Health Financial Systems	IU HEALTH JAY				u of Form CMS-2	552-10
This report is required by law (42 USC 1395g; 42 CF						
payments made since the beginning of the cost repor	ting period being	g deemed overp	ayments (42	USC 1395g).	OMB NO. 0938-0	
		5	1 15 1000	<u> </u>	EXPIRES 05-31-	2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPO AND SETTLEMENT SUMMARY	RI CERTIFICATION	Provider CCN		Period: From 03/01/2018	Worksheet S Parts I-III	
AND SETTLEMENT SUMMART				To 12/31/2018		ared:
					5/24/2019 10:1	3 am
PART I - COST REPORT STATUS						
Provider 1. [X] Electronically filed cost rep				Date: 5/24/20	19 Time: 10:	13 am
use only 2. [] Manually submitted cost repor		с				
3.[0] f this is an amended report 4.[F]Medicare Utilization. Enter '	E" for full or "	OF TIMES THE	provider res	submitted this c	ost report	
	Recei ved:	L TOT TOW.	10 NE	R Date:		
use only (1) As Submitted 7 Contr	actor No		11 Cc	ontractor's Vendo	or Code	4
(2) Settled without Audit 8. [N]	Initial Report f	or this Provid	der CCN 12.[0]If line 5, co	olumn 1 is 4: En	iter.
(3) Settled with Audit 9. [N]	Final Report for	this Provide	r CCN		nes reopened = 0	
(4) Reopened						
(5) Amended						
PART II - CERTIFICATION						
MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATI	ON CONTAINED IN T	THIS COST DEDC				
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						,
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY O)
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA						
CERTIFICATION BY CHIEF FINANCIAL OFFICER OF		= PROVIDER(S)				
I HEREBY CERTIFY that I have read the above					1 3 3	
electronically filed or manually submitted Expenses prepared by IU HEALTH JAY HOSPITAL						
ending 12/31/2018 and to the best of my know						
complete and prepared from the books and re	9					
except as noted. I further certify that I						
health care services, and that the services						
laws and regulations.			•			
[X]I have read and agree with the above o	ertification sta	tement cer	tify that L i	intend my electr	onic	
signature on this certification stater						
			N VANATOR		9	
	(Si gned			trator of Provic		
		Unice	I UI Auminis			
		CHIEF F	INANCIAL OFF	I CFR		
		Title				
		(Dated	when report i	is electronicall	y signed.)	
		Date				
		<u> </u>			T: 11 X1 X	
Cost Center Description	Title V	Part A	Part B	HIT 4.00	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY 1.00 Hospital	0	647, 260	2, 906, 92	5 0	0	1.00
2.00 Subprovider - IPF	0	1, 712	2, 900, 92		o	2.00
3. 00 Subprovider - IRF	0	1, 712		0	0	2.00
5.00 Swing bed - SNF	0	132, 323		0	0	5.00
6.00 Swing bed - NF	0	102, 020		Ĭ	0	6.00
200. 00 Total	0	781, 295	2,907,00	8 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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		ALTH JAY H TA			15-1320	Period: From 03/0	1/2018	Part I	eet S-2	2
							To 12/3	1/2018	Date/T 5/24/2	ime Pre 019 10:	
	1.00		00		3.00			4.00			
0	Hospital and Hospital Health Care Co Street: 500 W. VOTAW	PO Box:									1.
0	City: PORTLAND	State: I	N Z	ip Code	: 47371	1 Cour	nty: JAY				2.
		Component Na		CCN	CBSA				ent Sys		
			IN	lumber	Number	r Type	Certifie		, 0, or XVIII		-
		1.00		2.00	3.00	4.00	5.00	6.00	-	-	
	Hospital and Hospital-Based Componen										
0 0	Hospital Subprovider – IPF	IU HEALTH JAY HO IU HEALTH JAY HO		51320 5M320	99915 99915		01/01/200		0 P	P 0	
0		- PSYCH UNIT		5111520	///13		10/01/200		'		1
0	Subprovider - IRF										5
0 0	Subprovider – (Other) Swing Beds – SNF	IUHP SWING BEDS	1	5Z320	99915	5	01/01/200	04 N	0	N	6
0	Swing Beds - NF	TOTIL SWING DEDS		52520	///13		017017200				8
0	Hospital-Based SNF										9
00 00	Hospi tal-Based NF Hospi tal-Based OLTC										10
00	Hospital -Based HHA										12
00	Separately Certified ASC										13
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC										14
00	Hospital -Based Health Clinic - FQHC										16
00	Hospital-Based (CMHC) I										17
00 00	Renal Dialysis Other										18
00				I			Fro	m:	To	D:	
							1. (00	
00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						03/01/		12/31	/2018	20
	Inpatient PPS Information					1.00	2.0	00	3.	00	-
00	Does this facility qualify and is it	currently receiv	/ing payme	nts for		N	N				22
	disproportionate share hospital adju										
	§412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §-										
	hospital?) In column 2, enter "Y" for			lilent							
01	Did this hospital receive interim une		1 2			Ν	N				22
	cost reporting period? Enter in colu the portion of the cost reporting per										
	Enter in column 2, "Y" for yes or "N	for no for the	portion o	f the co							
02	reporting period occurring on or after Is this a newly merged hospital that	•				Ν	N				22
02	payments to be determined at cost re					IN	IN IN				22
	Enter in column 1, "Y" for yes or "N										
	cost reporting period prior to Octobe or "N" for no, for the portion of the										
	October 1.	e cost reporting	period on								
03	Did this hospital receive a geographi					Ν	N		1	N	22
	rural as a result of the OMB standard adopted by CMS in FY2015? Enter in co										
	for the portion of the cost reporting	g period prior to	October	1. Enter							
	in column 2, "Y" for yes or "N" for a reporting period occurring on or afte										
	Does this hospital contain at least				s						
	counted in accordance with 42 CFR 412	2.105)? Enter in	column 3,	"Y" for	r						
00	yes or "N" for no. Which method is used to determine Me	dicaid days on li	nes 24 an	d/or 25			3 N				23.
	below? In column 1, enter 1 if date				r 3						
00	if date of discharge. Is the method				ost						
00	reporting period different from the										
	reporting period different from the reporting period? In column 2, enter		In-State			Out-of	Out-of	Medi ca)ther	
			Modia	Medi c		State	State Medi cai d	HMO da	J	di cai d days	
			Medicaid paid days	eliai	ble M	Medi cai d 📗					
			Medicaid paid days	unpa	nid p	baid days	eligible			3	
			paid days	unpa day	nid p vs	baid days	el i gi bl e unpai d			, <u>oc</u>	
	reporting period? In column 2, ente	enter the	paid days	unpa day 2.0	nid p vs 00	aid days 3.00	el i gi bl e unpai d 4. 00	5.00		<u>6.00</u>) 24
	reporting period? In column 2, enter If this provider is an IPPS hospital, in-state Medicaid paid days in colum	n 1, in-state	paid days	unpa day	nid p vs	baid days	el i gi bl e unpai d	5. 00	0) 24
	reporting period? In column 2, enter If this provider is an IPPS hospital, in-state Medicaid paid days in colum Medicaid eligible unpaid days in colum	n 1, in-state umn 2,	paid days	unpa day 2.0	nid p vs 00	aid days 3.00	el i gi bl e unpai d 4. 00	5. 00) 24
	reporting period? In column 2, enter If this provider is an IPPS hospital, in-state Medicaid paid days in colum	n 1, in-state umn 2, olumn 3,	paid days	unpa day 2.0	nid p vs 00	aid days 3.00	el i gi bl e unpai d 4. 00	5. OC) 24.

OSPI ⁻	IFINANCIAL SYSTEMS IU HEA TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC				Worksh Part I Date/1	orm CMS- neet S-2 Time Pre 2019 10:	2 epared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Me	Other edi cai d days	
5.00	If this provider is an IRF, enter the in-state	1.00	2.00	3.00	4.00	5.00	0	6.00	25.0
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.				Urban/F	ural S		f Geogr	
					1.			00	
6.00 7.00 5.00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	rural. age) status "2" for ru cation in d	at the end ural. If ap column 2.	l of the cos oplicable,	it	2 2 0			26. 0 27. 0 35. 0
5.00	effect in the cost reporting period.					0			00.0
					Begi n			i ng: 00	
5. 00	Enter applicable beginning and ending dates of SCH st	atus. Subs	cript line	36 for numb		50	۷.	00	36.
7.00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		c of period	le MDH etatu	16	0			37.
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH trans	sitional pa	yment in		0			37.
	accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)	or yes or "I	N" for no.	(see					
3. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
					Y/	N	Y	/N	
					1.			00	
9. 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 t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? Ent requiremen	er in colum nts in	IN			N	39.
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Enter	∽"Y" for y				_	N	40.
						V 1.00	XVIII 2.00		-
_	Prospective Payment System (PPS)-Capital					1.00	2.00	- 3.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	·	·			N	N	N	45. 46.
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, Pt. II	I and Wkst	. L-1, Pt.	I through				
7.00 3.00	Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment Teaching Hospitals			2		N N	N N	N N	47. 48.
5.00	Is this a hospital involved in training residents in or "N" for no.				5	N			56.
. 00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or "N" th of this ((", complete	' for no in cost report e Worksheet	n column 1. ing period?	If column ' ' Enter "Y				57.
3. 00		oursement fo	or physicia	ins' service	es as				58.
	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59.
9.00		·		NAHE 413.8 Y/N	35 Worksh Lin	e #	Qualif	Through ication on Code	
9.00									
9.00				1.00	2.			00	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		eriod: rom 03/01/2018 o 12/31/2018		pared:
	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 	N			0. 00	0. OC	61.0
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
 O4 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 						61.0
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.20 Of the FTEs in line 61.05, specify each expanded program special ty, 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 name. 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. 				0.00		61. 1
					1.00	
ACA Provisions Affecting the Health Resources and Se						
 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct.) Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC production. 	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
Teaching Hospitals that Claim Residents in Nonprovid 3.00 Has your facility trained residents in nonprovider so "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes, complete "Y" for yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1. If yes or "N" for no in column 1.	ettings	during this co	67. (see instru	uctions)	N	63.0
			Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
Section 5504 of the ACA Base Year FTE Residents in N	onprovi	der Settings	1.00 This base vear	2.00 is vour cost r	3.00 Teporting	
4.00 Enter in column 1, if line 63 is yes, or your facilities in the base year period, the number of unweighted not resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair n-primar all nor d non-pr n columr	30, 2010. med residents ty care provider mary care m 3 the ratio	0. 00	-		64.0

		ATA Provider	Fr	riod: om 03/01/2018	Worksheet S-2 Part I	
			To	12/31/2018	Date/Time Pre 5/24/2019 10:	pared 13 am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	10 0
			FTEs	FTEs in	$(\operatorname{col} \cdot 3 + \operatorname{col} \cdot$	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
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)			Unweighted	Unweighted	Ratio (col. 1/	<i>,</i>
			FTEs	FTEs in	(col. 1 + col.	
			Nonprovider Site	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Current Y	/ear FTE Residents i	n Nonprovider Settin				
.00 Enter in column 1 the number of u FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp inweighted non-prima il. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0.000000 Ratio (col. 3/	
	Program Name	Program Code	Unweighted			
			FTEs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
.00 Enter in column 1, the program	1.00	2.00	Nonprovi der		4))	
.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)	1.00	2.00	Nonprovi der Si te 3.00	Hospital 4.00	4))	_
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	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00 0.00	4)) 5.00 0.000000	
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)	25		Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.000000 0.000000	
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)	25 Ychiatric Facility (IPF), or does it con	Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u> rovi der? Y	4)) 5.00 0.000000 0.000000 0.0000000	70. (
<pre>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)</pre>	≥S /chiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	Nonprovi der Si te 3. 00 0. 00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	Hospi tal 4.00 0.00 1.00 rovi der? Y he most N ing 0.	4)) 5.00 0.000000 0.000000 0.0000000	70. (
<pre>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)</pre>	2S rchiatric Facility (the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y / PPS nabilitation Facility	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	Nonprovi der Si te 3.00 0.00 tain an IPF subp ing program in ti yes or "N" for m s in a new teach yes or "N" for m s cost reporting	Hospi tal 4.00 0.00 1.00 rovi der? Y he most N ing 0.	4)) 5.00 0.000000 0.000000 0.000000 0.00000000	_

	Financial Systems IU HEALTH JAY AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	/ HOSPI TAL Provi der CO		In Lie Period: From 03/01/2018	u of Form CMS- Worksheet S-2 Part I		
				To 12/31/2018	Date/Time Pre 5/24/2019 10:		
					1.00		
	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes Is this a LTCH co-located within another hospital for part c "Y" for yes and "N" for no.			g period? Enter	N N	80. 00 81. 00	
	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				Ν	85. 00 86. 00	
87.00	18 this hospital an extended neoplastic disease care hospita 1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	al classified	under section		Ν	87.00	
				V 1.00	XI X 2.00	-	
	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospita	l convigor? E	ntor "V" for	N	Ŷ	90.00	
	yes or "N" for no in the applicable column.						
91.00	Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl	N	N	91.00			
92.00	Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica		ion)? (see		Ν	92.00	
93.00	Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	Ν	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes,	and "N" for n	o in the	N	Ν	94.00	
	applicable column. If line 94 is "Y", enter the reduction percentage in the app Does title V or XIX reduce operating cost? Enter "Y" for yes	0. 00 N	0. 00 N	95.00 96.00			
	applicable column. 0.00 00 If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in 0.00						
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the re C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for ti	. N	Y	98. 01			
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the ca bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes c			Ν	Y	98.02	
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a crit reimbursed 101% of inpatient services cost? Enter "Y" for ye			N 1	Ν	98.03	
98. 04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no in			Ν	Ν	98.04	
98. 05	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add ba Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in c				Y	98.05	
98.06	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in columr column 2 for title XIX.			Ν	Y	98.06	
105.00	Rural Providers Does this hospital qualify as a CAH?			Y		105.00	
	If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)	inclusive met	hod of paymen			106.00	
107.00	If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	n 1. (see inst	ructions) If	N		107.00	
	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dule? See 42	N		108.00	
	CFR Section 9412. TIS(C). Enter Y for yes of N for no.	Physi cal	Occupati ona		Respi ratory		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	<u>1.00</u> N	2.00 N	3.00 N	4.00 N	109.00	
					1.00	-	
	Did this hospital participate in the Rural Community Hospita Demonstration)for the current cost reporting period? Enter " complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	Y" for yes or	"N" for no.	lf yes,	N	110.00	

Health Financial Systems IU HEALTH JAY HOS				n CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovider CCN: 15-1320	Period: From 03/01/2 To 12/31/2	018 Date/Ti	et S-2 me Prepared: 19 10:13 am
		1.00	2.0	0
111.00 If this facility qualifies as a CAH, did it participate in the F Health Integration Project (FCHIP) demonstration for this cost r "Y" for yes or "N" for no in column 1. If the response to column integration prong of the FCHIP demo in which this CAH is partici Enter all that apply: "A" for Ambulance services; "B" for additi for tele-health services.	reporting period? Enter 1 is Y, enter the pating in column 2.	N	2.0	111.00
			1.00 2.00	3.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) b Pub. 15-1, chapter 22, \$2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for	column 2 is "E", enter or long term care (incl pased on the definition	in column udes	N	0 115.00
117.00 Is this facility legally-required to carry malpractice insurance		"N" for	N	117.00
118.00 Is the malpractice insurance a claims-made or occurrence policy?	'Enter 1 if the policy	is	1	118.00
	Premi ums	Losses	Insura	ance
	1.00	2.00	3.0	0
118.01List amounts of malpractice premiums and paid losses:	104, 9	210	0	0 118. 01
		1.00	2.0	0
118.02 Are malpractice premiums and paid losses reported in a cost cent Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Har §3121 and applicable amendments? (see instructions) Enter in col "N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	listing cost centers mless provision in AC/ umn 1, "Y" for yes or ies for the Outpatient		N	118. 02 119. 00 120. 00
121.00 Did this facility incur and report costs for high cost implantab patients? Enter "Y" for yes or "N" for no.	le devices charged to	Y		121.00
122.00 Does the cost report contain healthcare related taxes as defined Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.			5.0	0 122.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for ye	es and "N" for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter	the certification date	9		126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter t in column 1 and termination date, if applicable, in column 2.	he certification date			127.00
128.00 If this is a Medicare certified liver transplant center, enter t in column 1 and termination date, if applicable, in column 2.	he certification date			128.00
129.00 If this is a Medicare certified lung transplant center, enter the column 1 and termination date, if applicable, in column 2.	ne certification date i	n		129.00
130.00 If this is a Medicare certified pancreas transplant center, ente date in column 1 and termination date, if applicable, in column				130.00
I31.00 If this is a Medicare certified intestinal transplant center, er date in column 1 and termination date, if applicable, in column	ter the certification			131.00
I32.00 If this is a Medicare certified islet transplant center, enter t in column 1 and termination date, if applicable, in column 2.				132.00
33.00 If this is a Medicare certified other transplant center, enter t in column 1 and termination date, if applicable, in column 2.				133.00
134.00 f this is an organ procurement organization (OPO), enter the OF and termination date, if applicable, in column 2.	20 number in column 1			134.00
All Providers 140.00 Are there any related organization or home office costs as defir chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes,		Y	15H0	59 140.00

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX			HOSPI TAL Provi der CC	N: 15-13	I		3/01/2018	u of Form CMS Worksheet S- Part I	2
						To 12	2/31/2018	Date/Time Pr 5/24/2019 10	epared 13 am
1.00		2.00					3.00		
If this facility is part of a chain					the na	ame and	address	of the	
home office and enter the home office 41.00 Name: INDIANA UNIVERSITY HEALTH	<u>ce contractor name</u> Contractor's Na	me: WISC	ONSIN PHYSICI		tracto	r's Nu	mber: 0810	1	141. (
42.00 Street: 340 WEST TENTH STREET	PO Box:	SERV	TUES						142. (
43. 00 Ci ty: I NDI ANAPOLI S	State:	I N		Zip	Code:		4620	4	143. (
								1.00	-
44.00 Are provider based physicians' costs	s included in Works	heet A?						Y	144. (
							1.00	2.00	-
45.00 If costs for renal services are clai	med on Wkst A li	ne 74 a	are the costs	for			1.00	2.00	145. (
inpatient services only? Enter "Y" i no, does the dialysis facility inclu period? Enter "Y" for yes or "N" for 46.00 Has the cost allocation methodology Enter "Y" for yes or "N" for no in o	for yes or "N" for ude Medicare utiliz or no in column 2. changed from the p	no in co ation fo reviousl	olumn 1. lf c or this cost y filed cost	olumn 1 reporti report	ng ?		Y	11/15/2018	146. (
yes, enter the approval date (mm/dd,	•		-2, chapter 4	0, 9402	0) 11				
								1.00	
47.00 Was there a change in the statistica								Y	147.0
48.00Was there a change in the order of a 49.00Was there a change to the simplified					" for	00		N N	148.
			Part A		t B		tle V	Title XIX	147.
			1.00		00		3.00	4.00	1
Does this facility contain a provide or charges? Enter "Y" for yes or "N			t for Part A	and Par	тВ. (CFR §413	. 13)	
55.00 Hospi tal			N		1		N	N	155.
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N		l I		N N	N N	156. 157.
58. 00 SUBPROVI DER			i v		•		14		158.
59. 00 SNF			N	1	J		Ν	N	159. (
60.00 HOME HEALTH AGENCY			N		1		Ν	N	160. (
61.00 CMHC				1	J		N	N	161. (
								1.00	
Multicampus						ant CD	CA-0	N	1/5
65.00 Is this hospital part of a Multicam, Enter "Y" for yes or "N" for no.	ous nospitai that n	as one c	or more campu	ises i n	aitter	ent CB	SAS?	N	165. (
	Name		County	State	e Zip	Code	CBSA	FTE/Campus	
	0		1.00	2.00	3	. 00	4.00	5.00	
66.00 If line 165 is yes, for each campus enter the name in column								0.0	0 166. 0
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			1		1	1.00	-
Health Information Technology (HIT)						t Act			
67.00 Is this provider a meaningful user u 68.00 If this provider is a CAH (line 105 reasonable cost incurred for the HI	is "Y") and is a m	eani ngfu	ul user (line			enter	the	Y	167. 0168.
68.01 If this provider is a CAH and is no ⁻ exception under §413.70(a)(6)(ii)? I	t a meaningful user Enter "Y" for yes o	, does t r "N" fo	this provider or no. (see i	nstruct	í ons)		•		168.
69.00 If this provider is a meaningful use transition factor. (see instructions) and is	s not a CAH (line 10	5 is "				0169. (
						· · · · · ·	gi nni ng 1. 00	Endi ng 2. 00	-
70.00 Enter in columns 1 and 2 the EHR beg	ginning date and en	ding dat	te for the re	porting			01/2018	06/30/2018	170. (
							1.00	2.00	
71.00 If line 167 is "Y", does this provid	der have anv davs f	or indi∖	iduals enrol	led in			Y	1	5 171. (

	Financial Systems IU HEALTH JA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1320	In Lie Period:	u of Form CMS- Worksheet S-2	
5PI I.	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1320	From 03/01/2018 To 12/31/2018	Part II Date/Time Pre	epared
				Y/N	5/24/2019 10: Date	13 an
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ente	er all dates in 1	he	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c) Y	03/01/2018	1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	rogrom2 lf	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.					2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A	02/28/2019	4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	-
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider i	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see in	structions.		Ν		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	U	Ν		8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		N		9.
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			Ν		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts	· .				1 4 4
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
00	If line 12 is yes, were patient deductibles and/or co-payme	nts waived? If	°yes, see in	structions.	Ν	14.
00	Bed Complement Did total beds available change from the prior cost reporti	ng period?lf	yes, see ins	tructions.	N	15.
		Par	rt A	Par	tВ	
		Y/N 1.00	Date 2,00	Y/N	Date	
	PS&R Data	1.00	2.00	3.00	4.00	
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		N		16.
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	04/03/2019	Y	04/03/2019	17.
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.
	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		19.

Health Financial Sys	stems
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In Lieu of Form CMS-2552-10

ealth Financial Systems IU HEALTH JA	AY HOSPITAL		In Lie	eu of Form CN	IS-2552-1			
IOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1320	Peri od: From 03/01/2018 To 12/31/2018	Worksheet S Part II Date/Time F	5-2 Prepared:			
			V /N	5/24/2019	10:13 am			
		iption	Y/N	Y/N				
0.00 If line 16 or 17 is yes, were adjustments made to PS&R		0	1.00 N	3.00 N	20.00			
Report data for Other? Describe the other adjustments:	>/ />) (/NI					
	Y/N	Date	Y/N	Date				
	1.00	2.00	3.00	4.00	21.0			
1.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00			
				1.00				
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	OSPI TALS)						
Capital Related Cost		,						
2.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 0			
13.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made duri	ng the cost	Y	23. 0			
4.00 Were new leases and/or amendments to existing leases entere	ed into during	this cost rep	oorting period?	N	24. 0			
5.00 Have there been new capitalized leases entered into during	5 1 51 5							
instructions. 6.00 Were assets subject to Sec.2314 of DEFRA acquired during th	he cost reporti	ng period? If	Fyes, see	N	26.00			
instructions. 7.00 Has the provider's capitalization policy changed during the	e cost reportir	ng period? If	yes, submit	N	27.00			
copy. Interest Expense								
8.00 Were new loans, mortgage agreements or letters of credit en period? If yes, see instructions.	N	28.0						
9.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		N N	29.0 30.0					
instructions.	5 1 1 5							
11.00 Has debt been recalled before scheduled maturity without is instructions.	see	Ν	31.0					
Purchased Services			· · · ·					
 Have changes or new agreements occurred in patient care set arrangements with suppliers of services? If yes, see instruits. If line 32 is yes, were the requirements of Sec. 2135.2 applies 	uctions.	0		N	32.0			
no, see instructions.								
Provi der-Based Physi ci ans				-				
4.00 Are services furnished at the provider facility under an a	rrangement with	n provi der-bas	ed physi ci ans?	Y	34.0			
If yes, see instructions. 5.00 If line 34 is yes, were there new agreements or amended exi	isting agreemer	nts with the p	provi der-based	N	35.0			
physicians during the cost reporting period? If yes, see in	nstructions.							
			Y/N	Date				
			1.00	2.00	_			
Home Office Costs								
6.00 Were home office costs claimed on the cost report? 7.00 If line 36 is yes, has a home office cost statement been pu	repared by the	home office?	Y Y		36. 0 37. 0			
If yes, see instructions. 8.00 If line 36 is yes , was the fiscal year end of the home of			N		38.0			
the provider? If yes, enter in column 2 the fiscal year end 9.00 If line 36 is yes, did the provider render services to othe			Y		39. 0			
see instructions. 0.00 [f line 36 is yes, did the provider render services to the	home office?	lf yes, see	N		40.0			
instructions.								
Cast Depart Droparar Contact Information	1.	00	2.	00				
 Cost Report Preparer Contact Information 1.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, 	RHONDA		UTTER		41.0			
respectively. 2.00 Enter the employer/company name of the cost report	INDIANA UNIVER	SITY HEALTH			42.0			
preparer. 3.00 Enter the telephone number and email address of the cost	317-962-1093	·	RUTTER@I UHEALT	H. ORG	43.0			
report preparer in columns 1 and 2, respectively.								

Heal th	Financial Systems IU	HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2552-10		
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	INAI RE	Provi der		Period: From 03/01/2018 To 12/31/2018			
					10 12/31/2018	5/24/2019 10:	13 am	
			3	3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/pos	ition	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 repor	t					42.00	
	preparer.							
43.00	Enter the telephone number and email address of t	he cost					43.00	
	report preparer in columns 1 and 2, respectively.							

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IU HEALTH JAY	Provider C	^N· 15_1320	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC		TTOWIGET CO	SN. 13-1320	From 03/01/2018 To 12/31/2018	Part I	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	25	7, 6	50 39, 096. 00	0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		25	7, 6	50 39, 096. 00	0	6. 00 7. 00
8.00 9.00 10.00 11.00 12.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						8.00 9.00 10.00 11.00 12.00
13.00 14.00 15.00	NURSERY Total (see instructions) CAH visits	43.00	25	7, 6	50 39, 096. 00	0	13.00
16. 00 17. 00 18. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF SUBPROVI DER	40. 00	10	3, 0	50	0	16.00 17.00 18.00
19.00 20.00 21.00 22.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY						20.00 21.00 22.00
23.00 24.00 24.10 25.00	AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30. 00					23.00 24.00 24.10 25.00
26.00 26.25 27.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	89.00	35			0	26.00
28.00 29.00 30.00 31.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF					0	28.00 29.00 30.00 31.00
32.00 32.01 33.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days		0		0		32.00 32.01 33.00
	LTCH site neutral days and discharges						33.0

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	N: 15-1320		i od: m 03/01/2018 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/24/2019 10:	pared:
		I/P Days	/ O/P Visits	/ Trips		Full Time E		
	Component	Title XVIII	Title XIX	Total All Patients		otal Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00		9.00	10.00	
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 13. 00 14. 00 15. 00 14. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 26. 00 26. 00 27. 00 28. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	905 0 405	222 272 313 0 0 0 22 4 26 0 23 23	1, 62 14 1, 87 1, 96 1, 15	46 42 17 44 61 0 58 30 0	0. 00 0. 00 0. 00 0. 00 0. 00	192. 62 12. 41 0. 00 205. 03	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25
29.00 30.00 31.00 32.00 32.01 33.00	Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges	0	0		0 0 0 0			28.00 29.00 30.00 31.00 32.00 32.00 33.00 33.00

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1320	Period: From 03/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 5/24/2019 10:	pared:
		Full Time Equivalents		Di s	charges	0,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	12.00	12.00	14.00	Patients	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 34 9	15.00 630	1.00
2.00 3.00 4.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider				61 110 56 56 0		2.00 3.00 4.00
5.00 6.00 7.00 8.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT						5.00 6.00 7.00 8.00
9.00	CORONARY CARE UNI T						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00 13.00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00 13.00
14.00	Total (see instructions)	0.00	0	2	34 9	630	
15.00	CAH visits	0.00	0	2	,	000	15.00
16.00	SUBPROVIDER - IPF	0.00	0	!	51 5	197	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 23.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22. 0 23. 0
24.00	HOSPICE						23.0
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.2
27.00	Total (sum of lines 14-26)	0.00					27.0
28.00	Observation Bed Days						28.0
29.00	Ambulance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)						32.0
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.0
33.00	LTCH non-covered days				0		33.0
	LTCH site neutral days and discharges				0		33.0

Heal th	Financial Systems IU HEALTH JAY H	OSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	N: 15-1320	Peri od:	Worksheet S-1	0
				From 03/01/2018		
				To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared:
					572472017 10.	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lir	ne 202 columr	18)	0, 411457	1 1.00
	Medicaid (see instructions for each line)			/		
2.00	Net revenue from Medicaid				1, 217, 458	1 2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Ŷ	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemen	tal payments	s from Medica	ai d?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaio	b		0	5.00
6.00	Medi cai d charges				14, 598, 252	6.00
7.00	Medicaid cost (line 1 times line 6)				6, 006, 553	7.00
8.00	Difference between net revenue and costs for Medicaid program	(line 7 minu	us sum of lir	nes 2 and 5; if	4, 789, 095	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions f	or each line	e)			
9.00	Net revenue from stand-alone CHIP				0	
10.00	Stand-alone CHIP charges				0	
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mir	nus line 9; i	f < zero then	0	12.00
	enter zero)					
10.00	Other state or local government indigent care program (see ins					1 4 9 9 9
13.00	Net revenue from state or local indigent care program (Not inc				0	
14.00	Charges for patients covered under state or local indigent car	e program (r	vot included	In Tines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line 1	1)			0	15.00
16.00	Difference between net revenue and costs for state or local in		program (Lir	o 15 minus lino	0	
10.00	13; if < zero then enter zero)	urgent care			0	10.00
	Grants, donations and total unreimbursed cost for Medicaid, CH	IP and state	e/local_indic	ent care program	ns (see	
	instructions for each line)			, pg		
17.00	Private grants, donations, or endowment income restricted to f	unding chari	ty care		0	17.00
18.00	Government grants, appropriations or transfers for support of	hospital ope	erations		0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca	indigent o	care programs	s (sum of lines	4, 789, 095	19.00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
		-	patients	patients	+ col. 2)	
			1.00	2.00	3.00	
20.00	Uncompensated Care (see instructions for each line)		1 050 (/	2 705	1 0(2 200	1 20 00
20.00	Charity care charges and uninsured discounts for the entire fa (see instructions)	CITITY	1, 859, 68	3, 705	1, 863, 389	20.00
21.00	Cost of patients approved for charity care and uninsured disco	unte (soo	765, 18	30 3, 705	768, 885	21.00
21.00	instructions)		705, 10	50 5,705	700,005	21.00
22.00	Payments received from patients for amounts previously written	off as		0 0	0	22.00
22.00	chari ty care	orr us		0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		765, 18	30 3, 705	768, 885	23.00
		1	,			
					1.00	
24.00	Does the amount on line 20 column 2, include charges for patie	nt days beyo	ond a length	of stay limit	Ν	24.00
	imposed on patients covered by Medicaid or other indigent care	program?	-	-		
25.00	If line 24 is yes, enter the charges for patient days beyond t	he indigent	care program	n's length of	0	25.00
	stay limit					
26.00	Total bad debt expense for the entire hospital complex (see in				896, 642	
27.00	Medicare reimbursable bad debts for the entire hospital comple				56, 017	
27.01	Medicare allowable bad debts for the entire hospital complex (see instruct	tions)		86, 179	
28.00	Non-Medicare bad debt expense (see instructions)				810, 463	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see i	nstructions)		363, 633	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 132, 518	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			5, 921, 613	31.00

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	I U HEALTH JAY F EXPENSES	Provi der CC		eri od:	u of Form CMS- Worksheet A	2352-10
					rom 03/01/2018 o 12/31/2018	Date/Time Pre 5/24/2019 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS				1		
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	0			
1.01 1.02	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB		0	0		62, 689 29, 192	1
1.02	00103 CAP REL COSTS-BLDG & FIXT-WJ		0	0			1
1.04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST		0	0		0	
2.00	00200 CAP REL COSTS-MVBLE EQUIP		341, 765	341, 765			
2.01 2.02	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB		0	0	-,	5, 278 0	1
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ		0	0	0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	170, 330	35, 725	206, 055	2, 150, 668	-	
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 932, 493	2, 589, 858	4, 522, 351			
7.00	00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB	231, 227	2, 570, 464	2, 801, 691			1
7.01 7.02	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0	121, 683 50, 989	121, 683 50, 989			
7.02	00703 OPERATION OF PLANT - WJ	0	28, 949	28, 949			
8.00	00800 LAUNDRY & LINEN SERVICE	26, 477	3, 384	29, 861		65, 433	
9.00	00900 HOUSEKEEPI NG	297, 191	213, 260	510, 451		374, 240	
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	322, 746	359, 950 0	682, 696 0			
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 150, 346	285, 884	1, 436, 230			
14.00	01400 CENTRAL SERVICES & SUPPLY	0	25, 576	25, 576			
15.00	01500 PHARMACY	386, 181	1, 293, 934	1, 680, 115			1
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	-	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	1, 384, 644	1, 143, 699	2, 528, 343	-687, 491	1, 840, 852	30.00
40.00	04000 SUBPROVI DER – I PF	755, 803	318, 430	1, 074, 233			
43.00	04300 NURSERY	0	0	0	59, 092	59, 092	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1, 129, 150	2, 293, 132	3, 422, 282	-966, 593	2, 455, 689	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 2, 3, 132	0, 422, 202			
53.00	05300 ANESTHESI OLOGY	О	0	0		0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	631, 522	1, 166, 003	1, 797, 525			
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	0 315, 018	1, 652, 366 164, 860	1, 652, 366 479, 878			
66. 00	06600 PHYSI CAL THERAPY	408, 458	8, 584	417,042			1
67.00	06700 OCCUPATI ONAL THERAPY	74, 718	459	75, 177			
68.00	06800 SPEECH PATHOLOGY	14, 944	0	14, 944		14, 944	
69.00 71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	65, 695 0	65, 695 0		65, 695 238, 297	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	О	0	0	1, 363, 712	1, 363, 712	
76.00	03160 CARDI OPULMONARY	89, 943	214, 379	304, 322	-36, 996	267, 326	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90.00 90.01	09001 FAMILY PRACTICE OF JAY COUNTY	507, 115	603, 905	1, 111, 020	-		
90. 02	09002 JAY FAMILY MEDICINE	665, 653	806, 279	1, 471, 932			1
90.03	09003 WOUND CLINIC	50, 855	10, 816	61, 671	-5, 743		
90.04	09004 OP ORTHO CLINIC	0 219 E42	115, 349	115, 349			
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	318, 543 53, 079	544, 085 8, 299	862, 628 61, 378		695, 724 57, 503	
91.00	09100 EMERGENCY	788, 811	1, 804, 026	2, 592, 837			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 OUTPATIENT PSYCH	30, 195	13, 072	43, 267	5, 221	48, 488	93.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	11, 735, 442	18, 854, 859	30, 590, 301	99, 078	30, 689, 379	118 00
110.00	NONREIMBURSABLE COST CENTERS	11, 730, 442	10, 004, 009	30, 370, 301	77,078	30, 009, 379	
100.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-28	-28	28	0	190.00
190.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	28, 587	28, 587	-7, 860	20, 727	192.00
192.00							
192.00 193.00	19300 NONPAID WORKERS	0	0	0	-		193.00
192.00 193.00 194.00	19300 NONPAID WORKERS 07950 OTHER NONREIMBURSABLE COST CENTERS	0 0 235 530	0	0	0	0	194.00
192.00 193.00 194.00 194.02	19300 NONPAID WORKERS	0 0 235, 530 146, 242	0 0 435, 817 192, 434		0 -63, 571	0 607, 776	194. 00 194. 02

