALLOWABLE	B A		JAY FAMILY MEDICINE CARDIOPULMONARY	90. 02 76. 00	0	
33. 23 MISC NON-ALLOWABLE	A		NURSING ADMINISTRATION	13.00		33.22 33.23
	I A	1,000	PROVED NO ADMINI STRATION	1 13.00	0	55.23

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1320	Period:	Worksheet A-8	
				From 01/01/2022 To 12/31/2022		pared: 02 pm
			Expense Classification of			
			To/From Which the Amount i	s to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
cost center bescription	(2)	Amourt	cost center	LINC #	Ref.	
	1.00	2.00	3.00	4.00	5.00	
50.00 TOTAL (sum of lines 1 thru 49)		-3, 447, 451				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	IU HEALTH J	AY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1320	Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 01/01/2022		
				To 12/31/2022		
	Line No.	Cost Center	Expense Items	Amount of	5/26/2023 12: Amount	uz pili
	Li ne no.	COST Center	Expense i tems	Allowable Cost		
					Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST					
	OFFICE COSTS:	MENTO RECORDED NO A RECOEL OF			OEM MED HOME	
1.00		CAP REL COSTS-BLDG & FIXT	HOME OFFICE	95, 542	0	1.00
2.00		CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	132,094	0	2.00
3.00		EMPLOYEE BENEFITS DEPARTMENT		1, 966, 772	0	3.00
3.00		ADMI NI STRATI VE & GENERAL	HOME OFFICE	5, 764, 402	5, 855, 224	3.00
4.00		OPERATION OF PLANT	HOME OFFICE	3, 704, 402	29, 008	4.00
		EMPLOYEE BENEFITS DEPARTMENT		-	29,008	
4.01				59, 508	8	4.01
4.02			RELATED PARTY	750, 376	436, 641	4.02
4.03			RELATED PARTY	110, 217	169, 704	4.03
4.04			RELATED PARTY	9, 331	0	4.04
4.05			RELATED PARTY	354, 758	212, 831	4.05
4.06			RELATED PARTY	206, 799	156, 693	4.06
4.07			RELATED PARTY	151, 432	93, 316	4.07
4.08			RELATED PARTY	37, 113	21, 450	4.08
4.09			RELATED PARTY	39, 611	49, 499	4.09
4.10			RELATED PARTY	51, 202	22, 248	4.10
4.11	4.00	EMPLOYEE BENEFITS DEPARTMENT		13, 510	13, 510	4.11
4.12			SHARED EMPLOYEES	6, 962	6, 962	4.12
4.13	10.00		SHARED EMPLOYEES	38, 353	38, 353	4.13
4.14	13.00	NURSING ADMINISTRATION	SHARED EMPLOYEES	39, 214	39, 214	4.14
4.15	15.00	PHARMACY	SHARED EMPLOYEES	106, 695	106, 695	4.15
4.16	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	764, 726	764, 726	4.16
4.17	50.00	OPERATING ROOM	SHARED EMPLOYEES	18, 745	18, 745	4.17
4.18	60.00	LABORATORY	SHARED EMPLOYEES	2, 075, 412	2,075,412	4.18
4.19	66.00	PHYSI CAL THERAPY	SHARED EMPLOYEES	513, 525	513, 525	4.19
4.20	67.00	OCCUPATI ONAL THERAPY	SHARED EMPLOYEES	93, 938	93, 938	4.20
4.21	68.00	SPEECH PATHOLOGY	SHARED EMPLOYEES	18, 788	18, 788	4.21
4.22	76.00	CARDI OPULMONARY	SHARED EMPLOYEES	25, 996	25, 996	4.22
4.23		FAMILY PRACTICE OF JAY COUNT		33, 180	33, 180	4.23
4.24			SHARED EMPLOYEES	88, 479	88, 479	4.24
4.25		JAY FAMILY FIRST HEALTH CARE		16, 590	16, 590	4.25
4.26			SHARED EMPLOYEES	1, 393, 555	1, 393, 555	4.26
4.20	0.00			1, 373, 333	1, 373, 333	4.20
4.27	0.00			0	0	4.27
4.20 5.00	TOTALS (sum of lines 1-4).			14, 976, 825	12, 294, 282	4.20 5.00
5.00	Transfer column 6, line 5 to			14, 770, 023	12, 274, 202	5.00
	Worksheet A-8, column 2,					
	line 12.					
* The						

* 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.

1143	SILOL	been posted to worksheet A,				4 of this part.		
					Related Organization(s) and/	or Home Office		
		Symbol (1)	Name	Percentage of	Name	Percentage of		
				Ownership		Ownershi p		
		1.00	2.00	3.00	4.00	5.00		
B INTERPELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE								

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

i ci indui			
6.00	В	0.00 U HEALTH BALL 100.00	6.00
7.00	В	0.00 U HEALTH 100.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		1

Heal th	Financial Syste	ems		IU H	IEALTH J	AY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	NT OF COSTS OF	SERVI CES	FROM RELATED	ORGANI ZATI ONS	S AND HO	ME Provider	CCN: 15-1320	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS							From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
									5/26/2023 12:	
							Related Orga	nization(s) and/	or Home Office	
	Symbol	l (1)		Name		Percentage of	-	Name	Percentage of	
						Ownership			Ownership	
	1. (00		2.00		3.00		4.00	5.00	

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

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

Health Financial Systems	I U HEALTH JAY HOSPI TAL	In Lieu of Form CMS-2552-10
	TED ORGANIZATIONS AND HOME Provider CCN: 1	5-1320 Period: Worksheet A-8-1 From 01/01/2022
OFFICE COSTS		To 12/31/2022 Date/Time Prepared:
Net Wkst A-7 Ref		5/26/2023 12:02 pm

		Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME	
	OFFICE COSTS:			
1.00	95, 542			1.00
2.00	132, 094			2.00
3.00	1, 966, 772			3.00
3.01	-90, 822	0		3.01
4.00	-29, 008			4.00
4.01	59, 508	0		4.01
4.02	313, 735	0		4.02
4.03	-59, 487			4.03
4.04	9, 331	0		4.04
4.05	141, 927	0		4.05
4.06	50, 106	0		4.06
4.07	58, 116	0		4.07
4.08	15, 663			4.08
4.09	-9, 888	0		4.09
4.10	28, 954	0		4.10
4.11	0	0		4.11
4.12	0	0		4.12
4.13	0	0		4.13
4.14	0	0		4.14
4.15	0	0		4.15
4.16	0	0		4.16
4.17	0	0		4.17
4.18	0	0		4.18
4.19	0	0		4.19
4.20	0	0		4.20
4.21	0	0		4.21
4.22	0	0		4.22
4.23	0	0		4.23
4.24	0	0		4.24
4.25	0	0		4.25
4.26	0	0		4.26
4.27	0	0		4.27
4.28	0	0		4.28
5.00	2, 682, 543			5.00
			oscripts as appropriate) are transferred in detail to Worksheet A. column 6. lines as	

* 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.

1101	been posted to worksheet A,	
	Related Organization(s) and/or Home Office	
	Type of Business	
	6.00	
	D INTERDELATIONCULD TO DELA	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

i ci ilibui			
6.00	HOSPI TAL	6	6.00
7.00	HOME OFFICE	7	7.00
8.00		8	8.00
9.00		9	9.00
10.00		10	0.00
100.00		100	0.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organization.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

	Financial Syste		IU HEALTH J				eu of Form CMS-	
PROVI DE	ER BASED PHYSICI	AN ADJUSTMENT		Provider (CCN: 15-1320	Period:	Worksheet A-8	3-2
						From 01/01/2022 To 12/31/2022	2 Date/Time Pre 5/26/2023 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
					·		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	50.00	OPERATING ROOM	-2, 741	-2, 741		0 0	0	1.00
2.00		FAMILY PRACTICE OF JAY	33, 180	33, 180		0 0	0	2.00
2 00		COUNTY JAY FAMILY MEDICINE	88, 479	88, 479		0 0	0	2 00
3.00 4.00		JAY FAMILY MEDICINE	16, 590	16, 590			-	
4.00 5.00		EMERGENCY	1, 273, 293	7, 908		-	0	
5.00 6.00	0.00	EMERGENCY	1, 273, 293				-	
8.00 7.00	0.00		0	0			0	1
7.00 8.00	0.00		0	0			0	7.00
	0.00		0	0			0	
9.00			0	-			-	
10.00	0.00		1 400 001	0		-	0	
200.00	With A Line //	Cast Caster (Dhusi si an	1, 408, 801	143, 416		Provi der	0 Dhuai ai an Caat	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		Identifier	Limit	Unadjusted RCE Limit	Continuing	Component Share of col.	of Malpractice Insurance	
					Education	12	Thsurance	
	1.00	2.00	8.00	9,00	12.00	13.00	14.00	
1.00		OPERATING ROOM	0.00	0		0 0		1.00
2.00		FAMILY PRACTICE OF JAY	0	0				
		COUNTY	-	-			-	
3.00	90. 02	JAY FAMILY MEDICINE	0	0		o o	0	3.00
4.00	90.05	JAY FAMILY FIRST HEALTH CARE	0	0		o o	0	4.00
5.00	91.00	EMERGENCY	0	0		o o	0	5.00
6.00	0.00		0	0		o o	0	6.00
7.00	0.00		0	0		o o	0	7.00
8.00	0.00		0	0		o o	0	8.00
9.00	0.00		0	0		o o	0	9.00
10.00	0.00		0	0		o o	0	10.00
200.00			0	0		o o	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1/ 00	17.00	10.00		
1.00	1.00	2.00 OPERATING ROOM	15.00 0	16.00 0	17.00	18.00 0 -2,741		1.00
2.00		FAMILY PRACTICE OF JAY	0	0		0 33, 180		2.00
2.00		COUNTY	0	0		0 33,100		2.00
3.00		JAY FAMILY MEDICINE	0	0		0 88, 479		3.00
3.00 4.00		JAY FAMILY FIRST HEALTH CARE	0	0		0 16, 590		4.00
4.00 5.00		EMERGENCY		0		0 7,908		5.00
5.00 6.00	0.00		0	0		0 7,908		6.00
	0.00		0	0				
7.00 8.00	0.00			0				7.00
8.00 9.00	0.00		0	0				8.00 9.00
			0	0				9.00
10.00	0.00		0					200.00
200.00				0		0 143, 416		

ST ALLOO	CATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1320	Peri Fror To	od: n 01/01/2022 12/31/2022	Worksheet B Part I Date/Time Pi	repa	are
						ED COSTS	5/26/2023 12		
				CAPITAL	KELAI	ED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT-MOB		BLDG & FI XT-POB	BLDG & FIXT-WJ		
		0	1.00	1.01		1.02	1.03	+	_
GENI	ERAL SERVICE COST CENTERS	-							
	00 CAP REL COSTS-BLDG & FIXT	816, 353							1.
02 0010 03 0010	01 CAP REL COSTS-BLDG & FIXT-MOB 02 CAP REL COSTS-BLDG & FIXT-POB 03 CAP REL COSTS-BLDG & FIXT-WJ 04 CAP REL COSTS-BLDG & FIXT-INTEREST	0 -27, 040 0	0 0 0		0 0 0	-27, 040 0 0		0	1. 1. 1. 1.
00 0020 01 0020 02 0020	00 CAP REL COSTS-MVBLE EQUIP 01 CAP REL COSTS-MVBLE EQUIP - MOB 02 CAP REL COSTS-MVBLE EQUIP - POB	1, 710, 472 29, 787 0				Ĵ			2. 2. 2.
	03 CAP REL COSTS-MVBLE EQUIP - WJ 00 EMPLOYEE BENEFITS DEPARTMENT	0 2, 047, 123	0		0	0		0	2. 4.
	00 ADMI NI STRATI VE & GENERAL	8, 748, 016	93, 164		0	0		0	5.
	OO OPERATION OF PLANT	2, 812, 070	185, 083		0	0		0	7.
	01 OPERATION OF PLANT - MOB	43, 244	0		0	0		0	7.
	02 OPERATION OF PLANT - POB 03 OPERATION OF PLANT - WJ	51, 211 0	0		0	0		0	7.
	00 LAUNDRY & LINEN SERVICE	76, 763	5, 913		0	0		o	8
	DO HOUSEKEEPI NG	831, 899	5, 993		0	0		0	9
. 00 010	DO DI ETARY	320, 442	20, 267		0	0		0	10
	DO CAFETERI A	337, 120			0	0			11
	00 NURSING ADMINISTRATION	1, 721, 938			0	0			13
	00 CENTRAL SERVICES & SUPPLY	133, 918	0		0	0			14
	00 PHARMACY 00 MEDI CAL RECORDS & LI BRARY	1, 042, 501 0	9, 954 0		0 0	0			15 16
	00 SOCIAL SERVICE	0	0		0	0			17
	ATIENT ROUTINE SERVICE COST CENTERS							-	.,
	00 ADULTS & PEDIATRICS	2, 245, 363	98, 101		0	0		0	30
. 00 0400	00 SUBPROVI DER – I PF	0	0		0	0		0	40
	00 NURSERY	0	0		0	0		0	43
	I LLARY SERVICE COST CENTERS	1 425 200	39, 738		0	0		0	50
	00 DELIVERY ROOM & LABOR ROOM	1, 425, 200	39,738		0	0			50
	00 ANESTHESI OLOGY	0	0		0	0			53
	00 RADI OLOGY-DI AGNOSTI C	1, 312, 471	48, 398		0	Ō			54
00 060	DO LABORATORY	2, 357, 926	26, 031		0	0		0	60
	00 RESPI RATORY THERAPY	634, 705	7, 277		0	0			65
	00 PHYSI CAL THERAPY	566, 614	32, 969		0	0			66
	00 OCCUPATI ONAL THERAPY	93, 938			0	0			67
	00 SPEECH PATHOLOGY 00 ELECTROCARDI OLOGY	18, 788 1, 197	119 0		0	0			68 69
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	65, 063	0		0	0			71
	00 IMPL. DEV. CHARGED TO PATIENTS	23, 421	0		0	Ō			72
00 0730	00 DRUGS CHARGED TO PATIENTS	1, 693, 462	0		0	0		0	73
	60 CARDI OPULMONARY	271, 954	0		0	0			76
	00 ALLOGENEIC HSCT ACQUISITION PATIENT SERVICE COST CENTERS	0	0		0	0		0	77
	DO CLINIC	0	0		0	0		0	90
	01 FAMILY PRACTICE OF JAY COUNTY	917, 883	0		0	0			90 90
	02 JAY FAMILY MEDICINE	967, 666	0		0	ō			90
	D3 WOUND CLINIC	1	0		0	0			90
	04 OP ORTHO CLINIC	627	0		0	0			90
	05 JAY FAMILY FIRST HEALTH CARE	387, 924	50, 817		0	0			90
	06 INFUSION CLINIC 07 HEALTH BEGINNINGS PROGRAM	120, 285 336, 482	6, 152 37, 011		0	0			90 90
	00 EMERGENCY	3, 149, 477	47, 483		0	0			90 91
	00 OBSERVATION BEDS (NON-DISTINCT PART	_, , , , , , ,	,			Ű			92
	50 OUTPATIENT PSYCH	109, 089	15, 638		0	0		0	93
	ER REIMBURSABLE COST CENTERS	0	0		0	0		01	02
	CIAL PURPOSE COST CENTERS	0	0		0	0			02
з. 00	SUBTOTALS (SUM OF LINES 1 through 117)	37, 395, 353	766, 770		0	0		01	18
	REIMBURSABLE COST CENTERS								0.5
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	152 522	7,675		0	0		01	
	00 PHYSICIANS' PRIVATE OFFICES 00 NONPAID WORKERS	152, 522	0		0 0	0		0101	
	50 VACANT	-30	25, 931		0	0		01	
	52 WEST JAY CLINIC	0	0		Ō	0		01	
	53 JAY MERIDIAN URGENT CARE	0	15, 977		0	Ō		01	
0. 00	Cross Foot Adjustments							15	200

Heal th Financial	I Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provider CO		Period:	Worksheet B		
					From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:	
						5/26/2023 12:	02 pm	
				CAPITAL RE	ELATED COSTS			
Cos	st Center Description	Net Expenses	BLDG & FIXT	BLDG &	BLDG &	BLDG &		
		for Cost		FI XT-MOB	FI XT-POB	FIXT-WJ		
		Allocation						
		(from Wkst A						
		col. 7)						
		0	1.00	1.01	1.02	1.03		
201.00 Neg	ative Cost Centers		0	(0 -27, 040	0	201.00	
	TAL (sum lines 118 through 201)	37, 547, 845	816, 353	(-27, 040	0	202.00	

ST ALLOCA	ncial Systems ATION - GENERAL SERVICE COSTS	<u>IU HEALTH JA</u>	Provi der C		Period: From 01/01/2022	u of Form CMS- Worksheet B Part I	2002
					o 12/31/2022		epareo
			CAP	ITAL RELATED C	OSTS	10,20,2020 12.	
	Cost Center Description	BLDG &	MVBLE EQUIP		MVBLE EQUIP -		
		FIXT-INTEREST 1.04	2.00	MOB 2.01	P0B 2.02	WJ 2.03	
	RAL SERVICE COST CENTERS			1			1.
	1 CAP REL COSTS-BLDG & FIXT-MOB						1.
	2 CAP REL COSTS-BLDG & FIXT-POB 3 CAP REL COSTS-BLDG & FIXT-WJ						1.
	4 CAP REL COSTS-BLDG & FIXT-INTEREST	0					1. 1.
	O CAP REL COSTS-MVBLE EQUIP		1, 710, 472				2.
	1 CAP REL COSTS-MVBLE EQUIP - MOB 2 CAP REL COSTS-MVBLE EQUIP - POB		0	29, 787 C			2.
03 0020	3 CAP REL COSTS-MVBLE EQUIP - WJ		0	C		0	
	O EMPLOYEE BENEFITS DEPARTMENT O ADMINISTRATIVE & GENERAL	0	0 195, 202	1, 943	-	0	
00 0070	O OPERATION OF PLANT	0	387, 795	c c	0	0	7.
	1 OPERATION OF PLANT - MOB 2 OPERATION OF PLANT - POB	0	0	679		0	
03 0070	3 OPERATION OF PLANT - WJ	0	0	C	0	0	7.
	0 LAUNDRY & LINEN SERVICE 0 HOUSEKEEPING	0	12, 389 12, 556			0	
	0 DI ETARY	0	42, 465			0	
		0	46, 637			0	
	O NURSI NG ADMI NI STRATI ON O CENTRAL SERVI CES & SUPPLY	0	19, 397 0			0	
. 00 0150	0 PHARMACY	0	20, 857		-	0	
	0 MEDICAL RECORDS & LIBRARY 0 SOCIAL SERVICE	0	0 0		-	0	
I NPA	TIENT ROUTINE SERVICE COST CENTERS	-					
	0 ADULTS & PEDI ATRI CS 0 SUBPROVI DER – I PF	0	205, 547 0			0	
	O NURSERY	0	0			0	
	LLARY SERVICE COST CENTERS	0	83, 262	1, 253	0	0	50.
	D DELIVERY ROOM & LABOR ROOM	0	03, 202			0	
	0 ANESTHESI OLOGY 0 RADI OLOGY-DI AGNOSTI C	0	0 101, 407			0	
	LABORATORY	0	54, 541			0	
		0	15, 247			0	
	O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY	0	69, 079 10, 783			0	
. 00 0680	O SPEECH PATHOLOGY	0	250	C	, s	0	68.
	0 ELECTROCARDI OLOGY 0 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	-		0	
	O I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.
	O DRUGS CHARGED TO PATIENTS	0	0			0	
	0 CARDI OPULMONARY 0 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	2,076		0	
OUTP	ATIENT SERVICE COST CENTERS						
. 00 0900 . 01 0900	1 FAMILY PRACTICE OF JAY COUNTY	0	0 0	0 11, 958		0	
. 02 0900	2 JAY FAMILY MEDICINE	0	0	11, 689		0	90
	3 WOUND CLINIC 4 OP ORTHO CLINIC	0	0			0	
. 05 0900	5 JAY FAMILY FIRST HEALTH CARE	0	106, 476			0	90.
	6 INFUSION CLINIC 7 HEALTH BEGINNINGS PROGRAM	0	12, 890 77, 547		-	0	
	0 EMERGENCY	0	99, 488		0 0	0	
	O OBSERVATION BEDS (NON-DISTINCT PART		22 7/7				92.
	O OUTPATIENT PSYCH R REIMBURSABLE COST CENTERS	0	32, 767	[C	0 0	0	93.
2.001020	O OPIOID TREATMENT PROGRAM	0	0	C	0	0	102.
8.00	AL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 606, 582	29, 787	0	0	118.
NONR	EIMBURSABLE COST CENTERS	1		1	1		
	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 PHYSICIANS' PRIVATE OFFICES	0	16, 081 0				190. 192.
3. 00 1930	NONPAID WORKERS	0	0		0	0	193.
4.000795		0	54, 333		0		194.
	2 WEST JAY CLINIC 3 JAY MERIDIAN URGENT CARE	0	0 33, 476		0) 194.) 194.
0.00	Cross Foot Adjustments		,				200.
1.00	Negative Cost Centers		0	1 C		0	201.

