This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1320 Worksheet S Peri od: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 7/15/2021 1: 03 pm Manually prepared cost report use only]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [N] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH JAY HOSPITAL (15-1320) for the cost reporting period beginning 01/01/2020 and ending 12/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Si gned) JON VANATOR

Officer or Administrator of Provider(s)

CFO

Title

(Dated when report is electronically signed.)
Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	865, 315	1, 912, 000	0	0	1.00
2.00	Subprovider - IPF	0	3, 606	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	577, 863	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	1, 446, 784	1, 912, 000	0	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The 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.

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 1:03 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 1.00 Street: 500 W. VOTAW PO Box: State: IN 2.00 City: PORTLAND Zip Code: 47371 County: JAY 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N)
/ XVIII XIX Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH JAY HOSPITAL 151320 99915 01/01/2004 Ν 0 3.00 Subprovi der - IPF 0 4.00 LU HEALTH JAY HOSPITAL 99915 Р 4.00 15M320 4 10/01/2005 Ν PSYCH UNIT 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF LUHP SWING BEDS 157320 99915 01/01/2004 N N 0 7 00 7 00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospital -Based OLTC 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital -Based Health Clinic - RHC 15 00 15 00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2020 12/31/2020 20.00 21.00 Type of Control (see instructions) 21.00 1.00 2.00 3.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1.

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

report	ing period different from the method used in t	ne prior co	ST					
report	ing period? In column 2, enter "Y" for yes or	"N" for no).					
		In-State	In-State	Out-of	Out-of	Medi cai	d Other	
		Medi cai d	Medi cai d	State	State	HMO day	s Medicaid	
		paid days	eligible	Medi cai d	Medi cai d	_	days	
			unpai d	paid days	el i gi bl e			
			days		unpai d			
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
24.00 If thi	s provider is an IPPS hospital, enter the	0	0	0	0		0 0	24.00
i n-sta	nte Medicaid paid days in column 1, in-state							
Medi ca	nid eligible unpaid days in column 2,							
out-of	-state Medicaid paid days in column 3,							
out-of	-state Medicaid eligible unpaid days in column							
4, Med	licaid HMO paid and eligible but unpaid days in							
col umn	n 5, and other Medicaid days in column 6.							

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 1:03 pm In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medi cai d State State HMO days Medi cai d paid days eligible Medi cai d Medi cai d days unpai d pai d days el i gi bl e days unpai d 1.00 2. 00 3.00 4. 00 5. 00 6. 00 25.00 If this provider is an IRF, enter the in-state 25, 00 \cap Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Begi nni ng: Endi ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36.00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37 00 37 00 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in 37.01 accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions) 38 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38 00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume N N 39 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for 40 00 Ν Ν no in column 2, for discharges on or after October 1. (see instructions) XVIII 1.00 2. 00 3. 00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance 45.00 Ν Ν Ν with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exception for extraordinary circumstances Ν Ν Ν 46.00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. Ν Ν 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. N Ν N 48.00 Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. 57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved 57.00 GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00 defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2 59.00 NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for Ν 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustement? Enter "Y" for yes or "N" for no in column 2.

Health Financial Systems IU HEALTH HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 Peri od: Worksheet S-2 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 1: 03 pm Provider CCN: 15-1320