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IU HEALTH JA	Y HOSPITAL Provider CCN:	15 1220	Period:	u of Form CMS-2 Worksheet A	2552-10
RECEAS	STITCATION AND ADJUSTMENTS OF TRIAL DALANCE U	I LAFLINGLO	FIOVIDEI CON.	15-1520	From 03/01/2018 To 12/31/2018	Date/Time Pre	pared:
	Cost Center Description	Adjustments	Net Expenses			5/24/2019 10:	
	cost center bescription		For Allocation				
		6.00	7.00				
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	-267, 350	716, 974				1.00
1.00	00101 CAP REL COSTS-BLDG & FIXT-MOB	-62, 689	0				1.00
1.02	00102 CAP REL COSTS-BLDG & FIXT-POB	-29, 192	o				1.02
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ	-20, 127	0				1.03
1.04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0				1.04
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-710, 590	1, 306, 125				2.00
2.01 2.02	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB	14, 726 0	20, 004 0				2.01
2.02	00203 CAP REL COSTS-MVBLE EQUIP - WJ	0	0				2.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-94, 532	2, 262, 191				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	6, 343, 358	10, 701, 094				5.00
7.00	00700 OPERATION OF PLANT	91, 397	1, 669, 206				7.00
7.01	00701 OPERATION OF PLANT - MOB	0	56, 043				7.01
7.02 7.03	00702 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ	-19,028	7, 606				7.02
7.03 8.00	00800 LAUNDRY & LINEN SERVICE	-17, 157 0	65, 433				8.00
9.00	00900 HOUSEKEEPING	0	374, 240				9.00
10.00	01000 DI ETARY	0	192, 084				10.00
	01100 CAFETERI A	-130, 919	225, 381				11.00
	01300 NURSI NG ADMI NI STRATI ON	463, 261	1, 707, 937				13.00
	01400 CENTRAL SERVICES & SUPPLY	-785	492, 436				14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	248, 217 0	811, 050 0				15.00
	01700 SOCIAL SERVICE	0	0				17.00
	INPATIENT ROUTINE SERVICE COST CENTERS		-1				1
30.00	03000 ADULTS & PEDI ATRI CS	-412, 002	1, 428, 850				30.00
40.00	04000 SUBPROVIDER - IPF	-97, 160	803, 729				40.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	59, 092				43.00
50.00	05000 OPERATI NG ROOM	-1, 207, 122	1, 248, 567				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	20, 744				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	139, 462	1, 037, 684				54.00
60.00		0	1, 585, 758				60.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	26, 083 30, 623	386, 463 443, 687				65.00 66.00
	06700 OCCUPATI ONAL THERAPY	30, 023	74, 718				67.00
	06800 SPEECH PATHOLOGY	0	14, 944				68.00
69.00	06900 ELECTROCARDI OLOGY	0	65, 695				69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	238, 297				71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	38, 540				72.00
	03160 CARDI OPULMONARY	-168, 025	1, 363, 712 99, 301				73.00
70.00	OUTPATIENT SERVICE COST CENTERS	100,020	77,001				/ 0. 00
	09000 CLI NI C	0	0				90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	-251, 150	552, 527				90.01
	09002 JAY FAMILY MEDICINE	-472, 748	723, 998				90.02
	09003 WOUND CLINIC 09004 OP ORTHO CLINIC	0 115 246	55, 928 0				90.03
	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	-115, 246 -348, 239	347, 485				90.04
	09006 INFUSION CLINIC	0,239 0	57, 503				90.05
	09100 EMERGENCY	-1, 212, 743	1, 106, 188				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 OUTPATIENT PSYCH	0	48, 488				93.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	1, 720, 323	32, 409, 702				118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0	20, 727				192.00
	19300 NONPAID WORKERS 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				193.00 194.00
10/ 00	UT750 UTTER NUNRET MOURSADLE GUST GENTERS	0	U				
		0	607.776				194.02
194.02	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE	0	607, 776 311, 001				194. 02 194. 03

	Financial Systems		IU HEALTH J		CN: 15-1320 P		eu of Form CMS	
RECLAS.	STELEATIONS			Provider C	F	eriod: rom 03/01/2018 o 12/31/2018	3 Date/Time Pr	epared:
		Increases					5/24/2019 10): 13 am
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00				
	A – CAFETERIA							
1.00	CAFETERI A	<u>11.00</u>	<u>209, 6</u> 97 209, 697	<u>146, 603</u> 146, 603				1.00
	B - DRUGS RECLASS		L					
1.00 2.00	PHARMACY DRUGS CHARGED TO PATIENTS	15.00 73.00	0 0	29, 665 1, 363, 712				1.00
3.00	DRUGS CHARGED TO TATTENTS	0.00	0	1, 303, 712				3.00
4.00 5.00		0.00 0.00	0 0	0				4.00
6.00		0.00	0	0				6.00
7.00		0.00	0	0				7.00
8.00 9.00		0.00 0.00	0 0	0				8.00 9.00
10.00		0.00	0	0				10.00
11. 00 12. 00		0.00 0.00	0	0				11.00
13.00		0.00	0	0				13.00
14.00 15.00		0.00 0.00	0	0				14.00 15.00
16.00		0.00	0	0				16.00
17.00		0.00 0.00	0	0				17.00 18.00
18.00	<u> </u>	0.00	0	1, 393, 377				18.00
1 00	C - SUPPLIES/IMPLANTS CENTRAL SERVICES & SUPPLY	14.00	0	449 407				1 00
1.00 2.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	468, 697 238, 297				1.00
3.00	PATIENTS IMPL. DEV. CHARGED TO	72.00	0	38, 540				3.00
4.00	PATIENTS GIFT, FLOWER, COFFEE SHOP &	190.00	0	28				4.00
5.00	CANTEEN JAY MERI DI AN URGENT CARE	194.03	о	20				5.00
6.00 7.00		0.00 0.00	0	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				9.00
11.00		0.00	0	0				11.00
12.00		0.00	0 0	0				12.00
13.00 14.00		0.00 0.00	0	0				13.00 14.00
15.00		0.00	0	0				15.00
16.00 17.00		0.00 0.00	0 0	0				16.00 17.00
18.00		0.00	0	0				18.00
19. 00 20. 00		0.00 0.00	0	0				19.00 20.00
21.00		0.00	0	0				21.00
22.00 23.00		0.00 0.00	0	0				22.00 23.00
24.00		0.00	Ō	0				24.00
25.00	<u> </u>		0	00 745, 582				25.00
4 00	D - LAUNDRY	0.00						1
1.00 2.00	LAUNDRY & LINEN SERVICE	8.00 0.00	0 0	36, 727 0				1.00
3.00		0.00	0	0				3.00
4.00	<u> </u>		0					4.00
1 00	E - DEPRECIATION	4 00						1 00
1.00 2.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG &	1.00 1.01	0 0	960, 104 62, 689				1.00 2.00
3.00	FI XT-MOB CAP REL COSTS-BLDG & FI XT-POB	1.02	0	29, 192				3.00
4.00	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	20, 127				4.00
5.00 6.00	CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP -	2.00 2.01	0 0	1, 674, 950 5, 278				5.00 6.00
7.00	MOB	0.00	0	0				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
10.00		0.00	0	0				11.00

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

 Provider CCN: 15-1320
 Period: From 03/01/2018
 Worksheet A-6

RECEAS.					SN. 13 1320	From 03/01/2018 To 12/31/2018	Date/Time Pro	epared:
		Increases						
	Cost Center	Line #	Salary	Other				
12.00	2. 00	3.00	4.00	5.00				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0				16.00
17. 00 18. 00		0.00 0.00	0	0				17.00 18.00
19.00		0.00	0	0				19.00
20.00		0.00	0	0				20.00
21.00		0.00	0	0				21.00
22. 00 23. 00		0.00 0.00	0	0				22.00 23.00
23.00	b — — — — — — — — — — — — — — — — — — —	0.00	o	2, 752, 340				23.00
	F - PROPERTY TAXES							1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2, 702				1.00
2.00	<u> </u>		<u>0</u>	0/2,702				2.00
	G - PROPERTY INSURANCE		U	2,702				1
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	21, 518				1.00
			0	21, 518				
1.00	H - HOUSEKEEPI NG SUPPLI ES HOUSEKEEPI NG	9.00	0	4, 362				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10. 00 11. 00		0.00 0.00	0	0				10.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
	0		0	4, 362				
1.00	I - MAINTENANCE SALARIES OPERATION OF PLANT - MOB	7.01	2, 327	0				1.00
2.00	OPERATION OF PLANT - POB	7.02	4, 837	0				2.00
3.00	OPERATION OF PLANT - WJ	7.03	475	0				3.00
			7, 639	0				
1.00	J - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	2, 170, 609				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00		0.00 0.00	0	0				4.00
5.00 6.00		0.00	0	0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10. 00 11. 00		0.00 0.00	0	0				10.00 11.00
12.00		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14.00		0.00	0	0				14.00
15. 00 16. 00		0.00 0.00	0	0				15.00 16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20. 00 21. 00		0.00 0.00	0	0				20.00 21.00
21.00		0.00	0	0				21.00
	0		0	2, 170, 609				
1 00	K - NURSERY AND LABOR AND DEL		E4 (00	4 400				1 00
1.00 2.00	NURSERY DELIVERY ROOM & LABOR ROOM	43.00 52.00	54, 609 19, 170	4, 483 1, 574				1.00 2.00
2.00	TOTALS		73, 779	6, 057				2.00
	L - PSYCH							
1.00	OUTPATIENT PSYCH		<u>12, 752</u> 12, 752	_ <u>2, 709</u> 2, 709				1.00
500.00	Grand Total: Increases		303, 867	7, 282, 586				500.00
		. 1						•

Decreases Mkst. A-7 Ref Cost Center Line # Sal ary Other Wkst. A-7 Ref 6.00 7.00 8.00 9.00 10.00 A - CAFETERIA 10.00 209,697 146,603	5/24/2019 10: 13 am
6.00 7.00 8.00 9.00 10.00 A - CAFETERIA	<u>.</u>
A – CAFETERI A	
1. 00 DI ETARY 10. 00 209, 697 146, 603	0 1.00
0 209, 697 146, 603	
B - DRUGS RECLASS	
1. 00 PHARMACY 15. 00 0 1, 032, 531 2. 00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 19, 927	0 1.00 0 2.00
	0 2.00 0 3.00
	0 4.00
5.00 CENTRAL SERVICES & SUPPLY 14.00 0 152	0 5.00
	0 6.00
7. 00 SUBPROVIDER - IPF 40. 00 0 11	0 7.00
8. 00 OPERATI NG ROOM 50. 00 17, 027 9. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 29, 719	0 8.00 0 9.00
10.00 [RESPI RATORY THERAPY 65.00] 0 154	0 10.00
11.00 CARDI OPULMONARY 76.00 0 2,052	0 11.00
12. 00 FAMILY PRACTICE OF JAY 90. 01 0 133, 146	0 12.00
13. 00 JAY FAMILY MEDICINE 90. 02 0 75, 228 14. 00 WOUND CLINIC 90. 03 0 283	0 13.00 0 14.00
15.00 (PP ORTHO CLINIC 90.04 0 55	0 15.00
16.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 63, 863	0 16.00
	0 17.00
18. 00 $EMERGENCY$ 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 1. 393. 377 91. 00	0 18.00
0 0 1, 393, 377 C - SUPPLI ES/I MPLANTS	
	0 1.00
	0 2.00
	0 3.00
	0 4.00
5. 00 DI ETARY 10. 00 0 1, 454	0 5.00 0 6.00
6.00 NURSI NG ADMI NI STRATI ON 13.00 0 285 7.00 PHARMACY 15.00 0 3, 693	0 6.00 0 7.00
	0 8.00
9.00 SUBPROVIDER - I PF 40.00 0 4, 159	0 9.00
10. 00 OPERATING ROOM 50. 00 396, 959	0 10.00
11. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 73, 834	0 11.00
12. 00 LABORATORY 60. 00 0 370 13. 00 RESPI RATORY THERAPY 65. 00 0 13, 864	0 12.00 0 13.00
14. 00 PHYSI CAL THERAPY 66. 00 0 2, 706	0 14.00
15.00 OCCUPATIONAL THERAPY 67.00 0 459	0 15.00
	0 16.00
	0 17.00
COUNTY 18.00 JAY FAMILY MEDICINE 90.02 0 11, 550	0 18.00
19.00 WOUND CLINIC 90.03 0 2,341	0 19.00
	0 20.00
	0 21.00
	0 22.00
	0 23.00 0 24.00
25. 00 WEST JAY CLINIC 194. 02 0 931	0 25.00
D - LAUNDRY	
	0 1.00
	0 2.00 0 3.00
	0 3.00 4.00
E - DEPRECIATION	
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 69, 817	9 9 2.00
2. 00 OPERATI ON OF PLANT 7. 00 0 1, 136, 840 3. 00 OPERATI ON OF PLANT - MOB 7. 01 0 67, 967	9 2.00 9 3.00
4.00 OPERATION OF PLANT - MOB 7.01 0 87,967 4.00 OPERATION OF PLANT - POB 7.02 0 29,192	9 9 9 4.00
5. 00 OPERATION OF PLANT - WJ 7. 03 0 12, 267	9 5.00
6.00 HOUSEKEEPING 9.00 0 105	9 6.00
7. 00 DI ETARY 10. 00 9, 883	0 7.00
8.00 NURSING ADMINI STRATION 13.00 0 810	0 8.00
9.00 CENTRAL SERVICES & SUPPLY 14.00 0 900 10.00 PHARMACY 15.00 0 46,470	0 9.00 0 10.00
11. 00 ADULTS & PEDIATRICS 30. 00 0 202, 526	0 11.00
12. 00 SUBPROVI DER - I PF 40. 00 0 12, 534	0 12.00
	0 13.00
	0 14.00
15. 00 LABORATORY 60. 00 0 66, 238	0 15.00

Health Financial Systems RECLASSIFICATIONS

IU HEALTH JAY HOSPITAL

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10 Worksheet A-6 Peri od: Wo From 03/01/2018

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

IU HEALTI

IU HEALTH JA				u of Form CMS-	
	Provider (Peri od:	Worksheet A-6	•
			From 03/01/2018 To 12/31/2018	Date/Time Pre	narod
			10 12/31/2010	5/24/2019 10:	13 am
				0/21/2017 10.	
Salary	Other	Wkst. A-7 Ref.			
8.00	9,00	10.00	-		
0	36, 855		D C		16.00
0	1, 179				17.00
0	19,039				18.00
0	1, 028				19.00
0	297				20.00
o	75,008				21.00
0	6, 477				22.00
0	7, 860				23.00
· 0	2, 752, 340				23.00
U	2, 752, 540				
0	396	1;	3		1.00
0	2, 306	(b		2.00
o	2,702		1		
	· ·				
0	21, 518	1:	2		1.00
0 0	21, 518		1		
	· · ·				
0	26	(D		1.00
0	1, 937				2.00
0	537				3.00
0	171	(4.00
0	285				5.00
0	301				6,00
0	137				7.00
o	93				8.00
0	50				0.00 0.00

						10 12/31/2018	B Date/Time Prepar 5/24/2019 10:13
	Cost Costos	Decreases	Calarra	Oth			
	Cost Center	Li ne # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00	-	
16.00	6.00 RESPIRATORY THERAPY	65.00	8.00	<u> </u>)	1
	PHYSICAL THERAPY	66.00	0	1, 179			1
	CARDI OPULMONARY		0				
		76.00	0	19,039			1
		90.03	0	1, 028			1
	INFUSION CLINIC	90.06	0	297	0		2
	EMERGENCY	91.00	0	75, 008	(2
	OUTPATIENT PSYCH	93.00	0	6, 477	(ו	2
23.00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0_	7,860		2	2
	0		0	2, 752, 340			
	F - PROPERTY TAXES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	396	1:	3	
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	2, 306	(
	0			2,702		1	
	G - PROPERTY INSURANCE						
	ADMI NI STRATI VE & GENERAL	5.00	0	21, 518	1:	2	
			ŏ	21, 518		7	
	H - HOUSEKEEPING SUPPLIES		<u> </u>	21, 510			
	OPERATION OF PLANT	7.00	0	26	· · · · · · · · · · · · · · · · · · ·		
	DI ETARY		0				
		10.00	0	1, 937			
	ADULTS & PEDIATRICS	30.00	0	537			
	SUBPROVIDER - IPF	40.00	0	171	(
	OPERATING ROOM	50.00	0	285	(ין	
	RADI OLOGY-DI AGNOSTI C	54.00	0	301	(וכ	
	RESPI RATORY THERAPY	65.00	0	137	(ומ	
3.00	PHYSICAL THERAPY	66.00	0	93	()	
9.00	CARDI OPULMONARY	76.00	o	50	(
	FAMILY PRACTICE OF JAY	90.01	0	327		b	1
	COUNTY		-				
	JAY FAMILY MEDICINE	90. 02	0	203	(1
	JAY FAMILY FIRST HEALTH CARE	90.05	0	189			1
	EMERGENCY	91.00	0	106			1
13.00			0	4, 362			'
l			<u> </u>	4, 302			
1 00	I - MAINTENANCE SALARIES	7 00	7 (00				
	OPERATION OF PLANT	7.00	7, 639	0			
2.00		0.00	0	0	0		
3.00		0.00	0_	0		2	
	0		7, 639	0			
1	J - EMPLOYEE BENEFITS				1	1	
	ADMI NI STRATI VE & GENERAL	5.00	0	72, 847		ן	
	OPERATION OF PLANT	7.00	0	52, 942		ן ע	
3.00	LAUNDRY & LINEN SERVICE	8.00	0	1, 155	(D	
4.00	HOUSEKEEPI NG	9.00	0	104, 766	(
5.00	DI ETARY	10.00	0	120, 154	(
6.00	NURSING ADMINISTRATION	13.00	o	190, 459	(
7.00	PHARMACY	15.00	o	64, 253	(b	
	ADULTS & PEDIATRICS	30.00	0	290, 680	l i	bl	
	SUBPROVIDER - IPF	40.00	0	141,008			
	OPERATI NG ROOM	50.00		268, 308			1
	RADI OLOGY-DI AGNOSTI C	54.00	0	122, 242			1
			U			1	
		65.00	0	68, 488			1
		76.00	0	13, 322			1
	FAMILY PRACTICE OF JAY	90.01	0	152, 189	(ע	1
	COUNTY						
15.00	JAY FAMILY MEDICINE	90. 02	0	188, 205	(1
16.00	WOUND CLINIC	90.03	О	2, 091	(0	1
17.00	JAY FAMILY FIRST HEALTH CARE	90.05	o	88, 820	(1
	INFUSION CLINIC	90.06	o	2, 136		b	1
	EMERGENCY	91.00	0	132, 447	l i	bl	1
	OUTPATIENT PSYCH	93.00	0	3, 762			2
	WEST JAY CLINIC	194.02		62, 640			2
			0			ζ.	
22.00	JAY MERI DI AN URGENT CARE	<u> </u>		27,695		4	2
ł			0	2, 170, 609	l	I	
	K - NURSERY AND LABOR AND DEL			1 055			
	ADULTS & PEDIATRICS	30.00	73, 779	6, 057			
2.00			0	0		2	
ļ	TOTALS		73, 779	6, 057			
	L - PSYCH						
	SUBPROVI DER – I PF	40.00	12, 752	2, 709		2	
					1	1	
	TOTALS Grand Total: Decreases		12, 752 303, 867	2, 709 7, 282, 586			50

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		iod: m 03/01/2018 12/31/2018		pared:
			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 ASS	ET BALANCES		_				
1.00 Land	0	1, 006, 948		0	1, 006, 948	0	1.00
2.00 Land Improvements	0	0		0	0	0	2.00
3.00 Buildings and Fixtures	0	19, 125, 052		0	19, 125, 052	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	0	8, 736, 480		0	8, 736, 480	762, 425	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	0	28, 868, 480		0	28, 868, 480	762, 425	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	0	28, 868, 480		0	28, 868, 480	762, 425	10.00
	Endi ng Bal ance						
	Ű	Depreciated					
		Assets					
	6.00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL ASS	ET BALANCES						
1.00 Land	1, 006, 948	0					1.00
2.00 Land Improvements	0	0					2.00
3.00 Buildings and Fixtures	19, 125, 052	0					3.00
4.00 Building Improvements	0	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	7, 974, 055	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	28, 106, 055	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	28, 106, 055	0					10.00
							<u>-</u> '

PECONCILIATION OF CAPITAL COSTS CENTERS Provider CON: 15-1320 Period: From 30/01/2018 Period: Part II Worksheet A-7 Part II Cost Center Description Depreciation Lease Interest Instructions) Instructions) 1.00 CAP REL COSTS-BLDG & FIXT-NOB 0 <th>Heal th</th> <th>Financial Systems</th> <th>IU HEALTH JA</th> <th>Y HOSPI TAL</th> <th></th> <th>I</th> <th>n Lieu of</th> <th>Form CMS-2</th> <th>552-10</th>	Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		I	n Lieu of	Form CMS-2	552-10	
Cost Center Description Depreciation Lease Interest Insurance (see instructions) Taxes (see instructions) 9.00 10.00 11.00 12.00 13.00 1.00 CAP REL COSTS-BLDG & FIXT 0<	RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1320	From 03/01.	/2018 Part /2018 Date	t II e/Time Prep		
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 instructions) instructions) 1.00 CAP REL COSTS-BLDG & FIXT 0 0 0 0 0 0 0 0 0 0 0 1.00 1.01 CAP REL COSTS-BLDG & FIXT-M0B 0				SL	JMMARY OF CAF	PITAL				
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0		Cost Center Description	Depreciation	Lease	Interest					
1.00 CAP REL COSTS-BLOG & FIXT 0 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>12.00</td><td>)</td><td>13.00</td><td></td></td<>						12.00)	13.00		
1.01 CAP REL COSTS-BLDG & FLXT-MOB 0 0 0 0 1.01 1.02 CAP REL COSTS-BLDG & FLXT-POB 0 0 0 0 1.03 1.03 CAP REL COSTS-BLDG & FLXT-WJ 0 0 0 0 1.03 1.04 CAP REL COSTS-BLDG & FLXT-INTEREST 0 0 0 0 0 1.04 2.00 CAP REL COSTS-WUBLE EQUIP 341,765 0 0 0 0 2.00 2.01 CAP REL COSTS-MWBLE EQUIP - MOB 0 0 0 0 0 0 2.02 2.02 CAP REL COSTS-MWBLE EQUIP - WJ 0 0 0 0 0 0 2.02 2.03 CAP REL COSTS-MWBLE EQUIP - WJ 0 0 0 0 0 0 2.03 3.00 Total (Sum of Lines 1-2) 341,765 0 0 0 0 0 0 3.00 1.00 CAP REL COSTS-BLDG & FLXT 0 0 14.00 15.00 1 1 1 1 1 1 1 1			KSHEET A, COLUM	N 2, LINES 1 a	nd 2					
1.02 CAP REL COSTS-BLDG & FIXT-POB 0 0 0 0 0 0 0 0 1.02 1.03 CAP REL COSTS-BLDG & FIXT-WJ 0 0 0 0 0 0 0 0 0 1.03 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td></td>			0	0		0	0	0		
1.03 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 0 0 1.03 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 0 0 0 1.04 2.00 CAP REL COSTS-WBLE EQUIP 341,765 0 0 0 0 0 2.00 2.01 CAP REL COSTS-WBLE EQUIP - MOB 0 0 0 0 0 0 2.01 2.02 CAP REL COSTS-WBLE EQUIP - POB 0 0 0 0 0 2.02 2.03 CAP REL COSTS-WBLE EQUIP - WJ 0 0 0 0 0 2.02 3.00 Total (sum of lines 1-2) 341,765 0 0 0 3.00 SUMMARY OF CAPITAL Cost Center Description Other Total (1) (sum of cols. 9 1through 14) 1.00 1.01 CAP REL COSTS-BLDG & FIXT 0 0 0 1.00 1.01 CAP REL COSTS-BLDG & FIXT-MOB 0 0 1.02 1.02 1.02 CAP REL COSTS-BLDG & FIXT-POB 0 0 1.03 1.02 <			0	0		0	0	-		
1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0			0	0		0	0	°		
2.00 CAP REL COSTS-MVBLE EQUIP 341,765 0 0 0 0 2.00 2.01 CAP REL COSTS-MVBLE EQUIP - MOB 0			0	0		0	0	-		
2.01 CAP REL COSTS-MVBLE EQUIP - MOB 0			0	0		0	0	-		
2.02 CAP REL COSTS-MVBLE EQUIP - POB 0			341, 765	0		0	0	-		
2.03 CAP REL COSTS-MVBLE EQUIP - WJ 0			0	0		0	0			
3.00 Total (sum of lines 1-2) 341,765 0 0 0 0 3.00 SUMMARY OF CAPITAL Cost Center Description 0			0	0		0	0			
SUMMARY OF CAPITAL Other Description Other Total (1) (sum Capital -Relate of cols. 9 through 14) Interview of cols. 9 through 14) ART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT O O 1.00 CAP REL COSTS-BLDG & FIXT O O O 1.00 CAP REL COSTS-BLDG & FIXT-MOB O <th colspa<="" td=""><td></td><td></td><td>241 745</td><td>0</td><td></td><td>0</td><td>0</td><td></td><td></td></th>	<td></td> <td></td> <td>241 745</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td>			241 745	0		0	0		
Cost Center Description Other Total (1) (sum of cols. 9 d Costs (see instructions) PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 0 0 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 1.00 CAP REL COSTS-BLDG & FIXT-MOB 0 0 1.00 1.00 1.00 1.00 1.00 1.02 CAP REL COSTS-BLDG & FIXT-MOB 0 0 1.00 1.02 1.02 1.03 1.04 1.03 1.04 1.03 1.04 1.03 1.04 0 0 1.03 1.04 1.03 2.04 1.04 1.03 1.04 1.03 1.04 2.00 2.00	3.00	Total (sum of Times 1-2)				0	U	0	3.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 1.00 1.01 CAP REL COSTS-BLDG & FIXT 0 0 1.01 1.01 1.02 CAP REL COSTS-BLDG & FIXT-MOB 0 0 1.01 1.02 1.03 CAP REL COSTS-BLDG & FIXT-WJ 0 0 1.02 1.03 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 1.04 1.04 2.00 CAP REL COSTS-MVBLE EQUIP 0 341,765 2.00 2.00 2.02 CAP REL COSTS-MVBLE EQUIP - MOB 0 0 2.02 2.03 CAP REL COSTS-MVBLE EQUIP - WJ 0 0 2.03			SUMMARY U	FCAPITAL						
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 0 14.00 15.00 1.00 CAP REL COSTS-BLDG & FIXT 0 0 1.00 1.00 1.01 CAP REL COSTS-BLDG & FIXT 0 0 1.01 1.01 1.02 CAP REL COSTS-BLDG & FIXT-MOB 0 0 1.01 1.02 1.03 CAP REL COSTS-BLDG & FIXT-WJ 0 0 1.02 1.03 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 1.04 1.04 2.00 CAP REL COSTS-MVBLE EQUIP 0 341,765 2.00 2.00 2.02 CAP REL COSTS-MVBLE EQUIP - MOB 0 0 2.02 2.03 CAP REL COSTS-MVBLE EQUIP - WJ 0 0 2.03		Cost Center Description	Other	Total (1) (sum	-					
d Costs (see instructions) through 14) 14.00 15.00 14.00 15.00 100 CAP REL COSTS-BLDG & FLXT 0 0 1.00 CAP REL COSTS-BLDG & FLXT 0 0 1.01 CAP REL COSTS-BLDG & FLXT 0 0 1.02 CAP REL COSTS-BLDG & FLXT-MOB 0 0 1.03 CAP REL COSTS-BLDG & FLXT-WJ 0 0 1.04 CAP REL COSTS-BLDG & FLXT-WJ 0 0 1.04 CAP REL COSTS-MVBLE EQUIP 0 0 1.04 CAP REL COSTS-MVBLE EQUIP - MOB 0 0 2.00 CAP REL COSTS-MVBLE EQUIP - MOB 0 0 2.02 CAP REL COSTS-MVBLE EQUIP - POB 0 0 2.03 CAP REL COSTS-MVBLE EQUIP - WJ		Cost conter beschiption								
instructions) instructions) 14.00 15.00 PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUNN 2, LINES 1 and 2 1.00 1.00 1.00 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-MOB 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 - MOB 0 0 2.00 2.01 CAP REL COSTS-MVBLE EQUIP P - POB 0 0 2.02 2.03 CAP REL COSTS-MVBLE EQUIP P - WJ 0 0 2.03										
PART 11 - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 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-POB 0 0 1.02 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 1.04 2.00 CAP REL COSTS-MVBLE EQUIP 0 341,765 2.01 2.02 CAP REL COSTS-MVBLE EQUIP - MOB 0 0 2.01 2.02 CAP REL COSTS-MVBLE EQUIP - POB 0 0 2.02				J J J J						
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 1.02 1.04 CAP REL COSTS-BLDG & FIXT-WJ 0 0 1.03 1.04 CAP REL COSTS-MUBLE EQUIP 0 341,765 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			14.00	15.00	1					
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 0 341,765 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		PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2					
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 0 341,765 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	1.00		0	0					1.00	
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 0 341,765 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			0	0						
1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 1.04 2.00 CAP REL COSTS-MVBLE EQUIP 0 341,765 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			0	0						
2. 00 CAP REL COSTS-MVBLE EQUIP 0 341,765 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			0	0						
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			0	0						
2. 02 CAP REL COSTS-MVBLE EQUIP - POB 0 0 2.02 2. 03 CAP REL COSTS-MVBLE EQUIP - WJ 0 0 2.03			0	341, 765						
2. 03 CAP REL COSTS-MVBLE EQUIP - WJ 0 0 2. 03			0	0						
			0	0						
3. UU TOTAL (SUM OT LINES 1-2) U 341,765 3. 00			0							
	3.00	liotai (sum of lines 1-2)	0	341, 765	1			I	3.00	

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 03/01/2018 To 12/31/2018		bared:
		COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPI TAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
4 9 9	PART III - RECONCILIATION OF CAPITAL COSTS CE			00.40/.05			
1.00 1.01 1.02	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB	28, 106, 055 0 0	0	,,	0 0. 000000 0 0. 000000	0	1.00 1.01 1.02
1.03 1.04 2.00	CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP	0	0 0 0		0 0.00000 0 0.00000 0 0.000000	0	1.03 1.04 2.00
2. 01 2. 02 2. 03	CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ	0	0 0 0		0 0.00000 0 0.00000 0 0.00000	0 0	2. 01 2. 02 2. 03
3.00	Total (sum of lines 1-2)	28, 106, 055	TION OF OTHER (3.00
		ALLUCA	ITON OF OTHER O	JAPITAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other Capital-Relate		Depreciation	Lease	
		6.00	d Costs 7.00	through 7) 8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 1.01 1.02	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB	000000000000000000000000000000000000000	C C		0 692, 754 0 0 0 0	0	1.00 1.01 1.02
1.03 1.04 2.00 2.01	CAP REL COSTS-BLDG & FIXT-WJ CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB	0			0 0 0 0 0 1, 306, 125 0 20, 004	0 0 0	1.03 1.04 2.00 2.01
2.02 2.03 3.00	CAP REL COSTS-MVBLE EQUIP - POB CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0	0		0 0 0 0 2, 018, 883	0	2.02 2.03 3.00
			SI	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (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 CE		1	1			
1.00 1.01 1.02 1.03	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB CAP REL COSTS-BLDG & FIXT-WJ	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	CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP CAP REL COSTS-MVBLE EQUIP - MOB CAP REL COSTS-MVBLE EQUIP - POB	0 0 0			0 0 0 0 0 0 0 0	0 1, 306, 125 20, 004 0	1. 04 2. 00 2. 01 2. 02
2.03 3.00	CAP REL COSTS-MVBLE EQUIP - WJ Total (sum of lines 1-2)	0	0 21, 518		0 0 2 0		2.03 3.00

DJUST	MENTS TO EXPENSES				Period: From 03/01/2018	Worksheet A-8	
					o 12/31/2018	Date/Time Prep 5/24/2019 10:	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
00	Investment income CAD DEL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00 9	1
00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-43,864	CAP REL CUSIS-BEDG & FIXI	1.00	9	1.
01	Investment income - CAP REL COSTS-BLDG & FIXT-MOB (chapter 2)		C	CAP REL COSTS-BLDG & FIXT-MOB	1.01	0	1.
02	Investment income - CAP REL COSTS-BLDG & FIXT-POB (chapter		C	CAP REL COSTS-BLDG & FIXT-POB	1.02	0	1.
03	2) Investment income - CAP REL COSTS-BLDG & FIXT-WJ (chapter		C	CAP REL COSTS-BLDG & FIXT-WJ	1.03	0	1.
04	2) Investment income - CAP REL COSTS-BLDG & FIXT-INTEREST		C	CAP_REL_COSTS-BLDG_& FLXT-LNTEREST	1.04	0	1.
00	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
01	Investment income - CAP REL COSTS-MVBLE EQUIP - MOB (chapter 2)		C	CAP REL COSTS-MVBLE EQUIP - MOB	2.01	0	2.
02	Investment income - CAP REL COSTS-MVBLE EQUIP - POB		C	CAP REL COSTS-MVBLE EQUIP - POB	2.02	0	2.
03	(chapter 2) Investment income - CAP REL COSTS-MVBLE EQUIP - WJ		C	CAP REL COSTS-MVBLE EQUIP - WJ	2.03	0	2.
00	(chapter 2) Investment income - other (chapter 2)		C		0.00	0	3.
00	Trade, quantity, and time		C		0.00	0	4.
00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.
00	expenses (chapter 8) Rental of provider space by		(0.00	0	6.
00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C		0.00	О	7.
00	21) Television and radio service (chapter 21)		C		0.00	0	8.
00	Parking lot (chapter 21)		C		0.00	0	9.
. 00	Provider-based physician adjustment	A-8-2	-3, 262, 235			0	10.
. 00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11.
2. 00	Related organization transactions (chapter 10)	A-8-1	12, 538, 853	3		0	
8.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	-130, 919	CAFETERI A	0.00 11.00		
. 00	Rental of quarters to employee and others		C		0.00		
. 00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16.
. 00	Sale of drugs to other than patients		(0.00	0	17.
. 00	Sale of medical records and abstracts		C		0.00	0	18.
. 00	Nursing and allied health education (tuition, fees, books, etc.)		C		0.00	0	19.
. 00	Vending machines		C		0.00		
. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21.
2. 00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		C		0.00	0	22.
8. 00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	C	RESPI RATORY THERAPY	65.00		23.