	nancial Systems CATION - GENERAL SERVICE COSTS	IU HEALTH JAY	HOSPI TAL Provi der CO	CN: 15-1320 Pe	In Lieu eriod: rom 01/01/2022	u of Form CMS-2 Worksheet B Part I	2552-10
				To		Date/Time Pre 5/26/2023 12:	pared: 02 pm
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
		4.00	4A	5.00	7.00	7.01	
1.00 001 1.01 001 1.02 001 1.03 001 1.04 001	IERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT O1 CAP REL COSTS-BLDG & FIXT-MOB O2 CAP REL COSTS-BLDG & FIXT-POB O3 CAP REL COSTS-BLDG & FIXT-WJ O4 CAP REL COSTS-BLDG & FIXT-INTEREST O0 CAP REL COSTS-MVBLE EQUIP						1.00 1.01 1.02 1.03 1.04 2.00
2.02 002 2.03 002 4.00 004 5.00 005 7.00 007 7.01 007 7.02 007	201 CAP REL COSTS-MVBLE EQUIP - MOB 202 CAP REL COSTS-MVBLE EQUIP - POB 203 CAP REL COSTS-MVBLE EQUIP - WJ 203 CAP REL COSTS-MVBLE EQUIP - WJ 200 EMPLOYEE BENEFITS DEPARTMENT SOO ADMINISTRATIVE & GENERAL 200 OPERATION OF PLANT - MOB 201 OPERATION OF PLANT - MOB 202 OPERATION OF PLANT - POB 203 OPERATION OF PLANT - WJ	2, 047, 123 63, 227 84, 946 0 0	9, 101, 552 3, 469, 894 43, 923 51, 211 0	9, 101, 552 1, 109, 159 14, 040 16, 370	4, 579, 053 25, 910 32, 126 0	83, 873 0 0	2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.02 7.03
8.00 008 9.00 009 10.00 010 11.00 011	000 LAUNDRY & LI NEN SERVI CE 000 HOUSEKEEPI NG 000 CAFETERI A 000 NURSI NG ADMI NI STRATI ON	5, 922 70, 039 27, 324 30, 003 185, 263	100, 987 920, 487 410, 498 436, 018 1, 935, 856	32, 281 294, 236 131, 217 139, 374 618, 800	31, 029 31, 447 106, 355 116, 802 48, 581	0 0 0 0 0 0	8.00 9.00 10.00 11.00 13.00
14.00 014 15.00 015 16.00 016 17.00 017	IOOI CENTRAL SERVI CES & SUPPLY IOOI PHARMACY IOOI MEDI CAL RECORDS & LI BRARY IOO SOCI AL SERVI CE VATI ENT ROUTI NE SERVI CE COST CENTERS	87, 348 0	1, 160, 660 1, 160, 660 0 0	42, 807 371, 007 0	0 52, 237 0 0	0 0 0 0	14.00 15.00 16.00 17.00
30.00 030	000 ADULTS & PEDIATRICS 000 SUBPROVIDER - IPF	313, 335 0	2, 862, 346 0	914, 955 0	514, 797 0	0	30.00 40.00
43.00 043	300 NURSERY	0	0	0	0	0	43.00
50.00 050 52.00 052	CILLARY SERVICE COST CENTERS	160, 966 0 0	1, 710, 419 0 0	546, 739 0 0	590, 745 0 0	3, 869 0 0	50.00 52.00 53.00
54.00 054 60.00 060	000 RADI OLOGY-DI AGNOSTI C 000 LABORATORY 000 RESPI RATORY THERAPY	162, 899 99 85, 208	1, 625, 175 2, 438, 597 742, 437	519, 490 779, 502 237, 321	253, 977 136, 600 38, 185	0 0 0	54.00 60.00 65.00
66.00 066 67.00 067	000 PHYSI CAL THERAPY 000 OCCUPATI ONAL THERAPY 000 SPEECH PATHOLOGY	80, 869 14, 793 2, 959	749, 531 124, 660 22, 116	239, 589 239, 589 39, 848 7, 069	173, 009 27, 007 627	0 0 0 0	66.00 67.00 68.00
69.00 069 71.00 071	000 ELECTROCARDIOLOGY 000 ELECTROCARDIOLOGY 000 MEDICAL SUPPLIES CHARGED TO PATIENTS 200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 197 65, 063 23, 421	383 20, 798 7, 487	0000	0 0 0 0	69.00 71.00 72.00
73.00 073 76.00 031	000 DRUGS CHARGED TO PATIENTS 60 CARDI OPULMONARY 000 ALLOGENEI C HSCT ACQUI SI TI ON	0 23, 796 0	1, 693, 462 297, 826 0		0 79, 191 0	0	73.00 76.00
	PATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90.01 090 90.02 090	001 FAMILY PRACTICE OF JAY COUNTY 002 JAY FAMILY MEDICINE 003 WOUND CLINIC	111, 624 136, 905	1, 041, 465 1, 116, 260 1	332, 906 356, 815	456, 187 445, 896	36, 923 36, 089 0	90.01
90.04 090 90.05 090	004 OP ORTHO CLINIC 005 JAY FAMILY FIRST HEALTH CARE 006 INFUSION CLINIC	0 54, 819 17, 330	627 600, 225 156, 657	200 191, 863 50, 076	0 273, 984 32, 283	0 583 0	90.04
90. 07 090 91. 00 091	007 HEALTH BEGINNINGS PROGRAM 00 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	49, 503 243, 866	500, 543 3, 540, 314	160, 000 1, 131, 660	194, 218 249, 171	0	90.07 91.00 92.00
93.00 049 0TH	DESO OUTPATI ENT PSYCH IER REI MBURSABLE COST CENTERS	14, 490	171, 984	54, 975	82, 065	0	93.00
	200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
118.00 NON	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	2, 027, 533	37, 249, 330	8, 997, 487	3, 992, 429	83, 873	118.00
190. 00 190 192. 00 192	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0 19, 590	23, 756 172, 112	7, 594 55, 016	40, 275 326, 430	0	190.00 192.00
194.00079	300 NONPAID WORKERS 950 VACANT 952 WEST JAY CLINIC	0	0 80, 234 0	0 25, 647 0	0 136, 078 0	0	193.00 194.00 194.02
194. 03 079 200. 00	253 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	0	49, 453 0	15, 808	83, 841	0	194. 03 200. 00
201.00 202.00	Negative Cost Centers TOTAL (sum lines 118 through 201)	0 2, 047, 123	27, 040- 27, 547, 845- 37, 547, 845-		0 4, 579, 053	0 83, 873	201. 00 202. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C	F	Period: From 01/01/2022	Worksheet B Part I	
				To 12/31/2022	Date/Time Pre 5/26/2023 12:	
Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
GENERAL SERVICE COST CENTERS	7.02	7.03	8.00	9.00	10.00	
Image: Construction 1.00 00100 CAP REL COSTS CUSTS CUSTS	99, 707 0 0	0 0 0	164, 297			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 01000 DI ETARY 11.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 SOCI AL SERVICE INPATI ENT ROUTI NE SERVICE COST CENTERS	0 0 0 0 0	0 0 0 0 0 0 0		29,726 32,646 13,578 0 14,600 0 0	677, 796 0 0 0 0 0 0 0	
30. 00 03000 ADULTS & PEDIATRICS 40. 00 04000 SUBPROVI DER - I PF	0 0	0			677, 796 0	30. 00 40. 00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	(0	0	43.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY 54.00 05400 RADIOLOGY-DIAGNOSTIC 60.00 06000 LABORATORY 65.00 06500 RESPIRATORY 66.00 06600 PHYSICAL THERAPY 67.00 06700 OCCUPATIONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDIOLOGY	71, 537 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0 0 0 70, 987 0 38, 180 0 10, 673 0 48, 356 0 7, 548 0 175	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50.00 52.00 53.00 54.00 60.00 65.00 66.00 67.00 68.00 69.00
71.0007100MEDICAL SUPPLIES CHARGED TO PATIENTS72.0007200IMPL. DEV. CHARGED TO PATIENTS73.0007300DRUGS CHARGED TO PATIENTS	0 0 0	0 0 0		0 0 0 0	0 0 0	71.00 72.00 73.00
76. 00 03160 CARDI OPULMONARY 77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0			0	•
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 90.02 09002 JAY FAMILY PROTICE OF JAY COUNTY 90.02 09003 WOUND CLINIC 90.03 09004 OP ORTHO CLINIC 90.04 09006 JAY FAMILY FIRST HEALTH CARE 90.05 09006 INFUSION CLINIC 90.06 09006 INFUSION CLINIC 90.07 09007 HEALTH BEGINNINGS PROGRAM 91.00 09100 EMERGENCY 92.00 092000 0BSERVATION BEDS (NON-DISTINCT PART 93.00 04950 0UTPATIENT PSYCH 0THER REIMBURSABLE COST CENTERS 0THERS				127, 505 124, 629 0 0 0 76, 579 9, 023 54, 284 69, 644		90.00 90.01 90.02 90.03 90.04 90.05 90.06 90.07 91.00 92.00 93.00
102.00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	(0 0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	71, 537	0	1		677, 796	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS 194.00 07950 VACANT 194.02 07952 WEST JAY CLINIC 194.03 07953 JAY MERIDIAN URGENT CARE 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0 28, 170 0 0 0 0 0			91, 238 0 0 38, 034 0 23, 434 0 0	0 0 0 0 0 0	190.00 192.00 193.00 194.00 194.02 194.03 200.00 201.00
202.00 TOTAL (sum lines 118 through 201)	99, 707	0	164, 297	1, 246, 170	677, 796	202.00

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	ı of Form CMS-:	2552-10
	DCATION - GENERAL SERVICE COSTS		Provider CC		eriod: com 01/01/2022 0 12/31/2022	Worksheet B Part I Date/Time Pre	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	5/26/2023 12: MEDI CAL RECORDS & LI BRARY	02 pm
		11.00	13.00	14.00	15.00	16.00	
	NERAL SERVICE COST CENTERS						1 1 00
1.01 00 1.02 00 1.03 00 1.04 00	100 CAP REL COSTS-BLDG & FIXT 101 CAP REL COSTS-BLDG & FIXT-MOB 102 CAP REL COSTS-BLDG & FIXT-POB 103 CAP REL COSTS-BLDG & FIXT-WJ 104 CAP REL COSTS-BLDG & FIXT-INTEREST 200 CAP REL COSTS-MVBLE EQUIP						1.00 1.01 1.02 1.03 1.04 2.00
2.01 00 2.02 00 2.03 00 4.00 00	201 CAP REL COSTS-MVBLE EQUIP - MOB 202 CAP REL COSTS-MVBLE EQUIP - MOB 203 CAP REL COSTS-MVBLE EQUIP - POB 203 CAP REL COSTS-MVBLE EQUIP - WJ 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL						2.00 2.01 2.02 2.03 4.00 5.00
7.00 00 7.01 00	700 OPERATION OF PLANT - MOB 701 OPERATION OF PLANT - MOB 702 OPERATION OF PLANT - POB						7.00 7.01 7.02
8.00 00 9.00 00	703 OPERATI ON OF PLANT - WJ 800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG 000 DI ETARY						7.03 8.00 9.00 10.00
11.00 01 13.00 01 14.00 01	100 CAFETERI A 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY	724, 840 55, 352 0	2, 672, 167 0	176, 725			11.00 13.00 14.00
16.00 01 17.00 01	500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE PATI ENT ROUTI NE SERVI CE COST CENTERS	28, 399 0 0		1, 231 0 0	1, 628, 134 0 0	0	
	000 ADULTS & PEDI ATRI CS	103, 801	787, 065	27, 251	11, 885	0	30.00
	000 SUBPROVI DER – I PF	0		0	0	0	40.00
	300 NURSERY CILLARY SERVICE COST CENTERS	0	0	0	0	0	43.00
	000 OPERATI NG ROOM	51, 761	424, 905	21, 276	7, 181	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	400 RADI OLOGY-DI AGNOSTI C 000 LABORATORY	57, 030 56, 284		3, 820 289	5, 029 0	0	54.00 60.00
	500 RESPI RATORY THERAPY	25, 507	0	9, 619	0	0	65.00
	600 PHYSI CAL THERAPY	18, 699	0	120	0	0	66.00
	700 OCCUPATI ONAL THERAPY	7, 275		0	0	0	67.00
	800 SPEECH PATHOLOGY	1, 026	0	0	0	0	68.00
	900 ELECTROCARDI OLOGY 100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	1, 843 44, 582	0	0	69.00 71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	Ű	16, 049	0	0	
73.00 07	300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 552, 997	0	73.00
	160 CARDI OPULMONARY	9, 699	4, 954	156	126	0	•
	700 ALLOGENEI C HSCT ACQUI SI TI ON TPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	77.00
	000 CLINIC	0	0	0	0	0	90.00
	001 FAMILY PRACTICE OF JAY COUNTY	74, 471		5, 423	0	0	90.01
		84, 496	273, 546	2,830	0	0	90.02 90.03
	003 WOUND CLINIC 004 OP ORTHO CLINIC	0	0	52 0	0	0	90.03
	005 JAY FAMILY FIRST HEALTH CARE	35, 067	72, 652	5,006	Ő	0	90.05
	006 INFUSION CLINIC	4, 756		2, 218	6, 141	0	90.06
	007 HEALTH BEGI NNI NGS PROGRAM 100 EMERGENCY	21,637		174	373 44, 402	0	90.07 91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	65, 424	698, 451	34, 726	44, 402	0	91.00
	950 OUTPATI ENT PSYCH	10, 819	0	59	0	0	
	HER REIMBURSABLE COST CENTERS	-					
	200 OPI OI D TREATMENT PROGRAM ECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
118.00 NO	SUBTOTALS (SUM OF LINES 1 through 117) NREIMBURSABLE COST CENTERS	711, 503		176, 724	1, 628, 134		118.00
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 200 PHYSICIANS' PRIVATE OFFICES	0 13, 337	0 550	0	0		190. 00 192. 00
	300 NONPAID WORKERS	0	0	0	o		193.00
194.0007	950 VACANT	0	0	0	0	0	194.00
	952 WEST JAY CLINIC	0	0	0	0		194.02
194.0307 200.00	953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	0	0	0	0	0	194. 03 200. 00
200.00	Negative Cost Centers	0	о	0	о	0	200.00
202.00	TOTAL (sum lines 118 through 201)	724, 840	2, 672, 167	176, 725	1, 628, 134		202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1320	Period: From 01/01/2022	Worksheet B Part I
				To 12/31/2022	
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB 1. 03 00103 CAP REL COSTS-BLDG & FIXT-POB 1. 04 00104 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 2. 01 00203 CAP REL COSTS-MVBLE EQUIP POB 2. 03 00203 CAP REL COSTS-MVBLE EQUIP PUJ 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 7. 01 00701 OPERATION OF PLANT MOB 7. 02 00702 OPERATION OF PLANT PUB 7. 03 00703 OPERATION OF PLANT WJ 8. 00 00800 LAUNDRY & LINEN SERVICE	0				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
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	6, 208, 080		0 6, 208, 080	30,00
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	40.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	0		0 0	43.00
50. 00 05000 OPERATING ROOM	0	3, 593, 548		0 3, 593, 548	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY	0	0		0 0 0 0	52.00 53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 535, 508		0 2, 535, 508	54.00
60. 00 06000 LABORATORY	0	3, 449, 452		0 3, 449, 452	60.00
65. 00 06500 RESPIRATORY THERAPY	0	1,063,742		0 1, 063, 742 0 1, 229, 304	65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 229, 304 206, 338		0 1, 229, 304 0 206, 338	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	31, 013		0 200, 330	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 423		0 3, 423	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	130, 443		0 130, 443	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	46, 957		0 46, 957	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS	0	3, 787, 778		0 3, 787, 778	73.00
76. 00 03160 CARDI OPULMONARY 77. 00 07700 ALLOGENELC HSCT ACQUI SLTI ON	0	515, 696 0		0 515, 696 0 0	76.00 77.00
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	77.00
90. 00 09000 CLINIC	0	0		0 0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	2, 277, 976		0 2, 277, 976	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	2, 440, 561		0 2, 440, 561	90.02
90. 03 09003 WOUND CLINIC	0	53		0 53	90.03
90. 04 09004 OP ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	827 1, 255, 959		0 827 0 1, 255, 959	90.04 90.05
90. 06 09006 INFUSION CLINIC	0	317, 294		0 317, 294	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	1,082,037		0 1, 082, 037	90.07
91.00 09100 EMERGENCY	0	5, 833, 792		0 5, 833, 792	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93. 00 04950 OUTPATIENT PSYCH	0	342, 839		0 342, 839	93.00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI0ID TREATMENT PROGRAM	0	0		0 0	102.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	36, 352, 620		0 36, 352, 620	118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	82, 882		0 82, 882	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	686, 854		0 686, 854 0 0	192.00 193.00
193. 00 19300 NONPAT D WORKERS 194. 00 07950 VACANT	0	279, 993		0 279, 993	193.00
194. 02 07952 WEST JAY CLINIC	0	2, , , , , , , 0		0 0	194.02
194. 03 07953 JAY MERI DI AN URGENT CARE	0	172, 536		0 172, 536	194.03
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0	27, 040- 27, 547, 845		0 -27, 040 0 37, 547, 845	201.00 202.00
202.00 TOTAL (SUM TIMES TTO LIN OUGH 201)	U	57, 547, 645		51, 541, 645	J202.00

	Financial Systems	IU HEALTH JA		N. 15 1220	Darsiad		of Form CMS-	2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	JN: 15-1320		/01/2022 /31/2022	Worksheet B Part II Date/Time Pro	epared:
				CAPI TAL	RELATED (5/26/2023 12	<u>02 pm</u>
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	BLDG & FIXT-MOB		DG & T-POB	BLDG & FIXT-WJ	
		Related Costs 0	1.00	1.01	1	. 02	1.03	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT							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. 00 7. 01 7. 02 7. 03 8. 00 9. 00	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUI P 00201 CAP REL COSTS-MVBLE EQUI P - MOB 00202 CAP REL COSTS-MVBLE EQUI P - MOB 00203 CAP REL COSTS-MVBLE EQUI P - MOB 00203 CAP REL COSTS-MVBLE EQUI P - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 93, 164 185, 083 0 0 5, 913 5, 993		0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0		1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.00 7.01 7.03 8.00
10.00	01000 DI ETARY	0	20, 267		0	0	C	10.00
11.00 13.00 14.00 15.00 16.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		22, 258 9, 258 0 9, 954 0		0 0 0 0			13.00 14.00 15.00
	01700 SOCI AL SERVI CE	0			0	0	(
30. 00 40. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 04000 SUBPROVI DER - I PF 04300 NURSERY	000000000000000000000000000000000000000	0		0 0 0	0 0 0	(40.00
50.00	ANCILLARY SERVICE COST CENTERS	0	39, 738		0	0	(50.00
52.00 53.00 54.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	000000000000000000000000000000000000000			0 0	0 0	()	52.00 53.00
60.00 65.00 66.00	06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0 0 0	26, 031 7, 277 32, 969		0 0 0	0 0 0) 65.00) 66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 27100 MEDICAL SUPPLIES CUARCED TO DATIENTS	000000000000000000000000000000000000000	5, 146 119 0		0 0 0	0 0 0		68.00 69.00
72.00 73.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03160 CARDIOPULMONARY		0		0 0 0	0	(((() 72.00) 73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	-		0	0	(
90.00	OUTPATIENT SERVICE COST CENTERS	0	0		0	0	(90.00
90. 02 90. 03	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC 09004 OP ORTHO CLINIC	000000000000000000000000000000000000000	0 0		0 0 0	0 0 0	((((90.02 90.03
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM	0	50, 817 6, 152 37, 011		0 0 0	0 0 0	(90.05 90.06
91.00 92.00 93.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	0	47, 483 15, 638		0	0	(92.00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	0	0		0	0	(0 102.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	766, 770		0	0	(118.00
192.00 193.00 194.00 194.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 07950 VACANT 07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE		7, 675 0 25, 931 0 15, 977		0 0 0 0 0	0 0 0 0 0		190.00 192.00 193.00 194.00 194.02 194.03
200.00	Cross Foot Adjustments		0		0	-27, 040		200.00

Health Financial Systems	IU HEALTH JA				u of Form CMS	-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od:	Worksheet B	
				From 01/01/2022 To 12/31/2022		repared: 2:02 pm
			CAPITAL R	ELATED COSTS		
Cost Center Description	Di rectl y	BLDG & FIXT	BLDG &	BLDG &	BLDG &	
	Assigned New Capital		FIXT-MOB	FI XT-POB	FIXT-WJ	
	Related Costs					
	0	1.00	1.01	1.02	1.03	
202.00 TOTAL (sum lines 118 through 201)	0	816, 353		0 -27, 040		0 202.00