Heal th Financi	al Systems
ADJUSTMENTS T	0 EXPENSES

4030211	MENTS TO EXPENSES			Provider CCN: 15-1320	Period: From 03/01/2018	Worksheet A-8	
					To 12/31/2018	Date/Time Prep 5/24/2019 10:	
				Expense Classification of	on Worksheet A	372472017 10.	15 am
			Т	o/From Which the Amount i			
					,		
	Cost Contor Description	Dania (Cada (2)	Amount	Cost Costor	Line #	Wkst. A-7 Ref.	
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	4.00	5.00	
24 00	Adjustment for physical	A-8-3		HYSICAL THERAPY	66.00	5.00	24. C
1.00	therapy costs in excess of				00.00		21.0
	limitation (chapter 14)						
25.00	Utilization review -		0 *	** Cost Center Deleted **	* 114.00		25.0
	physicians' compensation						
	(chapter 21)						
26.00	Depreciation - CAP REL		O C.	AP REL COSTS-BLDG & FIXT	1.00	0	26. C
	COSTS-BLDG & FIXT						
26. 01	Depreciation - CAP REL			AP REL COSTS-BLDG &	1.01	0	26. C
	COSTS-BLDG & FIXT-MOB			IXT-MOB	1 00		24.0
26. 02	Depreciation - CAP REL COSTS-BLDG & FIXT-POB			AP REL COSTS-BLDG & IXT-POB	1.02	0	26. C
26 03	Depreciation - CAP REL			AP REL COSTS-BLDG & FIXT-\	NJ 1.03	0	26. C
20.00	COSTS-BLDG & FIXT-WJ		00.	AT REE COSTS DEDG & TTAT	1.05	U	20.0
26.04	Depreciation - CAP REL		00	AP REL COSTS-BLDG &	1.04	0	26.0
·	COSTS-BLDG & FIXT-INTEREST			I XT-I NTEREST		Ŭ	
27.00	Depreciation - CAP REL			AP REL COSTS-MVBLE EQUIP	2.00	0	27.0
-	COSTS-MVBLE EQUIP		1				
27.01	Depreciation - CAP REL		O C.	AP REL COSTS-MVBLE EQUIP	- 2.01	0	27.0
	COSTS-MVBLE EQUIP - MOB			OB			
27.02	Depreciation - CAP REL			AP REL COSTS-MVBLE EQUIP	- 2.02	0	27.0
	COSTS-MVBLE EQUIP - POB			OB			
27.03	Depreciation - CAP REL			AP REL COSTS-MVBLE EQUIP	- 2.03	0	27. C
00.00	COSTS-MVBLE EQUIP - WJ		W.		+ 10.00		20.0
	Non-physician Anesthetist		0^	** Cost Center Deleted ***			28.0
	Physicians' assistant	102	0		0.00		
30.00	Adjustment for occupational therapy costs in excess of	A-8-3	00	CCUPATI ONAL THERAPY	67.00		30. C
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0A	DULTS & PEDIATRICS	30.00		30. 9
	instructions)		07		50.00		50. 7
31.00	Adjustment for speech	A-8-3	os	PEECH PATHOLOGY	68.00		31. C
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. C
	Depreciation and Interest						
	EMPLOYEE BENEFITS	A		MPLOYEE BENEFITS DEPARTMEN			
	HOSPITAL ASSESSMENT FEES	В		DMI NI STRATI VE & GENERAL	5.00	0	
	MI SCELLANEOUS I NCOME	В		DMI NI STRATI VE & GENERAL	5.00	0	
	MI SCELLANEOUS I NCOME	В		PERATION OF PLANT	7.00	9	33.0
	MI SCELLANEOUS I NCOME	В		PERATION OF PLANT - WJ	7.03		
	MI SCELLANEOUS I NCOME	В		URSING ADMINISTRATION	13.00		
	MI SCELLANEOUS I NCOME	В		ENTRAL SERVICES & SUPPLY	14.00		
	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B	-20, 413 P -11, 001 E		15.00 91.00	0	
	ACCRUED PTO EXPENSE	A		MPLOYEE BENEFITS DEPARTME		0	
	MARKETING EXPENSES	A		DMI NI STRATI VE & GENERAL	5.00	0	
	MARKETING EXPENSES	A		PERATING ROOM	50.00	0	
	LATE FEES	A		ADI OLOGY-DI AGNOSTI C	54.00	0	
	MARKETING EXPENSES	A		ESPIRATORY THERAPY	65.00	0	
	MARKETING EXPENSES	A		AMILY PRACTICE OF JAY	90.01	0	
				OUNTY		-	
3. 15	MARKETING EXPENSES	A		AY FAMILY MEDICINE	90. 02	0	33.
3. 16	MARKETING EXPENSES	A	-1, 150 J.	AY FAMILY FIRST HEALTH CAN	RE 90.05	0	33.
	CONTRACTED HOSPI TALI ST	A		DULTS & PEDIATRICS	30.00	0	
	CONTRACTED CRNA	A		PERATING ROOM	50.00	0	
	START UP COSTS - HOME OFFICE	A		DMI NI STRATI VE & GENERAL	5.00	0	
	AMORTIZED START UP COST	A		DMI NI STRATI VE & GENERAL	5.00		
	RECRUITING EXPENSES	A		DMI NI STRATI VE & GENERAL	5.00		
	MEDICARE DEPRECIATION EXPENSE	A		AP REL COSTS-BLDG & FIXT	1.00		
33. 23	MEDICARE DEPRECIATION EXPENSE	A		AP REL COSTS-BLDG &	1.01	9	33.2
				IXT-MOB	4.00	_	
33. 24	MEDICARE DEPRECIATION EXPENSE	A		AP REL COSTS-BLDG &	1.02	9	33.2
22 25		Δ		IXT-POB	NI 1 00	_	22
	MEDICARE DEPRECIATION EXPENSE MISCELLANEOUS INCOME	A B		AP REL COSTS-BLDG & FIXT-	NJ 1.03 7.02		
	MEDICARE DEPRECIATION EXPENSE	A		PERATION OF PLANT - POB AP REL COSTS-MVBLE EQUIP	2.00		
	MEDICARE DEPRECIATION EXPENSE MEDICARE DEPRECIATION EXPENSE	A		AP REL COSTS-MUBLE EQUIP		9	
,u.∠U	MEDIONNE DEINEUTATION EAFENJE			OB	2.01	9	JJ. 2

Heal th	Financial Systems		IU HEALTH JA	Y HOSPI TAL	In Lie	u of Form CMS-	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 03/01/2018		norod.
					To 12/31/2018	Date/Time Pre 5/24/2019 10:	pareu: 13 am
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Pacie (Codo (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	· · · · ·			-		
		1.00	2.00	3.00	4.00	5.00	
50.00	TOTAL (sum of lines 1 thru 49)		1, 720, 323				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	eu of Form CMS-:	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1320	Peri od:	Worksheet A-8	-1
OFFI CE	COSTS			From 03/01/2018		
				To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared:
	Line No.	Cost Center	Expense Items	Amount of	Amount	IS dill
	Li ne No.	cost center	Expense i tellis	Allowable Cost	Included in	
					Wks. A, column	
					5 5 WKS. A, COLUMIT	
	1.00	2.00	3.00	4,00	5.00	
	A. COSTS INCURRED AND ADJUST					
	HOME OFFICE COSTS:				02.11.1120	
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	34, 038	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	HOME OFFICE	2, 245, 608	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	8, 021, 844	1, 470, 441	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE	1, 953, 005	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY	825, 906	184, 183	3. 02
3.03	7.00	OPERATION OF PLANT	RELATED PARTY	117, 306	0	3.03
3.04	13.00	NURSING ADMINISTRATION	RELATED PARTY	463, 556	0	3.04
3.05	15.00	PHARMACY	RELATED PARTY	268, 630	0	3.05
3.06	50, 00	OPERATING ROOM	RELATED PARTY	14, 855	0	3.06
3.07	54.00	RADI OLOGY-DI AGNOSTI C	RELATED PARTY	139, 852	0	3.07
3.08	65.00	RESPI RATORY THERAPY	RELATED PARTY	27, 269	0	3.08
3.09			RELATED PARTY	30, 623	0	3.09
3.10	30.00	ADULTS & PEDIATRICS	RELATED PARTY	412,002	412, 002	3.10
3.11	40.00	SUBPROVIDER – IPF	RELATED PARTY	97, 160	97, 160	3. 11
3.12			RELATED PARTY	495, 243	495, 243	3, 12
3.13	60, 00	LABORATORY	RELATED PARTY	1, 536, 932	1, 536, 932	3, 13
3.14	66.00	PHYSI CAL THERAPY	RELATED PARTY	408, 458	408, 458	3.14
3.15			RELATED PARTY	74, 718	74, 718	3.15
3.16			RELATED PARTY	14, 944	14, 944	3.16
3.17			RELATED PARTY	66, 385	66, 385	3.17
3.18			RELATED PARTY	168, 025	168, 025	3. 18
3.19		FAMILY PRACTICE OF JAY COUNT		250, 575	250, 575	3.19
3.20			RELATED PARTY	472, 149	472, 149	3.20
3.21		JAY FAMILY FIRST HEALTH CARE		347,089	347,089	3. 21
3.22			RELATED PARTY	1, 459, 475	1, 459, 475	3. 22
3.23			RELATED PARTY	342, 389	342, 389	3. 23
3.23			RELATED PARTY	152, 039	152,039	3.23
3.24			HOME OFFICE	50, 985	132,039	3.24
3.25			RELATED PARTY	61, 862	61, 862	3.25
3.20			RELATED PARTY	95, 357	95, 357	3.20
4.00	0.00			95, 357	95, 357	4.00
4.00 5.00	TOTALS (sum of lines 1-4).			20, 648, 279	8, 109, 426	4.00 5.00
5.00	Transfer column 6. line 5 to			20, 040, 279	0, 109, 420	5.00
	Worksheet A-8, column 2,					
	line 12.					
	amounts on Lines 1.4 (and sub					

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

nas no	t been posted to worksheet A,	columns I and/or 2, the amou	nt allowable sh	nould be indicated in column 4	F of this part.			
				Related Organization(s) and/	or Home Office			
				3 ()				
	Symbol (1)	Name	Percentage of	Name	Percentage of			
			Ownershi p		Ownershi p			
	1.00	2.00	3.00	4.00	5.00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6.00	В	0.00 U HEALTH BALL 100.00	6.00
7.00	В	0.00 I 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:		

Heal th	Financial Systems	IU HEALTH J	AY HOSPITAL		In Lie	eu of Form CMS-	2552-10
STATEME	INT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider (CCN: 15-1320	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 03/01/2018		
					To 12/31/2018	Date/Time Pre	
						5/24/2019 10:	
				Related Organ	nization(s) and/o	or Home Office	
	Symbol (1)	Name	Percentage of	1	lame	Percentage of	
			Ownershi p			Ownershi p	
	1.00	2.00	3.00	4	l. 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.

Heal th	Financial Syste	ems	IU HEALTH JAY	HOSPI TAL	In Lie	u of Form CMS-2552-1
		SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1320	Peri od:	Worksheet A-8-1
OFFICE	COSTS				From 03/01/2018 To 12/31/2018	Date/Time Prepared:
					10 12/31/2018	5/24/2019 10:13 am
	Net	Wkst. A-7 Ref.		· ·		
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR	CLAIMED
	HOME OFFICE CO					
1.00	34, 038					1.00
2.00	2, 245, 608					2.00
3.00	6, 551, 403					3.00
3.01	1, 953, 005					3. 0
3.02	641, 723					3. 02
3.03	117, 306					3. 03
3.04	463, 556					3. 04
3.05	268, 630					3. 05
3.06	14, 855					3.00
3.07	139, 852					3.0
3.08	27, 269					3. 08
3.09	30, 623					3.00
3.10	0	0				3. 10
3.11	0	0				3. 11
3.12	0	0				3. 12
3.13	0	0				3. 13
3.14	0	0				3. 14
3.15	0	0				3. 15
3.16	0	0				3. 10
3.17	0	9				3. 1
3.18	0	0				3. 18
3.19	0	0				3. 19
3.20	0	0				3. 20
3.21	0	0				3. 2
3.22	0	0				3. 22
3.23	0	0				3. 23
3.24	0	0				3. 24

9 0 3.25 50, 985 3.25 3.26 С 3.26 3.27 0 3.27 0 4.00 0 0 4.00 5.00 12, 538, 853 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as

appropriate. Positive amounts increase cost and negative amounts decrease cost. For related organization or home office cost which has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s) and/or Home Office		
 Type of Business		
6.00		
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOSPI TAL	6.	. 00
7.00	HOME OFFICE	7.	. 00
8.00		8.	8.00
9.00		9.	0. 00
10.00		10.	0. 00
10. 00 <u>100. 00</u>		100.	. 00

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

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

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

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

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

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

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

	Financial Syste		IU HEALTH J			In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period:	Worksheet A-8	3-2
						From 03/01/2018 To 12/31/2018	Date/Time Pre	epared.
							5/24/2019 10:	<u>13 am</u>
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remunerati on	Component	Component		ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
1.00		SUBPROVIDER - IPF	97, 160		5.00			1.00
2.00		OPERATI NG ROOM	609, 924		C	l i		2.00
3.00		RADI OLOGY-DI AGNOSTI C	325		0			3.00
4.00		CARDI OPULMONARY	168, 025		C	-	0	4.00
5.00		FAMILY PRACTICE OF JAY	250, 575		C	0	0	5.00
		COUNTY			-		-	
6.00	90. 02	JAY FAMILY MEDICINE	472, 149	472, 149	C	0	0	6.00
7.00	90.04	OP ORTHO CLINIC	115, 246	115, 246	C	0	0	7.00
8.00		JAY FAMILY FIRST HEALTH CARE	347, 089		C	0	0	8.00
9.00		EMERGENCY	1, 457, 894	1, 201, 742	256, 152		0	9.00
10. 00	0.00		0	0	C	0	0	10100
200.00			3, 518, 387		256, 152		0	200.00
	Wkst. A Line #		Unadjusted RCE		Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng Educati on	Share of col. 12	Insurance	
	1.00	2.00	8.00	9,00	12.00	13.00	14.00	
1.00		SUBPROVIDER - IPF	0.00		12.00			1.00
2.00		OPERATING ROOM	0					2.00
3.00		RADI OLOGY-DI AGNOSTI C	0		C			3.00
4.00		CARDI OPULMONARY	0		C			4.00
5.00	90.01	FAMILY PRACTICE OF JAY	0	0	C	0	0	5.00
		COUNTY						
6.00		JAY FAMILY MEDICINE	0	0	C	e e e e e e e e e e e e e e e e e e e	0	
7.00		OP ORTHO CLINIC	0	0	C	0	0	7.00
8.00		JAY FAMILY FIRST HEALTH CARE	0	-	C	e e e e e e e e e e e e e e e e e e e	0	8.00
9.00		EMERGENCY	0	-	C	0	0	,,
10.00	0.00		0	0	C	0	0	
200.00		Cart Cantan (Dhuai ai an	U Durau di alaur			0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	RCE Di sal I owance	Adjustment		
		rdentifier	Share of col.		DI Sal i Owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	40.00	SUBPROVIDER - IPF	0	0	C	97, 160		1.00
2.00	50.00	OPERATING ROOM	0	0	C	609, 924		2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	C	325		3.00
4.00		CARDI OPULMONARY	0	0	C	168, 025		4.00
5.00	90. 01	FAMILY PRACTICE OF JAY	0	0	C	250, 575		5.00
		COUNTY						
6.00		JAY FAMILY MEDICINE	0	-	C			6.00
7.00		OP ORTHO CLINIC	0		C			7.00
8.00		JAY FAMILY FIRST HEALTH CARE EMERGENCY	0	-	C			8.00
9.00 10.00	91.00		0					9.00 10.00
200.00	0.00		0	-	9	e e e e e e e e e e e e e e e e e e e		200.00
200.00	I	1	0	0		1 5,202,200		200.00

ealth Financial Systems OST ALLOCATION - GENERAL SERVICE COS		I U HEALTH JA'	Provider CC	N: 15-1320	Perio From To			
				CADITAL			5/24/2019 10:	
				CAPI TAL	RELATE	0 00515		
Cost Center Description	A	et 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	
GENERAL SERVICE COST CENTERS		716, 974	716 074					1 1 00
.00 00100 CAP REL COSTS-BLDG & FIXT .01 00101 CAP REL COSTS-BLDG & FIXT .02 00102 CAP REL COSTS-BLDG & FIXT .03 00103 CAP REL COSTS-BLDG & FIXT .04 00104 CAP REL COSTS-BLDG & FIXT .04 00104 CAP REL COSTS-BLDG & FIXT .00 00200 CAP REL COSTS-BLDG & FIXT .00 00200 CAP REL COSTS-MVBLE EQUI P .01 00201 CAP REL COSTS-MVBLE EQUI P .02 00202 CAP REL COSTS-MVBLE EQUI P .03 00203 CAP REL COSTS-MVBLE EQUI P .00 00400 EMPLOYEE BENEFI TS DEPARTM .00 00400 EMPLOYEE BENEFI TS DEPARTM .00	-POB -WJ -INTEREST - MOB - POB - WJ	0 0 0 1, 306, 125 20, 004 0 2, 262, 191 10, 701, 094 1, 669, 206 56, 043 7, 66 0 65, 433 374, 240 192, 084	716, 974 0 0 0 75, 624 43, 937 461 950 92 4, 105 4, 585 13, 367 23, 367					1.00 2.00 2.01 2.01 2.01 2.01 2.01 2.01 2.01 2.01 2.01 2.01 2.01 2.01 3.0101 <tr< td=""></tr<>
1.00 01100 CAFETERIA 3.00 01300 NURSI NG ADMINI STRATI ON 4.00 01400 CENTRAL SERVI CES & SUPPLY 5.00 01500 PHARMACY 6.00 01600 MEDI CAL RECORDS & LI BRARY 7.00 01700 SOCI AL SERVI CE INPATI ENT ROUTI NE SERVI CE COST	CENTERS	225, 381 1, 707, 937 492, 436 811, 050 0 0	24, 805 15, 378 11, 605 9, 465 13, 099 0		0 0 0 0 0	0 0 0 0 0		13.00 14.00 15.00 16.00
0.00 03000 ADULTS & PEDIATRICS 0.00 04000 SUBPROVIDER - IPF 3.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS		1, 428, 850 803, 729 59, 092	114, 460 41, 659 4, 575		0 0 0	0 0 0	C	40.00
ANCIELARY SERVICE COST CENTERS 05000 OPERATING ROOM 2.00 05200 DELIVERY ROOM & LABOR ROO 3.00 05300 ANESTHESI OLOGY	м	1, 248, 567 20, 744 0	49, 906 1, 605 0		0 0 0	000000000000000000000000000000000000000		52.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 00 06000 LABORATORY 5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY 6. 00 06600 PHYSI CAL THERAPY 7. 00 06600 PHYSI CAL THERAPY 8. 00 06600 SPEECH PATHOLOGY 9. 00 06800 SPEECH PATHOLOGY 9. 00 06900 ELECTROCARDI OLOGY 1. 00 07100 MEDI CAL SUPPLI ES CHARGED 2. 00 07200 IMPL. DEV. CHARGED TO PATI 3. 00 07300 DRUGS CHARGED TO PATI ENTS 6. 00 03160 CARDI OPULMONARY 0UTPATI ENT SERVI CE COST CENTERS 001741	IENTS	1, 037, 684 1, 585, 758 386, 463 443, 687 74, 718 14, 944 65, 695 238, 297 38, 540 1, 363, 712 99, 301	57, 830 23, 588 5, 147 1, 005 0 0 18, 468 0 0 0 0 0					54.00 60.00 65.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.00
0. 00 09000 CLINIC 0. 01 09001 FAMILY PRACTICE OF JAY CO 0. 02 09002 JAY FAMILY MEDICINE 0. 03 09003 WOUND CLINIC 0. 04 09004 OP ORTHO CLINIC 0. 05 09005 JAY FAMILY FIRST HEALTH C 0. 06 09006 INFUSION CLINIC 1. 00 09100 EMERGENCY 2. 00 09200 OBSERVATION BEDS (NON-DIS 3. 00 04950 OUTPATIENT PSYCH	ARE	0 552, 527 723, 998 55, 928 0 347, 485 57, 503 1, 106, 188 48, 488	0 0 79, 702 0 35, 681 0 41, 899 720					90.0 91.0 92.0
SPECIAL PURPOSE COST CENTERS 18. 00 SUBTOTALS (SUM OF LINES 1 NONREI MBURSABLE COST CENTERS	through 117)	32, 409, 702	693, 718		0	0		118.0
90. 00 19000 GIFT, FLOWER, COFFEE SHOP 92. 00 19200 PHYSICIANS' PRIVATE OFFIC 93. 00 19300 NONPAID WORKERS	ES	0 20, 727 0	8, 358 0 0		0 0 0	0 0 0	0 0	190. 0 192. 0 193. 0
94.00 07950 OTHER NONREIMBURSABLE COS 94.02 07952 WEST JAY CLINIC 94.03 07953 JAY MERIDIAN URGENT CARE 00.00 Cross Foot Adjustments	I GENTEKS	0 607, 776 311, 001	0 0 14, 898		0	0 0 0	0 0	194. 0 194. 0 194. 0 200. 0
01.00 Negative Cost Centers 02.00 TOTAL (sum lines 118 thro	ugh 201)	33, 349, 206	0 716, 974		0 0	0 0		201.0 202.0

ST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1320	Period: From 03/01/2018 To 12/31/2018		-2552- epared
			CAP	ITAL RELATED	COSTS	372472017 10	
	Cost Center Description	BLDG &	MVBLE EQUIP	MVBLE EQUIP	- MVBLE EQUIP -	MVBLE EQUIP -	
		FIXT-INTEREST	2.00	MOB	POB	WJ	
	GENERAL SERVICE COST CENTERS	1.04	2.00	2.01	2.02	2.03	-
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 00	00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP	0	1 204 125				1.
00	00200 CAP REL COSTS-MVBLE EQUIP		1, 306, 125	20, 00	14		2.
02	00202 CAP REL COSTS MVBLE EQUIP - POB		0	20,00	0 0		2.
03	00203 CAP REL COSTS-MVBLE EQUIP - WJ		0		0 0	(2.
00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	(3 4.
00	00500 ADMI NI STRATI VE & GENERAL	0	137, 766				J 5.
00	00700 OPERATION OF PLANT	0	80, 042) 7.
01	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0	840		0 0) 7.
02 03	00703 OPERATION OF PLANT - POB	0	1, 731 168		0 0		0 7. 0 7.
00	00800 LAUNDRY & LINEN SERVICE	0	7, 478		0 0) /.) 8.
00	00900 HOUSEKEEPING	0	8, 352		0 0) 9.
	01000 DI ETARY	0	24, 350		0 0	(0 10.
. 00	01100 CAFETERI A	0	45, 188		0 0	(D 11.
	01300 NURSING ADMINISTRATION	0	28, 014		0 0	(D 13.
	01400 CENTRAL SERVI CES & SUPPLY	0	21, 141		0 0		D 14.
	01500 PHARMACY	0	17, 242		0 0		D 15.
	01600 MEDICAL RECORDS & LIBRARY	0	23, 863		0 0) 16.
. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0		17.
00	03000 ADULTS & PEDIATRICS	0	208, 515		0 0	(30.
	04000 SUBPROVIDER - IPF	0	75, 891		0 0		2 40.
	04300 NURSERY	0	8, 335		0 0		3 43.
	ANCILLARY SERVICE COST CENTERS			1			
	05000 OPERATING ROOM	0	90, 914		0 0		50.
	05200 DELIVERY ROOM & LABOR ROOM	0	2, 924		0 0		52.
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 105, 350		0 0) 53.) 54.
	06000 LABORATORY	0	42, 970		0 0		5 54. 5 60.
	06500 RESPI RATORY THERAPY	0	9, 377		0 0		0 65.
	06600 PHYSI CAL THERAPY	0	1, 832		0 0	() 66.
00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	() 67.
	06800 SPEECH PATHOLOGY	0	0		0 0	() 68.
	06900 ELECTROCARDI OLOGY	0	33, 643		0 0		0 69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0) 71.) 72.
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0) 73.
	03160 CARDI OPULMONARY	0	0		0 0		0 76.
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	0		0 0) 90.
	09001 FAMILY PRACTICE OF JAY COUNTY	0	0	13, 55	0) 90.
	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	0	145, 194		0 0) 90.
	09004 OP ORTHO CLINIC	0	0				0 90. 0 90.
	09005 JAY FAMILY FIRST HEALTH CARE	0	65, 001		0 0) 90.) 90.
	09006 INFUSION CLINIC	0	0		0 0) 90.
00	09100 EMERGENCY	0	76, 328		0 0	() 91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
00	04950 OUTPATIENT PSYCH	0	1, 311		0 0	(<u>)</u> 93.
3. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 263, 760	20, 00	04 0	(0 118.
	NONREI MBURSABLE COST CENTERS	U	1,203,700	1 20, 00	U U		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 225		0 0	(0 190.
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0 0		0 192.
	19300 NONPAID WORKERS	0	0		0 0		0 193.
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0) 194.
	07952 WEST JAY CLINIC	0	0		0 0) 194.
	07953 JAY MERIDIAN URGENT CARE	0	27, 140		0 0	(0 194.
). 00			~		0		200. 201.
1.00							

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH JAY	Provider CC	F	Period: From 03/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet B Part I Date/Time Pre 5/24/2019 10:	pared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	
	[4.00	4A	5.00	7.00	7.01	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 01 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 11. \ 00 \\ 15. \ 00 \\ 15. \ 00 \\ 16. \ 00 \\ 17. \ 00 \end{array}$	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 EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	2, 262, 191 365, 924 42, 337 441 916 90 5, 014 56, 274 21, 406 39, 707 217, 823 0 73, 125 0 0	11, 283, 922 1, 838, 459 57, 785 11, 203 350 82, 030 443, 451 251, 207 335, 081 1, 969, 152 525, 182 910, 882 36, 962	11, 283, 922 940, 166 29, 551 5, 729 41, 949 226, 776 128, 464 171, 356 1, 007, 001 268, 572 465, 814 18, 902	2, 778, 625 2, 145 4, 419 429 19, 093 21, 324 62, 170 15, 372 71, 523 23, 975 44, 021 20, 0, 925	89, 481 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$
	INPATIENT ROUTINE SERVICE COST CENTERS					-	
30. 00 40. 00	03000 ADULTS & PEDIATRICS 04000 SUBPROVIDER - IPF	248, 218 140, 700	2, 000, 043 1, 061, 979			0	
40.00	04300 NURSERY	10, 340	82, 342	543, 083 42, 109		0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	213, 809	1, 603, 196	819, 855		0	
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	3, 630	28, 903	14, 781		0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	119, 581	1, 320, 445	675, 260	- -	0	54.00
60.00	06000 LABORATORY	0	1, 652, 316	844, 975		0	60.00
65.00	06500 RESPI RATORY THERAPY	59, 650	460, 637	235, 564		0	65.00
66.00	06600 PHYSI CAL THERAPY	77, 343	523, 867	267, 899		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	14, 148	88, 866			0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2,830	17, 774 117, 806	9, 089 60, 245		0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238, 297	121, 862		0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	38, 540	19, 709		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 363, 712			0	
76.00	03160 CARDI OPULMONARY	17,031	116, 332	59, 491	0	0	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	ſ		0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	96,024	662, 104	338, 592		89, 481	
	09002 JAY FAMILY MEDICINE	126, 044	1,074,938	549, 710		0	1
90.03	09003 WOUND CLINIC	9, 630	65, 558	33, 526		0	90.03
90.04	09004 OP ORTHO CLINIC	0	0	C	0 0	0	90.04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	60, 317	508, 484	260, 033		0	90.05
90.06 91.00	09006 INFUSION CLINIC 09100 EMERGENCY	10, 051 149, 365	67, 554 1, 373, 780	34, 546 702, 535		0	90.06 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	147, 303	1, 373, 700	702, 333	, , , , , , , , , , , , , , , , , , , ,	0	92.00
93.00	04950 OUTPATI ENT PSYCH	8, 132	58, 651	29, 993	3, 347	0	
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 189, 900	32, 271, 790	10, 732, 944	2, 670, 461	89, 481	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 583	12, 060	38, 872	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	o	20, 727	10, 600			192.00
	19300 NONPAI D WORKERS	0	0	(0		193.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	C	0 0		194.00
	07952 WEST JAY CLINIC	44, 599	652, 375	333, 617			194.02
194.03 200.00	07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	27, 692	380, 731	194, 701	69, 292		194.03 200.00
200.00		0	0	(0		200.00
202.00		2, 262, 191	33, 349, 206	11, 283, 922	2, 778, 625		

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: [^] om 03/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Pre	pared:
					5/24/2019 10:	
Cost Center Description	OPERATION OF PLANT - POB	OPERATION OF PLANT - WJ	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	7.02	7.03	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS	1 1		1			1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1.00 1.01
1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB						1.01
1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ						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						2.01
2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
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						7.00
7.02 00702 OPERATION OF PLANT - POB	21, 351					7.02
7.03 00703 OPERATION OF PLANT - WJ	0	958				7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	0		708, 876		8.00 9.00
10. 00 01000 DI ETARY	0	0		16, 136	462, 448	10.00
11. 00 01100 CAFETERI A	0	0	0	29, 944	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	-	18, 563	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	0	-	14, 009 11, 425	0	14.00 15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	-	15, 813	0	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	0	0	65, 590	138, 174	316, 769	30.00
40. 00 04000 SUBPROVI DER - I PF	0	0		50, 290	145, 679	40.00
43. 00 04300 NURSERY	0	0	2, 593	5, 523	0	43.00
ANCI LLARY SERVI CE COST CENTERS	21, 351	0	14, 903	60, 245	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	21, 331	0		1, 938	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		69, 811	0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0	-	28, 474 6, 214	0	60.00 65.00
66.00 06600 PHYSI CAL THERAPY	0	0	-	1, 214	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	-	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0	-	0 22, 294	0	68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	2, 901	22, 294	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 76. 00 03160 CARDI OPULMONARY	0	0		0	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.00
90. 00 09000 CLINIC	0	0	-	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0	0	-	06 214	0	90. 01 90. 02
90. 03 09003 WOUND CLINIC	0	0	-	96, 214 0	0	90.02
90. 04 09004 OP ORTHO CLINIC	0	0	0	0	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		43, 074	0	90.05
90. 06 09006 INFUSION CLINIC 91. 00 09100 EMERGENCY	0	0	Ŭ	0 50, 579	0	90.06 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0	17,071	00,077	Ũ	92.00
93. 00 04950 OUTPATIENT PSYCH	0	0	0	869	0	93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	21, 351	0	143, 072	680, 803	462, 448	118 00
NONREI MBURSABLE COST CENTERS	21,001		110,072	000,000	102, 110	110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	-	10, 089		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	0		0		192. 00 193. 00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	-	0		193.00
194.0207952WEST JAY CLINIC	0	958	0	0	0	194. 02
194. 03 07953 JAY MERIDIAN URGENT CARE	0	0	0	17, 984	0	194.03
200.00Cross Foot Adjustments201.00Negative Cost Centers	0	0	0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	21, 351	958	-	708, 876	462, 448	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	IU HEALTH JA	AY HOSPITAL Provider CC	N: 15-1320	In Lie Period:	u of Form CMS-: Worksheet B	2552-10
					From 03/01/2018 To 12/31/2018	Part I Date/Time Pre 5/24/2019 10:	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS		1				1 4 44
$\begin{array}{c} 1. \ 00 \\ 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 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 EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOVEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	651, 753 51, 301 C	3, 117, 540 0 0	861, 73			1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00
15.00	01500 PHARMACY	19, 436	0	3, 66	7 1, 455, 245		15.00
	01600 MEDICAL RECORDS & LIBRARY	C			0 0	132, 602	16.00
17.00	01700 SOCIAL SERVICE	C	0		0 0	0	17.00
30, 00	03000 ADULTS & PEDIATRICS	84, 512	664, 757	97, 37	5 10, 776	10, 507	30.00
	04000 SUBPROVI DER – I PF	49, 124		5, 17		3, 449	1
43.00	04300 NURSERY	2, 969	23, 410		0 0	311	43.00
	ANCI LLARY SERVI CE COST CENTERS		1				
	05000 OPERATING ROOM	76, 358		236, 91		30, 371	50.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1,069 0			0 0 0 0	1, 688 0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	34, 913	-	34, 76	-	17,004	54.00
	06000 LABORATORY	41, 959	0	44	1 0	12, 667	60.00
	06500 RESPI RATORY THERAPY	19, 515		16, 63		1, 386	
	06600 PHYSI CAL THERAPY	21,098		3, 27		1, 955	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	4, 988 871		51	3 0 0 0	425 39	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	871 C	1		0 0	1, 017	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		284, 17	-	1, 570	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0	45, 96	0 0	529	72.00
	07300 DRUGS CHARGED TO PATIENTS	C	0	0.05	0 1, 424, 105		73.00
76.00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	5, 898	1, 614	3, 05	3 0	2, 710	76.00
90.00	09000 CLINIC	C	0		0 0	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	59, 178		26, 35		2, 022	
	09002 JAY FAMILY MEDICINE	71, 924		13, 79		1, 775	
	09003 WOUND CLINIC	3, 404		2, 41		163	
	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	C 35, 784	-	6 16, 92		134 850	1
	09006 INFUSION CLINIC	2, 692		1, 20		2, 839	
	09100 EMERGENCY	45, 047		67, 92		22, 708	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04950 OUTPATIENT PSYCH	4, 354	0		5 0	236	93.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	636, 394	3, 117, 540	860, 62	8 1, 455, 245	132, 602	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0		0 0	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	C	1		0 0		192.00
172.00	19300 NONPAID WORKERS	C	0		0 0	0	193.00
193.00		0	N 0		o o	0	194.00
193.00 194.00	07950 OTHER NONREI MBURSABLE COST CENTERS	L	1				40.
193.00 194.00 194.02	07952 WEST JAY CLINIC		0	1, 11	0 0		194.02
193.00 194.00 194.02 194.03	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE	C C 15, 359		1, 11	0 0 0 0		194.03
193.00 194.00 194.02	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	C C 15, 359 C		1, 11		0	

Heal th	Financial Systems	IU HEALTH JAY	/ HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 03/01/2018	Worksheet B Part I	
					To 12/31/2018		epared:
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	- 372472017 10.	
				Residents Cos & Post	t		
				Stepdown			
		17.00	24.00	Adjustments 25.00	26.00		
	GENERAL SERVICE COST CENTERS	17.00	24.00	23.00	20.00		
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT						1.00 1.01
1.01	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB						1.01
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.04 2.00	00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP						1.04 2.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2.03 4.00	00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT						2.03 4.00
4.00 5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
7.01 7.02	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB						7.01 7.02
7.02	00703 OPERATION OF PLANT - WJ						7.02
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						14.00 15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCI AL SERVI CE	0					17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	4, 943, 665	-	0 4, 943, 665		20.00
30.00 40.00	04000 SUBPROVIDER - IPF	0	4, 943, 665 2, 419, 740		0 4, 943, 665 0 2, 419, 740		30.00 40.00
43.00	04300 NURSERY	0	180, 538		0 180, 538		43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	3, 549, 265		0 3, 549, 265		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	64, 321		0 64, 321		52.00
53.00	05300 ANESTHESI OLOGY	0	C		0 0		53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	2, 437, 429 2, 690, 541		0 2, 437, 429 0 2, 690, 541		54.00 60.00
65.00	06500 RESPIRATORY THERAPY	0	763, 892		0 2, 090, 341		65.00
66.00	06600 PHYSI CAL THERAPY	0	824, 911		0 824, 911		66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	140, 237 27, 773		0 140, 237 0 27, 773		67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	356, 432		0 356, 432		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	645, 904	1	0 645, 904		71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	104, 738		0 104, 738 0 3, 501, 450		72.00 73.00
	03160 CARDI OPULMONARY	0	3, 501, 450 189, 098		0 3, 501, 450 0 189, 098		76.00
	OUTPATIENT SERVICE COST CENTERS	1		1			
	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY	0	C 1, 572, 473		0 1 572 472		90.00 90.01
	09002 JAY FAMILY MEDICINE	0	2, 698, 107		0 1, 572, 473 0 2, 698, 107		90.01
90.03	09003 WOUND CLINIC	0	139, 772	2	0 139, 772		90.03
	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	0	203 1, 246, 800		0 203 0 1, 246, 800		90. 04 90. 05
	09006 INFUSION CLINIC	0	136, 486		0 1, 240, 800		90.05
	09100 EMERGENCY	0	2,835,918	3	0 2, 835, 918		91.00
92.00 93.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART 04950 OUTPATI ENT PSYCH	0	97, 455		0 0		92.00 93.00
7 3.00	SPECIAL PURPOSE COST CENTERS	0	97,400	7	97,433		93.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	31, 567, 148	3	0 31, 567, 148		118.00
190 00	NONREIMBURSABLE COST CENTERS	0	84, 604	1	0 84,604		190.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES	0	31, 327		0 31, 327		190.00
193.00	19300 NONPAI D WORKERS	0	C	þ	0 0		193.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	C 988, 060		0 0 0 988, 060		194. 00 194. 02
	07952 WEST JAY CEINIC	0	988, 060 678, 067		0 988, 060		194.02
200.00	Cross Foot Adjustments		C	D	0 0		200. 00
201.00 202.00		0	C 33, 349, 206		0 0 0 33, 349, 206		201.00 202.00
202.00		I O	55, 547, 200	4	0 55, 547, 200		1202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH JA	Provider CC	CN: 15-1320	Perio From To		B Date/Time Pre	epare
				CAPI TAL	RELATE	ED COSTS	5/24/2019 10:	13 ai
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	BLDG & FIXT-MOB		BLDG & FI XT-POB	BLDG & FIXT-WJ	
	1	0	1.00	1.01		1. 02	1.03	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT							1 1.
. 01 . 02 . 03 . 04 . 00 . 01 . 02 . 03 . 00 . 00 . 00 . 00 . 01 . 02 . 03 . 00 . 00 . 00 . 00 . 00 . 00	00101CAP REL COSTS-BLDG & FIXT-MOB00102CAP REL COSTS-BLDG & FIXT-POB00103CAP REL COSTS-BLDG & FIXT-WJ00104CAP REL COSTS-BLDG & FIXT-INTEREST00200CAP REL COSTS-MVBLE EQUI P00201CAP REL COSTS-MVBLE EQUI P00202CAP REL COSTS-MVBLE EQUI P - MOB00203CAP REL COSTS-MVBLE EQUI P - POB00203CAP REL COSTS-MVBLE EQUI P - WJ00400EMPLOYEE BENEFITS DEPARTMENT00500ADMINISTRATIVE & GENERAL00700OPERATION OF PLANT00701OPERATION OF PLANT00702OPERATION OF PLANT00703OPERATION OF PLANT00704DERATION OF PLANT00705DERATION OF PLANT00700OPERATION OF PLANT00701DERATION F PLANT00702DERATION F PLANT00703DERATION F PLANT00704DERATION OF PLANT00705DERATION OF PLANT00700DERATION OF PLANT00700DIETARY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	950 92 4, 105 4, 585 13, 367					1. 1. 1. 1. 2. 2. 2. 2. 3. 5. 7. 7. 8. 9. 10.
1.00 3.00 4.00 5.00 5.00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY		11, 605 9, 465		0 0 0 0	(((((13. 14. 15.
	01700 SOCIAL SERVICE	0			0	(0	
0. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	114, 460		0	(0	30.
). 00	04000 SUBPROVI DER – I PF	0			0	(
3.00	04300 NURSERY	0	4, 575		0	(0	43.
). 00	ANCI LLARY SERVI CE COST CENTERS	0	49, 906		0	(50.
2.00	05200 DELIVERY ROOM & LABOR ROOM	0			0	(
. 00	05300 ANESTHESI OLOGY	0	0		0	(0 0	53
. 00	05400 RADI OLOGY-DI AGNOSTI C	0	57, 830		0	(0 0	
. 00	06000 LABORATORY	0	23, 588		0	(0	
. 00	06500 RESPIRATORY THERAPY	0	5, 147		0	(0	
. 00 . 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	1, 005 0		0	(
	06800 SPEECH PATHOLOGY	0	-		0	(
	06900 ELECTROCARDI OLOGY	0	-		õ	(ol o	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	(0 0	71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	(0 0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	(0	
. 00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0		0	(0	76
00	09000 CLINIC	0	0		0	(0 0	90
	09001 FAMILY PRACTICE OF JAY COUNTY	0	0		Ö	(ol o	
	09002 JAY FAMILY MEDICINE	0	79, 702		0	(0 0	90
	09003 WOUND CLINIC	0	0		0	(0 0	90
	09004 OP ORTHO CLINIC	0	0		0	(0 0	1
0.05	09005 JAY FAMILY FIRST HEALTH CARE	0	35, 681		0	(0	1
	09006 INFUSION CLINIC	0	0		U	(0	
	09100 EMERGENCY	0	41, 899		U	(0	
	09200 OBSERVATI ON BEDS (NON-DI STINCT PART 04950 OUTPATI ENT PSYCH	0	720		0	(o o	92
. 00	SPECIAL PURPOSE COST CENTERS	0	/20		<u> </u>		<u>, 0</u>	73
8.00		0	693, 718		0	(0 0	118
	NONREI MBURSABLE COST CENTERS		2, 10					
0.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 358		0	(0 0	190
	19200 PHYSICIANS' PRIVATE OFFICES	0	0		0	(192
	19300 NONPALD WORKERS	0	0		0	(193
4. OC	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	(0 0	194
	07952 WEST JAY CLINIC	0	0		0	(194
	07953 JAY MERIDIAN URGENT CARE	0	14, 898		0	(0 0	194
00.00								200
01.00		0	0		0	(201.
2.00			716, 974		0	(N O	1000

ALLOCAT	Financial Systems TON OF CAPITAL RELATED COSTS		Y HOSPI TAL Provi der C	F	Period: From 03/01/2018	Worksheet B Part II	-2552-10
					o 12/31/2018	Date/Time Pr 5/24/2019 10	
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	BLDG &	MVBLE EQUIP		MVBLE EQUIP -		
		FIXT-INTEREST 1.04	2.00	MOB 2.01	P0B 2.02	WJ 2.03	
	GENERAL SERVICE COST CENTERS		2.00		2102	2.00	
	DO100 CAP REL COSTS-BLDG & FIXT DO101 CAP REL COSTS-BLDG & FIXT-MOB						1.00
	DO102 CAP REL COSTS-BLDG & FIXT-POB						1.01
1.03	DO103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
	DO104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
	DO2OO CAP REL COSTS-MVBLE EQUIP DO2O1 CAP REL COSTS-MVBLE EQUIP - MOB						2.00
	DO202 CAP REL COSTS-MVBLE EQUIP - POB						2.02
	DO2O3 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	127 744	2 514	-		0 4.00 0 5.00
	00700 OPERATION OF PLANT	0	137, 766 80, 042				5.00
	DO701 OPERATION OF PLANT - MOB	0	840				7.01
	DO702 OPERATION OF PLANT - POB	0	1, 731		-		7.02
	DO703 OPERATION OF PLANT - WJ DO800 LAUNDRY & LINEN SERVICE	0	168 7, 478				0 7.03 0 8.00
	DO900 HOUSEKEEPING	0	8, 352		-		9.00
	D1000 DI ETARY	0	24, 350		0		0 10.00
		0	45, 188				0 11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	28, 014 21, 141		-		0 13.00 0 14.00
	D1500 PHARMACY	0	17, 242		,		0 15.00
	01600 MEDICAL RECORDS & LIBRARY	0	23, 863				0 16.00
	01700 SOCIAL SERVICE	0	0	C	00	(17.00
	NPATIENT ROUTINE SERVICE COST CENTERS	0	208, 515	C) 0		30.00
	D4000 SUBPROVIDER - IPF	0	75, 891				40.00
	04300 NURSERY	0	8, 335	C	0 0	(3 43.00
-	ANCI LLARY SERVI CE COST CENTERS	0	90, 914	C) 0		50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	2, 924				52.00
	D5300 ANESTHESI OLOGY	0	0		-		53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	105, 350 42, 970		-		54.00 60.00
	06500 RESPI RATORY THERAPY	0	9, 377		-		00.00
	D6600 PHYSI CAL THERAPY	0	1, 832		0 0		0 66.00
		0	0		0		0 67.00 0 68.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0 33, 643	-			0 68.00 0 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		-		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	C	0		0 72.00
	07300 DRUGS CHARGED TO PATIENTS 03160 CARDI OPULMONARY	0	0				73.00 76.00
	DUTPATIENT SERVICE COST CENTERS	0	0	<u> </u>	,	<u> </u>	70.00
	09000 CLINIC	0	0				90.00
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0	145 104	13, 553			0 90.01
	D9002 DAY FAMILY MEDICINE D9003 WOUND CLINIC	0	145, 194 0				0 90.02 0 90.03
	D9004 OP ORTHO CLINIC	0	0	C	0		90.04
	09005 JAY FAMILY FIRST HEALTH CARE	0	65, 001	C	0		90.05
	09006 INFUSION CLINIC 09100 EMERGENCY	0	0 76, 328				0 90.06 0 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	70, 320				92.00
93.00	04950 OUTPATI ENT PSYCH	0	1, 311	C	0	(93.00
-	SPECIAL PURPOSE COST CENTERS	0	1 262 760	20.004	۱ O		110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	1, 263, 760	20,004	+ <u> </u>	(<u>0</u> 118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 225	C	0 0		0 190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	0		0 192.00
	19300 NONPALD WORKERS 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0				0 193.00 0 194.00
	07952 WEST JAY CLINIC	0	0		0		0 194.00
194.03	07953 JAY MERIDIAN URGENT CARE	0	27, 140	C	0		0 194. 03
	Cross Foot Adjustments						200.00
200.00 201.00	Negative Cost Centers	0	^				201.00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH JAY	Provi der CC		eriod: rom 03/01/2018	u of Form CMS-2 Worksheet B Part II Date/Time Prep 5/24/2019 10:	pared:
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	ro cim
		2A	4.00	5.00	7.00	7.01	
	GENERAL SERVICE COST CENTERS						
$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 15. \ 00 \\ 17. \ 00 \\ 10. \ 00 \ 00 \\ 10. \ 00 \ 00 \\ 10. \ 00 \ 00 \\ 10. \ 00 \ 00 \\ 10. \ 00 \ 00 \\ 10. \ 00 \ 00 \ 00 \ 00 \ 00 \ 00 \ 00 $	00100 CAP REL COSTS-BLDG & FIXT 00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-VJ 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 00200 CAP REL COSTS-MVBLE EQUIP - MOB 00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - POB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 216, 904 126, 916 1, 301 2, 681 260 11, 583 12, 937 37, 717 69, 993 43, 392 32, 746 26, 707 36, 962 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	216, 904 18, 072 568 110 3 806 4, 359 2, 469 3, 294 19, 357 5, 163 8, 954 363 0	144, 988 112 231 22 996 1, 113 3, 244 6, 020 3, 732 2, 816 2, 297 3, 179 0	1, 981 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 1.\ 00\\ 11.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 04000 SUBPROVI DER - I PF	322, 975 117, 550	0	19, 664 10, 439	27, 778 10, 110	0	30. 00 40. 00
	04300 NURSERY	12, 910	0	809	1, 110	0	
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM	140, 820	0	15, 759	12, 112	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	4, 529	0	284	390	0	52.00
	05300 ANESTHESI OLOGY	0	0	12,000	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	163, 180 66, 558	0	12, 980 16, 242	14, 035 5, 725	0	54.00 60.00
			0	4, 528		0	65.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	14, 524	0		1, 249	0	66.00
	06700 OCCUPATIONAL THERAPY	2, 837 0	0	5, 150 874	244 0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	175	0	0	68.00
	06900 ELECTROCARDI OLOGY	52, 111	0	1, 158	4, 482	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	02,111	0	2, 342	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	379	o	Ő	
	07300 DRUGS CHARGED TO PATIENTS	0	0	13, 405	0	0	73.00
	03160 CARDI OPULMONARY	0	0	1, 144	0	0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	13, 553	0	6, 508	0	1, 981	
	09002 JAY FAMILY MEDICINE	224, 896	0	10, 567	19, 343	0	90.02
	09003 WOUND CLINIC	0	0	644	0	0	90.03
	09004 OP ORTHO CLINIC	0	0	0	0	0	90.04
	09005 JAY FAMILY FIRST HEALTH CARE	100, 682	0	4, 998	8, 660	0	90.05
	09006 INFUSION CLINIC 09100 EMERGENCY	118, 227	0	664 13, 504	10, 169	0	90.06 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	110, 227	0	13, 304	10, 109	0	92.00
	04950 OUTPATI ENT PSYCH	2, 031	0	577	175	0	93.00
	SPECIAL PURPOSE COST CENTERS	2,031	0	577	175	0	75.00
118.00		1, 977, 482	0	206, 312	139, 344	1, 981	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	23, 583	0	232	2, 028	0	190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	204	0		192.00
	19300 NONPAID WORKERS	0	0	0	0		193.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	О	0	О		194.00
		ol	0	6, 413	ol	0	194.02
194. 00 194. 02	07952 WEST JAY CLINIC	U	0		0		
194.00 194.02 194.03	07953 JAY MERIDIAN URGENT CARE	42, 038	0	3, 743	3, 616	0	194. 03
194. 00 194. 02	07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	42, 038 0	0		3, 616	0	

Health Financial Systems	IU HEALTH JA'	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 03/01/2018	Worksheet B Part II	
			То	0 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 13 am
Cost Center Description	OPERATION OF	OPERATI ON OF	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
	PLANT - POB 7.02	PLANT - WJ 7.03	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS 1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00100 CAP REL COSTS-BLDG & FLXT-MOB						1.00
1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB 1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ						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 EQUIP						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2.01 2.02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT						7.00
7.01 00701 OPERATION OF PLANT - MOB 7.02 00702 OPERATION OF PLANT - POB	3, 022					7.01 7.02
7.03 00703 OPERATION OF PLANT - WJ	0	285				7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	0		20, 030		8.00 9.00
10. 00 01000 DI ETARY	0	0		456	44, 304	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMINI STRATI ON	0	0	-	846 525	0	11.00 13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	-	396	0	14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	-	323 447	0 0	15.00 16.00
17. 00 01700 SOCI AL SERVI CE	0	0		44 <i>7</i> 0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	0	6, 136	3, 902	30, 348	30.00
40. 00 04000 SUBPROVI DER - I PF	0	0	331	1, 421	13, 956	40.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	243	156	0	43.00
50. 00 05000 OPERATI NG ROOM	3, 022	0		1, 702	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESIOLOGY	0	0	-	55 0	0	52.00 53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	1, 063	1, 973	0	54.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0	-	805 176	0	60.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	87	34	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	-	630	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	-	0	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	0 0	0	0	76.00
90. 00 09000 CLI NI C	0	0	-	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0	0	-	0 2, 719	0 0	90. 01 90. 02
90. 03 09003 WOUND CLINIC	0	0	-	0	0	90. 03
90.04 09004 OP ORTHO CLINIC 90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	-	0 1, 217	0	90. 04 90. 05
90. 06 09006 INFUSION CLINIC	0	0	0	0	0	90.06
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	0	1, 813	1, 429	0	91.00 92.00
93. 00 04950 OUTPATI ENT PSYCH	0	0	0	25	0	93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3,022	0	13, 385	19, 237	44, 304	118 00
NONREI MBURSABLE COST CENTERS						1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	0 0	-	285 0		190. 00 192. 00
193. 00 19300 NONPAI D WORKERS	0	0		0	0	193. 00
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 194.02 07952 WEST JAY CLINIC	0	0 285		0		194. 00 194. 02
194.0307953 JAY MERIDIAN URGENT CARE	0	285		508		194. 03
200.00Cross Foot Adjustments201.00Negative Cost Centers		0	0		0	200. 00 201. 00
201.00 Negative cost centers 202.00 TOTAL (sum lines 118 through 201)	3, 022	285	-	20, 030	44, 304	

	Financial Systems	IU HEALTH JA	Provi der CC	N: 15-1320	Period: From 03/01/2018 To 12/31/2018	u of Form CMS- Worksheet B Part II Date/Time Pre 5/24/2019 10:	epared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
1 00	GENERAL SERVICE COST CENTERS		<u>г</u>		1		1 1 00
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 01\\ 7.\ 02\\ 7.\ 03\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 10.\ 00\\ 17.\ 00\\ 10.\ 00\\ 17.\ 00\\ 10.\ 00\\ 17.\ 00\\ 10.\ 00\\ 17.\ 00\\ 10.\ 00\\ 17.\ 00\\ 10.\ 00\\ 17.\ 00\\ 10.$	00100CAPRELCOSTS-BLDG & FIXT00101CAPRELCOSTS-BLDG & FIXT-MOB00102CAPRELCOSTS-BLDG & FIXT-POB00103CAPRELCOSTS-BLDG & FIXT-WJ00104CAPRELCOSTS-BLDG & FIXT-INTEREST00200CAPRELCOSTS-MVBLE00201CAPRELCOSTS-MVBLE00202CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00204CAPRELCOSTS-MVBLE00205CAPRELCOSTS-MVBLE00206CAPRELCOSTS-MVBLE00207CAPRELCOSTS-MVBLE00208CAPRELCOSTS-MVBLE00209CAPRELCOSTS-MVBLE00200CAPRELCOSTS-MVBLE00201CAPRELCOSTS-MVBLE00202CAPRELCOSTS-MVBLE00203CAPRELCOSTS-MVBLE00204COPERATIONOFPLANT00500ADMINISTRATIONOF00701OPERATIONOFPLANT00702OPERATIONOFPLANT00703OPERATIONOFPLANT00704CAPCAPRE00705OPERATIONOFPLANT01000DIETARY01100CAFCAF01100CAFERIA01400MEDICALSERVICES01500MARACY01600MEDICAL <td>80, 153 6, 309 0 2, 390 0 0</td> <td>73, 315 0 0 0</td> <td>41, 12 17</td> <td></td> <td>40, 951</td> <td>1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 13.00 14.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 10.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 10.00 15.00</td>	80, 153 6, 309 0 2, 390 0 0	73, 315 0 0 0	41, 12 17		40, 951	1.00 1.01 1.02 1.03 1.04 2.00 2.01 2.02 2.03 4.00 5.00 7.00 7.01 7.02 7.03 8.00 9.00 10.00 11.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 13.00 14.00 13.00 14.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 15.00 10.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 10.00 15.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0		0 0	0	17.00
30. 00 40. 00 43. 00	03000 ADULTS & PEDIATRICS 04000 SUBPROVIDER - IPF 04300 NURSERY	10, 394 6, 041 365	8, 552	4, 64 24		3, 247 1, 066 96	40.00
43.00	ANCI LLARY SERVICE COST CENTERS	505	331			/0	45.00
50.00 52.00 53.00 60.00 65.00 66.00 67.00 68.00 71.00 72.00 73.00 76.00 90.00	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 03160 CARDI OPULMONARY 0UTPATI ENT SERVI CE COST CENTERS	9, 391 131 0 4, 294 5, 160 2, 400 2, 595 613 107 0 0 0 0 0 0 0 725	0 0 0 0 1,557 0 0 0 38	79 15 2 13, 56 2, 19 14	0 0 0 0 0 0 0 137 21 0 04 0 04 0 04 0 04 0 04 0 04 0 0 0 0 0	9, 362 522 0 5, 255 3, 914 428 604 131 12 314 485 163 5, 021 837	$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 65.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 00\\ \end{array}$
90.00 90.01 90.02 90.03 90.04 90.05 90.06 91.00 92.00 93.00	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 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH SPECIAL PURPOSE COST CENTERS	0 7, 278 8, 845 419 0 4, 401 331 5, 540 535 78, 264	9, 283 12, 207 816 0 5, 069 645 8, 267 0	1, 25 65 11 80	58 0 58 0 15 0 3 0 57 6 11 212 0 0	625 548 50 41 263 877 7, 017 73	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
400 -	NONREI MBURSABLE COST CENTERS						100
192.00 193.00 194.00 194.02	Negative Cost Centers	0 0 0 1,889 0 80,153		5 41, 12	0 0 0 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. 00 202. 00

Hoal th Einanc	sial Systems	IU HEALTH JA			In Lio	u of Form CMS-	2552 10
Heal th Finance ALLOCATION OF	F CAPITAL RELATED COSTS	TO HEALTH JA		CN: 15-1320	Period:	Worksheet B	2552-10
					From 03/01/2018 To 12/31/2018		narod
						5/24/2019 10:	13 am
(Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total		
				Residents Cos & Post	t		
				Stepdown			
				Adjustments			
CENERA	L SERVICE COST CENTERS	17.00	24.00	25.00	26.00		
	CAP REL COSTS-BLDG & FIXT						1.00
1 1	CAP REL COSTS-BLDG & FIXT-MOB						1.01
	CAP REL COSTS-BLDG & FIXT-POB						1.02
1 1	CAP REL COSTS-BLDG & FIXT-WJ						1.03
	CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP						1.04 2.00
	CAP REL COSTS-MVBLE EQUIP - MOB						2.00
	CAP REL COSTS-MVBLE EQUIP - POB						2. 02
	CAP REL COSTS-MVBLE EQUIP - WJ						2.03
	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4.00 5.00
	OPERATION OF PLANT						7.00
	OPERATION OF PLANT - MOB						7.01
	OPERATION OF PLANT - POB						7.02
	OPERATION OF PLANT - WJ						7.03
	LAUNDRY & LINEN SERVICE HOUSEKEEPING						8.00 9.00
	DI ETARY						10.00
	CAFETERIA						11.00
	NURSI NG ADMI NI STRATI ON						13.00
	CENTRAL SERVICES & SUPPLY						14.00
	PHARMACY MEDICAL RECORDS & LIBRARY						15.00 16.00
	SOCIAL SERVICE	0					17.00
	ENT ROUTINE SERVICE COST CENTERS						
1 1	ADULTS & PEDIATRICS	0	445, 026		0 445, 026		30.00
	SUBPROVIDER – IPF NURSERY	0	169, 713 16, 240	1	0 169, 713 0 16, 240		40.00
	ARY SERVICE COST CENTERS	0	10, 240	1	0 10, 240		43.00
	OPERATING ROOM	0	215, 577		0 215, 577		50.00
	DELIVERY ROOM & LABOR ROOM	0	6, 110		0 6, 110		52.00
	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	204, 576		0 0 0 204, 576		53.00 54.00
	LABORATORY	0	98, 425		0 98, 425		60.00
	RESPI RATORY THERAPY	0	24, 099		0 24, 099		65.00
	PHYSI CAL THERAPY	0	11, 707		0 11, 707		66.00
	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	1, 642		0 1,642		67.00
	ELECTROCARDI OLOGY	0	294 60, 531		0 294 0 60, 531		68.00 69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	16, 388		0 16, 388		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	2, 735		0 2, 735		72.00
	DRUGS CHARGED TO PATIENTS	0	58, 399		0 58, 399		73.00
	CARDI OPULMONARY I ENT SERVI CE COST CENTERS	0	2, 890	1	0 2,890		76.00
90.00 09000		0	0		0 0		90.00
90.01 09001 1	FAMILY PRACTICE OF JAY COUNTY	0	40, 486		0 40, 486		90. 01
	JAY FAMILY MEDICINE	0	279, 783		0 279, 783		90.02
90.03 09003 V 90.04 09004 0	OP ORTHO CLINIC	0	2, 044 44		0 2,044 0 44		90. 03 90. 04
	JAY FAMILY FIRST HEALTH CARE	0	126, 102		0 126, 102		90.04
1 1	INFUSION CLINIC	0	2, 580		0 2, 580		90.06
	EMERGENCY	0	169, 419		0 169, 419		91.00
	OBSERVATION BEDS (NON-DISTINCT PART		0.444		0		92.00
	OUTPATIENT PSYCH L PURPOSE COST CENTERS	0	3, 416	1	0 3, 416		93.00
	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 958, 226		0 1, 958, 226		118.00
NONREL	MBURSABLE COST CENTERS			1	· · ·		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	26, 128		0 26, 128		190.00
	PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	204		0 204		192. 00 193. 00
	OTHER NONREIMBURSABLE COST CENTERS	0					193.00
	WEST JAY CLINIC	0	6, 751		0 6, 751		194.02
	JAY MERIDIAN URGENT CARE	0	51, 794		0 51, 794		194. 03
	Cross Foot Adjustments		0		0 0		200.00
	Negative Cost Centers TOTAL (sum lines 118 through 201)	0	2, 043, 103		0 0 0 2, 043, 103		201. 00 202. 00
		. 0	2, 810, 100		2, 510, 100		

	LOCATION - STATISTICAL BASIS		Provider CC		eriod: rom 03/01/2018	Worksheet B-1	
					o 12/31/2018	Date/Time Pre 5/24/2019 10:	pare
			CAPI	TAL RELATED CO	DSTS	572472019 10.	
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ	BLDG &	-
		(SQUARE FEET)	FIXT-MOB	FIXT-POB		FI XT-I NTEREST	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)	
		1.00	FEET-MOB) 1.01	FEET-POB) 1.02	FEET-WJ) 1.03	1.04	<u> </u>
	GENERAL SERVICE COST CENTERS	1.00	1.01	1.02	1.05	1.04	
	00100 CAP REL COSTS-BLDG & FLXT	77, 723	0.444				1
	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB	0	8, 146 0	10, 501			1
	00103 CAP REL COSTS-BLDG & FIXT-POB	0	0	10, 501	3, 300		
	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0	0	0,000	77, 723	
	00200 CAP REL COSTS-MVBLE EQUIP						2
	00201 CAP REL COSTS-MVBLE EQUIP - MOB						2
	00202 CAP REL COSTS-MVBLE EQUIP - POB						2
	00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
	00500 ADMINI STRATI VE & GENERAL	8, 198	1, 431	873	0	8, 198	
	00700 OPERATION OF PLANT	4, 763	1, 196	630	0	4, 763	7
	00701 OPERATION OF PLANT - MOB	50	0	0	0	50	7
	00702 OPERATION OF PLANT - POB	103	0	0	0	103	
	00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE	10 445	0	0	0	10 445	
	00900 HOUSEKEEPI NG	497	0	0	0	497	
	01000 DI ETARY	1, 449	0	0	0	1, 449	
	01100 CAFETERI A	2, 689	0	0	0	2, 689	1
	01300 NURSI NG ADMI NI STRATI ON	1,667	0	0	0	1,667	13
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 258 1, 026	0	0	0	1, 258 1, 026	
	01600 MEDICAL RECORDS & LIBRARY	1, 420	0	0	0	1, 420	
	01700 SOCIAL SERVICE	0	0	0	-	0	
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · ·					
	03000 ADULTS & PEDI ATRI CS	12, 408	0	0	0	12, 408	
	04000 SUBPROVI DER – I PF 04300 NURSERY	4, 516 496	0 0	0	0	4, 516 496	
	ANCI LLARY SERVI CE COST CENTERS	470	0	0	0	470	1
	05000 OPERATI NG ROOM	5, 410	0	8, 998		5, 410	
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	174 0	0	0	0	174	52
	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	6, 269	0	0	0	0 6, 269	53
	06000 LABORATORY	2, 557	0	0	0	2, 557	60
	06500 RESPI RATORY THERAPY	558	0	0	0	558	
	06600 PHYSI CAL THERAPY	109	0	0	0	109	66
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	2,002	0	0	0	0 2, 002	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73
	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76
	09000 CLINIC	0	0	0	0	0	90
01	09001 FAMILY PRACTICE OF JAY COUNTY	0	5, 519	0	0	0	90
	09002 JAY FAMILY MEDICINE	8, 640	0	0	0	8, 640	
	09003 WOUND CLINIC	0	0	0	0	0	90
	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE	0 3, 868	0	0	0	0 3, 868	
	09005 JAY FAMILY FIRST HEALTH CARE	3, 008 N	0	0	0	3,808	
	09100 EMERGENCY	4, 542	0	0	0	4, 542	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
-	04950 OUTPATIENT PSYCH	78	0	0	0	78	93
3. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	75, 202	8, 146	10, 501	0	75, 202	111
	NONREI MBURSABLE COST CENTERS	, 0, 202	3, 140	.0, 301		, 5, 202	1
). 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	906	0	0	0	906	
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192
	19300 NONPALD WORKERS	0	0	0	0		193
	07950 OTHER NONREIMBURSABLE COST CENTERS 07952 WEST JAY CLINIC	0	0	0	0 3, 300		194 194
	07952 WEST JAY CLINIC 07953 JAY MERIDIAN URGENT CARE	1, 615	0	0	3, 300 N	1, 615	
1. 03	Cross Foot Adjustments	1,010	0	0	0	1,010	200
					1		
0. 00 1. 00	Negative Cost Centers						
4.03 0.00 1.00 2.00		716, 974	0	0	0	0	201 202

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLC	OCATION - STATISTICAL BASIS		Provider CCN: 15-1320		Period: From 03/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/24/2019 10:	
			CAP	ITAL RELATED	COSTS		
	Cost Center Description	BLDG & FIXT	BLDG &	BLDG &	BLDG & FIXT-WJ		
		(SQUARE FEET)	FIXT-MOB	FIXT-POB		FIXT-INTEREST	
			(SQUARE	(SQUARE	(SQUARE	(SQUARE FEET)	
			FEET-MOB)	FEET-POB)	FEET-WJ)		
		1.00	1.01	1.02	1.03	1.04	
204.00	Cost to be allocated (per Wkst. B, Part II)						204.00
205.00	Unit cost multiplier (Wkst. B, Part						205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH JA	Y HOSPITAL Provider C	CN: 15-1320 P	In Lie	u of Form CMS-: Worksheet B-1	
					rom 03/01/2018 o 12/31/2018	Date/Time Pre 5/24/2019 10:	
			CAPI TAL REI	LATED COSTS		372472017 10.	
	Cost Center Description	MVBLE EQUI P (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)	
		2.00	2.01	2.02	2.03	4.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1			1.00
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 1.\ 02\\ 1.\ 03\\ 1.\ 04\\ 2.\ 00\\ 2.\ 01\\ 2.\ 02\\ 2.\ 03\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 7.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	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 EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - MOB 00203 CAP REL COSTS-MVBLE EQUIP - POB 00203 CAP REL COSTS-MVBLE EQUIP - WJ 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - MOB 00703 OPERATION OF PLANT - WJ 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	77, 723 0 0 0 8, 198 4, 763 50 103 10 445 497 1, 449 2, 689 1, 667 1, 258 1, 026 1, 420 0	8, 146 0 0 1, 431 1, 196 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 501 0 873 630 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		11, 946, 884 1, 932, 493 223, 588 2, 327 4, 837 475 26, 477 297, 191 113, 049 209, 697 1, 150, 346 0 386, 181 0	$\begin{array}{c} 1. \ 01 \\ 1. \ 02 \\ 1. \ 03 \\ 1. \ 04 \\ 2. \ 00 \\ 2. \ 01 \\ 2. \ 02 \\ 2. \ 03 \\ 4. \ 00 \\ 5. \ 00 \\ 7. \ 00 \\ 7. \ 00 \\ 7. \ 01 \\ 7. \ 02 \\ 7. \ 03 \\ 8. \ 00 \\ 9. \ 00 \\ 10. \ 00 \\ 11. \ 00 \\ 11. \ 00 \\ 13. \ 00 \\ 14. \ 00 \\ 15. \ 00 \\ 16. \ 00 \end{array}$
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	12,400				1 210 0/5	
30. 00 40. 00	03000 ADULTS & PEDIATRICS 04000 SUBPROVIDER - IPF	12, 408 4, 516				1, 310, 865 743, 051	30.00 40.00
43.00		496	0	0	0	54, 609	43.00
	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 03160 CARDI OPULMONARY 0UTPATI ENT SERVICE COST CENTERS 09000 CLI NI C	5, 410 174 0 6, 269 2, 557 558 109 0 2, 002 2, 002 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				1, 129, 150 19, 170 0 631, 522 0 315, 018 408, 458 74, 718 14, 944 0 0 0 0 89, 943	52.00 53.00 54.00 60.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.00
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY		0 5, 519		0	0 507, 115	
90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00 93. 00	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC 09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	8, 640 0 3, 868 0 4, 542 78	0 0 0 0 0 0 0			665, 653 50, 855 0 318, 543 53, 079 788, 811 42, 947	90. 02 90. 03 90. 04 90. 05 90. 06 91. 00 92. 00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	75, 202	8, 146	10, 501	0	11, 565, 112	118.00
	NONREI MBURSABLE COST CENTERS	1	1	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	906 0	0	0	0		190. 00 192. 00
193.00 194.00	19300 NONPAID WORKERS 07950 OTHER NONREIMBURSABLE COST CENTERS		0		0	0 0	193. 00 194. 00
194.03 200.00		1, 615	0	0	3, 300 0	235, 530 146, 242	194. 03 200. 00
201.00 202.00	0	1, 306, 125	20, 004	0	0	2, 262, 191	201. 00 202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 804871	2. 455684	0.000000	0. 000000	0. 189354	203.00

Health Financial Systems	IU HEALTH J	AY HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1320	Peri od:	Worksheet B-1	
				From 03/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	
		CAPI TAL RE	LATED COSTS			
Cost Center Description	MVBLE EQUIP (SQUARE FEET)		MVBLE EQUI P POB	- MVBLE EQUIP - WJ	EMPLOYEE BENEFI TS	
		(SQUARE FEET-MOB)	(SQUARE FEET-POB)	(SQUARE FEET-WJ)	DEPARTMENT (GROSS	
	2.00	2.01	2.02	2. 03	<u>SALARI ES)</u> 4. 00	
204.00 Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00 Unit cost multiplier (Wkst. B, Part					0.000000	205.00
206.00 NAHE adjustment amount to be allocat (per Wkst. B-2)	ed					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
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 03/01/2018	Worksheet B-1	
			T		Date/Time Pre	
Cast Contor Description	Reconciliation		OPERATION OF	OPERATION OF	5/24/2019 10: OPERATION OF	13 am
Cost Center Description	Reconciliation	& GENERAL	PLANT	PLANT - MOB	PLANT - POB	
		(ACCUM. COST)		(SQUARE	(SQUARE	
			7.00	FEET-MOB)	FEET-POB)	
GENERAL SERVICE COST CENTERS	5A	5.00	7.00	7.01	7.02	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1.01
1.02 00102 CAP REL COSTS-BLDG & FIXT-POB						1.02
1.03 00103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1.0400104CAPRELCOSTS-BLDG& FIXT-INTEREST2.0000200CAPRELCOSTS-MVBLEEQUI P						1.04 2.00
2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2.00
2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2.02
2.03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	11 000 000					4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT	-11, 283, 922	22, 065, 284 1, 838, 459				5.00 7.00
7.01 00701 OPERATION OF PLANT - MOB	0	57, 785		5, 519		7.00
7. 02 00702 OPERATION OF PLANT - POB	0	11, 203		0	8, 998	7.02
7.03 00703 OPERATION OF PLANT - WJ	0	350		0	0	7.03
8.00 00800 LAUNDRY & LINEN SERVICE	0	82, 030		0	0	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	443, 451		0	0	9.00 10.00
11. 00 01100 CAFETERIA	0	251, 207 335, 081		0	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	1, 969, 152		0	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	525, 182		0	0	14.00
15. 00 01500 PHARMACY	0	910, 882	1, 026	0	0	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	36, 962		0	0	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	0	2,000,043	12, 408	0	0	30.00
40. 00 04000 SUBPROVIDER - IPF	0			0	0	40.00
43. 00 04300 NURSERY	0	82, 342	496	0	0	43.00
ANCI LLARY SERVICE COST CENTERS		4 (00 40 (5 110			
50.00 05000 0PERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 603, 196 28, 903		0	8, 998 0	50.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	20,903	0	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 320, 445	-	0	0	54.00
60. 00 06000 LABORATORY	0	1, 652, 316		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	460, 637	1	0	0	65.00
66. 00 06600 PHYSICAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	523, 867		0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY	0	88, 866 17, 774		0	0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	117, 806	1	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	238, 297		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	1
73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY	0			0	0	
OUTPATIENT SERVICE COST CENTERS	0	116, 332	0	0	0	76.00
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	662, 104	0	5, 519	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	1, 074, 938		0	0	90. 02
90. 03 09003 WOUND CLINIC	0	65, 558	0	0	0	90.03
90.04 09004 OP ORTHO CLINIC 90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	508, 484	3, 868	0	0	90.04 90.05
90. 06 09006 INFUSION CLINIC	0	67, 554		0	0	90.05
91.00 09100 EMERGENCY	0	1, 373, 780	1	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 04950 OUTPATIENT PSYCH	0	58, 651	78	0	0	93.00
SPECIAL PURPOSE COST CENTERS		20 007 0/0	62 241	5, 519	0.000	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117 NONREI MBURSABLE COST CENTERS) -11, 283, 922	20, 987, 868	62, 241	5, 519	8, 998	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	23, 583	906	0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0			0	0	192.00
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193.00
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0	0	0		194.00
194.02 07952 WEST JAY CLINIC 194.03 07953 JAY MERIDIAN URGENT CARE		652, 375 380, 731		0		194.02 194.03
200.00 Cross Foot Adjustments		300,731	1,015	0	0	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,		11, 283, 922	2, 778, 625	89, 481	21, 351	202.00
Part I)		0 5110	10 00515	44 01004-	0.0700	000 00
203.00Unit cost multiplier (Wkst. B, Part I204.00Cost to be allocated (per Wkst. B,)	0. 511388 216, 904		16. 213263 1, 981	2.372861	203.00 204.00
Part II)		210, 904	144, 900	1, 701	3, 022	204.00
				I		

Heal th F	inancial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider C		Period: From 03/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 13 am
	Cost Center Description	Reconciliation	ADMI NI STRATI VE	OPERATION OF	OPERATION OF	OPERATION OF	
			& GENERAL	PLANT	PLANT - MOB	PLANT - POB	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE	(SQUARE	
					FEET-MOB)	FEET-POB)	
		5A	5.00	7.00	7.01	7.02	
205.00	Unit cost multiplier (Wkst. B, Part		0. 009830	2. 23878	2 0. 358942	0. 335852	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
COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 03/01/2018	Worksheet B-1	
			Ť		Date/Time Pre 5/24/2019 10:	
Cost Center Description	OPERATION OF PLANT - WJ	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY (MEALS SERVED)	CAFETERIA (MAN HOURS)	
	(SQUARE	(POUNDS OF	(SQUARE FEET)	(WEALS SERVED)	(MAN HOURS)	
	FEET-WJ) 7.03	LAUNDRY) 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS			1	101.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1.00
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
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 01 2. 02
2. 03 00203 CAP REL COSTS-MVBLE EQUI P - WJ						2.03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL						4.00 5.00
7.00 00700 OPERATION OF PLANT						7.00
7.01 00701 0PERATION OF PLANT - MOB 7.02 00702 0PERATION OF PLANT - POB						7.01 7.02
7. 03 00703 OPERATION OF PLANT - WJ	3, 300	44 000				7.03
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	46, 080 5, 580				8.00 9.00
10. 00 01000 DI ETARY	0	1, 440			1/ 4/5	10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	0	_,	0	16, 465 1, 296	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	0	1, 258		0	1
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		1, 026 1, 420		491 0	1
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	21, 125	12, 408	7, 554	2, 135	30.00
40. 00 04000 SUBPROVIDER - IPF	0				1, 241	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0	835	496	0	75	43.00
50. 00 05000 OPERATING ROOM	0				1, 929	1
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI 0LOGY	0	0	174 0		27 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	3, 660			882	1
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0		0	1, 060 493	1
66. 00 06600 PHYSI CAL THERAPY	0	300		0	533	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0		0	126 22	1
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	960			0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 00 03160 CARDI OPULMONARY	0	0	0		0	73.00
OUTPATIENT SERVICE COST CENTERS	0	0	<u>ı</u> 0	0	149	76.00
90. 00 09000 CLINIC	0	0	0	0	0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	0	0	8, 640	0	1, 495 1, 817	1
90. 03 09003 WOUND CLINIC 90. 04 09004 0P ORTHO CLINIC	0	0	0	0	86	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0	3, 868	0	0 904	1
90. 06 09006 INFUSION CLINIC 91. 00 09100 EMERGENCY	0	0	0	0	68	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	6, 240	4, 542	0	1, 138	91.00 92.00
93. 00 04950 OUTPATI ENT PSYCH	0	0	78	0	110	93.00
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	46, 080	61, 136	11, 028	16, 077	118.00
NONREI MBURSABLE COST CENTERS		1				
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	906 0	0		190.00 192.00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
194.00 07950 0THER NONREIMBURSABLE COST CENTERS 194.02 07952 WEST JAY CLINIC	0 3, 300		0 0	0		194.00 194.02
194. 03 07953 JAY MERIDIAN URGENT CARE	0	0	1, 615	0		194. 03
200.00Cross Foot Adjustments201.00Negative Cost Centers						200.00 201.00
202.00 Cost to be allocated (per Wkst. B,	958	143, 072	708, 876	462, 448	651, 753	1
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 290303	3. 104861	11. 135869	41. 933986	39. 584148	
204.00 Cost to be allocated (per Wkst. B,	285					204.00
Part II)	I	I	I	I I		I