LOCATI ON	OF CAPITAL RELATED COSTS		Provider C	F	Period: From 01/01/2022		
					o 12/31/2022	2 Date/Time Pre 5/26/2023 12:	
			CAP	PITAL RELATED C	0515		
	Cost Center Description	BLDG &	MVBLE EQUIP			MVBLE EQUIP -	
		FIXT-INTEREST 1.04	2.00	MOB 2.01	P0B 2.02	WJ 2.03	
	RAL SERVICE COST CENTERS		2100		2.02		
	O CAP REL COSTS-BLDG & FIXT						1.0
	1 CAP REL COSTS-BLDG & FIXT-MOB 2 CAP REL COSTS-BLDG & FIXT-POB						1.0
	3 CAP REL COSTS-BLDG & FIXT-POB						1.0
04 0010	4 CAP REL COSTS-BLDG & FIXT-INTEREST						1.0
	O CAP REL COSTS-MVBLE EQUIP						2.0
	1 CAP REL COSTS-MVBLE EQUIP - MOB 2 CAP REL COSTS-MVBLE EQUIP - POB						2.0
	3 CAP REL COSTS-MVBLE EQUIP - WJ						2.0
	O EMPLOYEE BENEFITS DEPARTMENT	0	C			o c	
1	O ADMINISTRATIVE & GENERAL O OPERATION OF PLANT	0	195, 202				
	1 OPERATION OF PLANT - MOB	0	387, 795				
	2 OPERATION OF PLANT - POB	0	0				
	3 OPERATION OF PLANT - WJ	0	(-			
	O LAUNDRY & LINEN SERVICE O HOUSEKEEPING	0	12, 389 12, 556				
	0 DI ETARY	0	42, 465				
	O CAFETERI A	0	46, 637	7 C			
	O NURSI NG ADMI NI STRATI ON	0	19, 397				
	O CENTRAL SERVICES & SUPPLY O PHARMACY	0	0 20, 857				
	O MEDICAL RECORDS & LIBRARY	0	20,007				
	O SOCIAL SERVICE	0) () 17.0
	TI ENT ROUTI NE SERVI CE COST CENTERS	0	205 54	1			1 20
	0 ADULTS & PEDIATRICS 0 SUBPROVIDER – IPF	0	205, 547 (
	0 NURSERY	0	(
	LLARY SERVICE COST CENTERS	-			.1	-1	
	O OPERATING ROOM O DELIVERY ROOM & LABOR ROOM	0	83, 262				
	O ANESTHESI OLOGY	0					
4.00 0540	0 RADI OLOGY-DI AGNOSTI C	0	101, 407	7 0) (
1		0	54, 541				
	0 RESPI RATORY THERAPY 0 PHYSI CAL THERAPY	0	15, 247 69, 079				
	O OCCUPATI ONAL THERAPY	0	10, 783				
	O SPEECH PATHOLOGY	0	250			o c	
	0 ELECTROCARDIOLOGY 0 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					
	O I MPL. DEV. CHARGED TO PATIENTS	0					
3.00 0730	O DRUGS CHARGED TO PATIENTS	0	C) (
	O CARDI OPULMONARY	0	(
	O ALLOGENEIC HSCT ACQUISITION ATIENT SERVICE COST CENTERS	0	() () () 77.
		0	() (90.
	1 FAMILY PRACTICE OF JAY COUNTY	0	(11, 958			
	2 JAY FAMILY MEDICINE 3 WOUND CLINIC	0) 11,689			
	4 OP ORTHO CLINIC	0					
0900 05 00	5 JAY FAMILY FIRST HEALTH CARE	0	106, 476	5 189			90.
	6 INFUSION CLINIC	0	12, 890				
	7 HEALTH BEGINNINGS PROGRAM 0 EMERGENCY	0	77, 547 99, 488				
	O OBSERVATION BEDS (NON-DISTINCT PART	0	///				92.
	O OUTPATIENT PSYCH	0	32, 767	7 0) (93.
	R REIMBURSABLE COST CENTERS	0	() 102. (
	I AL PURPOSE COST CENTERS	0					102.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 606, 582	2 29, 787	/		0 118. (
	EIMBURSABLE COST CENTERS	<u>^</u>	14 001) 190. (
	0 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 PHYSICIANS' PRIVATE OFFICES	0	16, 081) 190.
93.001930	O NONPAID WORKERS	0					193.
94.000795		0	54, 333	3 C			194.
	2 WEST JAY CLINIC	0))))) 194.
94.030795 00.00	3 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	0	33, 476				200.
01.00	Negative Cost Centers	0	(201.0
02.00	TOTAL (sum lines 118 through 201)	0	1, 710, 472	2 29, 787	(202.0

	nancial Systems	IU HEALTH JAY				of Form CMS-2	2552-10
ALLOCATI	ON OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2022 p 12/31/2022	Worksheet B Part II Date/Time Pre 5/26/2023 12:	pared:
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI V E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
		2A	4.00	5.00	7.00	7.01	
	NERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c ccccc} 1. & 00 & 00 \\ 1. & 01 & 00 \\ 1. & 02 & 00 \\ 1. & 03 & 00 \\ 1. & 04 & 00 \\ 2. & 00 & 00 \\ 2. & 01 & 00 \\ 2. & 02 & 00 \\ 2. & 03 & 00 \\ 4. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 01 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 & 00 \\ 7. & 00 $	D100 CAP REL COSTS-BLDG & FIXT-MOB D101 CAP REL COSTS-BLDG & FIXT-MOB D102 CAP REL COSTS-BLDG & FIXT-POB D103 CAP REL COSTS-BLDG & FIXT-POB D104 CAP REL COSTS-BLDG & FIXT-INTEREST D200 CAP REL COSTS-MVBLE EQUIP D201 CAP REL COSTS-MVBLE EQUIP D202 CAP REL COSTS-MVBLE EQUIP - D202 CAP REL COSTS-MVBLE EQUIP - MOB D202 CAP REL COSTS-MVBLE EQUIP - WJ D202 CAP REL COSTS-MVBLE EQUIP - WJ D203 CAP REL COSTS-MVBLE EQUIP - WJ D202 CAP REL COSTS-MVBLE EQUIP - WJ D203 CAP REL COSTS-MVBLE EQUIP - WJ D203	0 290, 309 572, 878 679 0 0 18, 302 18, 549 62, 732 68, 895 28, 655 0 30, 811 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	290, 309 35, 379 448 522 0 1, 030 9, 385 4, 185 4, 446 19, 738 1, 365 11, 834 0 0	608, 257 3, 442 4, 267 0 4, 122 4, 177 14, 128 15, 515 6, 453 0 6, 939 0 0	4, 569 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.00 7.01 7.02 7.03 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00
	IPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	U	0	17.00
	3000 ADULTS & PEDIATRICS	303, 648	0	29, 184	68, 383	0	30.00
	1000 SUBPROVI DER – I PF 1300 NURSERY	0	0	0	0	0	40.00
	ICI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50.00 05	OOO OPERATING ROOM	124, 253	0	17, 439	78, 473	211	50.00
	200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	300 ANESTHESI OLOGY 3400 RADI OLOGY-DI AGNOSTI C	0 149, 805	0	0 16, 570	33, 737	0	53.00 54.00
	000 LABORATORY	80, 572	0	24, 864	18, 145	0	60.00
	500 RESPI RATORY THERAPY	22, 524	0	7, 570	5, 072	0	65.00
	600 PHYSI CAL THERAPY	102, 048	0	7,642	22, 982	0	66.00
	0700 OCCUPATI ONAL THERAPY 0800 SPEECH PATHOLOGY	15, 929 369	0	1, 271 225	3, 587 83	0	67.00 68.00
	900 ELECTROCARDI OLOGY	0	0	12	0	0	69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	663	0	0	71.00
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0	239	0	0	
	300 DRUGS CHARGED TO PATIENTS 3160 CARDI OPULMONARY	0 2, 076	0	17, 267 3, 037	0 10, 519	0 349	
	700 ALLOGENEIC HSCT ACQUISITION	2,070	0	3,037	10, 519	0	77.00
OU	TPATIENT SERVICE COST CENTERS				1		
		0	0	0	0	0	
	2001 FAMILY PRACTICE OF JAY COUNTY 2002 JAY FAMILY MEDICINE	11, 958 11, 689	0	10, 619 11, 381	60, 597 59, 230	2, 011 1, 966	90.01 90.02
	WOUND CLINIC	0	Ō	0	0	0	90.03
	2004 OP ORTHO CLINIC	0	0	6	0	0	90.04
	2005 JAY FAMILY FIRST HEALTH CARE	157, 482	0	6, 120	36, 395	32	90.05
	2006 INFUSION CLINIC 2007 HEALTH BEGINNINGS PROGRAM	19, 042 114, 558	0	1, 597 5, 104	4, 288 25, 799	0	90.06 90.07
	2100 EMERGENCY	146, 971	0	36, 094	33, 099	0	91.00
	2200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
	1950 OUTPATIENT PSYCH	48, 405	0	1, 754	10, 901	0	93.00
	HER REIMBURSABLE COST CENTERS D200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
	ECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>	0	0	0	102.00
118.00 NO	SUBTOTALS (SUM OF LINES 1 through 117) INREIMBURSABLE COST CENTERS	2, 403, 139	0		530, 333		118.00
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 756	0	242	5, 350		190.00
	2200 PHYSICIANS' PRIVATE OFFICES 2300 NONPAID WORKERS	0	0	1, 755 0	43, 361		192.00 193.00
	950 VACANT	80, 264	0	818	18, 076		193.00
194.0207	952 WEST JAY CLINIC	0	0	0	0	0	194.02
	7953 JAY MERI DI AN URGENT CARE	49, 453	0	504	11, 137	0	194.03
200.00	Cross Foot Adjustments Negative Cost Centers	0 -27,040	0	0	0	0	200.00
201.00							

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		eriod: rom 01/01/2022	Worksheet B Part	
				o 12/31/2022	Date/Time Pre 5/26/2023 12:	
Cost Center Description	OPERATI ON OF	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT - POB 7.02	PLANT - WJ 7.03	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
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 & FIXT-POB						1.02
1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.03 1.04
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUI P - MOB 2. 02 00202 CAP REL COSTS-MVBLE EQUI P - POB						2.01 2.02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - VJ						2.02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
7.01 00701 OPERATION OF PLANT - MOB	4 700					7.01
7. 02 00702 OPERATION OF PLANT - POB 7. 03 00703 OPERATION OF PLANT - WJ	4, 789 0	0				7.02 7.03
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	23, 454			8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	0	0	32, 111 766	81, 811	9.00 10.00
11. 00 01100 CAFETERI A	0	0	0	841	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	0	0	350 0	0	13.00 14.00
15. 00 01500 PHARMACY	0	0	0	376	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	0	0 0	0	0 0	16.00 17.00
INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		3, 708	81, 811	30.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0	0	0	0	0	40.00 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 436	0	0	4, 253 0	0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	0	0	1, 829 984	0	54.00 60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	275	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	1, 246 195	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	5	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	69.00 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 77.00 07700 ALLOGENEI CHSCT ACQUI SITION	0	0			0	
OUTPATIENT SERVICE COST CENTERS						00.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0	0 3, 286	0	90.00 90.01
90. 02 09002 JAY FAMILY MEDICINE	0	0	0	3, 211	0	90.02
90. 03 09003 WOUND CLINIC 90. 04 09004 0P ORTHO CLINIC	0	0	0	0	0	90. 03 90. 04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	0	1, 973	0	90.05
90.06 09006 INFUSION CLINIC 90.07 09007 HEALTH BEGINNINGS PROGRAM	0	0	0	233 1, 399	0	90.06 90.07
91.00 09100 EMERGENCY	0	0	0	1, 795	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04950 OUTPATIENT PSYCH	0	0	o	591	0	92.00 93.00
OTHER REIMBURSABLE COST CENTERS				371	0	75.00
102. 00 10200 OPI 0I D TREATMENT PROGRAM SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 436	0	23, 454	27, 886	81, 811	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	200	0	100.00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	1, 353	0	0	290 2, 351	0	190. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00 194.00
194.0007950 VACANT 194.0207952 WEST JAY CLINIC	0	0	0	980 0		194.00 194.02
194.0307953 JAY MERIDIAN URGENT CARE	0	0	0	604		194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	0	О	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 789		23, 454	32, 111	81, 811	

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	F	eriod: rom 01/01/2022	Worksheet B Part II	
Cost Conton Description					Date/Time Pre 5/26/2023 12:	02 pm
Cost Center Description	CAFETERI A	NURSING ADMINISTRATIO	CENTRAL SERVICES &	PHARMACY	MEDI CAL RECORDS &	
	11.00	N 13.00	SUPPLY 14.00	15.00	LI BRARY 16.00	
GENERAL SERVICE COST CENTERS						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 1.01 00101 CAP REL COSTS-BLDG & FLXT-MOB						1.00 1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.04 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 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.03 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
7. 01 00701 OPERATION OF PLANT - MOB 7. 02 00702 OPERATION OF PLANT - POB						7.01 7.02
7. 03 00703 OPERATION OF PLANT - WJ						7.02
8.00 00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A	89, 697					11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	6, 850	62, 046				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0 3, 514	0	1, 365 10			14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0		0	16.00
17.00 01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS	12, 846	18, 273	210	390	0	30.00
40. 00 04000 SUBPROVI DER - I PF	12, 040	0	0		0	40.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	6, 405	9, 866	164	236	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0, 100	0	0		0	52.00
53.00 05300 ANESTHESI OLOGY	0	0	0		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	7, 057 6, 965	0	30 2		0	54.00 60.00
65. 00 06500 RESPI RATORY THERAPY	3, 156	0	74		0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 314	0	1		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	900 127	0	0 0		0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	14		0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	346		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0		124 0		0	72.00 73.00
76. 00 03160 CARDI OPULMONARY	1, 200		1		0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	9, 216		42		0	90.00
90. 02 09002 JAY FAMILY MEDICINE	10, 456		22		0	90.02
90. 03 09003 WOUND CLINIC 90. 04 09004 OP ORTHO CLINIC	0	0	0		0	90.03 90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	4, 339	-	39		0	90.05
90. 06 09006 I NFUSI ON CLI NI C	589		17		0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM 91. 00 09100 EMERGENCY	2, 678 8, 096		1 268		0	90.07 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0,090	10, 210	200	1,437	0	92.00
93.00 04950 OUTPATIENT PSYCH	1, 339	0	0	0	0	93.00
OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS		0	0	0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	88, 047	62, 033	1, 365	53, 484	0	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 650		0			192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
194.00 07950 VACANT 194.02 07952 WEST JAY CLINIC	0	0	0	0		194.00 194.02
194. 03 07953 JAY MERI DI AN URGENT CARE	0	0	0	0		194.03
200.00 Cross Foot Adjustments	<u>_</u>		~		~	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 89, 697	0 62, 046	0 1, 365	0 53, 484		201.00 202.00
			., 200		Ũ	

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1320	Period: From 01/01/2022	Worksheet B Part II
				To 12/31/2022	
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	17.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS					1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB 1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2. 00 00200 CAP REL COSTS-MVBLE EQUI P 2. 01 00202 CAP REL COSTS-MVBLE EQUI P - MOB 2. 02 00202 CAP REL COSTS-MVBLE EQUI P - POB 2. 03 00203 CAP REL COSTS-MVBLE EQUI P - POB 2. 03 00203 CAP REL COSTS-MVBLE EQUI P - WJ 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT 7. 01 00701 OPERATI ON OF PLANT 7. 02 00702 OPERATI ON OF PLANT - MOB 7. 03 00703 OPERATI ON OF PLANT - VJ 8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	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 7.00 7.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 17.00 10.00 11.00 13.00 14.00 15.00 10.00 11.00 13.00 14.00 13.00 14.00 13.00 14.00 13.00 14.00 13.00 13.00 14.00 13.00 14.00 13.00 14.00 15.00 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	541, 907		0 541, 907	30.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0 0	0 0		0 0 0 0	40.00 43.00
ANCI LLARY SERVICE COST CENTERS	0	244, 736	[0 244, 736	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	244, 730		0 244,730	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0	209, 193 131, 532		0 209, 193 0 131, 532	54.00 60.00
65.00 06500 RESPIRATORY THERAPY	0	38, 671		0 38,671	65.00
66. 00 06600 PHYSI CAL THERAPY	0	136, 233		0 136, 233	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	21, 882		0 21, 882	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	809 26		0 809 0 26	68.00 69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,009		0 1,009	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	363		0 363	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	68, 283		0 68, 283	73.00
76. 00 03160 CARDI OPULMONARY 77. 00 07700 ALLOGENELC HSCT ACQUI SITION	0	17, 871 0		0 17,871 0 0	76.00 77.00
OUTPATIENT SERVICE COST CENTERS	0	0			11.00
90. 00 09000 CLINIC	0	0		0 0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	102, 445		0 102, 445	90.01
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	0	104, 307		0 104, 307 0 0	90.02 90.03
90. 04 09004 0P ORTHO CLINIC	0	6		0 6	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	208, 067		0 208, 067	90.05
90. 06 09006 I NFUSI ON CLI NI C	0	27, 272		0 27, 272	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM 91. 00 09100 EMERGENCY	0	153, 053 244, 000		0 153, 053 0 244, 000	90.07 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	Ŭ	244,000		0	92.00
93. 00 04950 OUTPATI ENT PSYCH	0	62, 990		0 62, 990	93.00
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	0		0 0	102.00
SPECIAL PURPOSE COST CENTERS	0				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	2, 314, 655		0 2, 314, 655	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29, 638		0 29, 638	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	50, 483		0 50, 483	192.00
193. 00 19300 NONPAI D WORKERS 194. 00 07950 VACANT	0	0 100, 138		0 0 0 100, 138	193.00 194.00
194. 02 07952 WEST JAY CLINIC	0	00, 130		0 0	194.00
194. 03 07953 JAY MERI DI AN URGENT CARE	0	61, 698		0 61, 698	194.03
200.00 Cross Foot Adjustments	~	0			200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 0	27, 040- 2, 529, 572		0 -27, 040 0 2, 529, 572	201.00
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	Financial Systems NLLOCATION - STATISTICAL BASIS	IU HEALTH JA	Y HOSPITAL Provider CO	CN: 15-1320 F	In Lie Period:	u of Form CMS-2 Worksheet B-1	
00017				F	rom 01/01/2022 o 12/31/2022		
			CAP	ITAL RELATED C		5/26/2023 12:	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB	BLDG & FI XT-POB	BLDG & FIXT-WJ	BLDG & FIXT-INTEREST	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)	
		1.00	FEET-MOB) 1.01	FEET-POB) 1.02	FEET-WJ) 1.03	1.04	
1 00	GENERAL SERVICE COST CENTERS	82,009					1.00
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MOB	82,009	21, 753				1.00 1.01
1.02	00102 CAP REL COSTS-BLDG & FIXT-POB	0	0	9, 538			1.02
1.03 1.04	00103 CAP REL COSTS-BLDG & FIXT-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0				1.03
2.00	00200 CAP REL COSTS-MVBLE EQUIP		-				2.00
2. 01 2. 02	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB						2.01
2.02	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	C		0	4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	9, 359 18, 593	1, 419 0		-	9, 359 18, 593	5.00 7.00
7.01	00701 OPERATION OF PLANT - MOB	0	496			0	7.01
7.02 7.03	00702 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ	0	0	615 C		0	7.02
8.00	00800 LAUNDRY & LINEN SERVICE	594	0	C		594	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	602	0			602	9.00 10.00
11.00	01100 CAFETERI A	2, 036 2, 236	0			2, 036 2, 236	•
13.00	01300 NURSI NG ADMI NI STRATI ON	930	0	C	-	930	•
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0 1, 000	0		-	0 1, 000	14.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	C		0	16.00
17.00	01700 SOCIAL SERVICE	0	0	C	0 0	0	17.00
30.00	03000 ADULTS & PEDIATRICS	9, 855	0				30.00
40.00 43.00	04000 SUBPROVI DER – I PF 04300 NURSERY	0	0				40.00
43.00	ANCI LLARY SERVICE COST CENTERS		0		<u> </u>	0	43.00
50.00	05000 OPERATING ROOM	3, 992	915				•
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0			0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 862	0	C	-	4, 862	1
60.00 65.00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 615 731	0			2, 615 731	60.00 65.00
66.00	06600 PHYSI CAL THERAPY	3, 312	0	C	-	3, 312	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	517 12	0			517	•
	06900 ELECTROCARDI OLOGY	0	0		0 0		69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	•
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0		-	0	
76.00	03160 CARDI OPULMONARY	0	1, 516			0	76.00
77.00	07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	C	0 0	0	77.00
90.00	09000 CLI NI C	0	0	C		0	•
90.01 90.02	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0	8, 733 8, 536		-	0	90.01 90.02
90.03	09003 WOUND CLINIC	0	0, 550	C	-	0	90.03
90.04	09004 OP ORTHO CLINIC	0	0	C	0	0	90.04
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	5, 105 618	138 0			5, 105 618	•
90.07	09007 HEALTH BEGINNINGS PROGRAM	3, 718	0	C	0	3, 718	90.07
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 770	0	C	0	4, 770	91.00 92.00
93.00	04950 OUTPATI ENT PSYCH	1, 571	0	C	0	1, 571	93.00
102 00	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	·			,	0	102.00
118.00		77, 028	21, 753	7, 017	0	77, 028	118.00
190.00	NONREIMBURSABLE COST CENTERS	771	0	C	0	771	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	2, 521		0	192.00
	19300 NONPAI D WORKERS 07950 VACANT	0 2, 605	0				193.00 194.00
194.02	07952 WEST JAY CLINIC	0	0	C	0	0	194.02
194. 03 200. 00	07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	1, 605	0	C	0	1, 605	194.03 200.00
200.00							200.00