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 03/01/2018	Worksheet B-1	
				To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 13 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT - WJ	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(MAN HOURS)	
	(SQUARE	(POUNDS OF				
	FEET-WJ)	LAUNDRY)				
	7.03	8.00	9.00	10.00	11.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 086364	0. 290473	0. 31465	5 4.017410	4.868084	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)						

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH JAY	Y HOSPITAL Provider CO	CN: 15-1320 P	In Lie eriod:	eu of Form CMS-: Worksheet B-1	
				rom 03/01/2018 o 12/31/2018		
Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY (COSTED	MEDI CAL RECORDS &	SOCI AL SERVI CE	
	(DI RECT NRSI NG	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	(TIME SPENT)	
	HRS)	REQUIS.)	15.00	CHARGES)	17.00	
GENERAL SERVI CE 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						1.00
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
2. 00 00200 CAP REL COSTS MVBLE EQUIP						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 01 2. 02
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.02
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL 7. 00 00700 OPERATION OF PLANT						5.00 7.00
7.01 00701 OPERATION OF PLANT - MOB						7.01
7.02 00702 OPERATION OF PLANT - POB 7.03 00703 OPERATION OF PLANT - WJ						7.02
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.00
11. 00 01100 CAFETERI A						11.00
13.00 01300 NURSI NG ADMI NI STRATI ON	7, 724	700 (15				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	722, 615 3, 075	1, 393, 530			14.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	76, 720, 481		16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 647	81, 654			0	
40. 00 04000 SUBPROVIDER - TPF 43. 00 04300 NURSERY	901 58	4, 341 0				40.00
ANCI LLARY SERVI CE COST CENTERS				177,770		1 40.00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 106 21	198, 665 0	7, 235			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	29, 149 370	4, 690		0	54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0	13, 949	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 742	0	1, 131, 634		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	430 0		245, 782 22, 427		67.00 68.00
69.00 06900 ELECTROCARDI OLOGY	164	0	0			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	238, 297 38, 540				1 / 1. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	1, 363, 711	9, 402, 203	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	4	2, 560	0	1, 568, 060	0	76.00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	978 1, 286	22, 103 11, 566		1, 170, 050 1, 027, 091		90.01 90.02
90. 03 09003 WOUND CLINIC	86	2, 021	0	94, 549	0	90.03
90. 04 09004 OP ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0 534	58 14, 194		,		90.04 90.05
90. 06 09006 INFUSION CLINIC	68	1, 010				90.05
91.00 09100 EMERGENCY	871	56, 956	7, 227	13, 140, 972	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 93. 00 04950 OUTPATI ENT PSYCH	0	4	0	136, 724	0	92.00 93.00
SPECIAL PURPOSE COST CENTERS	7 704	704 (04	4 000 500		r r	110 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	7, 724	721, 684	1, 393, 530	76, 720, 481	0	118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS		0	0	0		192.00 193.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
194. 02 07952 WEST_JAY_CLINIC 194. 03 07953 JAY_MERIDIAN_URGENT_CARE	0	931		0		194. 02 194. 03
200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers	2 117 540	0/1 700	1 455 045	100 400		201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	3, 117, 540	861, 738	1, 455, 245	132, 602	0	202.00
202 00 Unit cost multiplier (Wkst P Dort I)	403. 617297	1. 192527	1.044287	0.001728	0. 000000	203 00
203.00Unit cost multiplier (Wkst. B, Part I)204.00Cost to be allocated (per Wkst. B,	73, 315	41, 121				204.00

Heal th Fi	nancial Systems	IU HEALTH JAY	(HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provider CC	CN: 15-1320	Period: From 03/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/24/2019 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NRSI NG	(COSTED		(GROSS		
		HRS)	REQUIS.)		CHARGES)		
		13.00	14.00	15.00	16.00	17.00	
205.00	Unit cost multiplier (Wkst. B, Part	9. 491844	0. 056906	0. 0293	0. 000534	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 03/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 10:	pared: 13 am
		Title	e XVIII	Hospi tal	Cost	_
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	4, 943, 665		4, 943, 66		.,	
40. 00 04000 SUBPROVIDER - IPF	2, 419, 740		2, 419, 74		=1	
43. 00 04300 NURSERY	180, 538		180, 53	8 0	180, 538	43.00
ANCI LLARY SERVI CE COST CENTERS		1	1	-		
50.00 05000 OPERATI NG ROOM	3, 549, 265		3, 549, 26		-, , =	
52.00 05200 DELIVERY ROOM & LABOR ROOM	64, 321		64, 32		/	
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 437, 429		2, 437, 42		2, 437, 429	
60. 00 06000 LABORATORY	2, 690, 541		2, 690, 54		2, 690, 541	
65. 00 06500 RESPI RATORY THERAPY	763, 892	C	763, 89	2 0	763, 892	
66. 00 06600 PHYSI CAL THERAPY	824, 911	C	824, 91	1 0	824, 911	66.00
67.00 06700 OCCUPATI ONAL THERAPY	140, 237	C	140, 23	7 0	140, 237	67.00
68.00 06800 SPEECH PATHOLOGY	27, 773	C	27,77	3 0	27, 773	68.00
69.00 06900 ELECTROCARDI OLOGY	356, 432		356, 43	2 0	356, 432	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATI	ENTS 645, 904		645, 90	4 0	645, 904	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	104, 738		104, 73	8 0	104, 738	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 501, 450		3, 501, 45	0 0	3, 501, 450	73.00
76.00 03160 CARDI OPULMONARY	189, 098		189, 09	8 0	189, 098	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0			0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1, 572, 473		1, 572, 47	3 0	1, 572, 473	90.01
90. 02 09002 JAY FAMILY MEDICINE	2, 698, 107		2, 698, 10	7 0	2, 698, 107	90.02
90. 03 09003 WOUND CLINIC	139, 772		139, 77		139, 772	
90. 04 09004 OP ORTHO CLINIC	203		20		203	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	1, 246, 800		1, 246, 80	0 0	1, 246, 800	90.05
90. 06 09006 INFUSION CLINIC	136, 486		136, 48		136, 486	
91. 00 09100 EMERGENCY	2, 835, 918		2, 835, 91		2, 835, 918	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT P			1, 398, 10		1, 398, 102	
93. 00 04950 OUTPATI ENT PSYCH	97, 455		97, 45			93.00
200.00 Subtotal (see instructions)	32, 965, 250				32, 965, 250	
201.00 Less Observation Beds	1, 398, 102		1, 398, 10		1, 398, 102	
202.00 Total (see instructions)	31, 567, 148					
	1 31, 307, 140		1 51, 557, 14	ч ч	51, 507, 140	1202.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 03/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	
			Title	XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	3, 211, 609		3, 211, 60)9		30.00
40.00	04000 SUBPROVI DER – I PF	1, 995, 996		1, 995, 9	96		40.00
	04300 NURSERY	179, 798		179, 7			43,00
	ANCI LLARY SERVI CE COST CENTERS				-	I	
50.00	05000 OPERATING ROOM	4, 435, 507	13, 124, 466	17, 559, 9	0. 202122	0.00000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	553, 931	422, 991			0. 000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0.000000	0. 000000	53.00
	05400 RADI OLOGY-DI AGNOSTI C	603, 491	9, 236, 938	9, 840, 42			
	06000 LABORATORY	1, 372, 906	5, 957, 335				
	06500 RESPI RATORY THERAPY	364, 931	436, 942				65.00
	06600 PHYSI CAL THERAPY	185, 282	946, 352				
	06700 OCCUPATI ONAL THERAPY	118, 777	127,005				
	06800 SPEECH PATHOLOGY	8, 145	14, 282				
	06900 ELECTROCARDI OLOGY	80, 485	507, 892				
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 140	441, 185				
	07200 IMPL. DEV. CHARGED TO PATIENTS	33, 760	272, 240			0,000000	
	07300 DRUGS CHARGED TO PATIENTS	2,096,579	7, 305, 624				
	03160 CARDI OPULMONARY	262, 464	1, 305, 596				
	OUTPATIENT SERVICE COST CENTERS		.,	.,,.			
	09000 CLI NI C	0	0		0 0.000000	0.000000	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	738	1, 169, 312	1, 170, 0			
	09002 JAY FAMILY MEDICINE	138	1, 026, 953			0,000000	
90.03	09003 WOUND CLINIC	0	94, 549			0.000000	90.03
	09004 OP ORTHO CLINIC	0	77, 465			0.000000	
	09005 JAY FAMILY FIRST HEALTH CARE	681	491, 306				
	09006 INFUSION CLINIC	0	1, 642, 916				
	09100 EMERGENCY	506, 948	12, 634, 024				
	09200 OBSERVATION BEDS (NON-DISTINCT PART	49, 271	2, 819, 807				
	04950 OUTPATIENT PSYCH	0	136, 724				
200.00	Subtotal (see instructions)	16, 528, 577	60, 191, 904				200.00
200.00	Less Observation Beds	.0,020,077	00, 1, 1, 701	,			201.00
202.00	Total (see instructions)	16, 528, 577	60, 191, 904	76, 720, 4	31		202.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1320	Period: From 03/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/24/2019 10:	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
40. 00 04000 SUBPROVIDER - IPF					40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS	· · · ·				1
50.00 05000 OPERATI NG ROOM	0. 202122				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 065840				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 247695				54.00
60. 00 06000 LABORATORY	0. 367047				60.00
65. 00 06500 RESPI RATORY THERAPY	0. 952635				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 728956				66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 570575				67.00
68.00 06800 SPEECH PATHOLOGY	1. 238373				68.00
69.00 06900 ELECTROCARDI OLOGY	0. 605788				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 711093				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 342281				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 372407				73.00
76.00 03160 CARDI OPULMONARY	0. 120594				76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000				90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 343937				90.01
90. 02 09002 JAY FAMILY MEDICINE	2. 626941				90.02
90. 03 09003 WOUND CLINIC	1. 478302				90.03
90. 04 09004 OP ORTHO CLINIC	0. 002621				90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	2. 534213				90.05
90.06 09006 INFUSION CLINIC	0. 083075				90.06
91.00 09100 EMERGENCY	0. 215807				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 487300				92.00
93. 00 04950 OUTPATI ENT PSYCH	0. 712786				93.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)					202.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	Provider CCN: 15-1320		Worksheet C Part I Date/Time Pre 5/24/2019 10:	pared: 13 am
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 943, 665		4, 943, 66		4, 943, 665	
40.00	04000 SUBPROVI DER – I PF	2, 419, 740		2, 419, 74		2, 419, 740	•
43.00	04300 NURSERY	180, 538		180, 53	8 0	180, 538	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	3, 549, 265		3, 549, 26	5 0	3, 549, 265	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	64, 321		64, 32	1 0	64, 321	52.00
53.00	05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 437, 429		2, 437, 42	9 0	2, 437, 429	54.00
60.00	06000 LABORATORY	2, 690, 541		2, 690, 54	1 0	2, 690, 541	60.00
65.00	06500 RESPI RATORY THERAPY	763, 892	0	763, 89	2 0	763, 892	65.00
66.00	06600 PHYSI CAL THERAPY	824, 911	0	824, 91	1 0	824, 911	66.00
67.00	06700 OCCUPATI ONAL THERAPY	140, 237	0	140, 23	7 0	140, 237	67.00
68.00	06800 SPEECH PATHOLOGY	27, 773		27, 77	3 0	27, 773	68.00
69.00	06900 ELECTROCARDI OLOGY	356, 432		356, 43	2 0	356, 432	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	645,904		645, 90		645, 904	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	104, 738		104, 73		104, 738	
	07300 DRUGS CHARGED TO PATIENTS	3, 501, 450		3, 501, 45		3, 501, 450	
	03160 CARDI OPULMONARY	189,098		189, 09		189, 098	
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0			0 0	0	90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 572, 473		1, 572, 47	3 0	1, 572, 473	
90.02	09002 JAY FAMILY MEDICINE	2, 698, 107		2, 698, 10		2, 698, 107	
	09003 WOUND CLINIC	139, 772		139, 77		139, 772	•
	09004 OP ORTHO CLINIC	203		20		203	
90.05	09005 JAY FAMILY FIRST HEALTH CARE	1, 246, 800		1, 246, 80		1, 246, 800	•
	09006 I NFUSI ON CLINIC	136, 486		136, 48		136, 486	
91.00	09100 EMERGENCY	2, 835, 918		2, 835, 91		2, 835, 918	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 398, 102		1, 398, 10		1, 398, 102	
	04950 OUTPATIENT PSYCH	97, 455		97, 45			93.00
200.00		32, 965, 250				32, 965, 250	
200.00		1, 398, 102		1, 398, 10		1, 398, 102	
201.00		31, 567, 148					
202.00		31, 307, 140	I U	ין גע <i>ו</i> , גער, אין	0	51, 507, 140	1202.00

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 03/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	
			e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 211, 609		3, 211, 60)9		30.00
40. 00 04000 SUBPROVI DER – I PF	1, 995, 996		1, 995, 99	96		40.00
43.00 04300 NURSERY	179, 798		179, 79	98		43.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	4, 435, 507	13, 124, 466	17, 559, 9	0. 202122	0. 000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	553, 931	422, 991	976, 92	0. 065840	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	603, 491	9, 236, 938	9, 840, 42	0. 247695	0. 000000	54.00
60. 00 06000 LABORATORY	1, 372, 906	5, 957, 335	7, 330, 24	0. 367047	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	364, 931	436, 942	801, 8	0. 952635	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	185, 282	946, 352	1, 131, 63	0. 728956	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	118, 777	127, 005			0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	8, 145	14, 282	22, 42	1. 238373	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	80, 485	507, 892	588, 3	0. 605788	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	467, 140	441, 185	908, 32	0. 711093	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	33, 760	272, 240	306, 00	0. 342281	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 096, 579	7, 305, 624	9, 402, 20	0. 372407	0.00000	73.00
76.00 03160 CARDI OPULMONARY	262, 464	1, 305, 596	1, 568, 00	0. 120594	0.00000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0.000000	0.00000	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	738	1, 169, 312	1, 170, 0	50 1.343937	0.00000	90.01
90.02 09002 JAY FAMILY MEDICINE	138	1, 026, 953	1, 027, 04		0. 000000	
90. 03 09003 WOUND CLINIC	0	94, 549			0.00000	
90.04 09004 OP ORTHO CLINIC	0	77, 465	77,40	0. 002621	0.00000	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	681	491, 306	491, 98	2. 534213	0. 000000	90.05
90.06 09006 INFUSION CLINIC	0	1, 642, 916	1, 642, 9	0. 083075	0. 000000	90.06
91.00 09100 EMERGENCY	506, 948	12, 634, 024			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	49, 271	2, 819, 807	2, 869, 0	0. 487300	0. 000000	92.00
93.00 04950 OUTPATI ENT PSYCH	0	136, 724			0. 000000	93.00
200.00 Subtotal (see instructions)	16, 528, 577	60, 191, 904	76, 720, 48	31		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	16, 528, 577	60, 191, 904	76, 720, 48	31		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1320 Period: From 02/07/2018 To 12/31/2018 Worksheet C Part I To 12/31/2018 Cost Center Description PPS Inpatient Ratio Title XIX Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS 30.00 43.00 43.00 43.00 0.00 03000 ADULTS & PEDIATRICS 43.00 43.00 43.00 0.00 04000 UNBSERV FROM 08/01 50.00 52.00 50.00 50.00 05200 OPERATINE ROOM 0.202122 50.00 53.00 50.00 05200 OPERATINE ROOM 0.202122 50.00 53.00 50.00 05200 OPERATINE ROOM 0.202122 50.00 53.00 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.202122 50.00 53.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.237047 60.00 60.00 66.00 06500 RESPIRATORY THERAPY 0.372875 51.00 52.00 70.00 0700 OCUPATIONAL THERAPY 0.573675 65.00 65.00 66.00 06700 DELICINCACRDI DL	Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lie	u of Form CMS-	2552-10
Cost Center Description PPS Inpatient Retio PPS Inpatient Retio PPS Inpatient Retio 30.00 03000 ADULTS & PEDLATRICS 30.00 40.00 040000 SUBPROVIDER - IPF 43.00 30.00 040000 VIRSERV 43.00 ANCILLARY SERVICE COST CENTERS 43.00 00.00 05000 OPERATING ROOM 0.202122 00.00 05000 OPERATING ROOM 0.465840 00.01 05000 OPERATING ROOM 0.4247695 00.01 05000 ORESPI RATORY THERAPY 0.367047 00.00 05000 RESPI RATORY THERAPY 0.728956 0.00 06000 SPEECH PATHOLOGY 1.238373 0.00 0.6000 SPEECH PATHOLOGY 1.238373 0.00 0.000 RUBCIAL SUPPLIES CHARED TO PATIENTS 0.3122401 0.100 0.000 RUBCIAL SUPPLIES CHARED TO PATIENTS 0.3222401 0.100 0.000 RUBCIAL SUPPLIES CHARED TO PATIENTS 0.322641 0.100 000 RUBCIAL SUPPLIES CHARED TO PATIENTS 0.3226401 0.100 000 RUBCIAL SUPPLIES CHARED TO PATIENTS 0.322407 76.00 0000 RUBCIAL SUPPLIES CHARED TO PAT	COMPUTATION OF RATIO OF COSTS TO CHARGES			From 03/01/2018 To 12/31/2018	Part I Date/Time Pre 5/24/2019 10:	
Ratio 11.00 30.00 03000 ADULTS & PEDIATRICS 30.00 40000 SUBPROVIDER - 1 FF 43.00 43.00 04000S UBPROVIDER - 1 FF 43.00 43.00 05000 OPERATING ROM 0.202122 50.00 50.00 05000 OPERATING ROM 0.202122 50.00 50.00 05000 OPERATING ROM 0.202122 50.00 52.00 05200 DELV VERY ROM & LABOR ROM 0.265840 53.00 53.00 05300 ANDESTHESI OLOGY 0.000000 53.00 66.00 06000 RESPI RATORY THERAPY 0.367047 60.00 66.00 06500 RESPI RATORY THERAPY 0.72856 66.00 67.00 05000 OPERATINONAL THERAPY 0.72856 66.00 67.00 05000 CLEVTREY THERAPY 0.73873 68.00 67.00 05000 OPHYSI CLAT THERAPY 0.73873 68.00 69.00 065000 SPECH PATHOLOGY 1.238373 68.00 69.00 06900 CLETROCARDIOLOGY 1.238373 69.00 70.00 07200 IMPL. DEV. CHARGED TO PATIENTS <td< td=""><td></td><td></td><td>Title XIX</td><td>Hospi tal</td><td>PPS</td><td></td></td<>			Title XIX	Hospi tal	PPS	
30.00 03000 ADULTS & PEDIATRICS 30.00 40.00 04000 SUBROVIDER - 1 PF 40.00 41.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 05000 PERATIN ROROM 0.202122 51.00 05000 PERATIN ROROM 0.065840 52.00 05200 DELIVERY ROM & LABOR ROOM 0.065840 53.00 05300 ASSID ALESTHESIOLOGY 0.000000 64.00 06600 LABORATORY 0.367047 65.00 06500 RESPI RATORY THERAPY 0.728956 65.00 06600 PHYSI CAL THERAPY 0.728956 67.00 06000 ELECTRCARDI OLOGY 1.238373 68.00 06800 SPECH PATHOLOGY 1.238373 69.00 07100 MEL CARDI OP PATI ENTS 0.372407 71.00 07300 PULMARCE ON TO PATI ENTS 0.32407 73.00 03000 SUBORATORY 0.120594 70.01 FAIL THER SERVICE COST CENTERS 90.01 73.00 03300 ORUGS CHARGED TO PAT	Cost Center Description	Ratio				
30.00 03000 ADULTS & PEDIATRICS 30.00 40.00 04000 SUBROVIDER - 1 PF 40.00 41.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 50.00 05000 PERATIN ROROM 0.202122 51.00 05000 PERATIN ROROM 0.065840 52.00 05200 DELIVERY ROM & LABOR ROOM 0.065840 53.00 05300 ASSID ALESTHESIOLOGY 0.000000 64.00 06600 LABORATORY 0.367047 65.00 06500 RESPI RATORY THERAPY 0.728956 65.00 06600 PHYSI CAL THERAPY 0.728956 67.00 06000 ELECTRCARDI OLOGY 1.238373 68.00 06800 SPECH PATHOLOGY 1.238373 69.00 07100 MEL CARDI OP PATI ENTS 0.372407 71.00 07300 PULMARCE ON TO PATI ENTS 0.32407 73.00 03000 SUBORATORY 0.120594 70.01 FAIL THER SERVICE COST CENTERS 90.01 73.00 03300 ORUGS CHARGED TO PAT	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	· · · · · ·				
43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROM 0.202122 51.00 05200 DELIVERY ROM & LABOR ROM 0.665840 52.00 52.00 05200 DELIVERY ROM & LABOR ROM 0.065840 52.00 53.00 05300 ANCSTHESIOLOGY 0.000000 53.00 54.00 05400 RADIOLOGY-DI AGNOSTIC 0.247695 54.00 65.00 06500 RSPI RATORY THERAPY 0.52635 65.00 66.00 06600 SPEECH PATHORY THERAPY 0.728956 66.00 67.00 06600 SPEECH PATHOLOGY 1.238373 68.00 69.00 06900 ELECTROCARDI DLOGY 0.405788 72.00 71.00 T100 DTIOLOS LARGED TO PATI ENTS 0.372407 73.00 73.00 07300 DRUES CHARGED TO PATI ENTS 0.372407 73.00 70.00 OPOOD CLINIC 0.000000 90.01 90.02 90.01 90001 FAMI LY PRACTICE OF JAY COUNTY 1.343937 90.02						30.00
ANCILLARY SERVICE COST CENTERS 50.00 05000 DERATING ROOM 0.202122 50.00 52.00 05200 DELVERY ROOM & LABOR ROOM 0.065840 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.247695 60.00 60.00 C6000 LABORATORY 0.367047 60.00 65.00 06600 PHSI CAL THERAPY 0.952635 65.00 66.00 06600 DCUTATI ONAL THERAPY 0.728956 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.570575 67.00 68.00 06800 SPEECH PATHOLOGY 1.238373 68.00 69.00 OBOOD ELECTROCARDI OLOGY 0.405788 71.00 71.00 71.00 7100 MEL CARD TO PATI ENTS 0.372407 73.00 73.00 07300 RUSC CHARGED TO PATI ENTS 0.322407 70.00 76.00 0316) CARDI OPULMONARY 0.120594 70.00 70.00	40. 00 04000 SUBPROVIDER - IPF					40.00
ANCILLARY SERVICE COST CENTERS 50.00 05000 DERATING ROOM 0.202122 50.00 52.00 05200 DELVERY ROOM & LABOR ROOM 0.065840 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.247695 60.00 60.00 C6000 LABORATORY 0.367047 60.00 65.00 06600 PHSI CAL THERAPY 0.952635 65.00 66.00 06600 DCUTATI ONAL THERAPY 0.728956 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0.570575 67.00 68.00 06800 SPEECH PATHOLOGY 1.238373 68.00 69.00 OBOOD ELECTROCARDI OLOGY 0.405788 71.00 71.00 71.00 7100 MEL CARD TO PATI ENTS 0.372407 73.00 73.00 07300 RUSC CHARGED TO PATI ENTS 0.322407 70.00 76.00 0316) CARDI OPULMONARY 0.120594 70.00 70.00	43. 00 04300 NURSERY					43.00
50.00 OSD00 OPERATI NG ROOM 0. 202122 50.00 52.00 OS200 DELIVERY ROOM & LABOR ROOM 0. 065840 52.00 53.00 OS300 ANESTHESI OLOCY 0. 000000 53.00 54.00 O5400 RADI OLOCY - DI AGNOSTI C 0. 247695 54.00 60.00 Cobool LABORATORY 0. 367047 65.00 06500 65.00 O6500 RESPI RATORY THERAPY 0. 728956 66.00 67.00 OCOTOO OCCUPATI ONAL THERAPY 0. 570575 67.00 68.00 D6600 PECK PATHOLOGY 1. 238373 68.00 69.00 OT200 INPL. DEV. CHARGED TO PATI ENTS 0. 711093 71.00 71.00 OT200 INPL. DEV. CHARGED TO PATI ENTS 0. 372407 73.00 73.00 OT300 DRUGS CHARGED TO PATI ENTS 0. 372407 76.00 70.00 OD3160 CARDI OPULMONARY 0. 120594 76.00 70.00 OD300 DRUGS CHARGED TO PATI ENTS 0. 372407 76.00 70.00 OD3160 CARDI OPULMONARY 0. 120594 76.00						1
53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.247695 54.00 60.00 06500 RADI OLOGY-DI AGNOSTI C 0.247695 65.00 65.00 06500 RESPI RATORY THERAPY 0.952635 65.00 66.00 06600 PHYSI CAL THERAPY 0.728956 67.00 67.00 05000 SPEECH PATHOLOGY 1.238373 68.00 69.00 06900 ELECTROCARDI OLOGY 0.665788 69.00 71.00 07100 MEDLES CHARGED TO PATIENTS 0.711093 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.32281 72.00 73.00 07300 DRUES CHARGED TO PATIENTS 0.322407 73.00 73.00 07300 DRUES CHARGED TO PATIENTS 0.322407 73.00 70.00 0100LLANCH CE OST CENTERS 0.000000 90.00 00100 PULMONARY 0.120594 90.01 90.01 90.01 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.02 90.02 90001 FAMILY	50.00 05000 OPERATI NG ROOM	0. 202122				50.00
54.00 05400 RADI OLOGY - DI AGNOSTI C 0.247695 54.00 60.00 06000 LABORATORY 0.367047 60.00 65.00 05500 RESPI RATORY THERAPY 0.952635 65.00 66.00 06400 PHYSI CAL THERAPY 0.728956 66.00 67.00 06400 PCPATI ONAL THERAPY 0.570575 67.00 68.00 06800 SPEECH PATHOLOGY 1.238373 68.00 69.00 06900 ELECTROCARDI OLOGY 0.605788 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.372407 71.00 72.00 OZ200 INPL. DEV. CHARGED TO PATI ENTS 0.372407 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.372407 73.00 74.00 0100 CARDI OPULMONARY 0.120594 90.00 90.01 GADI TO RATI ENT SERVICE COST CENTERS 90.00 90.01 FAMI LY PRACTI EC OF JAY COUNTY 1.343937 90.02 90.02 9002 JAY FAMI LY MEDI CI NE 2.6226941 90.02 90.03 090040 OP ORTHO CLI NI C 0.008201	52.00 05200 DELIVERY ROOM & LABOR ROOM	0.065840				52.00
60.00 6000 LABORATORY 0.367047 60.00 65.00 06500 RESPI RATORY THERAPY 0.952635 65.00 64.00 06000 PHYSI CAL THERAPY 0.570575 67.00 68.00 06000 SPEECH PATHOLOGY 1.238373 68.00 69.00 06000 ELECTROCARDIOLOGY 0.405788 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.312281 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.312281 72.00 73.00 03160 CARDI OPLIMONARY 0.120594 76.00 00101 FAMI LY PRACTICE OF JAY COUNTY 1.343937 90.01 90.00 1.9001 FAMI LY MEDI CI NE 2.626941 90.02 90.01 09001 FAMI LY MEDI CI NE 1.433937 90.01 90.02 9002 JAY FAMI LY MEDI CI NE 2.626941 90.02 90.03 09003 FAMI LY MEDI CI NE 2.626941 90.02 90.04 09004 PATHOLOLINIC 0.002621 90.03 90.05 9005 JAY FAMI L	53.00 05300 ANESTHESI OLOGY	0.000000				53.00
65.00 06500 RESPI RATORY THERAPY 0.952635 65.00 66.00 06600 PHYSI CAL THERAPY 0.728956 66.00 67.00 0CCUPATI ONAL THERAPY 0.570575 67.00 68.00 06800 SPECH PATHOLOGY 1.238373 68.00 69.00 06900 ELECTROCARDI OLOGY 0.605788 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.711093 71.00 72.00 O7200 IMEL DEV. CHARGED TO PATI ENTS 0.342281 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 0.372407 73.00 74.00 03160 CARDI OPULMONARY 0.120594 76.00 03160 CARDI OPULMONARY 0.120594 90.01 90.00 09000 CLI NI C 0.000000 90.01 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMI LY MEDI CI NE 2.626941 90.02 90.03 WOUND CLI NI C 1.478302 90.03 90.04 90.04 09004 PORTHO CLINI C<	54.00 05400 RADI OLOGY-DI AGNOSTI C					54.00
66.00 06600 PHYSI CAL THERAPY 0.728956 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0.570575 67.00 68.00 06800 SPECH PATHOLOGY 1.238373 68.00 69.00 06900 ELCTROCARDIOLOGY 0.605788 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.711093 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.342281 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.324221 73.00 74.00 03160 CARDI OPULMONARY 0.120594 73.00 75.00 09000 CLI NI C 0.000000 90.00 90.01 90.01 O9001 FAMI LY PRACTI CE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMI LY MEDI CI NE 2.626941 90.02 90.03 WOUND CLI NI C 0.002621 90.04 90.03 90.04 90.07 HID CLI NI C 0.003305 90.05 90.05 JAY FAMI LY FIRST HEALTH CARE 2.534213 90.05 90.04 9000	60. 00 06000 LABORATORY	0. 367047				60.00
67.00 06700 0CCUPATI 0NAL THERAPY 0.570575 67.00 68.00 06800 SPEECH PATHOLOGY 1.238373 68.00 69.00 06900 ELECTROCARDI 0LOGY 0.605788 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.711093 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.342281 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.372407 73.00 76.00 03160 CARDI OPULMONARY 0.120594 76.00 001PATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.01 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 JAY FAMILY MEDI CINE 2.626941 90.02 90.02 90.03 90000 CLINIC 1.478302 90.03 90.04 90.04 09004 OP ORTHO CLINIC 0.083075 90.05 90.05 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09100	65. 00 06500 RESPI RATORY THERAPY	0. 952635				65.00
67.00 06700 0CCUPATI 0NAL THERAPY 0.570575 67.00 68.00 06800 SPEECH PATHOLOGY 1.238373 68.00 69.00 06900 ELECTROCARDI 0LOGY 0.605788 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.711093 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.342281 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.372407 73.00 76.00 03160 CARDI OPULMONARY 0.120594 76.00 001PATIENT SERVICE COST CENTERS 0.000000 90.00 90.00 90.00 09000 CLINIC 0.000000 90.01 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 JAY FAMILY MEDI CINE 2.626941 90.02 90.02 90.03 90000 CLINIC 1.478302 90.03 90.04 90.04 09004 OP ORTHO CLINIC 0.083075 90.05 90.05 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09100	66. 00 06600 PHYSI CAL THERAPY	0. 728956				66.00
69.00 06900 ELECTROCARDIOLOGY 0.605788 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.711093 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.342281 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.372407 73.00 76.00 03160 CARDIOPULMONARY 0.120594 76.00 00TPATIENT SERVICE COST CENTERS 0.000000 90.01 70.00 90.01 90.00 090001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMILY MEDICINE 2.626941 90.02 90.03 09003 WOUND CLINIC 1.478302 90.03 90.04 09004 (PO RTHO CLINIC 0.002621 90.04 90.05 JAY FAMILY FIRST HEALTH CARE 2.534213 90.06 91.00 09100 EMERGENCY 0.215807 90.06 91.00 092000 DSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 92.00 092000 DSERVATION BEDS (NON-DISTINCT PART 0.487300 93.00 90.010		0. 570575				67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0.711093 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.342281 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0.372407 73.00 76.00 03160 CARDI OPULMONARY 0.120594 70.00 90.00 09000 CLI NI C 0.000000 90.01 90.01 09001 FAMI LY PRACTI CE OST CENTERS 90.00 90.01 90.02 09002 JAY FAMI LY MEDI CI NE 2.626941 90.02 90.03 09003 WOUND CLI NI C 1.478302 90.03 90.04 09004 OP ORTHO CLI NI C 0.002621 90.03 90.05 9005 JAY FAMI LY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSI ON CLI NI C 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 (DBSERVATI ON BEDS (NON-DI STI NCT PART 0.487300 92.00 92.00 09200 (DBSERVATI ON BEDS (NON-DI STI NCT PART 0.487300 92.00 93.00		1.238373				68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.342281 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.372407 73.00 0.0100 CARDI OPULMONARY 0.120594 76.00 00000 CLINIC 0.00000 70.00 90.00 09000 CLINIC 0.00000 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.02 09002 JAY FAMILY MEDICINE 2.626941 90.03 09003 WOUND CLINIC 1.478302 90.02 90.04 09004 OP ORTHO CLINIC 0.002621 90.03 90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.53213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 092SEVATION BEDS (NON-DI STINCT PART 0.487300 92.00 93.00 04950 UTPATIENT PSYCH 0.712786 200.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	69.00 06900 ELECTROCARDI OLOGY	0. 605788				69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0.372407 73.00 76.00 03160 CARDI OPULMONARY 0.120594 76.00 90.00 09000 CLI NI C 0.000000 90.01 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMI LY MEDI CI NE 2.626941 90.03 90.03 09003 WOUND CLI NI C 1.478302 90.03 90.04 09004 OP ORTHO CLI NI C 0.002621 90.03 90.05 09005 JAY FAMI LY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSI ON CLI NI C 0.083075 90.06 91.00 91000 EMERGENCY 0.215807 91.00 92.00 09200 DBSERVATI ON BEDS (NON-DI STI NCT PART 0.487300 92.00 93.00 04950 0UTPATI ENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 711093				71.00
76.00 03160 CARDI OPULMONARY 0.120594 76.00 OUTPATI ENT SERVICE COST CENTERS 0.00000 90.00 CLI NI C 90.00 90.00 90.00 90.00 90.01 90.01 90.01 90.01 FAMI LY PRACTICE OF JAY COUNTY 1.343937 90.01 90.01 90.02 90.02 90.02 90.03 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.04 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.05 90.06 90.06 90.06 90.05 90.05 90.05 90.05 90.05 90.05 90.06 90.06 90.05 90.05 90.06 <t< td=""><td>72.00 07200 IMPL. DEV. CHARGED TO PATIENTS</td><td>0. 342281</td><td></td><td></td><td></td><td>72.00</td></t<>	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 342281				72.00
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMILY MEDICINE 2.626941 90.02 90.03 09003 WOUND CLINIC 0.002621 90.03 90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 0UTPATIENT PSYCH 0.712786 93.00 200.00 Less Observation Beds 200.00 201.00 201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 372407				73.00
90.00 09000 CLINIC 0.00000 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMILY MEDICINE 2.626941 90.02 90.03 09003 WOUND CLINIC 1.478302 90.03 90.05 09004 OP ORTHO CLINIC 0.002621 90.04 90.06 09006 INFUSION CLINIC 0.083075 90.06 90.06 09000 EMERGENCY 0.215807 91.00 91.00 09100 EMERGENCY 0.487300 92.00 93.00 04950 UTPATIENT PSYCH 0.712786 93.00 90.00 Subtotal (see instructions) 200.00 201.00 201.00	76.00 03160 CARDI OPULMONARY	0. 120594				76.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1.343937 90.01 90.02 09002 JAY FAMILY MEDICINE 2.626941 90.02 90.03 09003 WOUND CLINIC 1.478302 90.03 90.04 09004 OP ORTHO CLINIC 0.002621 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 OUTPATIENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00	OUTPATIENT SERVICE COST CENTERS					
90.02 09002 JAY FAMILY MEDICINE 2.626941 90.02 90.03 09003 WOUND CLINIC 1.478302 90.03 90.04 09004 OP ORTHO CLINIC 0.002621 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 OUTPATIENT PSYCH 0.712786 93.00 200.00 Less Observation Beds 200.00 201.00	90. 00 09000 CLINIC	0. 000000				90.00
90.03 09003 WOUND CLINIC 1.478302 90.03 90.04 09004 OP ORTHO CLINIC 0.002621 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 OUTPATIENT PSYCH 0.712786 93.00 200.00 Less Observation Beds 201.00 201.00 201.00	90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1.343937				90.01
90.04 09004 0P ORTHO CLINIC 0.002621 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 UTPATIENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00						
90.05 09005 JAY FAMILY FIRST HEALTH CARE 2.534213 90.05 90.06 09006 INFUSION CLINIC 0.083075 90.06 91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 DSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 OUTPATIENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00						
90. 06 09006 INFUSION CLINIC 0.083075 90. 06 91. 00 09100 EMERGENCY 0.215807 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.487300 92. 00 93. 00 04950 OUTPATIENT PSYCH 0.712786 93. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 201. 00						
91.00 09100 EMERGENCY 0.215807 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 OUTPATIENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00						
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.487300 92.00 93.00 04950 0UTPATIENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00 201.00 201.00 201.00						
93.00 04950 OUTPATIENT PSYCH 0.712786 93.00 200.00 Subtotal (see instructions) 200.00						
200.00 Subtotal (see instructions) 200.00 200.00 201.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
201.00 Less Observation Beds 201.00		0. 712786				
202.00 Total (see instructions) 202.00						
	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 RA	TIOS NET OF	Provider C	CN: 15-1320	Peri od:	Worksheet C	
REDUCTIONS FOR MEDICALD ONLY				From 03/01/2018 To 12/31/2018	Part II Date/Time Pre	nared
				10 12/31/2010	5/24/2019 10:	13 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
	(Wkst. B, Part				Reduction	
	I, col. 26)	II col. 26)		-	Amount	
	1.00	2.00	col. 2) 3.00	4,00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	3, 549, 265	215, 577	3, 333, 68	38 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	64, 321	6, 110			0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 437, 429	204, 576	2, 232, 8	53 0	0	54.00
60. 00 06000 LABORATORY	2, 690, 541	98, 425			0	60.00
65. 00 06500 RESPI RATORY THERAPY	763, 892	24, 099			0	65.00
66. 00 06600 PHYSI CAL THERAPY	824, 911	11, 707	813, 20	04 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	140, 237	1, 642		95 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	27, 773	294	27, 4	79 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	356, 432	60, 531			0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	645, 904	16, 388			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	104, 738	2, 735			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 501, 450	58, 399			0	73.00
76.00 03160 CARDI OPULMONARY	189, 098	2, 890	186, 20	0 0	0	76.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0 1, 572, 473	0 40, 486		0 0 37 0	0	90.00 90.01
90.02 09002 JAY FAMILY MEDICINE	2, 698, 107	279, 783			0	90.01
90. 02 109002 JAT FAMILY MEDICINE 90. 03 109003 WOUND CLINIC	139, 772	2,044			0	90.02
90. 04 09004 0P ORTHO CLINIC	203	2, 044		59 0	0	90.03
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	1, 246, 800	126, 102			0	90.05
90. 06 09006 I NFUSI ON CLINIC	136, 486	2, 580			0	90.06
91. 00 09100 EMERGENCY	2, 835, 918	169, 419			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 398, 102	125, 856			0	92.00
93.00 04950 OUTPATIENT PSYCH	97, 455	3, 416			0	93.00
200.00 Subtotal (sum of lines 50 thru 199)	25, 421, 307	1, 453, 103		04 0	0	200.00
201.00 Less Observation Beds	1, 398, 102	125, 856	1, 272, 24	16 0	0	201.00
202.00 Total (line 200 minus line 201)	24, 023, 205	1, 327, 247	22, 695, 9	58 0	0	202.00