Health F	inancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST AL	LOCATION - STATISTICAL BASIS				Period: From 01/01/2022	Worksheet B-1		
					To 12/31/2022			
			CAPI	TAL RELATED (COSTS			
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG &	BLDG &		
		(SQUARE FEET)	FIXT-MOB	FI XT-POB	FIXT-WJ	FIXT-INTEREST		
			(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)		
			FEET-MOB)	FEET-POB)	FEET-WJ)			
		1.00	1.01	1.02	1.03	1.04		
202.00	Cost to be allocated (per Wkst. B,	816, 353	0	-27, 04	0 0	0	202.00	
	Part I)							
203.00	Unit cost multiplier (Wkst. B, Part I)	9. 954432	0. 000000	0.00000	0. 000000	0.000000	203.00	
204.00	Cost to be allocated (per Wkst. B,						204.00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part						205.00	
	11)							
206.00	NAHE adjustment amount to be allocated						206.00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,						207.00	
	Parts III and IV)							

	Financial Systems LLOCATION – STATISTICAL BASIS	IU HEALTH JA			Peri od:	u of Form CMS-: Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 12:	
			CAPI TAL RE	LATED COSTS		572072025 12.	
	Cost Center Description	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	
	CENEDAL SEDVICE COST CENTERS	2.00	2.01	2.02	2.03	4.00	
11.00 13.00 14.00 15.00	GENERAL SERVICE COST CENTERS 00100 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-WJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP 00202 CAP REL COSTS-MVBLE EQUIP POB 00202 CAP REL COSTS-MVBLE EQUIP POB 00203 CAP REL COSTS-MVBLE EQUIP POB 00203 CAP REL COSTS-MVBLE EQUIP PUB 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 0PERATION OF PLANT POB 00700 OPERATION <td>82, 009 C C 0 9, 359 18, 593 C C 0 594 602 2, 036 2, 236 930 C 1, 000</td> <td>21, 753 0 0 1, 419 496 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>9, 53 61</td> <td>3,728 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>12, 999, 359 401, 492 539, 413 0 0 37, 607 444, 751 173, 506 190, 522 1, 176, 430 0 554, 662 0</td> <td>$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$</td>	82, 009 C C 0 9, 359 18, 593 C C 0 594 602 2, 036 2, 236 930 C 1, 000	21, 753 0 0 1, 419 496 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	9, 53 61	3,728 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12, 999, 359 401, 492 539, 413 0 0 37, 607 444, 751 173, 506 190, 522 1, 176, 430 0 554, 662 0	$\begin{array}{c} 5.\ 00\\ 7.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
17.00 30.00 40.00	01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 04000 SUBPROVI DER - I PF	9, 855 C			0 0 0 0 0 0	0 1, 989, 713 0	17.00 30.00 40.00
43.00	04300 NURSERY ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM	3, 992	C		0 0	0	43.00
$\begin{array}{c} 52. \ 00\\ 53. \ 00\\ 54. \ 00\\ 65. \ 00\\ 66. \ 00\\ 67. \ 00\\ 68. \ 00\\ 69. \ 00\\ 71. \ 00\\ 72. \ 00\\ 73. \ 00\\ 76. \ 00\\ 77. \ 00 \end{array}$	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 OCCUPATIONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 03160 CADIOPULMONARY 07700 ALLOGENEIC HSCT ACQUISITION 0UTPATIENT SERVICE COST CENTERS	3, 992 C C 4, 862 2, 615 731 3, 312 517 12 C C C C C C C C C C C C C				0 0 1, 034, 417 630 541, 077 513, 525 93, 938 18, 788 0 0 0 0 151, 108 0	52.00 53.00 54.00 60.00 65.00 67.00 68.00 69.00 71.00 72.00 73.00 76.00 77.00
90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 91. 00 92. 00	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC 09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH 0THER REIMBURSABLE COST CENTERS	C C C 5, 105 618 3, 718 4, 770 1, 571			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 708, 816 869, 355 0 348, 101 110, 046 314, 345 1, 548, 565 92, 012	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07
102.00	10200 OPI OI D TREATMENT PROGRAM	C	0		0 0	0	102.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	77, 028	21, 753	7, 01	7 0	12, 874, 960	118.00
192.00 193.00 194.00 194.02	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CIANS' PRI VATE OFFICES 19300 NONPAI D WORKERS 07950 VACANT 07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	771 C 2, 605 C 1, 605		2, 52	0 0 1 3, 728 0 0 0 0 0 0 0 0 0 0	124, 399 0 0 0	190. 00 192. 00 193. 00 194. 00 194. 02 194. 03 200. 00

Health Finan	ncial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	TION – STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 12:	pared: 02 pm
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	MVBLE EQUIP (SQUARE FEET)	MVBLE EQUIP - MOB (SQUARE FEET-MOB)	MVBLE EQUIP - POB (SQUARE FEET-POB)	MVBLE EQUIP - WJ (SQUARE FEET-WJ)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	
		2.00	2.01	2.02	2.03	4.00	
205. 00 206. 00 207. 00	Negative Cost Centers Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)	1, 710, 472 20. 857125			0 0.000000	2, 047, 123 0. 157479 0 0. 000000	203. 00 204. 00

COST ALLOCATION - STATUSTICAL BASIS Period The Allocation - Statustical Basis The Allocation - Statustical Basis The Allocation - Statustical Basis December 2012 (2012) Period The Allocation - Statustical Basis December 2012 (2012) Period The Allocation - Statustical Basis December 2012 (2012) Period December 2012 (2012) December 2012 (2012) <thdecember (2012)<="" 2012="" th=""> December 2012 (2012)</thdecember>	Health Financial Systems	IU HEALTH JA				u of Form CMS-2	
Cost Center Description Record [1] at 0 AVXIII SURTY OPERATION 00 OPERATION 00 OPERATION 00 PAULY CONTOR 000000000000000000000000000000000000	COST ALLOCATION - STATISTICAL BASIS		Provider C	Fi	rom 01/01/2022	Date/Time Pre	pared:
FA F.00 7.00 7.01 7.02 000000 DECLED SET LODG & FLUXED 1.01 0.01 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	Cost Center Description		E & GENERAL	PLANT	PLANT - MOB (SQUARE	OPERATION OF PLANT - POB (SQUARE	02 pm
1.00 00100 CAP FEL COSTS-BLOD & FIXT 1.00 1.00 00100 CAP FEL COSTS-BLOD & FIXT-F08 1.00 1.00 00100 CAP FEL COSTS-BLOD & FIXT-F08 1.00 1.00 00100 CAP FEL COSTS-BLOD & FIXT-F08 2.00 1.00 00100 CAP FEL COSTS-MUEL EDUI P - MBL 2.00 2.00 00000 CAP FEL COSTS-MUEL EDUI P - MBL 2.01 2.00 00000 CAP FEL COSTS-MUEL EDUI P - MBL 2.01 2.00 00000 CAP FEL COSTS-MUEL EDUI P - MBL -9, 101, 552 28, 473, 333 4.00 2.00 00000 CAPERIT ON F PLANT - MBR 0 3, 466 894 87, 609 19, 858 8, 92, 209 2.01 00000 CAPERIT ON F PLANT - MBR 0 10, 09, 200 10, 09, 200 10, 09, 200 10, 09, 200 10, 09, 200 10, 09, 200 10, 09, 200 10, 09, 200 10, 09, 200 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 10, 000 <		5A	5.00	7.00			
1.01 00101 CAP FEL 0033-BLUE & FIXT-R08 1.01 1.02 00103 CAP FEL 0033-BLUE & FIXT-R08 1.02 1.03 00103 CAP FEL 0033-BLUE & FIXT-R08 1.02 1.03 00103 CAP FEL 0033-BLUE & FIXT-R04 2.01 2.00 00200 CAP FEL 0033-WUE E DUP P - M08 2.01 2.01 00200 CAP FEL 0033-WUE E DUP P - M08 2.01 2.00 00200 CAP FEL 0033-WUE E DUP P - M08 2.01 2.00 00200 CAP FEL 0033-WUE E DUP P - M08 2.01 2.01 00200 CAP FEL 0033-WUE E DUP P - M08 3.046 87.453 7.00 0.0000 CAP FEL 0033-WUE E DUP P - M08 0.3.466 87.453 87.453 7.00 0.0000 CAP FEL 0033-WUE P - M04 0.3.466 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 87.453 <							1 1 00
30.00 33000 ADULTS & PEDIATRICS 0 2,862,346 9,855 0 0 0 40.00 43.00 04300 NURSERV 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 00200 CAP REL COSTS-MVBLE EQUI P 2.01 00201 CAP REL COSTS-MVBLE EQUI P - MOB 2.02 00202 CAP REL COSTS-MVBLE EQUI P - POB 2.03 00203 CAP REL COSTS-MVBLE EQUI P - WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINI STRATI VE & GENERAL 7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - MOB 7.02 00702 OPERATION OF PLANT - MOB 7.03 00703 OPERATION OF PLANT - MUJ 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFTERIA 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 </td <td>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>3, 469, 894 43, 923 51, 211 0 100, 987 920, 487 410, 498 436, 018 1, 935, 856 133, 918 1, 160, 660 0</td> <td>87, 659 496 615 0 594 602 2, 036 2, 236 930 0 1, 000 0</td> <td>0 0 0 0 0 0 0 0 0 0 0</td> <td></td> <td>$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$</td>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3, 469, 894 43, 923 51, 211 0 100, 987 920, 487 410, 498 436, 018 1, 935, 856 133, 918 1, 160, 660 0	87, 659 496 615 0 594 602 2, 036 2, 236 930 0 1, 000 0	0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$
43. 00 043.00 VIEXERY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00 03000 ADULTS & PEDI ATRI CS	-					
50. 00 00 00 00 1, 710, 419 11, 309 915 6, 402 50. 00 52. 00 05300 DELL VERY NOM & LABOR ROM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
52:00 DS2:00 DESLURENY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 740 440	44,000	045	(100	50.00
53.00 loss of advestmest old GY 0 0 0 0 0 0 53.00 54.00 05400 RADD LOGYD LABORATORY 0 2,438,597 2,615 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>0</td> <td>1, 710, 419</td> <td></td> <td></td> <td></td> <td></td>		0	1, 710, 419				
60:00 00000 LABORATORY 0 2,438,577 2,615 0 0 60:00 0 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 60:00 71:00 71:00 71:00 71:00 71:00 72:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00 73:00<		0	0	-	0		
65:00 06500 RESPIRATORY THERAPY 0 742, 437 731 0 0 65.00 66:00 06600 PHYSICAL THERAPY 0 749, 531 3, 312 0 0 66.00 66:00 06000 PHYSICAL THERAPY 0 124, 660 517 0 0 67.00 68:00 05000 ELECTRCARDIOLOGY 0 2, 116 12 0 0 67.00 00 07100 DOLOLAL SUPPLIES CHARGED TO PATIENTS 0 1, 197 0 0 0 77.00 0100 DATIENT SERVICE COST CONTENTS 0 1, 633, 462 0 0 77.00 0 0700 ALLOGENEIC HSCT ACOULSTION 0 0 0 0 77.00 0 0700 ALLOGENEIC HSCT ACOULSTION 0 0 0 0 0 0 72.00 0 00000 CLINIC 0 1, 041, 465 8, 733 8, 733 0 90.02 0		0			0		
66:00 06:00 PHYSICAL THERAPY 0 74,9,531 3,312 0 0 66:00 67:00 06:00 OCCUPATIONAL THERAPY 0 124,660 517 0 0 67:00 68:00 06800 SPEECH PATHOLOGY 0 124,660 517 0 0 67:00 69:00 06900 ELECTROCARD (JLOGY 0 1,197 0 0 67:00 01:00 OTION (MEDICAL SUPPLIES CHARGED TO PATIENTS 0 1,693,462 0 0 72:00 0 0 73:00 73:00 70:00 OTOO ALLOGENE L HSCT ACOULSTTION 0 297,826 1,516 1,516 0 76:00 00:01 FAMILY PRACTICE OF JAY COUNTY 0 1,041,465 8;733 8;733 0 90:01 90:02 OPODI FAMILY PRACTICE OF JAY COUNTY 0 1,041,465 8;733 8;733 0 90:01 90:02 OPODI FAMILY PRACTICE OF JAY COUNTY 0 1,041,456 8;536 8;536 <td< td=""><td></td><td>0</td><td></td><td></td><td>-</td><td></td><td></td></td<>		0			-		
67:00 OCCUPATIONAL THERAPY 0 124.660 517 0 0 67:00 68:00 66000 SPECH PATHOLOGY 0 22.116 12 0 0 68:00 69:00 06900 ELECTROCARDIOLOGY 0 1.197 0 0 0 68:00 71:00 DTOO IMPL, DEV. CHARGED TO PATIENTS 0 23:421 0 0 0 73:00 0 0 73:00 0 0 73:00 0 0 73:00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td></td>		0			0		
69:00 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 </td <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td>		0			0	0	
17.100 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 65,063 0 0 0 71.00 72.00 07300 IMPL. DEV. CHARGED TO PATIENTS 0 23,421 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1,693,462 0 0 73.00 70.00 0700 LLOGENEIC HSC ACQUISITION 0 0 0 0 77.00 00.01 09000 FAMILY PRACTICE OF JAY COUNTY 0 1,041,465 8,733 8,733 90.01 90.02 09001 FAMILY PRACTICE OF JAY COUNTY 0 1,041,465 8,536 8,536 90.02 90.03 900.00 90.03 900.04 90.04 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.05 90.04 90.05 90.05 90.05 90.05 90.05 90.06 90.03 90.06 90.05 90.05 90.06 90.06 90.05 90.06 90.05 90.05 90.07 90.06 90.05 90.06 90.06 90.05 90.05		0			0		
72.00 07200 INPL DEV. CHARGED TO PATIENTS 0 23, 421 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 693, 462 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0	-	
73.00 DRUGS CHARGED TO PATIENTS 0 1, 693, 462 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 297, 826 1, 516 1, 516 0 76.00 00.0160 CARDI OPULMONARY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		-			0		
77.00 07700 ALLOGENEIC L HSCT ACQUISITION 0 0 0 0 0 77.00 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73.00 07300 DRUGS CHARGED TO PATIENTS				0		
OUTPATI ENT SERVICE COST CENTERS 90.00 OPDOOD CLINIC O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O O<							
90.00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	0	//.00
90. 02 09002 JAY FAMILY MEDICINE 0 1, 116, 260 8, 536 8, 536 0 90. 02 90. 03 09003 WOUND CLINIC 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0	0	90.00
90.03 09003 WOUND CLINIC 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0					
90.04 09004 0P ORTHO CLINIC 0 627 0 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 600,225 5,245 138 0 90.05 90.06 09005 JAY FAMILY FIRST HEALTH CARE 0 156,657 618 0 0 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0 500,543 3,718 0 0 90.07 91.00 D9100 EMERGENCY 0 3,540,314 4,770 0 0 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 171,984 1,571 0 0 92.00 93.00 04950 OUTPATI ENT PSYCH 0 171,984 1,571 0 0 93.00 012000 OPTALS (SUM OF LINES 1 through 117) -9,101,552 28,147,778 76,429 19,838 6,402 118.00 NORREI MBURSABLE COST CENTERS 190.00 IFT, FLOWER, COFFEE SHOP & CANTEEN 0 <t< td=""><td></td><td>0</td><td>1, 116, 260</td><td></td><td></td><td></td><td></td></t<>		0	1, 116, 260				
90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 600,225 5,245 138 0 90.05 90.06 09006 INFUSI ON CLINIC 0 156,657 618 0 0 90.06 90.07 HEALTH BEGI NNI NGS PROGRAM 0 500,543 3,718 0 0 90.07 91.00 OP200 DESERVATI ON BEDS (NON-DI STINCT PART 0 1.00 0 0 91.00 0 0 93.00 0 04950 0UTPATIENT PSYCH 0 171,984 1,571 0 0 93.00 92.00 10200 PI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	627	-	-		
90. 07 09007 HEALTH BEGINNINGS PROGRAM 0 500, 543 3, 718 0 0 90. 07 91. 00 09100 EMERGENCY 0 3, 540, 314 4, 770 0 0 91. 00 92. 00 92. 00 0 91. 00 91. 00 91. 00 92. 00 92. 00 93. 00 0 95. 00 171, 984 1, 571 0 0 92. 00 93. 00 93. 00 04950 0174 11ENT PSYCH 0 171, 984 1, 571 0 0 93. 00 012.00 10200 0PI 0ID TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS SUM OF LINES 1 through 117) -9, 101, 552 28, 147, 778 76, 429 19, 838 6, 402 118. 00 192.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 172, 112 6, 249 0 2, 521 192. 00 193.00 19300 NONPAI D WORKERS <		0			138		
91.00 09100 EMERGENCY 0 3, 540, 314 4, 770 0 0 91.00 92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0 171, 984 1, 571 0 93.00 93.00 04950 0UTPATI ENT PSYCH 0 171, 984 1, 571 0 0 93.00 01 0200 010 D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <		0			-		
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93.00 04950 0UTPATI ENT PSYCH 0 171,984 1,571 0 0 93.00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	3, 540, 514	4,770	0	0	
102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 102.00 SPECI AL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -9, 101, 552 28, 147, 778 76, 429 19, 838 6, 402 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 23, 756 771 0 0 190.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 0 172, 112 6, 249 0 2, 521 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 07950 VACANT 0 80, 234 2, 605 0 0 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.02 0 194.02 0 194.02 0 194.02 0 194.02 0 0 0 0 0 0	93. 00 04950 OUTPATIENT PSYCH	0	171, 984	1, 571	0	0	
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) -9, 101, 552 28, 147, 778 76, 429 19, 838 6, 402 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 23, 756 771 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 172, 112 6, 249 0 2, 521 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 VACANT 0 80, 234 2, 605 0 0 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.00 194.03 07953 JAY MERIDIAN URGENT CARE 0 49, 453 1, 605 0 0 194.03 200.00 Cross Foot Adjustments 200.00 201.00 201.00 201.00 201.00 201.00 202.00 Cost to be al located (per Wkst. B, 9, 101, 552 4, 579, 0							100.00
SUBTOTALS SUBTOTALS SUM OF LINES 1 through 117) -9, 101, 552 28, 147, 778 76, 429 19, 838 6, 402 118. 00 NONRE I MBURSABLE COST CENTERS 0 23, 756 771 0 0 190. 00 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 23, 756 771 0 0 190. 00 192. 00 19300 NONPAI D WORKER, COFFEE SHOP & CANTEEN 0 172, 112 6, 249 0 2, 521 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 07950 VACANT 0 80, 234 2, 605 0 0 194. 00 194. 02 07952 WEST JAY CLINIC 0 0 0 0 194. 00 194. 03 07953 JAY MERIDIAN URGENT CARE 0 49, 453 1, 605 0 194. 03 200. 00 Cross Foot Adj ustments 200. 00 201. 00 201. 00 201.		0	0	0	0	0	102.00
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 23,756 771 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 172,112 6,249 0 2,521 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 07950 VACANT 0 80,234 2,605 0 0 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.02 194.03 07953 JAY MERI DI AN URGENT CARE 0 49,453 1,605 0 0 194.02 200.00 Cross Foot Adjustments 200.00 201.00 201.00 201.00 201.00 201.00 202.00 Cost to be al located (per Wkst. B, 9,101,552 4,579,053 83,873 99,707 202.00	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-9, 101, 552	28, 147, 778	76, 429	19, 838	6, 402	118.00
193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 VACANT 0 80,234 2,605 0 0 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 0 0 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.02 194.03 07953 JAY MERIDIAN URGENT CARE 0 49,453 1,605 0 194.03 200.00 Cross Foot Adjustments 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 202.00 9,101,552 4,579,053 83,873 99,707 202.00	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			0		
194.00 07950 VACANT 0 80,234 2,605 0 194.00 194.02 07952 WEST JAY CLINIC 0 0 0 0 194.02 194.03 07953 JAY MERIDIAN URGENT CARE 0 49,453 1,605 0 0 194.03 200.00 Cross Foot Adjustments 0 49,453 1,605 200.00 200.00 201.00 Negative Cost Centers 201.00 201.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 9,101,552 4,579,053 83,873 99,707 202.00		0	172, 112	6, 249	0		
194.02 07952 WEST JAY CLINIC 0 0 0 0 194.02 194.03 07953 JAY MERIDIAN URGENT CARE 0 49,453 1,605 0 0 194.03 200.00 Cross Foot Adjustments 0 49,453 1,605 0 200.00 200.00 201.00 Negative Cost Centers 201.00 201.00 201.00 201.00 202.00 Cost to be allocated (per Wkst. B, 9,101,552 4,579,053 83,873 99,707 202.00		0	0		0		
194.03 07953 JAY MERIDIAN URGENT CARE 0 49,453 1,605 0 194.03 200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00		0	60, 234 N	2,005	0		
200.00 Cross Foot Adjustments 200.00 200.00 200.00 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00	194. 03 07953 JAY MERI DI AN URGENT CARE	Ő	49, 453	1, 605	Ō		194.03
202.00 Cost to be allocated (per Wkst. B, 9, 101, 552 4, 579, 053 83, 873 99, 707 202.00							
			9, 101, 552	4, 579, 053	83 873	99 707	
				., ., ,, .,			

Health Fi	nancial Systems	IU HEALTH JAY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLC	CATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1		
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 12:		
	Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF		
		n	E & 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		
203.00	Unit cost multiplier (Wkst. B, Part I)		0. 319652	52. 23711	2 4. 227896	11. 174157	203.00	
204.00	Cost to be allocated (per Wkst. B,		290, 309	608, 25	7 4, 569	4, 789	204.00	
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part		0. 010196	6. 93890	0. 230316	0. 536703	205.00	
206.00	NAHE adjustment amount to be allocated						206.00	
	(per Wkst. B-2)							
207.00	NAHE unit cost multiplier (Wkst. D,						207.00	
	Parts III and IV)							
I		1	I	I	1		1	

Health Financial Systems	IU HEALTH JA				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet B-1 Date/Time Pre	pared:
Cost Center Description	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS	5/26/2023 12: CAFETERI A (MAN HOURS)	02 pm
	(SQUARE FEET-WJ)	(TOTAL PATIENT DAYS)		SERVED)		
	7.03	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FLXT-MOB						1.01
1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB 1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ						1.02 1.03
1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2.00 2.01
2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2.02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.03 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - MOB						7.00 7.01
7. 02 00702 OPERATION OF PLANT - POB						7.02
7.03 00703 0PERATION OF PLANT - WJ 8.00 00800 LAUNDRY & LINEN SERVICE	3, 728 0	1, 379				7.03 8.00
9. 00 00900 HOUSEKEEPI NG	0	0				9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	0				15, 544	10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	2,200		1, 187	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0		-		0 609	14.00 15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0			0	16.00
17. 00 01700 SOCI AL SERVI CE I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	1, 379	9, 855	8, 520	2, 226	30.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	0				0 0	40.00 43.00
ANCILLARY SERVICE COST CENTERS	0			ц о		43.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0				1, 110 0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0		.,		1, 223 1, 207	54.00 60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	731	0	547	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0				401 156	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	12	0	22	68.00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0		-		0	69.00 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY	0				0 208	73.00 76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0				0	1
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	C	0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	8, 733		1, 597	90.01
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	0		8, 536 0 0		1, 812 0	90.02 90.03
90. 04 09004 OP ORTHO CLINIC	0	0	0	-	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	0		5, 245 618		752 102	
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0	3, 718	0	464	90.07
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		4, 770	0	1, 403	91.00 92.00
93. 00 04950 OUTPATIENT PSYCH	0	0	1, 571	0	232	1
OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 0I D TREATMENT PROGRAM	0	C	0	0	0	102.00
SPECIAL PURPOSE COST CENTERS		4.070				
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	1, 379	74, 122	8, 520	15, 258	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	3, 728 0	0	6, 249 0	0		192.00 193.00
194. 00 <mark>07950</mark> VACANT	0		2,605	0	0	194.00
194.02 07952 WEST JAY CLINIC 194.03 07953 JAY MERIDIAN URGENT CARE	0		1,605	0		194.02 194.03
200.00 Cross Foot Adjustments						200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	о	164, 297	1, 246, 170	677, 796	724, 840	201.00 202.00
Part I)						

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C	CN: 15-1320	Period:	Worksheet B-1	
			_		From 01/01/2022 To 12/31/2022		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI N		CAFETERI A	
			LINEN SERVICE	(SQUARE FEET	· · ·	(MAN HOURS)	
		(SQUARE	(TOTAL		SERVED)		
		FEET-WJ)	PATIENT DAYS)				
		7.03	8.00	9.00	10.00	11.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	119. 142132	14.6003	51 79. 553521	46. 631498	203.00
204.00	Cost to be allocated (per Wkst. B,	0	23, 454	32, 1	11 81, 811	89, 697	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	17.007977	0. 3762	9. 602230	5. 770522	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						
	(Parts III and IV)		I			I	I

Heal th Financial Systems	IU HEALTH JA		15 1000		u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Pre	pared:
Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDI CAL RECORDS & LI BRARY (GROSS CHARGES)	5/26/2023 12: SOCI AL SERVI CE (TI ME SPENT)	02 pm
GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 2.00 00200 CAP REL COSTS-MVBLE EQUI P 2.01 00201 CAP REL COSTS-MVBLE EQUI P - MOB 2.02 00202 CAP REL COSTS-MVBLE EQUI P - MOB 2.03 00203 CAP REL COSTS-MVBLE EQUI P - WJ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMI NI STRATI VE & GENERAL 7.01 00700 OPERATI ON OF PLANT 7.02 00702 OPERATI ON OF PLANT 7.03 00703 OPERATI ON OF PLANT - MOB 7.03 00703 OPERATI ON OF PLANT - WJ 8.00 00800 LAUNDRY & LI NEN SERVI CE 9.00 00900 HOUSEKEEPI NG 10.00 01100 CAFETERI A 13.00 01300 NURSI NG ADMI NI STRATI ON 14.00 01400 CENTRAL SERVI CES & SUPPLY	4, 855 0 0 0	257, 905 1, 796 0		0 85, 732, 275		$\begin{array}{c} 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.\ 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\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 00\\ 10.\ 0$
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER - 1 PF 43. 00 04300 NURSERY	1, 430 0 0	39, 769 0 0		0 7, 642, 151 0 0 0 0	0 0 0	30.00 40.00 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS	772 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31, 049 0 0 5, 575 422 14, 037 175 0 0 2, 689 65, 063 23, 421 0 227 0	5, 48 1, 693, 46 13	0 0 0 4 14, 061, 419 9, 725, 655 0 2, 380, 446 0 1, 610, 010 325, 129 0 23, 952 0 145, 500 0 221, 834 0 195, 990 2 11, 872, 058 7 2, 003, 151 0 0		72.00 73.00 76.00 77.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 90.02 09002 JAY FAMILY MEDICINE 90.03 09003 WOUND CLINIC 90.04 09004 OP ORTHO CLINIC 90.05 09005 JAY FAMILY FIRST HEALTH CARE 90.06 09006 INFUSION CLINIC 90.07 09007 HEALTH BEGINNINGS PROGRAM 91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 OUTPATIENT PSYCH OTHER REIMBURSABLE COST CENTERS	0 369 497 0 0 132 102 274 1, 269 0	0 7, 914 4, 130 76 0 7, 306 3, 237 254 50, 677 86	6, 69 40 48, 41	7 54,082 8 22,658,054 0 514,861		
102.00 10200 OPI OLD TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0		0 0		102.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4, 854	257, 903	1, 775, 39	5 85, 732, 275	0	118.00
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 193.00 19300 NONPAI D WORKERS 194.00 07950 VACANT 194.02 07952 WEST JAY CLINIC 194.03 07953 JAY MERI DI AN URGENT CARE 200.00 Cross Foot Adj ustments 201.00 Negati ve Cost Centers	0 1 0 0 0 0	0 2 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	190.00 192.00 193.00 194.00 194.02 194.03 200.00 201.00

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALL	DCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2022 To 12/31/2022		pared: 02 pm
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT	(COSTED		(GROSS		
		NRSING HRS)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00	17.00	
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 672, 167	176, 725	1, 628, 13	4 0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	550. 394851	0. 685233	0. 91705	5 0. 000000	0. 000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	62, 046	1, 365	53, 48	4 0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part	12. 779815	0. 005293	0. 03012	5 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

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 12:	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	6, 208, 080		6, 208, 08		0	
40. 00 04000 SUBPROVI DER – I PF	0			0 0	0	
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS			r			-
50.00 05000 OPERATING ROOM	3, 593, 548		3, 593, 54	8 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 535, 508		2, 535, 50	0 8	0	54.00
60. 00 06000 LABORATORY	3, 449, 452		3, 449, 45	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 063, 742	0	1, 063, 74	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 229, 304	0	1, 229, 30	04 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	206, 338	0	206, 33	8 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	31, 013	0	31, 01	3 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 423		3, 42	3 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	130, 443		130, 44	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	46, 957		46, 95	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 787, 778		3, 787, 77	8 0	0	73.00
76.00 03160 CARDI OPULMONARY	515, 696		515, 69		0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0			0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2, 277, 976		2, 277, 97	6 0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	2, 440, 561		2, 440, 56	01 0	0	90.02
90. 03 09003 WOUND CLINIC	53		5	0	0	90.03
90. 04 09004 OP ORTHO CLINIC	827		82	7 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 255, 959		1, 255, 95	9 0	0	90.05
90.06 09006 INFUSION CLINIC	317, 294		317, 29	04 0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	1,082,037		1,082,03	7 0	0	90.07
91.00 09100 EMERGENCY	5, 833, 792		5, 833, 79	02 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 654, 307		1,654,30		0	92.00
93.00 04950 OUTPATIENT PSYCH	342, 839		342, 83		0	1
OTHER REIMBURSABLE COST CENTERS						1
102.00 10200 OPI OI D TREATMENT PROGRAM	0			0	0	102.00
200.00 Subtotal (see instructions)	38, 006, 927	0				200.00
201.00 Less Observation Beds	1, 654, 307		1, 654, 30			201.00
202.00 Total (see instructions)	36, 352, 620	0				202.00
	,,,	J J			0	=

Heal th	Financial Systems	IU HEALTH JAY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CC	CN: 15-1320	Peri od:	Worksheet C	
					From 01/01/2022 To 12/31/2022	Part Date/Time Pre	narod
					10 12/31/2022	5/26/2023 12:	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 921, 652		3, 921, 65			30.00
40.00	04000 SUBPROVI DER – I PF	0			0		40.00
43.00	04300 NURSERY	0			0		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 492	7, 976, 762	7, 984, 25		0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0.000000	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	515, 063	13, 546, 356	14, 061, 41		0.00000	54.00
60.00	06000 LABORATORY	835, 029	8, 890, 626	9, 725, 65		0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	829, 969	1, 550, 477	2, 380, 44		0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	263, 740	1, 346, 270	1, 610, 01		0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	168, 624	156, 505	325, 12		0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	16, 836	7, 116	23, 95		0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	145, 500	145, 50		0.000000	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	25, 505	196, 329	221, 83		0.000000	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	195, 990	195, 99		0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 931, 082	9, 940, 976	11, 872, 05		0.000000	73.00
76.00	03160 CARDI OPULMONARY	128, 977	1, 874, 174	2,003,15		0.000000	76.00
77.00		0	0		0 0.00000	0.000000	77.00
00.00	OUTPATIENT SERVICE COST CENTERS				0 000000	0,00000	
90.00	09000 CLINIC	0	0	4 045 (4	0 0.00000	0.000000	90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	0	1,015,606	1,015,60		0.00000	90.01
90.02	09002 JAY FAMILY MEDICINE	0	1, 076, 479	1, 076, 47		0.000000	90.02
90.03	09003 WOUND CLINIC	0	0	24	0 0.000000	0.000000	90.03
90.04	09004 OP ORTHO CLINIC	0	265	26		0.000000	90.04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	370, 097	370, 09		0.000000	90.05
90.06	09006 I NFUSI ON CLI NI C	0	1,851,282	1, 851, 28		0.000000	90.06
90. 07 91. 00	09007 HEALTH BEGI NNI NGS PROGRAM	-	54,082	54, 08		0. 000000 0. 000000	90.07
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	626, 364	22,031,690	22, 658, 05		0.000000	91.00
	04950 OUTPATIENT PSYCH	11, 727	3, 708, 772	3, 720, 49			92.00
93.00	OTHER REIMBURSABLE COST CENTERS	0	514, 861	514, 86	0. 665887	0. 000000	93.00
102.00	010200 OPI OLD TREATMENT PROGRAM	0	0		0		102.00
200.00		9, 282, 060	76, 450, 215	85, 732, 27			200.00
200.00		7, 202, 000	70,400,215	00, 132, 21	5		200.00
201.00		9, 282, 060	76, 450, 215	85, 732, 27	15		201.00
202.00		7, 202, 000	10,400,210	00, 102, 21	5		202.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lieu	」of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 12:	epared: 02 pm
		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 SUBPROVIDER – IPF					40.00
43.00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60.00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03160 CARDI OPULMONARY	0. 000000				76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
OUTPATIENT SERVICE COST CENTERS	0.000000				//.00
90. 00 09000 CLINIC	0.000000				90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000				90.01
90. 02 09002 JAY FAMILY MEDICINE	0. 000000				90.01
90. 03 09003 WOUND CLINIC	0. 000000				90.02
90. 04 09004 OP ORTHO CLINIC	0.000000				90.03
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0.000000				90.04
90. 05 09005 JAT PAMILT FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	0.000000				90.05
90. 07 090007 HEALTH BEGINNINGS PROGRAM	0.000000				90.08
91.00 09100 EMERGENCY	0.000000				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000 0. 000000				92.00
93. 00 04950 OUTPATIENT PSYCH	0.000000				93.00
OTHER REIMBURSABLE COST CENTERS	1				100.00
102.00 10200 OPI OI D TREATMENT PROGRAM					102.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Health Financial Systems	IU HEALTH JAY	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 12:	epared: 02 pm
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	6, 208, 080		6, 208, 08	0 0	6, 208, 080	
40. 00 04000 SUBPROVIDER - IPF	0			0 0	0	
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	3, 593, 548		3, 593, 54	8 0	3, 593, 548	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 535, 508		2, 535, 50	8 0	2, 535, 508	54.00
60. 00 06000 LABORATORY	3, 449, 452		3, 449, 45	2 0	3, 449, 452	
65. 00 06500 RESPI RATORY THERAPY	1, 063, 742	0	1, 063, 74	2 0	1, 063, 742	
66. 00 06600 PHYSI CAL THERAPY	1, 229, 304	0	1, 229, 30	4 0	1, 229, 304	66.00
67.00 06700 OCCUPATI ONAL THERAPY	206, 338	0	206, 33	8 0	206, 338	67.00
68.00 06800 SPEECH PATHOLOGY	31, 013	0	31, 01	3 0	31, 013	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 423		3, 42	3 0	3, 423	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIE			130, 44		130, 443	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	46, 957		46, 95	7 0	46, 957	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 787, 778		3, 787, 77		3, 787, 778	
76.00 03160 CARDI OPULMONARY	515, 696		515, 69	6 0	515, 696	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2, 277, 976		2, 277, 97		2, 277, 976	
90. 02 09002 JAY FAMILY MEDICINE	2, 440, 561		2, 440, 56	1 0	2, 440, 561	
90. 03 09003 WOUND CLINIC	53		5		53	1
90.04 09004 OP ORTHO CLINIC	827		82		827	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 255, 959		1, 255, 95		1, 255, 959	
90.06 09006 INFUSION CLINIC	317, 294		317, 29		317, 294	
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	1, 082, 037		1, 082, 03		1, 082, 037	
91.00 09100 EMERGENCY	5, 833, 792		5, 833, 79		5, 833, 792	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PA			1, 654, 30		1, 654, 307	
93.00 04950 OUTPATIENT PSYCH	342, 839		342, 83	9 0	342, 839	93.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0			0		102.00
200.00 Subtotal (see instructions)	38, 006, 927	0			38, 006, 927	
201.00 Less Observation Beds	1, 654, 307		1, 654, 30		1, 654, 307	
202.00 Total (see instructions)	36, 352, 620	0	36, 352, 62	0 0	36, 352, 620	

	Financial Systems	IU HEALTH JA			In Lie	u of Form CMS-2	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1320	Peri od:	Worksheet C	
					From 01/01/2022	Part I	
					To 12/31/2022	Date/Time Pre 5/26/2023 12:	02 pm
			Ti †I	e XIX	Hospi tal	PPS	
			Charges	C XIX	nospi tai	113	
	Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
	cost center beschiption	inpatront	outputrent	+ col. 7	Ratio	Inpatient	
					Katro	Ratio	
		6.00	7.00	8.00	9.00	10.00	
1	NPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	03000 ADULTS & PEDIATRICS	3, 921, 652		3, 921, 65	2		30.00
	04000 SUBPROVI DER – I PF	0			0		40.00
	D4300 NURSERY	0			0		43.00
	ANCI LLARY SERVICE COST CENTERS				<u> </u>		10100
	D5000 OPERATING ROOM	7, 492	7, 976, 762	7, 984, 25	0. 450079	0, 000000	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0	1 1 1 1 1 2 0	0 0.000000	0.000000	
	05300 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	
	D5400 RADI OLOGY-DI AGNOSTI C	515,063	13, 546, 356	14, 061, 41		0.000000	
	06000 LABORATORY	835, 029	8, 890, 626			0.000000	
	06500 RESPIRATORY THERAPY	829, 969	1, 550, 477			0.000000	
	06600 PHYSI CAL THERAPY	263, 740	1, 346, 270			0.000000	
	06700 OCCUPATI ONAL THERAPY	168, 624	156, 505			0.000000	1
	06800 SPEECH PATHOLOGY	16, 836	7, 116			0.000000	
	06900 ELECTROCARDI OLOGY	10, 030	145, 500			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 505	145, 300			0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS	23, 303	195, 990			0.000000	
	D7300 DRUGS CHARGED TO PATIENTS	1,931,082	9, 940, 976			0.000000	
	03160 CARDI OPULMONARY	128, 977	1, 874, 174			0.000000	
	07700 ALLOGENEIC HSCT ACQUISITION	120, 777	1, 074, 174		0 0. 000000	0.000000	
	DUTPATIENT SERVICE COST CENTERS	U U	0		0 0.000000	0.000000	//.00
	09000 CLINIC	0	0		0 0.00000	0.00000	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	0	1,015,606			0.000000	
	09002 JAY FAMILY MEDICINE	0	1,076,479			0.000000	
	09003 WOUND CLINIC	0	1,070,477	1,070,47	0 0.000000	0.000000	
	09004 OP ORTHO CLINIC	0	265	26		0.000000	
	09005 JAY FAMILY FIRST HEALTH CARE	0	370, 097	370, 09		0.000000	
	09006 INFUSION CLINIC	0	1, 851, 282			0.000000	
	09007 HEALTH BEGINNINGS PROGRAM	0	54,082	54, 08		0.000000	
	D9100 EMERGENCY	626, 364	22, 031, 690			0.000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 727	3, 708, 772			0.000000	
	04950 OUTPATIENT PSYCH	0	514, 861			0.000000	
	THER REIMBURSABLE COST CENTERS	<u> </u>	517,001	514,00	0.003007	0.00000	/3.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
200.00	Subtotal (see instructions)	9, 282, 060	76, 450, 215		-		200.00
200.00	Less Observation Beds	7, 202, 000	70, 400, 213	00, 102, 21			200.00
201.00	Total (see instructions)	9, 282, 060	76, 450, 215	85, 732, 27	'5		202.00
_02.00		,, 202, 000		1 00, 102, 27	-1	I	