CALCULA	Financial Systems TION OF OUTPATIENT SERVICE COST TO CHARGE R ONS FOR MEDICAID ONLY	IU HEALTH JA ATIOS NET OF	Y HOSPITAL Provider C	CN: 15-1320	In Lie Period: From 03/01/2018	u of Form CMS-2552-10 Worksheet C Part II	
REDUCTI	UNS FOR MEDICALD UNLY				To 12/31/2018	Date/Time Pr 5/24/2019 10	epared: 0:13 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpatient			
			(Worksheet C,				
		Operating Cost			6		
		Reduction	8)	/ col. 7)			
		6.00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM	3, 549, 265	17, 559, 973				50.00
	D5200 DELIVERY ROOM & LABOR ROOM	64, 321	976, 922				52.00
53.00 0	D5300 ANESTHESI OLOGY	0	0	0.0000			53.00
54.00 0	D5400 RADI OLOGY-DI AGNOSTI C	2, 437, 429	9, 840, 429	0. 2476	95		54.00
60.00	D6000 LABORATORY	2, 690, 541	7, 330, 241	0.3670	47		60.00
65.00 0	06500 RESPI RATORY THERAPY	763, 892	801, 873	0. 9526	35		65.00
66.00	D6600 PHYSI CAL THERAPY	824, 911	1, 131, 634	0. 7289	56		66.00
67.00	06700 OCCUPATI ONAL THERAPY	140, 237	245, 782	0. 5705	75		67.00
68.00	D6800 SPEECH PATHOLOGY	27, 773	22, 427	1. 2383	73		68.00
69.00	D6900 ELECTROCARDI OLOGY	356, 432	588, 377	0.6057	38		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	645, 904	908, 325	0. 7110	73		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	104, 738	306, 000	0. 3422	31		72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS	3, 501, 450	9, 402, 203	0. 37240	07		73.00
76.00	D3160 CARDI OPULMONARY	189, 098	1, 568, 060	0. 1205	94		76.00
C	DUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.0000	00		90.00
90.01	09001 FAMILY PRACTICE OF JAY COUNTY	1, 572, 473	1, 170, 050	1. 34393	37		90.01
90.02	09002 JAY FAMILY MEDICINE	2, 698, 107	1, 027, 091		41		90.02
90. 03 0	D9003 WOUND CLINIC	139, 772	94, 549	1.4783	02		90.03
90.04	D9004 OP ORTHO CLINIC	203	77, 465	0.0026	21		90.04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	1, 246, 800	491, 987	2. 5342	13		90.05
	D9006 INFUSION CLINIC	136, 486	1, 642, 916				90.06
91.00	09100 EMERGENCY	2,835,918	13, 140, 972				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 398, 102	2, 869, 078				92.00
	04950 OUTPATIENT PSYCH	97, 455	136, 724				93.00
200.00	Subtotal (sum of lines 50 thru 199)	25, 421, 307	71, 333, 078				200.00
201.00	Less Observation Beds	1, 398, 102	0				201.00
202.00	Total (line 200 minus line 201)	24, 023, 205	-				202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 03/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 13 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	215, 577		0. 0122	1, 253, 650	15, 391	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 110	976, 922	0.0062	54 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	-	0.0000		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	204, 576	9, 840, 429	0. 0207	39 219, 225	4, 557	54.00
60. 00 06000 LABORATORY	98, 425	7, 330, 241	0. 01342	27 437, 495	5, 874	60.00
65. 00 06500 RESPI RATORY THERAPY	24, 099	801, 873	0. 0300	53 168, 195	5, 055	65.00
66. 00 06600 PHYSI CAL THERAPY	11, 707	1, 131, 634	0. 0103	45 76, 730	794	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 642	245, 782	0.0066	31 49, 440	330	67.00
68.00 06800 SPEECH PATHOLOGY	294	22, 427	0. 01310	3, 441	45	68.00
69. 00 06900 ELECTROCARDI OLOGY	60, 531	588, 377	0. 1028	78 13, 632	1, 402	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 388	908, 325	0. 01804	140, 826	2, 541	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 735	306, 000	0.00893	38 3, 361	30	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 399	9, 402, 203	0.0062	676, 131	4, 199	73.00
76.00 03160 CARDI OPULMONARY	2, 890	1, 568, 060	0.0018	157, 638	291	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	40, 486	1, 170, 050	0. 03460	02 0	0	90.01
90.02 09002 JAY FAMILY MEDICINE	279, 783	1, 027, 091	0. 27240	03 0	0	90.02
90. 03 09003 WOUND CLINIC	2,044	94, 549	0. 0216	18 0	0	90.03
90.04 09004 OP ORTHO CLINIC	44	77, 465	0.0005	68 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	126, 102	491, 987	0. 2563	12 0	0	90.05
90.06 09006 INFUSION CLINIC	2, 580	1, 642, 916	0.0015	70 0	0	90.06
91.00 09100 EMERGENCY	169, 419	13, 140, 972	0. 0128	2 21, 583	278	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	125, 856	2, 869, 078	0. 0438	66 980	43	92.00
93. 00 04950 OUTPATI ENT PSYCH	3, 416	136, 724	0. 02498	35 0	0	93.00
200.00 Total (lines 50 through 199)	1, 453, 103	71, 333, 078		3, 222, 327	40, 830	200. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider C		Period: From 03/01/2018 Fo 12/31/2018		
			e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C) (0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C) (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	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C) (0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76.00 03160 CARDI OPULMONARY	0	C		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C) (0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	C)	0 0	0	90.01
90.02 09002 JAY FAMILY MEDICINE	0	C)	0 0	0	90.02
90. 03 09003 WOUND CLINIC	0	C		0 0	0	90.03
90.04 09004 OP ORTHO CLINIC	0	C		0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	C		0 0	0	90.05
90. 06 09006 INFUSION CLINIC	0	C		0 0	0	90.06
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			D	0	92.00
93. 00 04950 OUTPATI ENT PSYCH	0	C		0 0	0	93.00
200.00 Total (lines 50 through 199)	0	C)	0 0	0	200.00
			•	1		

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS				From 03/01/2018 To 12/31/2018		narod
				10 12/31/2018	5/24/2019 10:	13 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
	4.00	F 00	and 4)	7.00	0.00	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0	1	0 17 550 072	0,000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 17, 559, 973	0. 000000 0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 976, 922 0 0		•
54. 00 05500 ANESTHEST 0LOGY 54. 00 05400 RADI 0LOGY-DI AGNOSTI C	0	0		0 9, 840, 429		
60. 00 06000 LABORATORY	0	0		0 7, 330, 241		
65. 00 06500 RESPIRATORY THERAPY	0			0 801, 873		
66. 00 06600 PHYSI CAL THERAPY	0			0 1, 131, 634		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 245, 782		
68. 00 06800 SPEECH PATHOLOGY	0	0		0 22, 427		•
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 588, 377	0. 000000	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 908, 325		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 306,000		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 402, 203	0. 000000	73.00
76. 00 03160 CARDI OPULMONARY	0	0		0 1, 568, 060	0. 000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0. 000000	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1, 170, 050	0. 000000	90. 01
90.02 09002 JAY FAMILY MEDICINE	0	0		0 1, 027, 091	0. 000000	
90. 03 09003 WOUND CLINIC	0	0		0 94, 549		
90.04 09004 OP ORTHO CLINIC	0	0		0 77, 465		
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 491, 987		
90. 06 09006 INFUSION CLINIC	0	0		0 1, 642, 916		
91.00 09100 EMERGENCY	0	0		0 13, 140, 972		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 2, 869, 078		
93. 00 04950 OUTPATIENT PSYCH	0	0		0 136, 724		•
200.00 Total (lines 50 through 199)	0	0	1	0 71, 333, 078	l	200. 00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS				From 03/01/2018		nored.
				To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared: 13 am
		Title	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-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 OPERATING ROOM	0. 000000	1, 253, 650		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	219, 225		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	437, 495		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	168, 195		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	76, 730		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	49, 440		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	3, 441		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	13, 632		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	140, 826		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 361		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	676, 131		0 0	0	73.00
76.00 03160 CARDI OPULMONARY	0. 000000	157, 638		0 0	0	76.00
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
91.00 09100 EMERGENCY	0. 000000	21, 583		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	980		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)		3, 222, 327		0 0	0	200.00
					•	•

	ncial Systems	IU HEALTH JAY				u of Form CMS-	2552-10
APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period: From 03/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/24/2019 10:	pared: 13 am
			Title	XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PS Reimbursed	Cost	Cost	PPS Services	
	•	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	0. 202122	0	3, 244, 09		0	
	O DELIVERY ROOM & LABOR ROOM	0. 065840	0		0 0	0	
	O ANESTHESI OLOGY	0. 000000	0		0 0	0	
	0 RADI OLOGY-DI AGNOSTI C	0. 247695	0	2, 653, 34		0	
	0 LABORATORY	0. 367047	0	1, 689, 28		0	
	0 RESPI RATORY THERAPY	0. 952635	0	116, 57	5 0	0	65.00
	0 PHYSI CAL THERAPY	0. 728956	0	385, 53	4 0	0	00.00
	0 OCCUPATI ONAL THERAPY	0. 570575	0	28, 86		0	
	O SPEECH PATHOLOGY	1. 238373	0	8, 55		0	
69.00 0690	0 ELECTROCARDI OLOGY	0. 605788	0	156, 44	4 0	0	69.00
71.00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 711093	0	93, 41	6 0	0	71.00
	OIMPL. DEV. CHARGED TO PATIENTS	0. 342281	0	54, 14	8 0	0	72.00
73.00 0730	O DRUGS CHARGED TO PATIENTS	0. 372407	0	2, 708, 65	0 83, 924	0	73.00
76.00 0316	O CARDI OPULMONARY	0. 120594	0	511, 86	7 0	0	76.00
	ATIENT SERVICE COST CENTERS						
		0. 000000	0		0 0	0	90.00
	1 FAMILY PRACTICE OF JAY COUNTY	1. 343937	0	254, 65	9 24, 148	0	90.01
90.02 0900	2 JAY FAMILY MEDICINE	2. 626941	0	478, 60	6 32, 506	0	90.02
90.03 0900	3 WOUND CLINIC	1. 478302	0	33, 41	6 0	0	90.03
90.04 0900	4 OP ORTHO CLINIC	0. 002621	0	34, 97	2 0	0	
90.05 0900	5 JAY FAMILY FIRST HEALTH CARE	2. 534213	0	109, 90	9 5, 006	0	90.05
90.06 0900	6 INFUSION CLINIC	0. 083075	0	898, 86	6 0	0	90.06
91.00 0910	0 EMERGENCY	0. 215807	0	2, 695, 73	3 6, 051	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART	0. 487300	0	1, 107, 04	9 216	0	92.00
93.00 0495	O OUTPATI ENT PSYCH	0. 712786	0	29, 21	4 0	0	93.00
200.00	Subtotal (see instructions)		0	17, 293, 20	8 151, 851	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	1	0	17, 293, 20	8 151, 851	0	202.00

lealth Financial Sys		IU HEALTH JA			In Lieu of Form CMS-2552-10		
APPORTIONMENT OF MED	ICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1320	Period: From 03/01/2018	Worksheet D Part V	
					To 12/31/2018		epared:
						5/24/2019 10:	
				XVIII	Hospi tal	Cost	1
Crat Cra			sts	-			
Cost Cer	nter Description	Cost Reimbursed	Cost Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coi ns.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00	1			
ANCI LLARY SERV	/ICE COST CENTERS		•				
50.00 05000 OPERATIN	IG ROOM	655, 703	C				50.00
52. 00 05200 DELI VERY	/ ROOM & LABOR ROOM	0	C				52.00
53.00 05300 ANESTHES	SI OLOGY	0	0				53.00
54. 00 05400 RADI OLOC		657, 221	0				54.0
50. 00 06000 LABORATO		620, 046	0				60.0
55. 00 06500 RESPI RAT		111, 053	0	1			65.0
66. 00 06600 PHYSI CAL		281, 037	0				66.0
67. 00 06700 0CCUPATI		16, 470	0				67.00
68.00 06800 SPEECH F		10, 599	0				68.0
69.00 06900 ELECTRO		94, 772	0	1			69.00
	SUPPLIES CHARGED TO PATIENTS	66, 427	0				71.0
	V. CHARGED TO PATIENTS	18, 534	0	1			72.0
73.00 07300 DRUGS CH		1,008,720		1			73.00
76.00 03160 CARDI OPL		61, 728	0				76.0
90.00 09000 CLINIC	RVICE COST CENTERS	0					
	PRACTICE OF JAY COUNTY	342, 246	0 32, 453				90.00 90.0
90.01 09001 FAMILY F 90.02 09002 JAY FAMI		1, 257, 270					90.0
90. 02 09002 JAY PAWI 90. 03 09003 WOUND CL		49, 399	00, 391	1			90.0
90.03 09003 WOUND CL		47, 377					90.0
	LY FIRST HEALTH CARE	278, 533	12, 686				90.0
90.06 09005 JAT TAMI		74, 673	12,000	1			90.0
91.00 09100 EMERGEN		581, 758	1, 306				91.00
	ION BEDS (NON-DISTINCT PART	539, 465	105				92.0
93. 00 04950 OUTPATI E		20, 823		1			93.00
	(see instructions)	6, 746, 569	163, 195	1			200.00
	Clinic Lab. Services-Program	0					201.00
Only Cha							
	ges (line 200 - line 201)	6, 746, 569	163, 195				202.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
		Component	CCN: 15-M320	From 03/01/2018 To 12/31/2018		narod
		component	CCN. 15-W320	10 12/31/2016	5/24/2019 10:	13 am
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	215, 577	17, 559, 973	0.0122	77 185	2	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 110					52.00
53. 00 05300 ANESTHESI OLOGY	0, 110				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	204, 576	-				
60. 00 06000 LABORATORY	98, 425					60.00
65. 00 06500 RESPI RATORY THERAPY	24, 099					65.00
66. 00 06600 PHYSI CAL THERAPY	11, 707					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 642					67.00
68. 00 06800 SPEECH PATHOLOGY	294					68.00
69. 00 06900 ELECTROCARDI OLOGY	60, 531					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 388				0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	2,735				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	58, 399				-	73.00
76. 00 03160 CARDI OPULMONARY	2,890					76.00
OUTPATIENT SERVICE COST CENTERS		, ,				
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	40, 486	1, 170, 050	0. 03460	138	5	90.01
90.02 09002 JAY FAMILY MEDICINE	279, 783	1, 027, 091	0. 27240	03 0	0	90.02
90. 03 09003 WOUND CLINIC	2,044	94, 549	0. 0216	0 8	0	90.03
90.04 09004 OP ORTHO CLINIC	44			68 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	126, 102	491, 987	0. 2563	12 185	47	90.05
90.06 09006 INFUSION CLINIC	2, 580	1, 642, 916	0.0015	70 0	0	90.06
91. 00 09100 EMERGENCY	169, 419	13, 140, 972			523	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_,,			0	92.00
93. 00 04950 OUTPATI ENT PSYCH	3, 416				-	93.00
200.00 Total (lines 50 through 199)	1, 327, 247	71, 333, 078		336, 613	4, 823	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1320 Component CCN: 15-M320 Period 3/01/2018 Part IV Date/Time Prepared: 5/24/2019 10: 13 am PPS	Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
Andown Social Component CCN: 15-M320 To 12/31/2018 Date/Time Prepared: 5/24/2019 Date/Times/S/25/2010 Date/Times/S/25/2010	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C	CN: 15-1320		Worksheet D	
Anci LLARY SERVICE COST CENTERS Non Physician Nursing School Nursing School Nursing School All ide Health Post-Stepdown Adjustments All ied Health Post-Stepdown Adjustments ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 50.00 50.00 05000 (PERATI NG ROM 0 0 0 0 0 0 0 0 52.00 50.00 05000 (DEPRATI NG ROM 0 0 0 0 0 0 52.00 52.00 05200 ANESTHESI OLOCY 0 0 0 0 0 0 52.00 50.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 54.00 54.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 60.00 66.00 67.00 60.00 66.00 67.00 67.00 60.00 66.00 67.00 60.00 67.00 67.00	THROUGH COSTS			001 45 1000			
Cost Center Description Non Physic clain Nursing School Nursing School All Hied Halth All ied Health Post-Stepdown Adjustments All ied Health All ied Health Post-Stepdown Adjustments ANCI LLARY SERVICE COST CENTERS 0			Component	CCN: 15-M320	10 12/31/2018		
Cost Center Description Non Physician Nursing School Nursing School Allied Health Post-Stepdown Adjustments Allied Health Post-Stepdown Adjustments ANCILLARY SERVICE COST CENTERS 0 2A 2.00 3A 3.00 50.00 05000 DEPLATING ROOM 0 <			Title	e XVIII			
AncitLary Service Cost Centers AncitLary Service Cost Centers Adjustments Adjustments ANCILLARY SERVICE COST CENTERS 0 2A 2.00 3A 3.00 ANCILLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
Cost Adj ustments Adj ustments Adj ustments 1.00 2A 2.00 3A 3.00 50.00 05000 DPERATI NG ROOM 0 <	Cost Center Description					Allied Health	
I.00 2A 2.00 3A 3.00 ANCI LLARY SERVI CE COST CENTERS							
ANCI LLARY SERVICE COST CENTERS 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>							
50.00 05000 0PERATING ROOM 0 0 0 0 0 0 0 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 00 0		1.00	2A	2.00	3A	3.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 53.00 60.00 06000 LABORATORY 0 0 0 0 0 0 60.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 0 66.00 0 66.00 0 66.00 67.00 66.00 67.00 66.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.00 67.		_	-	1	-	-	
53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 54.00 60.00 LABORATORY 0 0 0 0 0 64.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06600 SPEECH PATHOLOGY 0 0 0 67.00 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 67.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 68.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 0 0 0 0 0 0 0 73.00		0	0		0 0		
54.00 05400 RADI OLOGY - DI AGNOSTI C 0		0	C		0 0	-	
60.00 CABORATORY 0		0	C		0 0	-	
65.00 06500 RESPI RATORY THERAPY 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 66.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 73.00 74.00 09000 CLINIC 0 0 0 0 0 73.00 75.00 09000 CLINIC 0 0 0 0 0 0 0 0 76.00 09000 CLINIC 0 0		0	C		0 0	-	
66.00 06600 PHYSI CAL THERAPY 0<		0	C		0 0	-	
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 73.00 70.01 D9000 CLINIC 0 0 0 0 0 90.00 90.01 90.02 JAY FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 0 90.02 90.02 90.02 90.02 90.03 90.03 90.04 <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>-</td><td></td></td<>		0	C		0 0	-	
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 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 73.00 76.00 09000 CLI NI C 0 0 0 0 0 0 70.00 90.01 09001 FAMI LY PRACTICE OF JAY COUNTY 0 <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></td<>		0	C		0 0	0	
69.00 06900 ELECTROCARDIOLOGY 0<		0	C		0 0	-	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 73.00 000 09000 CLI NI C 0<		0	C		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 76.00 03160 CARDI OPULMONARY 0 0 0 0 0 73.00 001000 CLINIC 0		0	C		0 0	-	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 70.00 90.01 90.01 90.01 90.01 90.01 90.01 90.01 <th< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>-</td><td></td></th<>		0	C		0 0	-	
76.00 03160 CARDI OPULMONARY 0 0 0 0 0 0 76.00 OUTPATI ENT SERVICE COST CENTERS 0		0	C		0 0	-	
OUTPATI ENT 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 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 93.00 93.00 04950 OUTPATI ENT PSYCH 0 <td< td=""><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td></td><td></td></td<>		0	C		0 0		
90.00 09000 CLINIC 0 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 90.03 90.04 09004 OP ORTHO CLINIC 0 0 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 0 90.06 90.06 09006 INFUSION CLINIC 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 92.00 93.00 04950 0UTPATI ENT PSYCH 0 0 0		0	0		0 0	0	76.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0 0 0 0 90.01 90.02 09002 JAY FAMILY MEDICINE 0 0 0 0 90.02 90.03 09003 WOUND CLINIC 0 0 0 0 90.03 90.04 09004 OP ORTHO CLINIC 0 0 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 90.05 90.05 90.06 09006 INFUSION CLINIC 0 0 0 90.05 90.06 09100 EMERGENCY 0 0 0 90.06 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04950 0UTPATIENT PSYCH 0 0 0 0 93.00							
90.02 09002 JAY FAMILY MEDICINE 0		0	C		0 0	-	
90.03 09003 WOUND CLINIC 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 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04950 OUTPATIENT PSYCH 0 0 0 0 93.00		0	C		0 0	0	
90.04 09004 0P ORTHO CLINIC 0 0 0 0 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04950 0UTPATI ENT PSYCH 0 0 0 0 93.00		0	C		0 0	0	
90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 0 0 90.05 90.06 09006 INFUSION CLINIC 0 0 0 0 90.06 91.00 09100 EMERGENCY 0 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 93.00 04950 0UTPATIENT PSYCH 0 0 0 0 93.00		0	C		0 0	0	
90. 06 09006 INFUSION CLINIC 0 0 0 0 90. 06 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92. 00 93. 00 04950 0UTPATIENT PSYCH 0 0 0 0 93. 00		0	C		0 0	0	
91.00 09100 EMERGENCY 0 0 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 92.00 92.00 93.00 0 0 0 0 93.00		0	C		0 0	-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 92.00 93.00 0 93.00 0 0 0 93.00 93.00 0 0 0 0 0 93.00		0	C		0 0	0	
93.00 04950 OUTPATI ENT PSYCH 0 0 0 0 93.00		0	C		0 0	-	
		0			0	-	
200.00 Total (Lines 50 through 199) 0 0 0 0 0 0 200.00		0	0		0 0	-	
	200.00 Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	6 Provider C		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 03/01/2018 To 12/31/2018		narod
		Component	CCN. 13-W320	10 12/31/2010	5/24/2019 10:	13 am
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and 4)	Cost (sum of	8)	(col. 5 ÷ col. 7)	
		4)	cols. 2, 3, and 4)	0)	()	
	4.00	5.00	6.00	7.00	8,00	
ANCI LLARY SERVI CE COST CENTERS	1100	0.00	0100	1100	0.00	
50. 00 05000 OPERATI NG ROOM	0	0		0 17, 559, 973	0.000000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 976, 922	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 840, 429	0. 000000	54.00
60. 00 06000 LABORATORY	0	0		0 7, 330, 241	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 801, 873		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 131, 634		•
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 245, 782		
68.00 06800 SPEECH PATHOLOGY	0	0		0 22, 427	0. 000000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 588, 377		•
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 908, 325		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 306, 000		•
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 402, 203		•
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 1, 568, 060	0. 000000	76.00
90. 00 09000 CLINIC	0	0		0 0	0. 000000	90.00
90.00 09000 CEINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1, 170, 050		
90. 02 09002 JAY FAMILY MEDICINE	0			0 1, 027, 091		
90. 03 09003 WOUND CLINIC	0	0		0 94, 549		•
90. 04 09004 0P ORTHO CLINIC	0	0		0 77, 465		
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 491, 987		
90. 06 09006 INFUSION CLINIC	0	0		0 1, 642, 916		
91. 00 09100 EMERGENCY	0	0		0 13, 140, 972		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 2, 869, 078		
93. 00 04950 OUTPATIENT PSYCH	0	0		0 136, 724	0. 000000	93.00
200.00 Total (lines 50 through 199)	0	0		0 71, 333, 078		200. 00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provider C	CN: 15-1320	Peri od:	Worksheet D	
THROUGH COSTS		Component	CON. 15 M220	From 03/01/2018 To 12/31/2018		nored.
		component	CCN: 15-M320	To 12/31/2018	Date/Time Pre 5/24/2019 10:	13 am
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 000000	185		0 0	-	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	-	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	15, 304		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	92, 480		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	6, 427		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	8, 690		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	5, 350		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	532		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	13, 845		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	1	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	150, 637		0 0	0	73.00
76.00 03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0. 000000	138		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	185		0 0	0	90.05
90. 06 09006 I NFUSI ON CLI NI C	0. 000000	0		0 0	0	90.06
91. 00 09100 EMERGENCY	0. 000000	40, 530		0 160		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	2, 310		0 0	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0. 000000	2, 0.0		0 0	0	93.00
200.00 Total (lines 50 through 199)		336, 613		0 160		200.00
	i I		1	1		

lealth Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider CC Component (CN: 15-1320 CCN: 15-M320	Period: From 03/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pre 5/24/2019 10:	epared: 13 am
		Title	XVIII	Subprovider - IPF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 202122	0		0 0	C	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 065840	0		0 0	C	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	C	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 247695	0		0 0	C	54.00
50. 00 06000 LABORATORY	0. 367047	0		0 0	C	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 952635	0		0 0	C	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 728956	0		0 0	C	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 570575	0		0 0	C	67.00
58.00 06800 SPEECH PATHOLOGY	1. 238373	0		0 0	C	68.00
59. 00 06900 ELECTROCARDI OLOGY	0. 605788	0		0 0	C	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 711093	0		0 0	C	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 342281	0		0 0	C	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 372407	0		0 491	C	73.00
76. 00 03160 CARDI OPULMONARY	0. 120594	0		0 0	C	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 343937	0		0 0	0	
90.02 09002 JAY FAMILY MEDICINE	2. 626941	0		0 0	0	90.02
90. 03 09003 WOUND CLINIC	1. 478302	0		0 0	C	90.03
90.04 09004 OP ORTHO CLINIC	0. 002621	0		0 0	C	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	2. 534213	0		0 0	C	90.05
90.06 09006 INFUSION CLINIC	0. 083075	0		0 0	C	90.06
91. 00 09100 EMERGENCY	0. 215807	160		0 0	35	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 487300	0		0 0	C	
93. 00 04950 OUTPATI ENT PSYCH	0. 712786	0		0 0	C	
200.00 Subtotal (see instructions)		160		0 491	35	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		160		0 491	35	202.00

Health Financial Systems	IU HEALTH JAY	(HOSPI TAL		In Lie	u of Form CMS-2552	2-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider CC Component C	CN: 15-1320 CCN: 15-M320	Period: From 03/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Prepare 5/24/2019 10:13 a	ed: am
		Title	XVIII	Subprovider - IPF	PPS	
	Cos					
Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.) 7.00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7100				
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52.). 00 2. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 0			54.	8.00 4.00
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY	0	0). 00 5. 00
66. 00 06600 PHYSI CAL THERAPY	0	0			66.	. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0				2.00 3.00
69. 00 06900 ELECTROCARDI OLOGY	0	0). 00). 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0 183				2.00
76.00 03160 CARDI OPULMONARY	0	0			76.	. 00
0UTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	0). 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0). 00
90.02 09002 JAY FAMILY MEDICINE	0	0				0. 02
90. 03 09003 WOUND CLINIC 90. 04 09004 0P ORTHO CLINIC	0	0). 03). 04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0). 04
90. 06 09006 INFUSION CLINIC	0	0				0. 06
91.00 09100 EMERGENCY	0	0				. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 93.00 04950 OUTPATIENT PSYCH	0	0				2.00
200.00 Subtotal (see instructions)	0	183			200.	0. 00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0				201.	
202.00 Net Charges (line 200 - line 201)	0	183			202.	. 00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL			u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C		Period:	Worksheet D	
		Component		From 03/01/2018 To 12/31/2018		narod
		component	JUN. 15-Z320	10 12/31/2016	5/24/2019 10:	13 am
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
	1.00		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.000100				0	50.00
50.00 05000 OPERATING ROOM	0. 202122	0		0 0	, s	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.065840	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000 0. 247695	0			0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0. 247695	0			0	
		0			0	
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0. 952635 0. 728956	0			0	
67. 00 06700 0CCUPATI ONAL THERAPY	0. 728956	0			0	
68. 00 06800 SPEECH PATHOLOGY	1. 238373	0			0	
69. 00 06900 ELECTROCARDI OLOGY	0. 605788	0			0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 711093	0			0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 342281	0			0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 372407	0			0	
76. 00 03160 CARDI OPULMONARY	0. 120594	0			-	
OUTPATIENT SERVICE COST CENTERS	0. 120374	0		0 0	0	/0.00
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	1. 343937	0		0 0	0	
90. 02 09002 JAY FAMILY MEDICINE	2. 626941	0		0 0	0	
90. 03 09003 WOUND CLINIC	1. 478302	0		0 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0.002621	0		0 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	2. 534213	0		0 0	0	90.05
90.06 09006 INFUSION CLINIC	0. 083075	0		0 0	0	90.06
91.00 09100 EMERGENCY	0. 215807	0	1	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 487300	0		0 0	0	92.00
93. 00 04950 OUTPATI ENT PSYCH	0. 712786	0		0 0	0	93.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	l	0 0	0	202.00

Health Financial Systems	IU HEALTH JAY HOSPITAL			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1320	Peri od:	Worksheet D		
		Comment	CON 15 7000	From 03/01/2018	Part V		
		Component	CCN: 15-Z320	To 12/31/2018	Date/Time Pre 5/24/2019 10:		
		Title	e XVIII	Swing Beds - SNF		10 411	
	Cos	sts					
Cost Center Description	Cost	Cost					
	Reimbursed	Reimbursed					
	Servi ces	Services Not					
	Subject To	Subject To					
		Ded. & Coins.					
	(see inst.) 6.00	<u>(see inst.)</u> 7.00	-				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00					
50. 00 05000 OPERATI NG ROOM	0	0				50.00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00	
53. 00 05300 ANESTHESI OLOGY	0	C				53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00	
60. 00 06000 LABORATORY	0	0				60.00	
65. 00 06500 RESPI RATORY THERAPY	0	0)			65.00	
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0	C				67.00	
68.00 06800 SPEECH PATHOLOGY	0	0				68.00	
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				71.00	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00	
76.00 03160 CARDI OPULMONARY	0	0				76.00	
0UTPATI ENT_SERVI CE_COST_CENTERS 90. 00 09000 CLI NI C	0	C				90.00	
90. 00 09000 CEINIC 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	•			90.00	
90. 02 09002 JAY FAMILY MEDICINE	0	0	1			90.02	
90. 03 09003 WOUND CLINIC	0	0	-			90.03	
90. 04 09004 0P ORTHO CLINIC	0	0				90.04	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	0				90.05	
90. 06 09006 INFUSION CLINIC	0	0)			90.06	
91.00 09100 EMERGENCY	0	C				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00	
93. 00 04950 OUTPATI ENT PSYCH	0	C				93.00	
200.00 Subtotal (see instructions)	0	C				200.00	
201.00 Less PBP Clinic Lab. Services-Program	0					201.00	
Only Charges							
202.00 Net Charges (line 200 - line 201)	0	C	1			202.00	

Health Financial Systems	IU HEALTH JA	I U HEALTH JAY HOSPI TAL			In Lieu of Form CMS-2552-		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D		
				From 03/01/2018			
				To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared:	
			e XIX	Hospi tal	972472019 10. PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS		•	•	·			
30. 00 ADULTS & PEDIATRICS	445, 026	26, 701	418, 32	5 2, 330	179. 54	30.00	
40.00 SUBPROVIDER - IPF	169, 713	C	169, 71	3 1, 158	146.56	40.00	
43.00 NURSERY	16, 240		16, 24	0 144	112. 78	43.00	
200.00 Total (lines 30 through 199)	630, 979		604, 27	8 3, 632		200.00	
Cost Center Description	I npati ent	Inpati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)	-				
	6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS			1				
30. 00 ADULTS & PEDIATRICS	22					30.00	
40. 00 SUBPROVIDER - IPF	23					40.00	
43.00 NURSERY	4	451	•			43.00	
200.00 Total (lines 30 through 199)	49	7,772	2			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 03/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	215, 577	17, 559, 973	0. 01227	7 39, 611	486	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 110	976, 922	0. 00625	4 8, 555	54	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	204, 576	9, 840, 429	0. 02078	8, 387	174	54.00
60. 00 06000 LABORATORY	98, 425	7, 330, 241	0. 01342	13, 604	183	60.00
65. 00 06500 RESPI RATORY THERAPY	24, 099	801, 873	0. 03005	3, 591	108	65.00
66. 00 06600 PHYSI CAL THERAPY	11, 707	1, 131, 634	0. 01034	5 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1,642	245, 782	0. 00668	81 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	294	22, 427	0. 01310	09 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	60, 531	588, 377	0. 10287	'8 639	66	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 388	908, 325	0. 01804	2 1, 935	35	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2,735	306, 000	0.00893	8 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	58, 399	9, 402, 203	0. 00621	1 43, 073	268	73.00
76.00 03160 CARDI OPULMONARY	2,890	1, 568, 060	0. 00184	3 2, 918	5	76.00
OUTPATIENT SERVICE COST CENTERS			_			
90. 00 09000 CLI NI C	0	0	0.0000	0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	40, 486	1, 170, 050	0. 03460	02 0	0	90.01
90.02 09002 JAY FAMILY MEDICINE	279, 783	1, 027, 091	0. 27240	3 138	38	90.02
90. 03 09003 WOUND CLINIC	2,044	94, 549	0. 02161	8 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	44	77, 465	0.00056	0 8	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	126, 102	491, 987	0. 25631	2 81	21	90.05
90.06 09006 INFUSION CLINIC	2, 580	1, 642, 916	0.00157	0 0	0	90.06
91.00 09100 EMERGENCY	169, 419	13, 140, 972	0. 01289	2 21, 089	272	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	125, 856	2, 869, 078	0. 04386	6 0	0	92.00
93. 00 04950 OUTPATI ENT PSYCH	3, 416	136, 724	0. 02498	85 0	0	93.00
200.00 Total (lines 50 through 199)	1, 453, 103	71, 333, 078		143, 621	1, 710	200. 00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COSTS			Period: From 03/01/2018 To 12/31/2018	Date/Time Pre 5/24/2019 10:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School Nu Post-Stepdown Adjustments 1A	ursing School	Allied Healt Post-Stepdow Adjustments 2A		All Other Medical Education Cost 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	27	2.00	5.00	
And the service cost centers 30.00 03000 ADULTS & PEDIATRICS 40.00 04000 SUBPROVIDER - IPF 43.00 04300 NURSERY 200.00 Total (lines 30 through 199)	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0	0 0 0 0	40.00
Cost Center Description	Adjustment (Amount (see instructions) m	Total Costs sum of cols. 1 through 3, inus col. 4)	Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4.00	5.00	6.00	7.00	8.00	
INPATI ENT ROUTINE SERVICE COST CENTERS30.0003000 ADULTS & PEDIATRICS40.0004000 SUBPROVIDER - IPF43.0004300 NURSERY200.00Total (lines 30 through 199)	0	000000000000000000000000000000000000000	2, 33 1, 15 14 3, 63	8 0.00 4 0.00	23 4	
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)						30.00 40.00 43.00 200.00