Health Fi	nancial Systems	IU HEALTH JAY	HOSPI TAL	In Lieu	ı of Form CMS-	2552-10
COMPUTATI	ION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/26/2023 12:	epared: 02 pm
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
IN	PATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS					30.00
40.00 04	000 SUBPROVIDER - IPF					40.00
43.00 04	300 NURSERY					43.00
AN	CILLARY SERVICE COST CENTERS					
50.00 05	OOO OPERATING ROOM	0. 450079				50.00
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00 05	300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	0. 180317				54.00
60.00 06	000 LABORATORY	0. 354676				60.00
	500 RESPIRATORY THERAPY	0. 446867				65.00
66.00 06	600 PHYSI CAL THERAPY	0. 763538				66.00
	700 OCCUPATI ONAL THERAPY	0. 634634				67.00
	800 SPEECH PATHOLOGY	1. 294798				68.00
	900 ELECTROCARDI OLOGY	0. 023526				69.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 588021				71.00
	200 I MPL. DEV. CHARGED TO PATIENTS	0. 239589				72.00
	300 DRUGS CHARGED TO PATIENTS	0. 319050				73.00
	160 CARDI OPULMONARY	0. 257442				76.00
	700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00
	TPATIENT SERVICE COST CENTERS	0.000000				//.00
	000 CLINIC	0.000000				90.00
	0001 FAMILY PRACTICE OF JAY COUNTY	2. 242972				90.00
	002 JAY FAMILY MEDICINE	2. 242972				90.01
	003 WOUND CLINIC	0. 000000				90.02
	004 OP ORTHO CLINIC	3. 120755				90.04
	005 JAY FAMILY FIRST HEALTH CARE	3. 393594				90.05
	006 INFUSION CLINIC	0. 171392				90.06
	007 HEALTH BEGINNINGS PROGRAM	20.007341				90.07
	100 EMERGENCY	0. 257471				91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 444647				92.00
	950 OUTPATIENT PSYCH	0. 665887				93.00
	HER REIMBURSABLE COST CENTERS	1 1				
	200 OPI OI D TREATMENT PROGRAM					102.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	epared:
			e XIX	Hospi tal	5/26/2023 12: PPS	02 pm
Cost Center Description	Total Cost	Capital Cost		Capital	Operating	
cost center bescription	(Wkst. B,	(Wkst. B,	Cost Net of		Cost	
	Part I, col.	Part II col.	Capital Cos		Reduction	
	26)	26)	(col. 1 -		Amount	
	20)	20)	col. 2)		Allount	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 05000 OPERATI NG ROOM	3, 593, 548	244, 736	3, 348, 8	12 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 535, 508	209, 193	2, 326, 3	15 0	0	54.00
60. 00 06000 LABORATORY	3, 449, 452				0	60.00
65. 00 06500 RESPI RATORY THERAPY	1,063,742		1,025,0	71 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 229, 304				0	
67.00 06700 OCCUPATI ONAL THERAPY	206, 338				0	67.00
68.00 06800 SPEECH PATHOLOGY	31,013				0	68,00
69.00 06900 ELECTROCARDI OLOGY	3, 423				0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	130, 443				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	46, 957				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 787, 778				0	
76.00 03160 CARDI OPULMONARY	515, 696				0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0		
OUTPATIENT SERVICE COST CENTERS				<u> </u>		
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2, 277, 976	102, 445	2, 175, 5	31 0	0	
90. 02 09002 JAY FAMILY MEDICINE	2, 440, 561	104, 307				
90. 03 09003 WOUND CLINIC	53			53 0	0	
90. 04 09004 OP ORTHO CLINIC	827	6		21 0	0	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 255, 959	208, 067			0	•
90. 06 09006 I NFUSI ON CLINIC	317, 294				0	
90. 07 09007 HEALTH BEGI NNINGS PROGRAM	1,082,037				0	
91. 00 09100 EMERGENCY	5, 833, 792				0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 654, 307				0	
93. 00 04950 OUTPATIENT PSYCH	342, 839					
OTHER REIMBURSABLE COST CENTERS	2.2,007					1
102.00 10200 OPI 0I D TREATMENT PROGRAM	0	0		0 0	0	102.00
200.00 Subtotal (sum of lines 50 thru 199)	31, 798, 847			· · · ·		200.00
201.00 Less Observation Beds	1, 654, 307					201.00
202.00 Total (line 200 minus line 201)	30, 144, 540					202.00
					-	

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RAREDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2022 To 12/31/2022	2 Date/Time Prepared: 5/26/2023 12:02 pm
			e XIX	Hospi tal	PPS
Cost Center Description	Cost Net of	Total Charges	Outpati ent		
	Capital and	(Worksheet C,	Cost to		
	Operati ng	Part I,	Charge Rati	0	
	Cost	column 8)	(col. 6 /		
	Reduction	7.00	col. 7)		
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	0 500 540	7 004 054	0.4500		
50.00 ODERATING ROOM	3, 593, 548				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	-			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 535, 508				54.00
60. 00 06000 LABORATORY	3, 449, 452				60.00
65. 00 06500 RESPIRATORY THERAPY	1,063,742				65.00
66. 00 06600 PHYSI CAL THERAPY	1, 229, 304				66.00
67.00 06700 OCCUPATI ONAL THERAPY	206, 338				67.00
68.00 06800 SPEECH PATHOLOGY	31, 013				68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 423				69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	130, 443				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	46, 957				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 787, 778				73.00
76.00 03160 CARDI OPULMONARY	515, 696				76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000	00	77.00
OUTPATIENT SERVICE COST CENTERS	i			[
90. 00 09000 CLINIC	0	-			90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	2, 277, 976				90.01
90. 02 09002 JAY FAMILY MEDICINE	2, 440, 561	1, 076, 479			90.02
90. 03 09003 WOUND CLINIC	53				90.03
90. 04 09004 OP ORTHO CLINIC	827				90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	1, 255, 959				90.05
90. 06 09006 INFUSION CLINIC	317, 294				90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	1,082,037				90.07
91.00 09100 EMERGENCY	5, 833, 792				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 654, 307				92.00
93. 00 04950 OUTPATIENT PSYCH	342, 839	514, 861	0.6658	87	93.00
OTHER REIMBURSABLE COST CENTERS	-	-	0.0777	22	
102.00 10200 OPI OI D TREATMENT PROGRAM	0			00	102.00
200.00 Subtotal (sum of lines 50 thru 199)	31, 798, 847				200.00
201.00 Less Observation Beds	1, 654, 307				201.00
202.00 Total (line 200 minus line 201)	30, 144, 540	81, 810, 623	I		202.00

						2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COS	TS	Provider C		Period:	Worksheet D	
				From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	pared [.]
					5/26/2023 12:	
			XVIII	Hospi tal	Cost	
		Total Charges			Capital Costs	
	ted Cost	(from Wkst.	to Charges	Program	(column 3 x	
	om Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	Part II, I. 26)	col. 8)	col. 2)			
	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 OPERATI NG ROOM	244, 736	7, 984, 254	0. 03065	2 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000		0	52.00
53.00 05300 ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	209, 193	14, 061, 419	0. 01487	7 143, 363	2, 133	54.00
60. 00 06000 LABORATORY	131, 532	9, 725, 655	0. 01352	4 306, 727	4, 148	60.00
65. 00 06500 RESPI RATORY THERAPY	38, 671	2, 380, 446	0. 01624	5 273, 392	4, 441	65.00
66. 00 06600 PHYSI CAL THERAPY	136, 233	1, 610, 010	0. 08461			66.00
67.00 06700 OCCUPATI ONAL THERAPY	21, 882	325, 129	0.06730		1, 908	67.00
68.00 06800 SPEECH PATHOLOGY	809	23, 952	0. 03377		370	68.00
69. 00 06900 ELECTROCARDI OLOGY	26	145, 500	0.00017		0	69.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 009	221, 834	0.00454		29	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	363	195, 990	0.00185		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	68, 283	11, 872, 058	0.00575		3, 983	73.00
76.00 03160 CARDI OPULMONARY	17, 871	2,003,151	0. 00892		609	76.00
77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0.00000	0 0	0	77.00
90. 00 09000 CLINIC	0	0	0. 00000	0 0	0	90.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	102, 445	1,015,606	0. 10087		0	90.00 90.01
90.02 09002 JAY FAMILY MEDICINE	102, 445	1,015,808	0. 09689		0	90.01
90. 03 09003 WOUND CLINIC	104, 307	1,070,479	0.00000		0	90.02
90. 04 09004 0P ORTHO CLINIC	6	265	0. 02264		0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	208, 067	370, 097	0. 56219		0	90.05
90. 06 09006 INFUSION CLINIC	27, 272	1, 851, 282	0.01473		0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	153,053	54, 082	2.83001		0	90.07
91.00 09100 EMERGENCY	244,000	22, 658, 054	0.01076	9 24, 180	260	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	144, 406	3, 720, 499	0. 03881	4 1, 190	46	92.00
93. 00 04950 OUTPATI ENT PSYCH	62, 990	514, 861	0. 12234		0	93.00
200.00 Total (lines 50 through 199)	1, 917, 154	81, 810, 623		1, 614, 320	22, 915	200.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In	Lieu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/20 To 12/31/20		epared: 02 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Heal	th Allied Health	
	Anesthetist	Program	Program	Post-Stepdo	wn	
	Cost	Post-Stepdown		Adjustment	s	
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0	0 0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0 0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0	0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	54.00
60. 00 06000 LABORATORY	0	0		0	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0 0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0 0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0	0 0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0 0	71.00
72.00 07200 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	0		0	0 0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0 0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0	0 (90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0 0	90.01
90.02 09002 JAY FAMILY MEDICINE	0	0		0	0 0	90.02
90. 03 09003 WOUND CLINIC	0	0		0	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	0	0		0	0 0	90.05
90.06 09006 INFUSION CLINIC	0	0		0	0 0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0		0	0 0	90.07
91.00 09100 EMERGENCY	0	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 0	
200.00 Total (lines 50 through 199)	0	0		0	0 0	200.00
						•

Heal th Financial Systems IU HEALTH JAY HOSPITAL			2552-10
	Period:	Worksheet D	
	From 01/01/2022		
1	Го 12/31/2022	Date/Time Pre 5/26/2023 12:	
Title XVIII	Hospi tal	Cost	
Cost Center Description All Other Total Cost Total		Ratio of Cost	
Medical (sum of cols. Outpatient	(from Wkst.	to Charges	
Education 1, 2, 3, and Cost (sum of	C, Part I,	(col. 5 ÷	
Cost 4) col s. 2, 3,	col. 8)	col. 7)	
and 4)		(see	
		instructions)	
4.00 5.00 6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			
50. 00 05000 OPERATING ROOM 0 0 0	7, 984, 254		
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0	0 0	0. 000000	
53. 00 05300 ANESTHESI OLOGY 0 0	0 0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0			
60. 00 06000 LABORATORY 0 0 0	.,,		
65. 00 06500 RESPI RATORY THERAPY 0 0 0			
66. 00 06600 PHYSICAL THERAPY 0 0 0	0 1, 610, 010		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0	325, 129		
68. 00 06800 SPEECH PATHOLOGY 0 0	23, 952		
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	145, 500		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0	,		
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0			
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0			
76. 00 03160 CARDI OPULMONARY 0 0 0			
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0	0 0	0.00000	77.00
OUTPATIENT SERVICE COST CENTERS			
90. 00 09000 CLINIC 0 0 0			
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0			
90. 02 09002 JAY FAMILY MEDICINE 0 0 0	1, 076, 479		
90. 03 09003 WOUND CLINIC 0 0	0 0		
90. 04 09004 OP ORTHO CLINIC 0 0	265		
90. 05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0	370, 097		
90. 06 09006 I NFUSI ON CLI NI C 0 0 0	1, 851, 282		
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM 0 0 0			
91.00 09100 EMERGENCY 0 0 0			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0			
93.00 04950 OUTPATIENT PSYCH 0 0 0			
200.00 Total (lines 50 through 199) 0 0 0	81, 810, 623	1	200.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1320	Period: From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/26/2023 12:	pared: 02 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	· · · · · ·					
50.00 05000 OPERATING ROOM	0. 000000	0		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	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	143, 363		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	306, 727		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	273, 392		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	58, 950		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	28, 346		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	10, 948		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	6, 466		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	692, 519		0 0	0	73.00
76.00 03160 CARDI OPULMONARY	0. 000000	68, 239		0 0	0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	0		0 0	0	90.01
90.02 09002 JAY FAMILY MEDICINE	0. 000000	0		0 0	0	90.02
90. 03 09003 WOUND CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0. 000000	0		0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0. 000000	0		0 0	0	90.05
90.06 09006 INFUSION CLINIC	0. 000000	0		0 0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0. 000000	0	1	0 0	0	90.07
91.00 09100 EMERGENCY	0. 000000	24, 180		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	1, 190		0 0	0	92.00
93.00 04950 OUTPATIENT PSYCH	0. 000000	0		0 0	0	93.00
200.00 Total (lines 50 through 199)		1, 614, 320		0 0	0	200.00

Health Financial Systems	IU HEALTH JA				u of Form CMS-	2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 01/01/2022 To 12/31/2022		norod.
				10 12/31/2022	5/26/2023 12:	02 nm
		Title	e XVIII	Hospi tal	Cost	02 piii
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins			
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	0. 450079		1 ., ., _, .,		Ű	1 00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0		
53. 00 05300 ANESTHESI OLOGY	0. 000000			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 180317				0	
50. 00 06000 LABORATORY	0. 354676	C	1, 659, 34	1 0	0	60.0
55. 00 06500 RESPI RATORY THERAPY	0. 446867	C	277, 23		0	1 001 0
6. 00 06600 PHYSI CAL THERAPY	0. 763538	C	321, 22	2 0	0	66.0
57. 00 06700 OCCUPATI ONAL THERAPY	0. 634634	C	18, 18	3 0	0	67.0
58.00 06800 SPEECH PATHOLOGY	1. 294798	C	12	9 0	0	68.0
59. 00 06900 ELECTROCARDI OLOGY	0. 023526	C	13, 15	7 0	0	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 588021	C	18, 35	2 0	0	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 239589	C	19, 24	2 0	0	72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 319050	C	1, 764, 00	3 133, 017	0	73.0
76. 00 03160 CARDI OPULMONARY	0. 257442	C	685,00	9 0	0	76.0
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	C		0 0	0	77.0
OUTPATIENT SERVICE COST CENTERS		·			•	1
20. 00 09000 CLINIC	0. 000000	C)	0 0	0	90.0
20.01 09001 FAMILY PRACTICE OF JAY COUNTY	2. 242972	C	266, 46	1 71, 816	0	90.0
0.02 09002 JAY FAMILY MEDICINE	2. 267170	C	457, 38	4 77,664	0	90.0
0.03 09003 WOUND CLINIC	0. 000000	C		0 0	0	90.0
0.04 09004 OP ORTHO CLINIC	3. 120755	C	26	5 0	0	90.0
0.05 09005 JAY FAMILY FIRST HEALTH CARE	3. 393594	C	87,13	6 23, 169	0	90.0
0.06 09006 INFUSION CLINIC	0. 171392	C	365, 71	0 0	0	90.0
0. 07 09007 HEALTH BEGI NNI NGS PROGRAM	20. 007341	c c		0 0	0	90.0
1.00 09100 EMERGENCY	0. 257471	l c	3, 222, 50	8 0	0	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 444647				0	
23.00 04950 OUTPATIENT PSYCH	0. 665887					
200.00 Subtotal (see instructions)	0.00007		14,043,32		-	200.0
201.00 Less PBP Clinic Lab. Services-Program				0 0	l	201.0
Only Charges						
202.00 Net Charges (line 200 - line 201)		l c	14, 043, 32	8 306, 416	n –	202.00
	1		1 11,010,02	000,410	0	1-02.0

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST		CN: 15-1320	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pr 5/26/2023 12	
			XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						_
50.00 OPERATING ROOM	671, 732	0	1			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	459, 354	0				54.00
60. 00 06000 LABORATORY	588, 528	0	1			60.00
65. 00 06500 RESPI RATORY THERAPY	123, 886	0				65.00
66. 00 06600 PHYSI CAL THERAPY	245, 265	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	11, 540	0				67.00
68.00 06800 SPEECH PATHOLOGY	167	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	310	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 791	0)			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 610	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	562, 805	42, 439				73.00
76.00 03160 CARDI OPULMONARY	176, 350	0				76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0)			90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	597, 665	161, 081				90.01
90.02 09002 JAY FAMILY MEDICINE	1, 036, 967	176, 077				90.02
90. 03 09003 WOUND CLINIC	0	0				90.03
90.04 09004 OP ORTHO CLINIC	827	0				90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	295, 704	78, 626				90.05
90.06 09006 INFUSION CLINIC	62, 680	0				90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0				90.07
91.00 09100 EMERGENCY	829, 702	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	351, 190	333				92.00
93.00 04950 OUTPATIENT PSYCH	25, 449	c c				93.00
200.00 Subtotal (see instructions)	6,055,522	458, 556				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	6, 055, 522	458, 556				202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre 5/26/2023 12:	epared:
		Ti +I	e XIX	Hospi tal	PPS	02 pili
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
Cost Center Description	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.	Aujustment	Related Cost		col. 4)	
	B, Part II,		(col. 1 -		COI. 4)	
	col. 26)		col. 2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	541, 907	64, 037	477,870	1, 985	240. 74	30.00
40. 00 SUBPROVIDER - IPF	341, 707	04,037	477,070	1, 200	0.00	•
43. 00 NURSERY	0	0			0.00	•
200.00 Total (lines 30 through 199)	541, 907		477, 870	1, 985		200.00
Cost Center Description	Inpati ent	Inpati ent	477,070	1, 705		200.00
cost center bescription	Program days	Program				
	Frogram days	Capital Cost				
		(col. 5 x				
		col. 6)				
	6, 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	1			
30. 00 ADULTS & PEDIATRICS	17	4, 093				30.00
40. 00 SUBPROVIDER - IPF	0	4,075				40.00
43. 00 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	17	4, 093				200.00
	1 17	1 4,093	1			200.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2022	Worksheet D Part II	
				To 12/31/2022		pared:
					5/26/2023 12:	
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II, col. 26)	col. 8)	col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	244, 736	7, 984, 254	0. 03065	52 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	209, 193	14, 061, 419	0. 01487	5, 373	80	54.00
60. 00 06000 LABORATORY	131, 532	9, 725, 655	0. 01352	4, 990	67	60.00
65. 00 06500 RESPI RATORY THERAPY	38, 671	2, 380, 446	0. 01624	11, 736	191	65.00
66. 00 06600 PHYSI CAL THERAPY	136, 233		0. 0846	1, 334	113	66.00
67.00 06700 OCCUPATI ONAL THERAPY	21, 882				70	67.00
68.00 06800 SPEECH PATHOLOGY	809				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	26	145, 500			0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 009				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	363				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	68, 283					73.00
76.00 03160 CARDI OPULMONARY	17, 871	2, 003, 151	0. 00892		0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.0000	000	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0					90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	102, 445				0	90.01
90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC	104, 307	1, 076, 479			0	90.02 90.03
90.03 09003 WOUND CLINIC 90.04 09004 0P ORTHO CLINIC	0	0 265			0	90.03
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	208, 067		0. 56219		0	90.04 90.05
90. 05 09005 JAT FAMILT FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC	208,087				0	90.05
90. 07 09007 HEALTH BEGINNINGS PROGRAM	153, 053				0	90.00
91. 00 09100 EMERGENCY	244,000				98	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	144, 406				0	92.00
93. 00 04950 OUTPATIENT PSYCH	62, 990				0	93.00
200.00 Total (lines 50 through 199)	1, 917, 154			49, 499		200.00
			1			

Health Financial Systems	IU HEALTH JA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	HER PASS THROUGH COS	TS Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part III Date/Time Pre 5/26/2023 12:	epared: O2 pm
		Ti tl	e XIX	Hospi tal	PPS	-
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
	Program	Program	Post-Stepdowr	n Cost	Medi cal	
	Post-Stepdown		Adjustments		Educati on	
	Adjustments				Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	0	30.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
43.00 04300 NURSERY	0	0		0 0	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem	I npati ent	
•	Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
	Amount (see	1 through 3,		col. 6)	5 5	
		minus col. 4)				
	4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 98	5 0.00	17	30.00
40. 00 04000 SUBPROVIDER - IPF	0	0		0.00	0	40.00
43. 00 04300 NURSERY		C		0.00	0	43.00
200.00 Total (lines 30 through 199)		0	1, 98	5	17	200.00
Cost Center Description	I npati ent					
· ·	Program					
	Pass-Through					
	Cost (col. 7					
	x col. 8)					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
40. 00 04000 SUBPROVIDER - IPF	0					40.00
43. 00 04300 NURSERY						43.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PAS			Peri Fror To	iod: m 01/01/2022 12/31/2022	Worksheet D Part IV Date/Time Pre 5/26/2023 12:	pared: 02 pm
		Ti tl	e XIX		Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	AI	llied Health	Allied Health	
	Anesthetist	Program	Program	Po	ost-Stepdown		
	Cost	Post-Stepdown	_	A	Adjustments		
		Adjustments			-		
	1.00	2A	2.00		3A	3.00	
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0		0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
53.00 05300 ANESTHESI OLOGY	0	0		0	0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	0	54.00
60.00 06000 LABORATORY	0	0		0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	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	0	0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	l o		0	o	0	77.00
OUTPATI ENT SERVI CE COST CENTERS							
90. 00 09000 CLINIC	0	0		0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	0		0	0	0	90.02
90. 03 09003 WOUND CLINIC	0	0		0	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	0	0		0	0	0	90.05
90.06 09006 INFUSION CLINIC	0	0		0	0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0	0		0	0	0	90.07
91.00 09100 EMERGENCY	0	0		0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	-	0	92.00
93. 00 04950 OUTPATI ENT PSYCH	0	0		0	о	0	93.00
200.00 Total (lines 50 through 199)	0	0		0	ō	0	200.00
					- 1	-	•

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PAS	S Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022		norod.
				To 12/31/2022	Date/Time Pre 5/26/2023 12:	02 nm
		Ti tl	e XIX	Hospi tal	PPS	<u>02 pm</u>
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum o	f C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	1					
50.00 O5000 OPERATING ROOM	0			0 7, 984, 254	0.00000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 14,061,419		
60. 00 06000 LABORATORY	0	0		0 9, 725, 655	0.00000	
65.00 06500 RESPI RATORY THERAPY	0	0		0 2, 380, 446	0.00000	
66.00 06600 PHYSI CAL THERAPY	0	0		0 1, 610, 010		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 325, 129		
68.00 06800 SPEECH PATHOLOGY	0	0		0 23, 952	0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 145, 500		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 221, 834	0.000000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 195, 990		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 11, 872, 058		
76.00 03160 CARDI OPULMONARY	0	0		0 2,003,151	0.000000	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS			1		0.00000	
90. 00 09000 CLINIC	0			0 0	0.00000	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1,015,606	0.000000	
90. 02 09002 JAY FAMILY MEDICINE	0	0		0 1, 076, 479		
90. 03 09003 WOUND CLINIC	0	0		0 0	0.000000	
90. 04 09004 OP ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 265 0 370,097	0.000000	
	0	0				
90. 06 09006 INFUSION CLINIC 90. 07 09007 HEALTH BEGINNINGS PROGRAM	0			0 1, 851, 282 0 54, 082	0. 000000 0. 000000	
90. 07 09007 HEALTH BEGINNINGS PROGRAM 91. 00 09100 EMERGENCY	0				0.000000	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 22, 658, 054 0 3, 720, 499		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93. 00 04950 OUTPATIENT PSYCH	0			0 3, 720, 499 0 514, 861		
200.00 Total (lines 50 through 199)	0	-		0 81, 810, 623		200.00
200.00 [TOTAL (THES SO THEOUGH 199)	0	0	1	01,010,023	I	l≥00.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV	pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Outpatient	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 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	· · · · · ·					
50.00 05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	5, 373		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	4, 990		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	11, 736		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	1, 334		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	1, 037		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	15, 965		0 0	0	73.00
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	0		0 0	0	90.01
90.02 09002 JAY FAMILY MEDICINE	0. 000000	0		0 0	0	90.02
90. 03 09003 WOUND CLINIC	0. 000000	0		0 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0. 000000	0		0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0. 000000	0		0 0	0	90.05
90.06 09006 INFUSION CLINIC	0. 000000	0		0 0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM	0. 000000	0	1	0 0	0	90.07
91.00 09100 EMERGENCY	0. 000000	9, 064		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
93.00 04950 OUTPATIENT PSYCH	0. 000000	0		0 0	0	93.00
200.00 Total (lines 50 through 199)		49, 499		0 0	0	200.00

MPUT	Financial Systems IU HEALTH JAY TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022		pare
		Title XVIII	Hospi tal	5/26/2023 12: Cost	02 p
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS		1		
00	Inpatient days (including private room days and swing-bed day			2, 503	
00 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		rivate room days	1, 985 0	2
00	do not complete this line.	aysy. If you have only p	rivate room days,	0	
00	Semi-private room days (excluding swing-bed and observation h			1, 379	4
00	Total swing-bed SNF type inpatient days (including private reporting period	oom days) through Decemb	er 31 of the cost	266	5
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through Decembe	r 31 of the cost	252	7
00	Total swing-bed NF type inpatient days (including private roo	om davs) after December	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable newborn days) (see instructions)	to the Program (excludin	g swing-bed and	576	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of	onlv (including private	room davs)	266	10
	through December 31 of the cost reporting period (see instruc	ctions)	3,		
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12
	through December 31 of the cost reporting period	5 . 6 .	3,		
. 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 Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)	am (exer daring swring bed	aaysy	0	
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	cos through Docombor 21	of the cost		17
. 00	reporting period	Les thiough becember 31	of the cost		''
. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	as through Docombor 21 c	f the cost	250. 44	10
. 00	reporting period	es through becember 51 d	the cost	250.44	
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20
. 00	reporting period Total general inpatient routine service cost (see instruction	ne)		6, 208, 080	21
	Swing-bed cost applicable to SNF type services through Decemi		ting period (line		22
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporti	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	63, 111	24
	7 x line 19)	·	0 1 1		
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			789, 259	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 418, 821	
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ad and observation had a	harges)	0	1 20
	Private room charges (excluding swing-bed charges)		nai yes)	0	28
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
. 00 . 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 mi	inus line 33)(see instru	ctions)	0.00	
. 00	Average per diem private room cost differential (line 34 x li			0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (lind	0 5 418 821	36
. 00	27 minus line 36)	and private room cost o		5, 418, 821	3/
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			2, 729. 88	2
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			2, 729, 88 1, 572, 411	39
	Medically necessary private room cost applicable to the Progr	-		0	40
	Total Program general inpatient routine service cost (line 30			0	

Health Financial Systems	IU HEALTH JA				u of Form CMS-2		
COMPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Worksheet D-1		
					5/26/2023 12:		
Cost Center Description	Total Inpatient Cost 1.00	Total Inpatient Days 2.00	<pre>xVIII Average Per Di em (col. 1</pre>	Hospi tal Program Days 4.00	Cost Program Cost (col. 3 x col. 4) 5.00		
42.00 NURSERY (title V & XIX only)	0	2.00				42.00	
Intensive Care Type Inpatient Hospital Units 43.00 INTENSIVE CARE UNIT 44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						43.00 44.00 45.00 46.00 47.00	
					1.00	10.00	
 48.00 Program inpatient ancillary service cost (Wks 48.01 Program inpatient cellular therapy acquisition 49.00 Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS 	n cost (Worksh	neet D-6, Part		, column 1)	583, 058 0 2, 155, 469	48.01	
50.00 Pass through costs applicable to Program inpa	tient routine	servi ces (fro	m Wkst. D, su	m of Parts I and	0	50.00	
51.00 Pass through costs applicable to Program inpa and IV)	tient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00	
52.00 Total Program excludable cost (sum of lines 55 53.00 Total Program inpatient operating cost exclud medical education costs (line 49 minus line 55	ing capital re	elated, non-ph	ysician anest	hetist, and	0		
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	54.00	
55.00 Target amount per discharge 55.01 Permanent adjustment amount per discharge						55.00 55.01	
55.02 Adjustment amount per discharge (contractor us					0.00	55.02	
56.00 Target amount (line 54 x sum of lines 55, 55.) 57.00 Difference between adjusted inpatient operation			line 56 minus	line 53)	0		
58.00 Bonus payment (see instructions)	j 1 1 5 5 ()						
59.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)						59.00	
60.00 Expected costs (lesser of line 53 ÷ line 54, market basket)			60.00				
61.00 Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x - enter zero. (see instructions)	er of 50% of t	he amount by	which operati	ng costs (line	0	61.00	
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment	nt (see instru	ictions)			0		
PROGRAM INPATIENT ROUTINE SWING BED COST		· · · · ·					
64.00 Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	-				726, 148		
65.00 Medicare swing-bed SNF inpatient routine cost: instructions)(title XVIII only)	s after Decemb	per 31 of the	cost reportin	g period (See	0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine CAH, see instructions		·	, .	5,	726, 148		
67.00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	n December 31	of the cost r	eporting period	0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)				orting period	0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient ro PART III - SKILLED NURSING FACILITY, OTHER NUR					0	69.00	
70.00 Skilled nursing facility/other nursing facili 71.00 Adjusted general inpatient routine service co)		70.00	
72.00 Program routine service cost (line 9 x line 7	1)					72.00	
73.00 Medically necessary private room cost applical 74.00 Total Program general inpatient routine service						73.00	
75.00 Capital related cost allocated to inpatient re 26, line 45)				Part II, column		75.00	
76.00 Per diem capital-related costs (line 75 ÷ line						76.00	
77.00 Program capital-related costs (line 9 x line 78.00 Inpatient routine service cost (line 74 minus						77.00 78.00	
79.00 Aggregate charges to beneficiaries for excess 80.00 Total Program routine service costs for compa				nus lino 70)		79.00 80.00	
80.00 Instal Program routine service costs for compa 81.00 Inpatient routine service cost per diem limit.		Jost i i i i i i i i i i i i i i i i i i i	יי (ייוש אס שוויי) יי	nus IIIE /9)		81.00	
82.00 Inpatient routine service cost limitation (li	ne 9 x line 8´					82.00	
83.00 Reasonable inpatient routine service costs (see ins: 84.00 Program inpatient ancillary services (see ins:		15)				83.00 84.00	
85.00 Utilization review - physician compensation (see instructio					85.00	
86.00 Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)				86.00	
87.00 Total observation bed days (see instructions)		line 2)				87.00	
88.00 Adjusted general inpatient routine cost per d	iem (line 2/ +	- rine 2)			2, 729. 88	88.00	

Health Financial Systems	IU HEALTH JA	u of Form CMS-2	2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2022	Worksheet D-1	
					Date/Time Pre 5/26/2023 12:0	pared: 02 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 654, 307	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	541, 907	6, 208, 080	0.08729	1, 654, 307	144, 406	90.00
91.00 Nursing Program cost	0	6, 208, 080	0.00000	0 1, 654, 307	0	91.00
92.00 Allied health cost	0	6, 208, 080	0.00000	0 1, 654, 307	0	92.00
93.00 All other Medical Education	0	6, 208, 080	0.00000	0 1, 654, 307	0	93.00

OMPUT	Financial Systems IU HEALTH JAY HOSPITAL ATION OF INPATIENT OPERATING COST Provider CC		Period: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet D-1 Date/Time Prep 5/26/2023 12:0	pared
	Cost Center Description	e XIX	Hospi tal	PPS	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	I NPATI ENT DAYS			2 502	1 1 0
. 00 . 00	Inpatient days (including private room days and swing-bed days, excluding Inpatient days (including private room days, excluding swing-bed and new	vborn days)		2, 503 1, 985	
. 00	Private room days (excluding swing-bed and observation bed days). If you		rivate room days,	0	
. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)			1, 379	4.0
. 00	Total swing-bed SNF type inpatient days (including private room days) thr	ough Decembe	er 31 of the cost	266	
. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) aft	ter December	31 of the cost	0	6.0
	reporting period (if calendar year, enter 0 on this line)				
. 00	Total swing-bed NF type inpatient days (including private room days) through reporting period	bugh December	⁻ 31 of the cost	252	7.0
. 00	Total swing-bed NF type inpatient days (including private room days) after	er December 3	31 of the cost	0	8.0
. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Progra	m (oveluding	a cwing bod and	17	9.0
. 00	newborn days) (see instructions)		, <u> </u>	17	7.0
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (includi through December 31 of the cost reporting period (see instructions)	ng private i	room days)	0	10. (
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (includi	ng private i	room days) after	0	11.0
2 00	December 31 of the cost reporting period (if calendar year, enter 0 on the		to room dovo)	0	12
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (incl through December 31 of the cost reporting period	uung priva	te room days)	0	12.0
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (incl			0	13.0
4.00	after December 31 of the cost reporting period (if calendar year, enter 0 Medically necessary private room days applicable to the Program (excludin	on this iir ng swing-bed	days)	0	14.
5.00	Total nursery days (title V or XIX only)	5 5	5 7	0	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to services through D	December 31 d	of the cost		17.
8.00	reporting period Medicare rate for swing-bed SNF services applicable to services after Dec	combor 31 of	the cost		18.
5.00	reporting period	cember 51 01	the cost		10.
9.00	Medicaid rate for swing-bed NF services applicable to services through De reporting period	ecember 31 of	f the cost	0.00	19.
D. 00	Medicaid rate for swing-bed NF services applicable to services after Dece	ember 31 of t	the cost	0.00	20.
1 00	reporting period			(200, 000	21
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the	e cost report	ting period (line	6, 208, 080 0	
2 00	5 x line 17)				0.00
3.00	Swing-bed cost applicable to SNF type services after December 31 of the c x line 18)	cost reportin	ng period (iine e	0	23.
4.00	Swing-bed cost applicable to NF type services through December 31 of the	cost reporti	ng period (line	0	24.
5.00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the co	ost reportino	period (line 8	0	25.
	x line 20)				
6.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 min	nus line 26)		733, 607 5, 474, 473	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				1
	General inpatient routine service charges (excluding swing-bed and observ Private room charges (excluding swing-bed charges)	ation bed cl	narges)	0	
D. 00	Semi -private room charges (excluding swing-bed charges)			Ő	
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 minus line 33)	(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)			0.00	
	Private room cost differential adjustment (line 3 x line 35)	room cost -!	fforontial (1)-	0	36.
<i>i</i> . UU	General inpatient routine service cost net of swing-bed cost and private 27 minus line 36)	TOOM COST O	rierential (IIne	5, 474, 473	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instruction	ns)	I	2, 757. 92	38.
3. 00					1
9.00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14			46, 885 0	39. 40.

	TION OF INPATIENT OPERATING COST		Provider C		Peri od:	Worksheet D-1	2552-1
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 12:	
	Cost Center Description	Total Inpatient Cost 1.00	Titl Total Inpatient Days 2.00	e XIX Average Per Di em (col. 1 ÷ col. 2) 3.00	Hospital Program Days 4.00	PPS Program Cost (col. 3 x col. 4) 5.00	
	NURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units	0	C				42.0
3.00 4.00 5.00 6.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						43.0 44.0 45.0 46.0 47.0
	Cost Center Description					1.00	
18.00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)			17, 088	
19.00 ·	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of PASS THROUGH COST ADJUSTMENTS				column 1)	0 63, 973	
io. oo 🛛	Pass through costs applicable to Program inpa III)	atient routine :	servi ces (fro	m Wkst. D, su	n of Parts I and	4, 093	50.0
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	711	51.0
53.00 ¹	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclud medical education costs (line 49 minus line EDUCT AUGUNT AUGUNT (AUGUNT)	ding capital re	lated, non-ph	ysician anest	netist, and	4, 804 59, 169	
	FARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.0
	Target amount per discharge						55.0
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor u	ise only)				0.00	55.0 55.0
	Target amount (line 54 x sum of lines 55, 55.					0.00	1
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (line 56 minus	line 53)	0	1
8.00 Bonus payment (see instructions) 9.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996,							58.0
 19.00 Trended costs (lesser of line 53 ÷ line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket) 10.00 Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the 						0.00	59. C
1	market basket)						
!	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operati	ng costs (line	0	61.0
3. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos ⁻	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.0
5.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	-					65. C
6.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	I only); for	0	66. C
7.00	CAH, see instructions Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.0
8.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 of	the cost rep	orting period	0	68.0
9.00	Total title V or XIX swing-bed NF inpatient i PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.0
0.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	tine service	cost (line 37)		70.0
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.0
	Program routine service cost (line 9 x line 3 Medically necessary private room cost applica		(line 14 v l	ine 35)			72.0
	Total Program general inpatient routine servi						74.0
	Capital-related cost allocated to inpatient 1 26, line 45)		costs (from	Worksheet B,	Part II, column		75. C
1	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76.C
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus					l	78.0
	Aggregate charges to beneficiaries for excess		rovider recor	ds)		l	79.0
	Total Program routine service costs for compa		ost limitatio	n (line 78 mi	nus line 79)	1	80.0
	Inpatient routine service cost per diem limi		`				81.0
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s					l	82.0
1	Program inpatient ancillary services (see ins		3)				84.0
	Utilization review - physician compensation		ns)				85.0
	Total Program inpatient operating costs (sum	of lines 83 th				L	86.0
F	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						87.0

Health Financial Systems	IU HEALTH JA	u of Form CMS-2	2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1320 Period: From 01/01/2			Worksheet D-1	
					Date/Time Pre 5/26/2023 12:	pared: 02 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			1, 671, 300	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	541, 907	6, 208, 080	0.08729	1, 671, 300	145, 889	90.00
91.00 Nursing Program cost	0	6, 208, 080	0.00000	0 1, 671, 300	0	91.00
92.00 Allied health cost	0	6, 208, 080	0.00000	0 1, 671, 300	0	92.00
93.00 All other Medical Education	0	6, 208, 080	0.00000	0 1, 671, 300	0	93.00

	Financial Systems IU ENT ANCILLARY SERVICE COST APPORTIONMENT	HEALTH JAY HOSPITAL Provider C	CN. 15 1220	Perio		u of Form CMS- Worksheet D-3	
INPAIL	ENT ANCILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-1320		01/01/2022	worksneet D-	3
					12/31/2022	Date/Time Pro	epared:
						5/26/2023 12	
		Title	XVIII		ospi tal	Cost	
	Cost Center Description		Ratio of Cos		npati ent	Inpati ent	
			To Charges		Program	Program Costs	
				(Charges	(col. 1 x	
						col. 2)	
	INDATIENT DOUTINE CEDVICE COST CENTERS		1.00		2.00	3.00	_
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS		-		1 000 ((0		
30.00	03000 ADULTS & PEDIATRICS				1, 399, 663		30.00
40.00	04000 SUBPROVIDER - IPF				0		40.00
43.00							43.00
F0 00	ANCI LLARY SERVICE COST CENTERS		0.4500	70			50.00
50.00	05000 OPERATING ROOM		0.4500		0	(
52.00	05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	(
53.00	05300 ANESTHESI OLOGY		0.0000		0	(
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1803		143, 363		
60.00	06000 LABORATORY		0. 3546		306, 727	108, 789	
65.00	06500 RESPIRATORY THERAPY		0. 4468		273, 392		
66.00	06600 PHYSI CAL THERAPY		0. 7635		58, 950	45, 011	
67.00	06700 OCCUPATI ONAL THERAPY		0. 6346		28, 346	17, 989	
68.00	06800 SPEECH PATHOLOGY		1. 2947		10, 948		
69.00	06900 ELECTROCARDI OLOGY		0. 0235		0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5880		6, 466	3, 802	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2395		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 3190	50	692, 519	220, 948	
76.00	03160 CARDI OPULMONARY		0. 2574		68, 239	17, 568	
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0.0000	00	0	(0 77.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0.0000		0	0	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY		2. 2429		0	C	
90. 02	09002 JAY FAMILY MEDICINE		2. 2671		0	0	
90.03	09003 WOUND CLINIC		0.0000		0	0	
90.04	09004 OP ORTHO CLINIC		3. 1207		0	0	90.04
90.05	09005 JAY FAMILY FIRST HEALTH CARE		3. 3935	94	0	(90.05
90.06	09006 INFUSION CLINIC		0. 1713	92	0	C	90.06
90.07	09007 HEALTH BEGINNINGS PROGRAM		20.0073	41	0	C	90.07
91.00	09100 EMERGENCY		0. 2574	71	24, 180	6, 226	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4446	47	1, 190	529	92.00
93.00	04950 OUTPATI ENT PSYCH		0. 6658	87	0	(93.00
200.00	Total (sum of lines 50 through 94 and 96 thr	ough 98)			1, 614, 320	583, 058	3 200. 00
201.00	U U				0		201.00
202.00		,		1	1, 614, 320		202.00

Health Financial Systems IU HEALTH JAY HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z320	From 01/01/2022 To 12/31/2022		pared: 02 pm
	Title	XVIII	Swing Beds - SNF		
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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS		1			20.00
					30.00
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY					40.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 4500	79 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.4300			52.00
53. 00 05300 ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1803			54.00
60. 00 06000 LABORATORY		0. 1803			60.00
65. 00 06500 RESPIRATORY THERAPY		0. 3340			
66. 00 06600 PHYSI CAL THERAPY		0. 4408			66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 6346			67.00
68. 00 06800 SPEECH PATHOLOGY		1. 2947		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 0235		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5880		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0. 2395		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3190			73.00
76. 00 03160 CARDI OPULMONARY		0. 2574		0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.0000			77.00
OUTPATI ENT SERVI CE COST CENTERS			· · .		
90. 00 09000 CLINIC		0.0000	00 0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		2. 2429	72 0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE		2. 2671	70 0	0	90.02
90. 03 09003 WOUND CLINIC		0. 0000	00 0	0	90.03
90. 04 09004 OP ORTHO CLINIC		3. 1207	55 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE		3. 3935	94 0	0	90.05
90.06 09006 INFUSION CLINIC		0. 1713	92 0	0	90.06
90. 07 09007 HEALTH BEGI NNI NGS PROGRAM		20.0073	41 0	0	90.07
91. 00 09100 EMERGENCY		0. 2574	71 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4446		0	92.00
93. 00 04950 OUTPATI ENT PSYCH		0. 6658		0	93.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			344, 476	162, 557	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		I	344, 476		202.00

	Financial Systems IU HEALTH JAY H		01 15 1000			u of Form CMS-2	
INPAIL	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320		riod: om 01/01/2022	Worksheet D-3	
				To		Date/Time Pre	pared:
					12/01/2022	5/26/2023 12:	
		Ti tl	e XIX		Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	st	Inpatient	Inpati ent	
			To Charges	5	Program	Program Costs	
					Charges	(col. 1 x	
						col. 2)	
			1.00		2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1				
30.00	03000 ADULTS & PEDIATRICS				29, 579		30.00
	04000 SUBPROVI DER – I PF				0		40.00
43.00	04300 NURSERY				0		43.00
	ANCI LLARY SERVICE COST CENTERS		0.4500	-			
	05000 OPERATING ROOM		0.4500		0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	0	52.00
	05300 ANESTHESI OLOGY		0.0000		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0. 1803		5, 373	969	54.00
60.00	06000 LABORATORY		0. 3546		4, 990	1,770	
	06500 RESPI RATORY THERAPY		0. 4468		11, 736	5, 244	
	06600 PHYSI CAL THERAPY		0. 7635		1, 334	1,019	
	06700 OCCUPATI ONAL THERAPY		0.6346		1, 037	658	
	06800 SPEECH PATHOLOGY		1. 2947		0	0	68.00
	06900 ELECTROCARDI OLOGY		0. 0235		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 5880		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2395		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03160 CARDI OPULMONARY		0. 3190		15, 965	5, 094	
	07700 ALLOGENEIC HSCT ACQUISITION		0.2574		0	0	76.00 77.00
	OUTPATIENT SERVICE COST CENTERS		0.0000		U	0	//.00
	09000 CLINIC		0.0000		0	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY		2. 2429		0	0	90.00
	09002 JAY FAMILY MEDICINE		2. 2424		0	0	90.01
	09003 WOUND CLINIC		0. 0000		0	0	90.02
	09003 WOOND CLINIC		3. 1207		0	0	90.03
90.04 90.05	09005 JAY FAMILY FIRST HEALTH CARE		3. 3935		0	0	90.04
	09005 JAY FAMILY FIRST HEALTH CARE		0. 1713		0	0	90.05
	09000 HEALTH BEGINNINGS PROGRAM		20. 0073		0	0	90.00
	09100 EMERGENCY		0. 2574		9, 064	2, 334	90.07
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2374		9,004	2, 334	91.00
	04950 OUTPATIENT PSYCH		0. 4440			0	93.00
200.00			0.0000	.07	49, 499	17,088	
200.00		: (line 61)			49, 499	17,000	200.00
201.00		s (rine of)			49, 499		201.00