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	6 Provider C		Period: From 03/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	I Allied Health	Allied Health	
	Anestheti st	Post-Stepdown	-	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	C)	0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0	C		o o	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ċ		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ċ		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76. 00 03160 CARDI OPULMONARY	0	C		0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS	-	-		-	-	
90, 00 09000 CLI NI C	0	C)	0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	C		0 0	0	90.01
90. 02 09002 JAY FAMILY MEDICINE	0	C		0 0	0	90.02
90. 03 09003 WOUND CLINIC	0	C		0 0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0	C		0 0	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	0	C		0 0	0	90.05
90. 06 09006 INFUSION CLINIC	0	C		0 0	0	90.06
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			o	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0	c c		0 0	0	93.00
200.00 Total (lines 50 through 199)	0			0 0	-	200.00
	-	-	i.		-	

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2								
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	S Provider C	CN: 15-1320	Peri od:	Worksheet D				
THROUGH COSTS				From 03/01/2018 To 12/31/2018		narod		
				10 12/31/2018	5/24/2019 10:	13 am		
		Titl	e XIX	Hospi tal	PPS			
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost			
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,				
	Education Cost		Cost (sum of		(col. 5 ÷ col.			
		4)	col s. 2, 3,	8)	7)			
	1.00	5.00	and 4)	7.00	0.00			
	4.00	5.00	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	0	1	0 17 550 072	0,000000	50,00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 17, 559, 973	0. 000000 0. 000000			
53. 00 05300 ANESTHESI OLOGY	0			0 976, 922 0 0		•		
54. 00 05400 RADI OLOGY DI AGNOSTI C	0	0		0 9, 840, 429				
60. 00 06000 LABORATORY	0			0 7, 330, 241				
65. 00 06500 RESPIRATORY THERAPY	0	0		0 7, 330, 241				
66. 00 06600 PHYSI CAL THERAPY	0			0 1, 131, 634				
67. 00 06700 OCCUPATI ONAL THERAPY	0			0 245, 782				
68. 00 06800 SPEECH PATHOLOGY	0	0		0 22, 427		•		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 588, 377	0. 000000	•		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 908, 325				
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 306,000				
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 9, 402, 203		•		
76.00 03160 CARDI OPULMONARY	0	0		0 1, 568, 060	0. 000000	76.00		
OUTPATIENT SERVICE COST CENTERS						1		
90. 00 09000 CLI NI C	0	0		0 0	0.00000	90.00		
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0 1, 170, 050	0. 000000	90. 01		
90.02 09002 JAY FAMILY MEDICINE	0	0		0 1, 027, 091	0. 000000			
90. 03 09003 WOUND CLINIC	0	0		0 94, 549		•		
90. 04 09004 OP ORTHO CLINIC	0	0		0 77, 465				
90.05 09005 JAY FAMILY FIRST HEALTH CARE	0	0		0 491, 987				
90.06 09006 INFUSION CLINIC	0	0		0 1, 642, 916				
91. 00 09100 EMERGENCY	0	0		0 13, 140, 972				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 2, 869, 078				
93. 00 04950 OUTPATIENT PSYCH	0	0		0 136, 724		•		
200.00 Total (lines 50 through 199)	0	0	1	0 71, 333, 078	l	200. 00		

Health Financial Systems	eu of Form CMS-2	2552-10					
			Provider CCN: 15-1320		Worksheet D		
THROUGH COSTS				From 03/01/2018		norod.	
				To 12/31/2018	Date/Time Pre 5/24/2019 10:	pareu: 13 am	
		Titl	e XIX	Hospi tal	PPS		
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-Throug		Pass-Through		
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9		
	7)		x col. 10)		x col. 12)		
	9.00	10.00	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	· · ·			-			
50.00 OPERATING ROOM	0. 000000	39, 611		0 0	0	50.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	8, 555		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	8, 387		0 0	0	54.00	
60. 00 06000 LABORATORY	0. 000000	13, 604		0 0	0	60.00	
65. 00 06500 RESPI RATORY THERAPY	0.000000	3, 591		0 0	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	0		0 0	0	66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	0		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	639		0 0	0	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	1, 935		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	43, 073		0 0	0	73.00	
76.00 03160 CARDI OPULMONARY	0. 000000	2, 918		0 0	0	76.00	
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	138		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	81		0 0	0	90.05	
90.06 09006 INFUSION CLINIC	0.000000	0		0 0	0	90.06	
91.00 09100 EMERGENCY	0. 000000	21, 089		0 0	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00	
93. 00 04950 OUTPATI ENT PSYCH	0. 000000	0		0 0	0	93.00	
200.00 Total (lines 50 through 199)		143, 621		0 0	0	200.00	
				,			

	Financial Systems IU HEALTH JAY HOSPI ATION OF INPATIENT OPERATING COST Pro	ovider CCN: 15-1320	Peri od: From 03/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet D-1 Date/Time Prep	bared:		
		Title XVIII	Hospi tal	5/24/2019 10:1 Cost	13 am		
	Cost Center Description		-	1.00			
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed days, ex	xcluding newborn)		2, 518	1.00		
2.00	Inpatient days (including private room days, excluding swing-bed a		·····	2, 330	2.00		
3.00	Private room days (excluding swing-bed and observation bed days). do not complete this line.	it you have only pr	rivate room days,	0	3.00		
4.00	Semi-private room days (excluding swing-bed and observation bed da			1, 629	4.00		
5.00	Total swing-bed SNF type inpatient days (including private room da reporting period	ays) through Decembe	er 31 of the cost	146	5.00		
6.00	Total swing-bed SNF type inpatient days (including private room da	ays) after December	31 of the cost	0	6.00		
7.00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room day	vs) through December	31 of the cost	42	7.00		
	reporting period						
8.00	Total swing-bed NF type inpatient days (including private room day reporting period (if calendar year, enter 0 on this line)	ys) after December 3	1 of the cost	0	8.00		
9.00	Total inpatient days including private room days applicable to the	e Program (excluding	swing-bed and	759	9.00		
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only o	(including private r	noom days)	146	10.00		
	through December 31 of the cost reporting period (see instructions	s)	5 /				
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only December 31 of the cost reporting period (if calendar year, enter		room days) after	0	11.00		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX onl		e room days)	0	12.00		
13.00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX onl	ly (including privat	o room dave)	0	13.00		
15.00	after December 31 of the cost reporting period (if calendar year,			0	13.00		
14.00 15.00	Medically necessary private room days applicable to the Program (Total nursery days (title V or XIX only)	excluding swing-bed	days)	0	14.00 15.00		
16.00	Nursery days (title V or XIX only)			0	16.00		
17 00	SWING BED ADJUSTMENT	hrough December 21 a	f the east		17 00		
17.00	Medicare rate for swing-bed SNF services applicable to services the reporting period	nrougn December 31 c	or the cost		17.00		
18.00	Medicare rate for swing-bed SNF services applicable to services at	fter December 31 of	the cost		18.00		
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services the	rough December 31 of	the cost	129.14	19.00		
20.00	reporting period		h+	0.00	20.00		
20.00	Medicaid rate for swing-bed NF services applicable to services aft reporting period	ter December 31 of t	ne cost	0.00	20.00		
21.00	Total general inpatient routine service cost (see instructions)			4, 943, 665			
22.00	Swing-bed cost applicable to SNF type services through December 37 5 x line 17)	1 of the cost report	ing period (line	0	22.00		
23.00	Swing-bed cost applicable to SNF type services after December 31 of	of the cost reportir	ng period (line 6	0	23.00		
24.00	x line 18) Swing-bed cost applicable to NF type services through December 31	of the cost reporti	ng period (line	5. 424	24.00		
	7 x line 19)						
25.00	Swing-bed cost applicable to NF type services after December 31 of x line 20)	t the cost reporting	period (line 8	0	25.00		
26.00	Total swing-bed cost (see instructions)			296, 612			
27.00	General inpatient routine service cost net of swing-bed cost (line PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	e 21 minus line 26)	l	4, 647, 053	27.00		
	General inpatient routine service charges (excluding swing-bed and	d observation bed ch	arges)	0	28.00		
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29.00 30.00		
	General inpatient routine service cost/charge ratio (line 27 ÷ lin	ne 28)		0. 000000	31.00		
	Average private room per diem charge (line 29 ÷ line 3)			0.00			
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus I	line 33)(see instruc	tions)	0.00 0.00	33.00 34.00		
35.00	0 Average per diem private room cost differential (line 34 x line 31) 0.00						
36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and p	private room cost di	fferential (line	0 4, 647, 053	36.00 37.00		
	27 minus Line 36)			., 5, 650	200		
37.00							
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME	FNTS					
37. 00 38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME Adjusted general inpatient routine service cost per diem (see inst			1, 994. 44			
37. 00 38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTME	tructions)		1, 994. 44 1, 513, 780 0	38. 00 39. 00 40. 00		

NPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1320	Peri od:	Worksheet D-1	1	
				From 03/01/2018 To 12/31/2018	Date/Time Pre		
		Title	× XVIII	Hospi tal	5/24/2019 10: Cost	13 a	
Cost Center Description	Total Inpatient CostI	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
00 NURSERY (title V & XIX only)	0	0	0.0	00 0	0) 42.	
Intensive Care Type Inpatient Hospital Ur 00 INTENSIVE CARE UNIT						43.	
00 CORONARY CARE UNI T						44	
00 BURN I NTENSI VE CARE UNI T						45	
00 SURGICAL INTENSIVE CARE UNIT						46	
00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description			<u> </u>			47	
					1.00	+	
00 Program inpatient ancillary service cost					1, 102, 393		
00 Total Program inpatient costs (sum of lin	nes 41 through 48)(s	ee instructio	ns)		2, 616, 173	3 49	
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program	innationt routine s	ervices (from	Wkst D su	m of Parts 1 and	0	50	
(111)	inpatrent routine s		WKST. D, SU		l	/ 30	
00 Pass through costs applicable to Program	inpatient ancillary	services (fr	om Wkst. D, s	sum of Parts II	0	51.	
and IV)	NOD EQ 07-1 51				-		
00 Total Program excludable cost (sum of lir 00 Total Program inpatient operating cost ex		ated non-phy	sician anest	netist and	0		
medical education costs (line 49 minus li				istrot, unu			
TARGET AMOUNT AND LIMIT COMPUTATION							
00 Program di scharges					0		
00 Target amount per discharge 00 Target amount (line 54 x line 55)					0.00		
00 Difference between adjusted inpatient ope	erating cost and tar	aet amount (I	ine 56 minus	line 53)	0		
00 Bonus payment (see instructions)							
00 Lesser of lines 53/54 or 55 from the cost	reporting period e	nding 1996, u	pdated and co	ompounded by the	0.00	59	
market basket 00 Lesser of lines 53/54 or 55 from prior ye	ar cost roport und	lated by the m	arkat backat		0.00	60	
00 If line 53/54 is less than the lower of l				the amount by	0.00		
which operating costs (line 53) are less							
amount (line 56), otherwise enter zero (s	see instructions)						
00 Relief payment (see instructions)00 Allowable Inpatient cost plus incentive plus	avment (see instruc	tions)			0		
PROGRAM INPATIENT ROUTINE SWING BED COST							
00 Medicare swing-bed SNF inpatient routine	costs through Decem	ber 31 of the	cost reporti	ng period (See	291, 188	64	
instructions)(title XVIII only) 00 Medicare swing-bed SNF inpatient routine	costs after Decembe	r 31 of the c	ost reportin	n period (See	0	65	
instructions) (title XVIII only)	COSTS al tel Decembe		ust reporting	j period (See	l	/ 03	
00 Total Medicare swing-bed SNF inpatient ro	outine costs (line 6	4 plus line 6	5)(title XVI	l only). For	291, 188	66	
CAH (see instructions) 00 Title V or XIX swing-bed NF inpatient rou	iti na casta thraugh	Decomber 21 a	f the cost r	porting ported	0	67	
(line 12 x line 19)	time costs through	December 31 C	i the cost it	sporting period			
00 Title V or XIX swing-bed NF inpatient rou	itine costs after De	cember 31 of	the cost repo	orting period	0	68 (
(line 13 x line 20)	nt routing goots ()	ing (7 , ling	(0)				
00 Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHE					0) 69.	
00 Skilled nursing facility/other nursing fa)		70	
00 Adjusted general inpatient routine service		ne 70 ÷ line	2)			71	
00 Program routine service cost (line 9 x li	,	(line 14	DO 3E)			72	
00 Medically necessary private room cost app 00 Total Program general inpatient routine s						73	
00 Capital -related cost allocated to inpatie	•			Part II, column	1	75	
26, line 45)		-					
00 Per diem capital related costs (line 75 -	,					76	
00 Program capital-related costs (line 9 x l 00 Inpatient routine service cost (line 74 m	,					77	
00 Aggregate charges to beneficiaries for ex		ovider record	s)		1	79	
00 Total Program routine service costs for o	•	st limitation	(line 78 mir	nus line 79)		80	
00 Inpatient routine service cost per diem I						81	
00 Inpatient routine service cost limitation	•					82	
00 Reasonable inpatient routine service cost 00 Program inpatient ancillary services (see	•	·)				83	
00 Utilization review - physician compensati		is)			1	85	
00 Total Program inpatient operating costs	sum of lines 83 thr				l	86	
PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST						
					-		
0 Total observation bed days (see instructi 0 Adjusted general inpatient routine cost p	ons)	lino 2)			701 1, 994. 44		

Health Financial Systems	alth Financial Systems IU HEALTH JAY HOSPITAL					2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 03/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	445, 026	4, 943, 665	0. 09001	9 1, 398, 102	125, 856	90.00
91.00 Nursing School cost	0	4, 943, 665	0.00000	0 1, 398, 102	0	91.00
92.00 Allied health cost	0	4, 943, 665	0.00000	0 1, 398, 102	0	92.00
93.00 All other Medical Education	0	4, 943, 665	0.00000	0 1, 398, 102	0	93.00

JIVIPUI	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Peri od:	Worksheet D-1	
		Component CCN: 15-M320	From 03/01/2018 To 12/31/2018	Date/Time Prep 5/24/2019 10:	
		Title XVIII	Subprovider - IPF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS		I		
	I NPATI ENT DAYS				
00	Inpatient days (including private room days and swing-bed da			1, 158	
00	Inpatient days (including private room days, excluding swing			1, 158	
00	Private room days (excluding swing-bed and observation bed d do not complete this line.	iays). It you nave only pr	ivate room days,	0	3
00	Semi-private room days (excluding swing-bed and observation	bed days)		1, 158	4
00	Total swing-bed SNF type inpatient days (including private r		r 31 of the cost	0	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)		04 C II		
00	Total swing-bed NF type inpatient days (including private ro reporting period	oom days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	nom davs) after December 3	1 of the cost	0	8
50	reporting period (if calendar year, enter 0 on this line)			0	
00	Total inpatient days including private room days applicable	to the Program (excluding	swing-bed and	405	9
	newborn days)				
00	Swing-bed SNF type inpatient days applicable to title XVIII		oom days)	0	10
00	through December 31 of the cost reporting period (see instru Swing-bed SNF type inpatient days applicable to title XVIII		oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year,		oom days) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or X		e room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
00	Total nursery days (title V or XIX only)	I all (excluding swing-bed	uays)	0	14
00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1		
. 00	Medicare rate for swing-bed SNF services applicable to servi	ces through December 31 o	f the cost		17
~~	reporting period				
00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost		18
00	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	0.00	19
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of t	he cost	0.00	20
~ ~	reporting period			0 440 740	
. 00	Total general inpatient routine service cost (see instructio		ing posied (line	2, 419, 740	
. 00	Swing-bed cost applicable to SNF type services through Decem 5 x line 17)	iber 31 01 the cost report	ing period (ine	0	22
. 00	Swing-bed cost applicable to SNF type services after Decembe	er 31 of the cost reportin	a period (line 6	0	23
	x line 18)		5 P		
. 00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	0	24
~~	7 x line 19)				
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 419, 740	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b	ed and observation bed ch	arges)	0	
00	Private room charges (excluding swing-bed charges)			0	29
00 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	/ ÷ line 28)		0 0. 000000	30 31
00	Average private room per diem charge (line 29 ÷ line 3)			0.000000	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
00	Average per diem private room charge differential (line 32 m		tions)	0.00	
00	Average per diem private room cost differential (line 34 x l			0.00	
00	Private room cost differential adjustment (line 3 x line 35)		fforontial (liss	0	36
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	inerentiai (IIne	2, 419, 740	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD	JUSTMENTS			1
00	Adjusted general inpatient routine service cost per diem (se			2,089.59	
. 00	Program general inpatient routine service cost (line 9 x lin			846, 284	
. 00	Medically necessary private room cost applicable to the Prog Total Program general inpatient routine service cost (line 3			0	40
00				846, 284	1 /1

alth Financial Systems DMPUTATION OF INPATIENT OPERATING COST	IU HEALTH JAY		CN: 15-1320	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-M320	From 03/01/2018 To 12/31/2018	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	5/24/2019 10: PPS	13 a
Cost Contor Description	Total	Total	Average Der	IPF Program Days	Drogram Cost	_
Cost Center Description	Total Inpatient CostI	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1.00	2.00	3.00 0.	4.00	5.00 0) 42.
.00 <u>NURSERY (title V & XIX only)</u> Intensive Care Type Inpatient Hospital Ur			<u>, 0.</u>	00 0	0	42
B. OO INTENSIVE CARE UNIT						43
. OO CORONARY CARE UNIT . OO BURN INTENSIVE CARE UNIT						44
. 00 SURGICAL INTENSIVE CARE UNIT						40
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	-
.00 Program inpatient ancillary service cost	(Wkst. D-3, col. 3,	line 200)			128, 955	5 48
.00 Total Program inpatient costs (sum of lin	•		ons)		975, 239	
PASS THROUGH COST ADJUSTMENTS	innationt nouting a	and and (from	What D and	n of Donto L and		
00 Pass through costs applicable to Program	inpatient routine s	ervices (Tro	n wkst. D, Su	n of Parts I and	0	50
.00 Pass through costs applicable to Program	inpatient ancillary	services (fr	om Wkst. D,	sum of Parts II	4, 823	3 51
and IV) 2.00 Total Program excludable cost (sum of lin	10550 and 51				4, 823	1 50
3.00 Total Program inpatient operating cost ex		ated, non-phy	vsician anest	netist. and	970, 416	
medical education costs (line 49 minus li	5 1			,		
TARGET AMOUNT AND LIMIT COMPUTATION					0	54
5.00 Target amount per discharge					0.00	
.00 Target amount (line 54 x line 55)					0	
00 Difference between adjusted inpatient op	erating cost and tar	get amount (I	ine 56 minus	line 53)	0	
8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cos	t reporting period e	nding 1996 i	indated and c	omnounded by the	0.00	
market basket	r reporting period e	naring 1770, t		sinpounded by the	0.00	
0.00 Lesser of lines 53/54 or 55 from prior ye					0.00	
1.00 If line 53/54 is less than the lower of which operating costs (line 53) are less					0) 61
amount (line 56), otherwise enter zero (i tho tai got		
2.00 Relief payment (see instructions)					0	
3.00 Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COST	payment (see Instruc	tions)			0	63
1.00 Medicare swing-bed SNF inpatient routine	costs through Decem	ber 31 of the	e cost report	ng period (See	0	64
instructions) (title XVIII only)	costs after Decembe	r 21 of the	act reportin	a partial (Saa	0	65
6.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	COSTS after Decembe	r 31 OF the c	ost reportin	y period (see	0	/ 05
5.00 Total Medicare swing-bed SNF inpatient re	outine costs (line 6	4 plus line 6	55)(title XVI	ll only). For	0	66
CAH (see instructions)	iting costs through	December 21	of the cost r	porting poriod	0	67
7.00 Title V or XIX swing-bed NF inpatient rom (line 12 x line 19)	time costs through	December 31 0	of the cost i	eporting period	0	
3.00 Title V or XIX swing-bed NF inpatient ro	utine costs after De	cember 31 of	the cost rep	orting period	0	68
line 13 x line 20) 2.00 Total title V or XIX swing-bed NF inpatio	ont routino costs (l	ino 67 Llin	5 60)		0	69
PART III - SKILLED NURSING FACILITY, OTHE					0	1 07
0.00 Skilled nursing facility/other nursing f)		70
.00 Adjusted general inpatient routine service.00 Program routine service cost (line 9 x li		ne 70 ÷ line	2)			71
. 00 Medically necessary private room cost ap		(line 14 x li	ne 35)			73
.00 Total Program general inpatient routine	service costs (line	72 + line 73))			74
5.00 Capital-related cost allocated to inpatio	ent routine service	costs (from W	Vorksheet B,	Part II, column		75
26, line 45) 0.00 Per diem capital-related costs (line 75 -	÷line 2)					76
.00 Program capital-related costs (line 9 x)	ine 76)					77
.00 Inpatient routine service cost (line 74 m .00 Aggregate charges to beneficiaries for each		ovi den rocan	1c)			78
.00 Aggregate charges to beneficiaries for ex .00 Total Program routine service costs for e				nus line 79)		80
.00 Inpatient routine service cost per diem	•		(81
. 00 Inpatient routine service cost limitation	, , ,					82
 00 Reasonable inpatient routine service cost 00 Program inpatient ancillary services (see 	•)				83
00 Utilization review - physician compensati		s)				85
.00 Total Program inpatient operating costs	(sum of lines 83 thr					86
PART IV - COMPUTATION OF OBSERVATION BED					0	07
7.00 Total observation bed days (see instruct 3.00 Adjusted general inpatient routine cost	-	line 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)	-	- /				89

Health Financial Systems					In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 03/01/2018	Worksheet D-1			
		Component (Component CCN: 15-M320		Date/Time Prep 5/24/2019 10:	pared: 13 am		
		Title	XVIII	Subprovider - IPF	PPS			
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on			
		(from line 21)	column 2	Observati on	Bed Pass			
				Bed Cost (from	Through Cost			
				line 89)	(col. 3 x col.			
					4) (see			
					instructions)			
	1.00	2.00	3.00	4.00	5.00			
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST		•					
90.00 Capital-related cost	C	2, 419, 740	0.00000	0 0	0	90.00		
91.00 Nursing School cost	C	2, 419, 740	0. 00000	0 0	0	91.00		
92.00 Allied health cost	C	2, 419, 740	0. 00000	0 0	0	92.00		
93.00 All other Medical Education	C	2, 419, 740			0	93.00		

COMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320 Title XIX	Peri od: From 03/01/2018 To 12/31/2018 Hospi tal	Worksheet D-1 Date/Time Prep 5/24/2019 10: PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1.00	
. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	rs aveluding newborn)		2, 518	1.0
2.00	Inpatient days (including private room days, excluding swing-			2, 318	2.0
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.0
I. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		1, 629	4.0
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 02 9	5.0
	reporting period				
o. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. (
. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	42	7.(
3. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m dave) after December (1 of the cost	0	8. (
. 00	reporting period (if calendar year, enter 0 on this line)	in days) arter becenber (in on the cost	0	0.1
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	22	9. (
0.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	nlv (including private r	oom davs)	0	10.
	through December 31 of the cost reporting period (see instruc	tions)	3 4		
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		room days) after	0	11. (
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.
2 00	through December 31 of the cost reporting period				10
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.
	Medically necessary private room days applicable to the Progr				14.
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			144	15. 16.
0.00	SWING BED ADJUSTMENT		I	4	10.
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost		17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	129. 14	19.
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20.
1 00	reporting period			4 042 775	21
21.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb	2	ing period (line	4, 943, 665 0	
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23.
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	5, 424	24.
	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the east reporting	namiad (line 0	0	25.
25.00	x line 20)			0	20.
26.00	Total swing-bed cost (see instructions)	<i></i>		296, 612	
27.00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 647, 053	27.
28.00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	28.
	Private room charges (excluding swing-bed charges)		_	0	29.
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	- line 28)		0 0. 000000	30. 31.
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li	, ,	(LI ONS)	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36.
87.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	4, 647, 053	37.
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		· · · · · · · · · · · · · · · · · · ·		
8.00	Adjusted general inpatient routine service cost per diem (see	-		1, 994. 44 43, 878	
9.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		43, 070	40.

JIVIPUI	ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1320	Peri od:	Worksheet D-1	1
					From 03/01/2018 To 12/31/2018	Date/Time Pre	
			Tit	e XIX	Hospi tal	5/24/2019 10: PPS	13 80
	Cost Center Description	Total Inpatient Cost	Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only)	180, 538	2.00				42 (
2.00	Intensive Care Type Inpatient Hospital Units	100,000		1,200.		0,010	, 12
3.00	INTENSIVE CARE UNIT						43. (
4.00	CORONARY CARE UNIT						44.0
5.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 46.
	OTHER SPECIAL CARE (SPECIFY)						40.
. 00	Cost Center Description						17.
						1.00	
8.00	Program inpatient ancillary service cost (Wks			>		42, 335	
0. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ons)		91, 228	3 49.
0. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	n Wkst. D. su	n of Parts I and	4, 401	50.
I. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	1, 710) 51.
2. 00	and IV) Total Program excludable cost (sum of lines !	50 and 51				6, 111	52.
3.00	Total Program inpatient operating cost exclude		lated, non-ph	sician anest	netist, and	85, 117	
	medical education costs (line 49 minus line !		· · · · · · · · · · · · · · · · · · ·	,			
	TARGET AMOUNT AND LIMIT COMPUTATION					1	
. 00	Program discharges Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount (ine 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	0	0		ŗ	0) 58.) 59.
. 00							
. 00	market basket Lesser of lines 53/54 or 55 from prior year of	cost coport up	dated by the	markat backat		0.00	60.
. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	
	which operating costs (line 53) are less than					-	
	amount (line 56), otherwise enter zero (see i	nstructions)				_	
2.00	Relief payment (see instructions)	opt (coo instru	ations)			0	
. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost report	ng period (See	0	64.
	instructions)(title XVIII only)						
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reporting	g period (See	0	65.
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line (5)(title XVI	l only). For	0	66.
	CAH (see instructions)	· · · · · · · · · · · · · · · · · · ·			57	-	
. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31	of the cost r	eporting period	0	67.
3. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	a costs after D	locombor 21 of	the cost rop	orting poriod		68.
5. 00	(line 13 x line 20)		ecember 31 01	the cost rep	bitting period		00.
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	e 68)		0) 69.
	PART III - SKILLED NURSING FACILITY, OTHER NU		•				
00 .	Skilled nursing facility/other nursing facili)		70.
. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line		ine /u ÷ line	Z)			71.
. 00	Medically necessary private room cost applica		(line 14 x li	ne 35)			73.
. 00	Total Program general inpatient routine servi	ice costs (line	72 + line 73)			74.
. 00	Capital-related cost allocated to inpatient	routine service	costs (from)	Vorksheet B,	art II, column		75.
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
. 00	Program capital -related costs (line 9 x line						77.
. 00	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess	• •					79.
. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost limitation	i (iine /8 mii	ius i i ne 79)		80.
. 00	Inpatient routine service cost per drem rim)				82
. 00	Reasonable inpatient routine service costs (s						83.
. 00	Program inpatient ancillary services (see in						84.
. 00	Utilization review - physician compensation						85.
. 00	Total Program inpatient operating costs (sum		rough 85)				86.
00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					701	87.
. 00							
7.00 8.00	Adjusted general inpatient routine cost per o	diem (line 27 ÷	line 2)			1, 994. 44	88.

Health Financial Systems	IU HEALTH JAY HOSPITAL			In Lieu of Form CMS-25			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 03/01/2018	Worksheet D-1		
				To 12/31/2018		pared: 13 am	
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST		_				
90.00 Capital-related cost	445, 026	4, 943, 665	0. 09001	9 1, 398, 102	125, 856	90.00	
91.00 Nursing School cost	0	4, 943, 665	0.00000	0 1, 398, 102	0	91.00	
92.00 Allied health cost	0	4, 943, 665	0.00000	0 1, 398, 102	0	92.00	
93.00 All other Medical Education	0	4, 943, 665	0. 00000	0 1, 398, 102	0	93.00	

OMPUI	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1320	Period: From 03/01/2018	Worksheet D-1	
		Component CCN: 15-M320	To 12/31/2018	Date/Time Pre 5/24/2019 10:	
		Title XIX	Subprovider - IPF	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed d	avs. excluding newborn)		1, 158	1 1
00	Inpatient days (including private room days, excluding swin			1, 158	
00	Private room days (excluding swing-bed and observation bed	days). If you have only pr	ivate room days,	0	3
00	do not complete this line.	had days)		1, 158	4
00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private		r 31 of the cost	1, 156	
	reporting period	·		-	
00	Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private r	com dave) through December	21 of the cost	0	-
00	reporting period	com days) thi ough becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private r	oom days) after December 3	1 of the cost	0	8
~~	reporting period (if calendar year, enter 0 on this line)		and a second and	22	
00	Total inpatient days including private room days applicable newborn days)	to the program (excluding	swing-bed and	23	Ģ
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	oom days)	0	10
	through December 31 of the cost reporting period (see instr				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		oom days) after	0	11
2. 00	Swing-bed NF type inpatient days applicable to titles V or		e room days)	0	12
	through December 31 of the cost reporting period	3	3 /		
8.00	Swing-bed NF type inpatient days applicable to titles V or			0	13
. 00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Pro			0	14
5.00	Total nursery days (title V or XIX only)	gi am (onor dar ng on ng boa		144	
. 00	Nursery days (title V or XIX only)			4	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to serv	icos through December 21 a	f the cost		17
. 00	reporting period	rees through becember 51 0	T the cost		
8. 00	Medicare rate for swing-bed SNF services applicable to serv	ices after December 31 of	the cost		18
	reporting period	and through December 21 of	the east	100 14	10
0. 00	Medicaid rate for swing-bed NF services applicable to servi reporting period	ces through beceilber 31 of	the cost	129.14	19
0. 00	Medicaid rate for swing-bed NF services applicable to servi	ces after December 31 of t	he cost	0.00	20
00	reporting period	`		0 440 740	
1.00 2.00	Total general inpatient routine service cost (see instructi Swing-bed cost applicable to SNF type services through Dece		ing period (line)	2, 419, 740 0	
2.00	5 x line 17)	inder 31 of the cost report	rng period (rine	0	
8.00	Swing-bed cost applicable to SNF type services after \ensuremath{Decemb}	er 31 of the cost reportin	g period (line 6	0	23
I. 00	x line 18) Swing had cast applicable to NE type carvices through Decem	bar 21 of the cost reporti	ng pariod (line	0	24
. 00	Swing-bed cost applicable to NF type services through Decem 7×1 (ine 19)	bei 31 01 the cost report	ng period (inne	0	24
5.00	Swing-bed cost applicable to NF type services after Decembe	r 31 of the cost reporting	period (line 8	0	25
	x line 20)			0	
5.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cos	t (line 21 minus line 26)		0 2, 419, 740	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		I	2/ 11// 10	1 - 1
	General inpatient routine service charges (excluding swing-	bed and observation bed ch	arges)	0	
00	Private room charges (excluding swing-bed charges)			0	
. 00 . 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 2	7 ÷ line 28)		0 0. 000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4			0.00	
. 00 . 00	Average per diem private room charge differential (line 32 Average per diem private room cost differential (line 34 x		tions)	0.00 0.00	
. 00 . 00	Private room cost differential adjustment (line 3 x line 35			0.00	
. 00	General inpatient routine service cost net of swing-bed cos		fferential (line	2, 419, 740	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AI	DIUSTMENTS			-
. 00	Adjusted general inpatient routine service cost per diem (s			2,089.59	38
. 00	Program general inpatient routine service cost (line 9 x li			48, 061	
0. 00	Medically necessary private room cost applicable to the Pro	S 1		0	
o -	Total Program general inpatient routine service cost (line	20 Lino (0)		48, 061	1 11

	Financial Systems ATION OF INPATIENT OPERATING COST	IU HEALTH JAY		CN: 15-1320	Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-M320	From 03/01/2018 To 12/31/2018	Date/Time Pre	epare
			Titl	e XIX	Subprovider -	5/24/2019 10: Cost	13 a
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost		col. 2)		(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00 C	3.00	4.00	5.00	42.
	Intensive Care Type Inpatient Hospital Units		-	1		-	
00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43.
00	BURN INTENSIVE CARE UNIT						45
00	SURGI CAL I NTENSI VE CARE UNI T						46
00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
00	Program inpatient ancillary service cost (Wk	st D_3 col 3	line 200)	-		1.00	48
00	Total Program inpatient costs (sum of lines			ons)		54, 802	
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine ·	services (from		of Parts L and	0	50
00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51
. 00	Total Program excludable cost (sum of lines					0	
00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		rated, non-phy	si ci an anestr	ietist, and	0	53
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
00	Target amount per discharge					0.00	
00	Target amount (line 54 x line 55)					0	
00 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	
00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, ι	pdated and co	ompounded by the		
00	market basket Lesser of lines 53/54 or 55 from prior year	cost report up	dated by the m	arkat baskat		0.00	60
. 00	If line 53/54 is less than the lower of line	s 55, 59 or 60 (enter the less	er of 50% of	the amount by	0.00	
	which operating costs (line 53) are less tha		s (lines 54 x	60), or 1% of	the target		
. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	Instructions)				0	62
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reporti	ng period (See	0	64
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ar 31 of the c	ost reporting	period (See	0	65
00	instructions) (title XVIII only)	ts arter becenb			g period (see		/ 03
00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line)	64 plus line 6	5)(title XVII	l only). For	0	66
. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 c	of the cost re	eporting period	0	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repo	orting period	0	68
00	(line 13 x line 20)				5 1		
00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69
. 00	Skilled nursing facility/other nursing facil				I		70
. 00 . 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71
00	Medically necessary private room cost applic	0	•				73
. 00 . 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74
	26, line 45)			or Kaneet D, I			
00 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
00	Inpatient routine service cost (line 74 minu						78
00	Aggregate charges to beneficiaries for exces						79
. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost limitation	ı (IINE /8 mir	ius line /9)		80
. 00	Inpatient routine service cost per drem frim Inpatient routine service cost limitation (I)				82
. 00	Reasonable inpatient routine service costs (see instruction					83
. 00	Program inpatient ancillary services (see in						84
. 00 . 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85
	PART IV - COMPUTATION OF OBSERVATION BED PAS	S THROUGH COST				1	
	Total observation bed days (see instructions	5)				0	87
. 00 . 00	Adjusted general inpatient routine cost per	diam (line 27	Line 2			0.00	88

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 03/01/2018	Worksheet D-1	
		Component (CCN: 15-M320	To 12/31/2018		pared: 13 am
		Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	169, 713	2, 419, 740	0.07013	7 0	0	90.00
91.00 Nursing School cost	0	2, 419, 740	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 419, 740	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 419, 740	0.00000	0 0	0	93.00