	Financial Systems IU HEALTH JAY ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 12:	pared:
		Title XVIII	Hospi tal	Cost	
				1.00	
1.00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			6, 514, 078	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	ctions)		0,011,070	2.00
3.00	OPPS payments			0	
4.00	Outlier payment (see instructions)			0	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instru	uctions)		0 0. 000	4.01 5.00
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions)	W and 12 Line 200		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, THE 200		0	9.00 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			6, 514, 078	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, 1	line 69)		0	
	Total reasonable charges (sum of lines 12 and 13)			0	14.00
15.00	Customary charges Aggregate amount actually collected from patients liable for	normant for convisor on	a charge bacile	0	15.00
16.00	Amounts that would have been realized from patients liable for	1 5	0	0	16.00
	had such payment been made in accordance with 42 CFR §413.13		5		
	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete or	nlvifline 18 exceeds l	ne 11) (see	0	18.00 19.00
17.00	instructions)			0	17.00
20.00	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds l	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			6, 579, 219	21.00
	Interns and residents (see instructions)			0, 579, 219	
	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
25.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	ns)		125, 264	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on lin		ructions)	2, 257, 786	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	4, 196, 169	27.00
28 00	instructions) Direct graduate medical education payments (from Wkst. E-4, 1	line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			4, 196, 169	
	Primary payer payments Subtotal (line 30 minus line 31)			1, 672 4, 194, 497	
52.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	ICES)		4, 174, 477	52.00
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00 35.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			470, 748 305, 986	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		174, 844	
37.00	Subtotal (see instructions)	<i>,</i>		4, 500, 483	
38.00	MSP-LCC reconciliation amount from PS&R			0	38.00
39.00 39.50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.00 39.50
39.75	N95 respirator payment adjustment amount (see instructions)			0	
39.97	Demonstration payment adjustment amount before sequestration			0	-
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctions)	0	39.98 39.99
40.00	Subtotal (see instructions)			4, 500, 483	
40.01	Sequestration adjustment (see instructions)			56, 706	
40.02	Demonstration payment adjustment amount after sequestration			0	40.02
40. 03 41. 00	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			4,056,996	40.03 41.00
	Interim payments-PARHM or CHART			4,030,770	41.00
42.00	Tentative settlement (for contractors use only)			0	
42.01	Tentative settlement-PARHM or CHART (for contractor use only))		20/ 701	42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			386, 781	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	chapter 1,	361, 566	
	\$115.2				
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
93.00 94.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)			0	
у т . ОО				0	1 / 1.00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 01/01/2022	Worksheet E	
		To 12/31/2022	Date/Time Pre 5/26/2023 12:	pared: 02 pm
	Title XVIII	Hospi tal	Cost	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022		pared:
					5/26/2023 12:0	02 pm
		litle Inpatien	XVIII	Hospi tal Par	Cost	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00		1.00	2.00	3.00	4.00	1 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 services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 904, 66	6 D	4, 056, 996 0	1.00 2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.00
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03			1	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				0	0	3.5
3.52				0	0	3.52
3.53				0	0	3.53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			D	0	3.99
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)		1, 904, 66	6	4, 056, 996	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, write "NONE" or enter a zero. (1)					5.00
	Program to Provider			_1	-	
5. 01 5. 02	TENTATI VE TO PROVI DER			0	0	5.01 5.02
5.02 5.03				0	0	5.02
2.00	Provider to Program			-	0	5.00
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51				0	0	5.5
5.52	Subtatal (sum of lines E 01 E 40 minus sum of list-			0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			D	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		66, 53	7	386, 781	6. 0 ⁻
6.02	SETTLEMENT TO PROGRAM			D	0	6.02
7.00	Total Medicare program liability (see instructions)		1, 971, 20		4, 443, 777	7.00
				Contractor	NPR Date	
		C)	Number 1.00	(Mo/Day/Yr) 2.00	
8.00	Name of Contractor			1.00	2.00	8.00

VALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/202		
		Component (CCN: 15-Z320	To 12/31/202	2 Date/Time Pre 5/26/2023 12:	
			XVIII	Swing Beds - SN		
		Inpati en	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		755, 0	88	0	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero					2
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider				1	
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3
04				0	0	
05				0	0	3
	Provider to Program			2		
50	ADJUSTMENTS TO PROGRAM			0	0	-
51 52				0	0	-
5∠ 53				0	0	
53				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	
	3. 50-3. 98)			-	-	
00	Total interim payments (sum of lines 1, 2, and 3.99)		755, 0	88	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
~~	TO BE COMPLETED BY CONTRACTOR				1	۱.
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	15
02				0	0	5
03				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
77	5. 50-5. 98)			0	0	1 3
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		123, 8	17	0	6
02	SETTLEMENT TO PROGRAM			0	0	
00	Total Medicare program liability (see instructions)		878, 9		0	7
				Contractor	NPR Date	
)	Number	(Mo/Day/Yr)	-
	Name of Contractor	()	1.00	2.00	8

Heal th	Financial Systems IU HEALTH JAY	/ HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Period: From 01/01/2022 To 12/31/2022		epared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
	Total hospital discharges as defined in AARA §4102 from Wks	t. S-3, Pt. I col. 15 lin	e 14		1.00
	Medicare days (see instructions)				2.00
	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
	Total inpatient days (see instructions)				4.00
	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	line 20			6.00
	CAH only - The reasonable cost incurred for the purchase of line 168 $$	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestratio	n (see instructions)			10.00
I	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

LCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1320	Peri od:	Worksheet E-2	
		Component CCN: 15-Z320	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/26/2023 12:0	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
CONDUTATION OF NET COST OF COVERED			1.00	2.00	
COMPUTATION OF NET COST OF COVERED 00 Inpatient routine services - swing			733, 409	0	1.0
00 Inpatient routine services - swing 00 Inpatient routine services - swing	. ,		733, 409	0	2.0
00 Ancillary services (from Wkst. D-3		t A and sum of Wkst D	164, 183	0	3.0
Part V, cols. 6 and 7, line 202, f instructions)		-		0	5.0
01 Nursing and allied health payment-	PARHM or CHART (see instruc	tions)			3. (
00 Per diem cost for interns and resi		·		0.00	4.0
instructions)					
00 Program days			266	0	5.0
00 Interns and residents not in appro				0	6.0
00 Utilization review - physician com		thod only	0		7.0
00 Subtotal (sum of lines 1 through 3			897, 592	0	8.0
00 Primary payer payments (see instru	ctions)		0	0	9. (
.00 Subtotal (line 8 minus line 9)			897, 592	0	10. (
.00 Deductibles billed to program pati	ents (exclude amounts applic	cable to physician	0	0	11. (
professional services)			007 500		10 /
. 00 Subtotal (line 10 minus line 11)			897, 592	0	12.0
. 00 Coinsurance billed to program pati) (exclude col nsurance	7, 586	0	13. (
for physician professional service				0	14.(
.00 80% of Part B costs (line 12 x 80% .00 Subtotal (see instructions))		800.004	0	14.0
.00 Subtotal (see instructions) .00 OTHER ADJUSTMENTS (SEE INSTRUCTION	S) (SDECLEV)		890, 006 0	0	16.0
. 50 Pioneer ACO demonstration payment	, , ,	-)	0	0	16.
. 55 Rural community hospital demonstra	5		0		16.
adjustment (see instructions)	tion project (9410A Demonstr	atton) payment	0		10.
. 99 Demonstration payment adjustment a	mount before sequestration		0	0	16.
. 00 Allowable bad debts (see instructi			176	0	17.
.01 Adjusted reimbursable bad debts (s	-		114	0	17.
.00 Allowable bad debts for dual eligi		ructions)	0	0	18.
.00 Total (see instructions)	· · · · · · · · · · · · · · · · · · ·		890, 120	0	19.
.01 Sequestration adjustment (see inst	ructions)		11, 215	0	19.
.02 Demonstration payment adjustment a	mount after sequestration)		0	0	19.
. 03 Sequestration adjustment-PARHM or	CHART pass-throughs				19.
. 25 Sequestration for non-claims based	amounts (see instructions)		0	0	19.
.00 Interim payments			755, 088	0	20.
.01 Interim payments-PARHM or CHART					20.
.00 Tentative settlement (for contract	or use only)		0	0	21.
.01 Tentative settlement-PARHM or CHAR					21.
.00 Balance due provider/program (line			123, 817	0	22.
. 01 Balance due provider/program-PARHN					22.
.00 Protested amounts (nonallowable co	st report items) in accorda	nce with CMS Pub. 15-2,	49, 526	0	23.
chapter 1, §115.2					
Rural Community Hospital Demonstra					000
0.00 Is this the first year of the curr Century Cures Act? Enter "Y" for y		Tod under the 21st			200.
Cost Reimbursement					
1.00 Medicare swing-bed SNF inpatient r	outine service costs (from)	Wkst D_1 Pt II line			201.
66 (title XVIII hospital))		INST. D-1, Ft. 11, 1111e			201.
2.00 Medicare swing-bed SNF inpatient a	ncillary service costs (from	n Wkst D-3 col 3 li	he		202.
200 (title XVIII swing-bed SNF))					202.
3.00 Total (sum of lines 201 and 202)					203.
4.00 Medi care swing-bed SNF di scharges	(see instructions)				204.
Computation of Demonstration Targe		first year of the curr	ent 5-year demons	tration	
period)	· · · · · ·	,			
5.00 Medicare swing-bed SNF target amou	nt				205.
6.00 <u>Medicare swing-bed SNF inpatient r</u>	outine cost cap (line 205 ti	mes line 204)			206.
Adjustment to Medicare Part A Swin	g-Bed SNF Inpatient Reimburs	sement			
7.00 Program reimbursement under the §4	10A Demonstration (see inst	ructions)			207.
8.00 Medicare swing-bed SNF inpatient s	ervice costs (from Wkst. E-2	2, col. 1, sum of lines	1		208.
and 3)					
9.00 Adjustment to Medicare swing-bed S	NF PPS payments (see instruc	ctions)			209.
0.00 Reserved for future use					210.
Comparision of PPS versus Cost Rei			1		0.4 -
5.00 Total adjustment to Medicare swing	-ped SNF PPS pavment (line 2	209 plus line 210) (see			215.

ALCOL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Peri od: From 01/01/2022		
			To 12/31/2022	Date/Time Prep 5/26/2023 12:0	par 02
		Title XVIII	Hospi tal	Cost	
			-	1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR ME	DI CARE PART A SERVICES - COS	T REIMBURSEMENT		
00	Inpatient services			2, 155, 469] 1
00	Nursing and Allied Health Managed Care payment (see ins	structions)		0	2
00	Organ acquisition			0	3
01	Cellular therapy acquisition cost (see instructions)			0	3
00	Subtotal (sum of lines 1 through 3.01)			2, 155, 469	4
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructi	ons)		2, 177, 024	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
00	Routine service charges			0	
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	10
	Customary charges				
. 00	Aggregate amount actually collected from patients liabl			0	
. 00	Amounts that would have been realized from patients lia	1 5	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 41	13.13(e)			
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (compl	ete only if line 14 exceeds l	ine 6) (see	0	1
	instructions)				
5.00	Excess of reasonable cost over customary charges (compl	ete only if line 6 exceeds li	ne 14) (see	0	16
. 00	instructions) Cost of physicians' services in a teaching hospital (se	e instructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
. 00	Direct graduate medical education payments (from Worksh	ieet E-4, TThe 49)		0	
. 00	Cost of covered services (sum of lines 6, 17 and 18)			2, 177, 024	
. 00	Deductibles (exclude professional component)			197, 540	
. 00	Excess reasonable cost (from line 16)			0	
. 00	Subtotal (line 19 minus line 20 and 21)			1, 979, 484	
. 00	Coinsurance			1, 979, 484	23
	Subtotal (line 22 minus line 23) Allowable bad debts (exclude bad debts for professional	convisco) (coo instructions)			
. 00		services) (see fistructions)		25, 958	
. 00 . 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (se	(a instructions)		16, 873 13, 374	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 996, 357	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 990, 337	
. 50	Pioneer ACO demonstration payment adjustment (see instr	suctions)		0	
. 98	Recovery of accel erated depreciation.			0	
. 99	Demonstration payment adjustment amount before sequestr	ation		0	
. 00	Subtotal (see instructions)			1, 996, 357	
. 00	Sequestration adjustment (see instructions)			25, 154	
. 01	Demonstration payment adjustment amount after sequestra	ation			30
. 02	Sequestration adjustment-PARHM or CHART			U	30
. 00	Interim payments			1, 904, 666	
. 01	Interim payments-PARHM or CHART			1, 201,000	3
. 00	Tentative settlement (for contractor use only)			0	
. 01	Tentative settlement-PARHM or CHART (for contractor use	e only)		U	32
. 00	Balance due provider/program (line 30 minus lines 30.01			66, 537	
3. 01	Balance due provider/program-PARHM or CHART (lines 2, 3		03. 31.01 and	00,007	33
		.,, and 20, mindo rinos 00.	, oo., and		1
	32.01)			1	1

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: rom 01/01/2022 o 12/31/2022	Worksheet G Date/Time Pre 5/26/2023 12:	
		General Fund	Speci fi c Purpose Fund	Endowment Fund 3.00	Plant Fund 4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-5, 650, 246	0	0	0	1.0
00	Temporary investments	0	0	0	0	
00	Notes receivable	0	0	0	0	3.0
00 00	Accounts receivable Other receivable	3, 536, 629 1, 693, 573	0	0	0	4.0 5.0
00	Allowances for uncollectible notes and accounts receivable	1,075,575	0	0	0	6.0
00	Inventory	418, 736	0	0	0	
00	Prepai d'expenses	114, 519	0	0	0	8. C
00	Other current assets	0	0	0	0	
0.00	Due from other funds	0	0	0	0	10.0
. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	113, 211	0	0	0	11. C
2.00	Land	989, 148	0	0	0	12.0
8.00	Land improvements	0	0	0	0	13.0
. 00	Accumulated depreciation	0	0	0	0	14.0
	Bui I di ngs	18, 977, 852	0	0	0	
	Accumulated depreciation	-6, 157, 586	0	0	0	16.0
	Leasehold improvements	0	0	0	0	17.0 18.0
	Accumulated depreciation Fixed equipment		0	0	0	19.0
	Accumulated depreciation	0	0	0	0	20.0
	Automobiles and trucks	42, 146	0	0	0	21.0
2.00	Accumulated depreciation	-28, 976	0	0	0	22.0
	Major movable equipment	11, 300, 181	0	0	0	
	Accumulated depreciation	-7, 230, 344	0	0	0	24.0
	Minor equipment depreciable	0	0	0	0	25.0
	Accumulated depreciation HIT designated Assets			0	0	26.0
	Accumulated depreciation	0	0	0	0	28.0
. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.0
0. 00	Total fixed assets (sum of lines 12-29)	17, 892, 421	0	0	0	30.0
	OTHER ASSETS					1
	Investments	0	0	0	0	31.C
	Deposits on leases Due from owners/officers		0	0	0	33.0
	Other assets	0	0	0	0	34.0
5.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.0
. 00	Total assets (sum of lines 11, 30, and 35)	18, 005, 632	0	0	0	36.0
	CURRENT_LIABILITIES	4 4 9 4 9 9 9				1
7.00 3.00	Accounts payable Salaries, wages, and fees payable	1, 191, 029 1, 065, 929		0	0 0	37.0
	Payrol I taxes payable	62, 177	0	0	0	
	Notes and Loans payable (short term)	0	0	0	0	
	Deferred income	0	0	0	0	41.0
2.00	Accelerated payments	268, 533				42.0
8.00	Due to other funds	0	0	0	0	
	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	6, 376, 908 8, 964, 576		0	0	
. 00	LONG TERM LIABILITIES	0, 704, 370	0	0	0	45.0
. 00	Mortgage payable	0	0	0	0	46.0
. 00	Notes payable	0	0	0	0	
8.00	Unsecured Loans	0	0	0	0	48.0
	Other long term liabilities	0	0	0	0	49.0
	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	
. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	8, 964, 576	0	0	0	51.0
2. 00	General fund balance	9, 041, 056				52.0
3. 00	Specific purpose fund	, , , , , , , , , , , , , , , , , , , ,	0			53.0
. 00	Donor created - endowment fund balance - restricted			0		54.
5.00	Donor created - endowment fund balance - unrestricted			0		55.
. 00	Governing body created - endowment fund balance			0		56.
. 00	Plant fund balance - invested in plant				0	
8.00	Plant fund balance - reserve for plant improvement,				0	58.
. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	9, 041, 056	0	0	0	59.
	istai iunu purunoos (sum or rinos sz tillu so)	7,041,000	. 0	U	0	1 07.

	Financial Systems	IU HEALTH JAY					u of Form CN		552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1320		iod: m 01/01/2022 12/31/2022		Prep	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5/26/2023 12: 02 Endowment Fund 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 10 0 10 11 0 12 13		
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2,0041,058	3.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0	3.00		1.00 2.00 3.00 4.00 5.00 6.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0 0		0 0 0 0				10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	Financial Systems IU HEALTH JAY	Provi der CCN	L 1E 1220	Peri od:	u of Form CMS-2	
STATEN	IENT OF PATTENT REVENUES AND OPERATING EXPENSES	Provider CCM	1: 15-1320	From 01/01/2022 To 12/31/2022	Worksheet G-2 Parts I & II Date/Time Pre 5/26/2023 12:	pared:
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		3, 416, 50		3, 416, 503	1.00
2.00	SUBPROVIDER - IPF			0	0	2.00
3.00 4.00	SUBPROVIDER - IRF					3.00
4.00 5.00	SUBPROVI DER Swing bed - SNF		499, 20	00	499, 200	4.00 5.00
5.00 6.00	Swing bed - NF		499, 20	0	499,200	6.00
7.00	SKILLED NURSING FACILITY			0	0	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)		3, 915, 70)3	3, 915, 703	10.00
	Intensive Care Type Inpatient Hospital Services	ł			· · · ·	1
11.00	I NTENSI VE CARE UNI T					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum	oflines		0	0	16.00
47 00	11-15)				0.045.700	17 00
17.00	Total inpatient routine care services (sum of lines 10 and	16)	3, 915, 70		3, 915, 703	
18.00	Ancillary services		4, 722, 31		50, 549, 398	•
19.00 20.00	Outpatient services RURAL HEALTH CLINIC		644, 04	0 30, 623, 134 0 0	31, 267, 174 0	19.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
21.00	HOME HEALTH AGENCY			0	0	21.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (SPECI FY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 to Wkst.	9, 282, 06	60 76, 450, 215	85, 732, 275	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			40, 995, 296		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 35.00				0		34.00 35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
37.00				0		37.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		40, 995, 296		43.00
	to Wkst. G-3, line 4)					

	2	TH JAY HOSPITAL		u of Form CMS-2	
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1320	Period: From 01/01/2022	Worksheet G-3	
			To 12/31/2022	Date/Time Pre	pared.
				5/26/2023 12:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, colum			85, 732, 275	1.00
2.00	Less contractual allowances and discounts on patients	' accounts		46, 899, 345	
3.00	Net patient revenues (line 1 minus line 2)			38, 832, 930	
4.00	Less total operating expenses (from Wkst. G-2, Part I			40, 995, 296	
5.00	Net income from service to patients (line 3 minus lin	ne 4)		-2, 162, 366	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous commu	inication services		0	
9.00	Revenue from television and radio service			0	
	Purchase di scounts			0	
	Rebates and refunds of expenses			0	
	Parking lot receipts			0	
	Revenue from laundry and linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	15.00
	Revenue from sale of medical and surgical supplies to	o other than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
	Revenue from gifts, flowers, coffee shops, and cantee	en		0	
	Rental of vending machines			0	
	Rental of hospital space			0	22.00
	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			463, 733	24.00
24.50	COVI D-19 PHE Fundi ng			0	24.50
25.00	Total other income (sum of lines 6-24)			463, 733	25.00
	Total (line 5 plus line 25)			-1, 698, 633	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29 00	Net income (or loss) for the period (line 26 minus li	ne 28)		-1, 698, 633	29.00