5	ALTH JAY HOSPITAL			In Lie	u of Form CMS-2	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1320		i od:	Worksheet D-3	
			To	m 03/01/2018 12/31/2018	Date/Time Pre	nared
			10	12/ 31/ 2010	5/24/2019 10:	
	Title	XVIII		Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	Inpati ent	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
		1.00		2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS		-	-	1, 324, 059		30.00
40. 00 04000 SUBPROVIDER - IPF				1, 324, 039		40.00
43. 00 04300 NURSERY				0		43.00
ANCI LLARY SERVICE COST CENTERS		1				1 45.00
50. 00 05000 OPERATING ROOM		0. 2021	22	1, 253, 650	253, 390	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0658		0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2476		219, 225	54, 301	54.00
60. 00 06000 LABORATORY		0. 3670	47	437, 495	160, 581	60.00
55. 00 06500 RESPI RATORY THERAPY		0. 9526	35	168, 195	160, 228	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7289		76, 730	55, 933	
57. 00 06700 OCCUPATI ONAL THERAPY		0. 5705		49, 440	28, 209	
58.00 06800 SPEECH PATHOLOGY		1. 2383		3, 441	4, 261	
59. 00 06900 ELECTROCARDI OLOGY		0.6057		13, 632	8, 258	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.7110		140, 826	100, 140	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3422		3, 361	1, 150	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3724		676, 131	251, 796	
76. 00 03160 CARDI OPULMONARY		0. 1205	94	157, 638	19, 010	76.00
0UTPATI ENT_SERVI CE_COST_CENTERS 00.00 09000 CLI NI C		0.0000	00	0	0	90.00
90.00 09000 CLINIC 90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 3439		0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY 90.02 09002 JAY FAMILY MEDICINE		2. 6269		0	0	90.0
90. 03 09002 3AT PAMILT MEDICINE 90. 03 09003 WOUND CLINIC		1. 4783		0	0	90.0
90. 04 09004 OP ORTHO CLINIC		0. 0026		0	0	90.0
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		2. 5342		0	0	90.0
90. 06 09006 INFUSION CLINIC		0. 0830		0	0	90.0
91. 00 09100 EMERGENCY		0. 2158		21, 583	4, 658	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4873		980	478	
93. 00 04950 OUTPATIENT PSYCH		0. 7127		0	0	
200.00 Total (sum of lines 50 through 94 and 96 throug	ıh 98)			3, 222, 327	1, 102, 393	
201.00 Less PBP Clinic Laboratory Services-Program onl				0		201.00
202.00 Net charges (line 200 minus line 201)			1	3, 222, 327		202.00

Health Financial Systems IU HEALTH	H JAY HOSPITAL Provider C	CN: 15-1320	Peri od:	u of Form CMS- Worksheet D-3	
		011. 10 1020	From 03/01/2018		,
	Component	CCN: 15-M320	To 12/31/2018		
				5/24/2019 10:	13 am
	Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		J		(col. 1 x col.	
			J	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30. 00
40. 00 04000 SUBPROVIDER - IPF			693, 046		40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2021		37	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 06584	40 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000	0 00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2476	95 15, 304	3, 791	54.00
60. 00 06000 LABORATORY		0.36704	47 92, 480	33, 945	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 9526	35 6, 427	6, 123	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 7289	56 8, 690	6, 335	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5705	75 5, 350	3, 053	67.00
68.00 06800 SPEECH PATHOLOGY		1. 2383	73 532	659	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.6057	88 13, 845	8, 387	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7110	93 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3422	81 0	0	1 12:00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 37240	07 150, 637	56, 098	73.00
76. 00 03160 CARDI OPULMONARY		0. 1205	94 0	0	76.00
OUTPATIENT SERVICE COST CENTERS		-	E		
90. 00 09000 CLINIC		0.0000			
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 34393		185	
90.02 09002 JAY FAMILY MEDICINE		2. 62694		0	
90. 03 09003 WOUND CLINIC		1. 47830		0	90.03
90. 04 09004 OP ORTHO CLINIC		0. 0026		0	
90.05 09005 JAY FAMILY FIRST HEALTH CARE		2. 5342		469	
90.06 09006 INFUSION CLINIC		0. 0830		e e	
91. 00 09100 EMERGENCY		0. 2158			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48730		1, 126	
93. 00 04950 OUTPATI ENT PSYCH		0. 7127	86 0	-	
200.00 Total (sum of lines 50 through 94 and 96 through 9			336, 613	128, 955	
201.00 Less PBP Clinic Laboratory Services-Program only c	charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			336, 613		202.00

Health Financial Systems	U HEALTH JAY HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
			From 03/01/2018		
	Component	CCN: 15-Z320	To 12/31/2018	Date/Time Pre 5/24/2019 10:	
	Ti tl e	e XVIII	Swing Beds - SNF		13 dill
Cost Center Description	in the	Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
		J	Charges	(col. 1 x col.	
			5	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
40. 00 04000 SUBPROVI DER – I PF			0		40.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		1	-1	1	-
50.00 05000 OPERATING ROOM		0. 20212		-	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 06584			
53. 00 05300 ANESTHESI OLOGY		0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24769			
60. 00 06000 LABORATORY		0. 36704			
65. 00 06500 RESPI RATORY THERAPY		0. 95263			
66. 00 06600 PHYSI CAL THERAPY		0. 72895			•
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 57057			•
69. 00 06900 ELECTROCARDI OLOGY		1.23837 0.60578			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 71109			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 34228		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 37240		-	
76. 00 03160 CARDI OPULMONARY		0. 12059			76.00
OUTPATIENT SERVICE COST CENTERS		0.12037	2,710	552	/0.00
90. 00 09000 CLINIC		0.00000	0 0	0	90.00
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 34393		-	90.01
90. 02 09002 JAY FAMILY MEDICINE		2. 62694		0	90.02
90. 03 09003 WOUND CLINIC		1. 47830		0	90.03
90. 04 09004 OP ORTHO CLINIC		0.00262	1 0	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE		2. 53421		0	90.05
90.06 09006 INFUSION CLINIC		0. 08307	5 0	0	90.06
91.00 09100 EMERGENCY		0. 21580	7 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 48730	0 0	0	92.00
93.00 04950 OUTPATIENT PSYCH		0. 71278	6 0	0	93.00
200.00 Total (sum of lines 50 through 94 and 96 t			230, 771	132, 363	200.00
201.00 Less PBP Clinic Laboratory Services-Progra	m only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			230, 771		202.00

Health Financial Systems IU HEALTH JAY	HOSPI TAL		In L	ieu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1320	Peri od:	Worksheet D-3	5
			From 03/01/20 To 12/31/20		narod
			10 12/31/20	5/24/2019 10:	
	Titl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDIATRICS			40, 4		30.00
40. 00 04000 SUBPROVI DER - I PF				0	40.00
43. 00 04300 NURSERY			4,6	37	43.00
ANCI LLARY SERVI CE COST CENTERS		T			-
50. 00 05000 OPERATI NG ROOM		0. 2021			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0658			
53. 00 05300 ANESTHESI OLOGY		0.0000		0 0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2476			
60. 00 06000 LABORATORY		0. 3670			
65. 00 06500 RESPI RATORY THERAPY		0. 9526			
66. 00 06600 PHYSI CAL THERAPY		0. 7289		0 0	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 5705		0 0	
68.00 06800 SPEECH PATHOLOGY		1. 2383		0 0	
69. 00 06900 ELECTROCARDI OLOGY		0.6057		39 387	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7110			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3422		0 0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3724			
76.00 03160 CARDI OPULMONARY		0. 1205	94 2, 9	18 352	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000		0 0	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 3439		0 0	
90. 02 09002 JAY FAMILY MEDICINE		2. 6269		38 363	
90. 03 09003 WOUND CLINIC		1.4783		0 0	
90. 04 09004 OP ORTHO CLINIC		0. 0026		0 0	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		2. 5342		31 205	
90.06 09006 INFUSION CLINIC		0. 0830		0 0	
91. 00 09100 EMERGENCY		0. 2158			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4873		0 0	
93. 00 04950 OUTPATIENT PSYCH		0. 7127		0 0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			143, 6	21 42, 335	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)			0	201.00
202.00 Net charges (line 200 minus line 201)		1	143, 6	21	202.00

Health Financial Systems IU HE INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ALTH JAY HOSPITAL Provider C	CN: 15-1320	Peri od:	worksheet D-3	
			From 03/01/2018		
	Component	CCN: 15-M320	To 12/31/2018	Date/Time Pre 5/24/2019 10:	pared:
		e XIX	Subprovider -	Cost	13 dill
		C MIN	IPF	0031	
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	0	1	30.00
40. 00 04000 SUBPROVIDER - 1 PF			46, 344		40.00
43. 00 04300 NURSERY			40, 344		40.00
ANCI LLARY SERVI CE COST CENTERS		1	0	1	43.00
50. 00 05000 OPERATI NG ROOM		0. 2021	22 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0658			
53. 00 05300 ANESTHESI OLOGY		0.0000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2476			
60. 00 06000 LABORATORY		0.3670			
65. 00 06500 RESPIRATORY THERAPY		0. 9526			
66. 00 06600 PHYSI CAL THERAPY		0. 7289		0	
67.00 06700 OCCUPATI ONAL THERAPY		0. 5705		0	67.00
68.00 06800 SPEECH PATHOLOGY		1. 2383	73 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.6057	88 1, 278	774	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 7110	93 0	0	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 3422	81 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3724	07 4, 588	1, 709	73.00
76. 00 03160 CARDI OPULMONARY		0. 1205	94 0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000			
90.01 09001 FAMILY PRACTICE OF JAY COUNTY		1. 3439			
90. 02 09002 JAY FAMILY MEDICINE		2. 6269		0	
90. 03 09003 WOUND CLINIC		1.4783		0	
90. 04 09004 OP ORTHO CLINIC		0.0026		-	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE		2.5342			
90. 06 09006 INFUSION CLINIC		0.0830		-	
91.00 09100 EMERGENCY		0. 2158			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4873			
93. 00 04950 OUTPATIENT PSYCH		0. 7127		0	
200.00 Total (sum of lines 50 through 94 and 96 throu			18, 720	6, 741	200.00
201.00 Less PBP Clinic Laboratory Services-Program on	iy charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	18, 720	1	202.00

LCUL	Financial Systems IU HEALTH JAY	Provider CCN: 15-1320	Period: From 03/01/2018	Worksheet E Part B	
			To 12/31/2018	Date/Time Pre 5/24/2019 10:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	ti ana)		6, 909, 764	
00 00	Medical and other services reimbursed under OPPS (see instruc OPPS payments	(LI ONS)		0	2.0
00	Outlier payment (see instructions)			0	4.0
01	Outlier reconciliation amount (see instructions)			0	
00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0.000	
00 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	6. 7.
00	Transitional corridor payment (see instructions)			0	
00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	
. 00	Organ acquisitions			0	10.0
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			6, 909, 764	11. (
	Reasonabl e charges				
	Ancillary service charges				12.0
. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	ine 69)		0	
. 00	Customary charges			0	14.0
. 00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.0
. 00	Amounts that would have been realized from patients liable fo	1 3	on a chargebasis	0	16. 0
. 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17 (
	Total customary charges (see instructions)			0.000000	
. 00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	ne 11) (see	0	
00	instructions)		10) (
. 00	Excess of reasonable cost over customary charges (complete on instructions)	ily if ille il exceeds il	ne 18) (see	0	20. (
. 00	Lesser of cost or charges (see instructions)			6, 978, 862	21. (
	Interns and residents (see instructions)			0	
. 00	Cost of physicians' services in a teaching hospital (see inst Total prospective payment (sum of lines 2, 4, 4, 01, 8 and 0)	ructions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.0
. 00	Deductibles and coinsurance amounts (for CAH, see instruction			38, 598	
. 00	Deductibles and Coinsurance amounts relating to amount on lin	-		3, 107, 824	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 2.	z and z3j (see	3, 832, 440	27.0
. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. (
. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 832, 440	30.0 31.0
	Subtotal (line 30 minus line 31)			3, 832, 362	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)				33.
. 00 . 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			76, 212 49, 538	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		76, 212	
. 00	Subtotal (see instructions)			3, 881, 900	
	MSP-LCC reconciliation amount from PS&R			0	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	is)		0	39. 39.
. 97	Demonstration payment adjustment amount before sequestration			0	
. 98	Partial or full credits received from manufacturers for repla	ced devices (see instru	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION			0	
. 00	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 881, 900 77, 638	
	Demonstration payment adjustment amount after sequestration			0	
. 00	Interim payments			897, 337	41.0
. 00	Tentative settlement (for contractors use only)			0	
. 00 . 00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accorda	ince with CMS Pub 15-2	chanter 1	2, 906, 925 263, 527	
. 00	§115. 2	THEE WITH OWD FUD. 10-2,		203, 327	44.
	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions)				90.
. 00 . 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0.00	
. 00	Time Value of Money (see instructions)				92.
. 00					

CULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1320	Period: From 03/01/2018	u of Form CMS-: Worksheet E Part B	
	Component CCN: 15-M320	To 12/31/2018		
	Title XVIII	Subprovider -	PPS	15 0
		I PF		
PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
Medical and other services (see instructions)			183	
 Medical and other services reimbursed under OPPS (s OPPS payments 	see instructions)		35	
0 Outlier payment (see instructions)			0	
01 Outlier reconciliation amount (see instructions)			0	
00 Enter the hospital specific payment to cost ratio ((see instructions)		0.000	5
00 Line 2 times line 5			0	6
0 Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
0 Transitional corridor payment (see instructions) 0 Ancillary service other pass through costs from Wks	at D Pt IV col 13 line 200		0	
00 Organ acqui si ti ons	St. D, 11. 1V, COL. 13, 1116 200		0	10
00 Total cost (sum of lines 1 and 10) (see instruction	าร)		183	
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonabl e charges			101	
00 Ancillary service charges 00 Organ acquisition charges (from Wkst. D-4, Pt. III,	col (1 lipo 60)		491 0	12
00 Total reasonable charges (sum of lines 12 and 13)			491	
Customary charges				1.
00 Aggregate amount actually collected from patients I			0	
00 Amounts that would have been realized from patients		n a chargebasis	0	16
had such payment been made in accordance with 42 CF 00 Ratio of line 15 to line 16 (not to exceed 1.000000			0. 000000	17
00 Total customary charges (see instructions)			491	18
00 Excess of customary charges over reasonable cost (c	complete only if line 18 exceeds li	ne 11) (see	308	
instructions)		, ,		
00 Excess of reasonable cost over customary charges (c	complete only if line 11 exceeds li	ne 18) (see	0	20
instructions) 00 Lesser of cost or charges (see instructions)			183	21
00 Interns and residents (see instructions)			0	
00 Cost of physicians' services in a teaching hospital	(see instructions)		0	
00 Total prospective payment (sum of lines 3, 4, 4.01,	8 and 9)		65	24
COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	
00 Deductibles and coinsurance amounts (for CAH, see i 00 Deductibles and Coinsurance amounts relating to amo		uctions)	0	
00 Subtotal [(lines 21 and 24 minus the sum of lines 2	•		248	
instructions)				
00 Direct graduate medical education payments (from Wk	· · · · · · · · · · · · · · · · · · ·		0	
00 ESRD direct medical education costs (from Wkst. E-4	4, line 36)		0	
00 Subtotal (sum of lines 27 through 29) 00 Primary payer payments			248	30
00 Subtotal (line 30 minus line 31)			248	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSI	ONAL SERVICES)			
00 Composite rate ESRD (from Wkst. I-5, line 11)			0	
00 Allowable bad debts (see instructions)			0	
00 Adjusted reimbursable bad debts (see instructions) 00 Allowable bad debts for dual eligible beneficiaries	s (see instructions)		0	
00 Subtotal (see instructions)			248	
00 MSP-LCC reconciliation amount from PS&R			0	
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
50 Pioneer ACO demonstration payment adjustment (see i				39
97 Demonstration payment adjustment amount before sequ 98 Partial or full credits received from manufacturers		tions)	0	39
98 PARTIAL OF FULL CLEAR TED DEPRECIATION	s ion repraced devices (see ilistide	G 0113 <i>)</i>	0	
00 Subtotal (see instructions)			248	
01 Sequestration adjustment (see instructions)			5	40
02 Demonstration payment adjustment amount after seque	estration		0	
00 Interim payments			160	
00 Tentative settlement (for contractors use only) 00 Balance due provider/program (see instructions)			0 83	
00 Protested amounts (nonallowable cost report items)	in accordance with CMS Pub. 15-2.	chapter 1,	0	
§115. 2		· · ·		
TO BE COMPLETED BY CONTRACTOR				
00 Original outlier amount (see instructions)	tructions)		0	
00 Outlier reconciliation adjustment amount (see inst 00 The rate used to calculate the Time Value of Money	LT UCTIONS)		0 0.00	
00 Time Value of Money (see instructions)			0.00	
				94

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 03/01/2018 To 12/31/2018		
		Title		Hospi tal	Cost	
		I npati ent	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 620, 36	0 0	897, 337 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	09/11/2018	87, 50	0	0	3. 01
3.02 3.03 3.04				0 0 0	0 0 0	3. 02 3. 03 3. 04
3.05				0	0	3.05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM	1		0	0	2 50
3.50 3.51	ADJUSTWENTS TO PROGRAM			0	0	3.50 3.51
3.52				0	Ő	3. 52
3.53				0	0	3.53
3.54 3.99			07 50	0	0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		87,50	10	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, 707, 86	98	897, 337	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) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50				0	0	5. 50
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		647, 26	0	2, 906, 925	6.01
6.02 7.00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		2, 355, 12		0 3, 804, 262	6.02 7.00
,.00	Total moundare program traditity (see fistructions)		2, 300, 12	Contractor Number	NPR Date (Mo/Day/Yr)	7.00
		0		1.00	2.00	

NALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		CN: 15-1320 CCN: 15-M320	Peri od: From 03/01/2018 To 12/31/2018	Worksheet E-1 Part I Date/Time Prep 5/24/2019 10:	
		Title	e XVIII	Subprovider - IPF	PPS	
		I npati er	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	T	1.00	2.00	3.00	4.00	1.0
. 00 . 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		748, 2	0	160 0	1.0 2.0
. 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. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3. (
. 02				0	0	3.
. 03 . 04				0	0	3. 3.
. 05				0	0	3.
	Provider to Program		1	-	· · · ·	
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
	3. 50-3. 98)			-		
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)		748, 2	69	160	4.
	TO BE COMPLETED BY CONTRACTOR					
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.
	Program to Provider		1			
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03	Provider to Program			0	0	5.
50	TENTATI VE TO PROGRAM		1	0	0	5.
51				0	0	5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		1, 7	12	83	6.
02	SETTLEMENT TO PROGRAM			0	0	6.
00	Total Medicare program liability (see instructions)		749, 9		243	7.
				Contractor	NPR Date	
			0	<u>Number</u> 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor		0	1.00	2.00	8

VALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 03/01/2018 To 12/31/2018		
					5/24/2019 10:	
				Swing Beds - SNI		-
		Inpatien	t Part A	Par	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		286, 90		0	1.0
00	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			O	0	
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)					3. (
	Program to Provider		I			
01	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03				0	0	
04				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
50 51				0	0	
52				0	0	3.
53				0	0	3.
54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99)		286, 90	08	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	
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					
)1	TENTATI VE TO PROVI DER			0	0	5
)2				0	0	
)3				0	0	5.
	Provider to Program			-	-	
50	TENTATIVE TO PROGRAM			0	0	
51 52				0	0	
72 79	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on					6.
11	the cost report. (1)		100.00			
)1)2	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		132, 32	23	0	
02 00	Total Medicare program liability (see instructions)		419, 23	0	0	
50	Total meandare program traditity (see thistractions)		417,20	Contractor	NPR Date	/.
				Number	(Mo/Day/Yr)	
)	1,00	2.00	

Heal th	Financial Systems IU HEALTH JAY H	IOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULA	TION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1320	Period: From 03/01/2018	Worksheet E-' Part II	1
			To 12/31/2018		
		Title XVIII	Hospi tal	Cost	
				1.00	
-	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_
	Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00
	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2.00
	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			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 [ine 20			6.00
	CAH only - The reasonable cost incurred for the purchase of co line 168	ertified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
1	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 l	ine 31) (see instruction	s)		32.00

ALCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1320	Period: From 03/01/2018	Worksheet E-2	
		Component CCN: 15-Z320	To 12/31/2018	Date/Time Pre 5/24/2019 10:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		204 100	0	
	npatient routine services - swing bed-SNF (see instructions)		294, 100	0	1.
	npatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of West D	133, 687	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst		133,007	0	3.
	Per diem cost for interns and residents not in approved teachir			0.00	4.
	nstructions)	51 5 (
00	Program days		146	0	
	nterns and residents not in approved teaching program (see ins			0	
	Jtilization review - physician compensation - SNF optional meth	hod only	0		7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		427, 787	0	
	Primary payer payments (see instructions)		407 707	0	
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applica	able to physician	427, 787 0	0	
	professional services)	able to physiciali	0	0	11.
	Subtotal (line 10 minus line 11)		427, 787	0	12.
	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	
	for physician professional services)				
. 00	30% of Part B costs (line 12 x 80%)			0	14.
	Subtotal (enter the lesser of line 12 minus line 13, or line 14	4)	427, 787	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstra	ation) payment	0		16
	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0	0	
	Fotal (see instructions)	,	427, 787	0	19
. 01	Sequestration adjustment (see instructions)		8, 556	0	19
	Demonstration payment adjustment amount after sequestration)		0	0	
	nterim payments		286, 908	0	
	Fentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, ar	-	132, 323	0	
	Protested amounts (nonallowable cost report items) in accordanc chapter 1, §115.2	ce with CMS Pub. 15-2,	16, 164	0	23
	ural Community Hospital Demonstration Project (§410A Demonstra	ation) Adjustment			
	s this the first year of the current 5-year demonstration peri				200
(Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement				
	Medicare swing-bed SNF inpatient routine service costs (from We	kst. D-1, Pt. II, line			201
	66 (title XVIII hospital))				000
	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	WKST. D-3, COL. 3, IIN	e		202
	Fotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				203
	computation of Demonstration Target Amount Limitation (N/A in f	first vear of the curre	nt 5-vear demonst	ration	
	eriod)	, , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , ,		
5. OO	<i>N</i> edicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 tim				206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
	Program reimbursement under the §410A Demonstration (see instru				207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	, col. 1, sum of lines	1		208
1	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruct	tions)			209
	Reserved for future use	(1013)			209
	Comparision of PPS versus Cost Reimbursement				12 10
	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 20				215

	Financial Systems IU HEALTH ATION OF REIMBURSEMENT SETTLEMENT	JAY HOSPITAL Provider CCN: 15-1320	Period:	u of Form CMS-2 Worksheet E-3	
ALCUL	ATTON OF RELMBORSEMENT SETTLEMENT	Provider CCN: 15-1320	From 03/01/2018 To 12/31/2018	Part V Date/Time Pre 5/24/2019 10:	pare
		Title XVIII	Hospi tal	Cost	10 01
		, . ,			
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDI	CARE PART A SERVICES - COST	REIMBURSEMENT		
. 00	Inpatient services			2, 616, 173	
. 00	Nursing and Allied Health Managed Care payment (see instr	ructions)		0	
. 00 . 00	Organ acquisition Subtotal (sum of lines 1 through 3)			0 2, 616, 173	
. 00	Primary payer payments			2,010,173	
. 00	Total cost (line 4 less line 5). For CAH (see instruction	ns)		2, 642, 335	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES	13)		2,042,333	0.
	Reasonable charges				
. 00	Routine service charges			0	7.
. 00	Ancillary service charges			0	8.
. 00	Organ acquisition charges, net of revenue			0	9.
0. 00	Total reasonable charges			0	10.
	Customary charges				
1.00	Aggregate amount actually collected from patients liable			0	
2.00	Amounts that would have been realized from patients liable		n a charge basis	0	12.
	had such payment been made in accordance with 42 CFR 413.	.13(e)		0,000000	10
3.00 4.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
4.00 5.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (completed)	to only if line 14 exceeds li	no 6) (coo	0	
5.00	instructions)	te only if the 14 exceeds if	TTE 0) (See	0	15.
6.00	Excess of reasonable cost over customary charges (complet	te only if line 6 exceeds lin	e 14) (see	0	16.
	instructions)	<u> </u>		-	
7.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
8.00	Direct graduate medical education payments (from Workshee	et E-4, line 49)		0	
9.00	Cost of covered services (sum of lines 6, 17 and 18)			2, 642, 335	
0.00	Deductibles (exclude professional component)			243, 880	
. 00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21) Coinsurance			2, 398, 455 0	
I. 00	Subtotal (line 22 minus line 23)			2, 398, 455	
5.00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		2, 370, 433	
5.00 5.00	Adjusted reimbursable bad debts (see instructions)			4, 737	
7.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		7, 287	
3.00	Subtotal (sum of lines 24 and 25, or line 26)	· · · · · · · · · · · · · · · · · · ·		2, 403, 192	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	29
. 99	Demonstration payment adjustment amount before sequestra	tion		0	29
0. 00	Subtotal (see instructions)			2, 403, 192	
). 01	Sequestration adjustment (see instructions)			48, 064	
0. 02	Demonstration payment adjustment amount after sequestrati	i on		0	
. 00	Interim payments			1, 707, 868	
2.00	Tentative settlement (for contractor use only)			0	32
3.00	Balance due provider/program (line 30 minus lines 30.01,			647, 260	
4.00	Protested amounts (nonallowable cost report items) in acc	cordance with CMS Pub. 15-2,	cnapter 1,	99, 834	34.

	Financial Systems IU HEALTH ATION OF REIMBURSEMENT SETTLEMENT	JAY HOSPITAL Provider CCN: 15-1320	Peri od:	u of Form CMS-2 Worksheet E-3	
		Component CCN: 15-M320	From 03/01/2018 To 12/31/2018	Part II Date/Time Pre 5/24/2019 10:	
		Title XVIII	Subprovider -	PPS	10 11
			·	1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS				
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and	d medical education payments)		391, 666	
00	Net IPF PPS Outlier Payments			421, 459	
00	Net IPF PPS ECT Payments			0	
00	Unweighted intern and resident FTE count in the most rece	ent cost report filed on or b	etore November	0.00	4.
01	15, 2004. (see instructions)	count for residents that were	o dical acad by	0.00	4
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted wi			0.00	4
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		ment under 42		
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents wit	hin the new program growth p	eriod of a "new	0.00	7
	teaching program" (see instuctions)				
00	Intern and resident count for IPF PPS medical education a	adjustment (see instructions)		0.00	
00	Average Daily Census (see instructions)			3.784314	
0.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0.000000	
. 00	Teaching Adjustment (line 1 multiplied by line 10).	11)		0	
. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and			813, 125	
. 00	Nursing and Allied Health Managed Care payment (see instr	uction)		0	13
5. 00	Organ acquisition (DO NOT USE THIS LINE) Cost of physicians' services in a teaching hospital (see	instructions)		0	
. 00	Subtotal (see instructions)			813, 125	
	Primary payer payments			013, 123	
. 00	Subtotal (line 16 less line 17).			813, 125	
	Deducti bl es			49, 580	
. 00	Subtotal (line 18 minus line 19)			763, 545	
. 00	Coinsurance			0	21
. 00	Subtotal (line 20 minus line 21)			763, 545	22
. 00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		2, 680	23
. 00	Adjusted reimbursable bad debts (see instructions)			1, 742	24
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		2, 680	
	Subtotal (sum of lines 22 and 24)			765, 287	
. 00	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	
. 00	Other pass through costs (see instructions)			0	
. 00	Outlier payments reconciliation			0	
. 00 . 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruct	ati and		0	
. 99	Demonstration payment adjustment amount before sequestrat	-		0	
. 00	Total amount payable to the provider (see instructions)	.1011		765, 287	
. 00	Sequestration adjustment (see instructions)			15, 306	
. 02	Demonstration payment adjustment amount after sequestrati	on		13, 300	
	Interim payments			748, 269	
. 00	Tentative settlement (for contractor use only)			0	
. 00	Balance due provider/program (line 31 minus lines 31.01,	31.02, 32 and 33)		1, 712	
6.00	Protested amounts (nonallowable cost report items) in acc	cordance with CMS Pub. 15-2,	chapter 1,	7	
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount from Worksheet E-3, Part II, line			421, 459	
	Outlier reconciliation adjustment amount (see instruction	IS)		0	
2.00	The rate used to calculate the Time Value of Money			0.00	52

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	eriod: rom 03/01/2018 o 12/31/2018		
-		General Fund	Specific Purpose Fund	Endowment Fund	5/24/2019 10: Plant Fund	
		1.00	2.00	3.00	4.00	
00	Cash on hand in banks	6, 153, 629	C	0	0	1 1.0
00	Temporary investments	0	C	0	0	
00	Notes receivable	0	C	0	0	3.0
00	Accounts receivable	4, 290, 341	C	0	0	4.0
00	Other receivable	-1, 866, 165	C	0	0	
00 00	Allowances for uncollectible notes and accounts receivable Inventory	0 516, 943		0	0	
00	Prepai d expenses	283, 140		0	0	
00	Other current assets	0	C	0	0	
. 00	Due from other funds	0	C	0	0	10. (
. 00	Total current assets (sum of lines 1-10)	9, 377, 888	C	0	0	11. (
	FIXED ASSETS		1	1		
	Land	1, 006, 948	C	-	0	12.0
	Land improvements Accumulated depreciation	0		0	0	13.0
	Buildings	19, 125, 052		0	0	14.
	Accumulated depreciation	-1, 072, 112		0	0	16.
	Leasehold improvements	0		o o	0	17.
. 00	Accumulated depreciation	0	C	0	0	18.
	Fixed equipment	0	C	0	0	19.
	Accumulated depreciation	0	C	0	0	20.
	Automobiles and trucks	0		0	0	21.
	Accumulated depreciation Major movable equipment	8, 604, 553		0	0	22.
	Accumulated depreciation	-1, 250, 698		0	0	24.
	Minor equipment depreciable	0		0	0	25.
	Accumul ated depreciation	0	C	0	0	26.
. 00	HIT designated Assets	0	C	0	0	27.
	Accumulated depreciation	0	C	0	0	28.
	Minor equipment-nondepreciable	0	C	0	0	29.
	Total fixed assets (sum of lines 12-29) OTHER ASSETS	26, 413, 743	C	0	0	30.
	Investments	0	C	0	0	31.
	Deposits on Leases	0		0	0	32.
	Due from owners/officers	0	c	0	0	33.
. 00	Other assets	0	C	0	0	34.
	Total other assets (sum of lines 31-34)	0	C	0	0	35.
. 00	Total assets (sum of lines 11, 30, and 35)	35, 791, 631	C	0	0	36.
	CURRENT LI ABI LI TI ES	44.440.044			0	1
. 00 . 00	Accounts payable Salaries, wages, and fees payable	11, 460, 261 1, 194, 167			0	37. 38.
	Payroll taxes payable	1, 194, 107			0	
	Notes and Loans payable (short term)	0		0	0	40.
	Deferred income	0	C	0	0	
. 00	Accelerated payments	0				42.
-	Due to other funds	0	C	0	0	
	Other current liabilities	105, 414			0	
. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	12, 759, 842	C	0	0	45.
. 00	Mortgage payable	0	C	0	0	46.
	Notes payable	0		0	0	47.
	Unsecured Loans	0	C C	Ő	0	
	Other long term liabilities	0	C	0	0	49.
	Total long term liabilities (sum of lines 46 thru 49)	0	C	0	0	50.
. 00	Total liabilities (sum of lines 45 and 50)	12, 759, 842	C	0	0	51.
00	CAPITAL ACCOUNTS	22 021 700				1 50
	General fund balance Specific purpose fund	23, 031, 789	c			52. 53.
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55.
	Governing body created - endowment fund balance			Ő		56.
	Plant fund balance - invested in plant				0	57.
	Plant fund balance - reserve for plant improvement,				0	58.
_	replacement, and expansion					
00	Total fund balances (sum of lines 52 thru 58)	23, 031, 789			0	
. 00	Total liabilities and fund balances (sum of lines 51 and	35, 791, 631	l 0	0	0	60.

Heal th	Financial Systems	IU HEALTH JAY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES			Provider CCN: 15-1320		Period: From 03/01/2018 To 12/31/2018	Worksheet G-1 Date/Time Prepared: 5/24/2019 10:13 am	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
			0.00			5.00	
1.00	Fund balances at beginning of period	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) ROUNDING NET INTERCOMPANY TRANSACTIONS Total deductions (sum of lines 12-17)	0 0 0 0 0 0 0 29, 311 0 0 0	23, 061, 100 23, 061, 100 0 23, 061, 100 23, 061, 100				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	Fund balance at end of period per balance sheet (line 11 minus line 18)		23, 031, 789		C		19.00
		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 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) Deductions (debit adjustments) (specify) ROUNDING NET INTERCOMPANY TRANSACTIONS 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		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

TATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C		Period: From 03/01/2018 To 12/31/2018	Worksheet G-2 Parts I & II Date/Time Pre 5/24/2019 10:	pared:
Cost Center Description		Inpati ent	Outpati ent	Total	
		1.00	2.00	3.00	
PART I – PATIENT REVENUES					
General Inpatient Routine Services		1			
.00 Hospital		3, 238, 75		3, 238, 751	1.0
. 00 SUBPROVIDER - IPF		1, 995, 99	96	1, 995, 996	2.0
. 00 SUBPROVI DER – I RF					3.0
. 00 SUBPROVI DER					4.0
. 00 Swing bed - SNF		152, 65		152, 656	5.0
.00 Swing bed - NF			0	0	6.0
. 00 SKILLED NURSING FACILITY					7.0
. 00 NURSING FACILITY					8.0
. OO OTHER LONG TERM CARE		E 007 40		F 007 400	9.0
0.00 Total general inpatient care services (sum of lines 1-	-9)	5, 387, 40	03	5, 387, 403	10.0
Intensive Care Type Inpatient Hospital Services		1			1
1. 00 INTENSIVE CARE UNIT					11.0
2. 00 CORONARY CARE UNIT					12.0
3. 00 BURN INTENSIVE CARE UNIT					13.0
4. 00 SURGICAL INTENSIVE CARE UNIT					14.0
5.00 OTHER SPECIAL CARE (SPECIFY)			0	0	15.0
6.00 Total intensive care type inpatient hospital services	(sum of lines		0	0	16.0
11-15) 7.00 Total inpatient routine care services (sum of lines 10	2 and 1(2)	5, 387, 40		5, 387, 403	17.0
8.00 Ancillary services		10, 583, 39			
9.00 Outpatient services		557, 77		20, 650, 832	19.0
0.00 RURAL HEALTH CLINIC		557,77	0 20, 093, 038	20, 050, 852	20.0
1.00 FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	20.0
2.00 HOME HEALTH AGENCY			0 0	0	21.0
3. 00 AMBULANCE SERVICES					22.0
4. 00 CMHC					24.0
5.00 AMBULATORY SURGICAL CENTER (D. P.)					24.0
6. 00 HOSPICE					26.0
7. 00 OTHER (SPECIFY)			0 0	0	27.0
8.00 Total patient revenues (sum of lines 17-27)(transfer o	column 3 to Wkst	16, 528, 57	60, 191, 904	76, 720, 481	28.0
G-3, line 1)		10, 020, 07	,	70,720,101	20.0
PART II - OPERATING EXPENSES					1
9.00 Operating expenses (per Wkst. A, column 3, line 200)			31, 628, 883		29.0
0. 00 ADD (SPECIFY)			0		30.0
1.00			0		31.0
2.00			0		32.0
3. 00			0		33.0
4.00			0		34.0
5. 00			0		35.0
6.00 Total additions (sum of lines 30-35)			0		36.0
7.00 DEDUCT (SPECIFY)			0		37.0
8.00			0		38.0
9.00			0		39.0
0. 00			0		40.0
1.00			0		41.0
2.00 Total deductions (sum of lines 37-41)			0		42.0
3.00 Total operating expenses (sum of lines 29 and 36 minus	s line 42)(transfer		31, 628, 883		43.0
to Wkst. G-3, line 4)					

Heal th	Financial Systems IU HEALTH	I JAY HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-		Provider CCN: 15-1320	Peri od:	Worksheet G-3	
			From 03/01/2018 To 12/31/2018	Date/Time Pre	nared
			10 12/31/2010	5/24/2019 10:	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3			76, 720, 481	
2.00	Less contractual allowances and discounts on patients'	accounts		55, 074, 798	
3.00	Net patient revenues (line 1 minus line 2)			21, 645, 683	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			31, 628, 883	
5.00	Net income from service to patients (line 3 minus line 4)			-9, 983, 200	5.00
	OTHER I NCOME				
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 communi	cation services		0	0.00
9.00	Revenue from television and radio service			0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	111.00
12.00	Parking lot receipts			0	12100
13.00	Revenue from Laundry and Linen service			0	
	Revenue from meals sold to employees and guests			0	
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies to o	ther than patients		0	
	Revenue from sale of drugs to other than patients				17.00
	Revenue from sale of medical records and abstracts				18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)				19.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	
	Rental of vending machines			0	
	Rental of hospital space			0	
23.00	Governmental appropriations			0	
24.00	OTHER (MI SCELLANEOUS I NCOME)			33, 044, 300	
25.00	Total other income (sum of lines 6-24)			33, 044, 300	
	Total (line 5 plus line 25)			23, 061, 100	
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts)			0	
29.00	Net income (or loss) for the period (line 26 minus line	28)		23, 061, 100	29.00