					1	7/15/2021 1:0	3 pm
		Y/N	IME	Direct GME	IME	Direct GME	
		4 00		0.00	4.00		
(1.00	D' la contract de ETE al al contract AOA	1.00	2. 00	3. 00	4. 00	5. 00	(1.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.00
	column 1. (see instructions)						
61 01	Enter the average number of unweighted primary care						61. 01
01.01	FTEs from the hospital's 3 most recent cost reports						0
	ending and submitted before March 23, 2010. (see						
	instructions)						
61.02	Enter the current year total unweighted primary care						61.02
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						
61. 03	Enter the base line FTE count for primary care						61.03
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see						
41 04	instructions) Enter the number of unweighted primary care/or						61. 04
01.04	surgery allopathic and/or osteopathic FTEs in the						01.04
	current cost reporting period. (see instructions).						
61 05	Enter the difference between the baseline primary						61.05
01.00	and/or general surgery FTEs and the current year's						0 00
	primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
61.06	Enter the amount of ACA §5503 award that is being						61.06
	used for cap relief and/or FTEs that are nonprimary						
	care or general surgery. (see instructions)	_					
		Pro	ogram Name	Program Code	Unweighted	Unwei ghted	
					IME FTE Count	Direct GME	
			1 00	2.00	2.00	FTE Count	
(1 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	(1 10
61. 10	specialty, if any, and the number of FTE residents				0.00	0.00	61. 10
	for each new program. (see instructions) Enter in						
	column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME						
	FTE unweighted count.						
61. 20	Of the FTEs in line 61.05, specify each expanded				0.00	0. 00	61. 20
	program specialty, if any, and the number of FTE						
	residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column						
	3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1. 00	
	ACA Provisions Affecting the Health Resources and Ser	rvi ces	Admi ni strati or	ı (HRSA)		1.00	
62 00	Enter the number of FTE residents that your hospital				iod for which	0.00	62.00
02.00	your hospital received HRSA PCRE funding (see instruc			reporting per	rod ror will cir	0.00	02.00
62. 01	Enter the number of FTE residents that rotated from a			nter (THC) into	your hospital	0. 00	62.01
	during in this cost reporting period of HRSA THC prog				,		
	Teaching Hospitals that Claim Residents in Nonprovide						
63.00	Has your facility trained residents in nonprovider se					N	63.00
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lin	es 64 through	· '			
				Unwei ghted	Unwei ghted	Ratio (col.	
				FTES	FTEs in	1/ (col. 1 +	
				Nonprovi der	Hospi tal	col. 2))	
				Si te	2.00	2 00	
	Section 5504 of the ACA Base Year FTE Residents in No	opprovi	der Settings	1.00	2. 00	3.00	
	period that begins on or after July 1, 2009 and before			- mis base year	is your cost	reporting	
64. 00	Enter in column 1, if line 63 is yes, or your facilit			0.00	0.00	0. 000000	64 00
57.00	in the base year period, the number of unweighted nor			0.00	0.00	0.00000	07.00
	resident FTEs attributable to rotations occurring in						
	settings. Enter in column 2 the number of unweighted	a-non-b	rimary care				
	resident FTEs that trained in your hospital. Enter in						
	of (column 1 divided by (column 1 + column 2)). (see						
	, , , , , , , , , , , , , , , , , , , ,		•	•	•	•	

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2020 Part I 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1. (00 2	2. 00	3.00	
Inpatient Psychiatric Facility PPS					
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub-	provi der? Y	/			70.00
Enter "Y" for yes or "N" for no.					
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in	the most N	1	N	0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for	no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac					
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for					
Column 3: If column 2 is Y, indicate which program year began during this cost reporting	ng period.				
(see instructions)					
Inpatient Rehabilitation Facility PPS					
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	l N	1			75.00
subprovi der? Enter "Y" for yes and "N" for no.					

Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)?

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

Enter "Y" for yes or "N" for no in column 2. (see instructions)

Ν

Ν

107.00

108.00

131.00

131.00 If this is a Medicare certified intestinal transplant center, enter the certification

date in column 1 and termination date, if applicable, in column 2.

Health Financial Systems	IU HEALTH	JAY HOSPITAL		In Li	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	N: 15-1320	Peri od: From 01/01/202	Worksheet S- 20 Part I	-2
				To 12/31/202	20 Date/Time Pr 7/15/2021 1:	
				1.00	2.00	
132.00 If this is a Medicare certified is in column 1 and termination date,			ication date		2.00	132.00
133.00 Removed and reserved 134.00 If this is an organ procurement or and termination date, if applicabl		er the OPO number	in column 1			133. 00 134. 00
All Providers 140.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	'N" for no in column 1.	If yes, and home	office cost	s Y	15H059	140. 00
1.00 If this facility is part of a chai	n organization, enter	2.00 on lines 141 thro	uah 143 the	3.00 name and addre	ss of the home	
office and enter the home office of the North Annual Company of the North Annual Compa	contractor name and co					141. 00
		SERVICES	TAN COITTIACT	or s number. oo	101	
142.00 Street: 340 WEST TENTH STREET 143.00 City: INDIANAPOLIS	PO Box: State:	IN	Zi p Code	:: 46	204	142. 00 143. 00
					1. 00	
144.00 Are provider based physicians' cos	sts included in Worksho	eet A?			Y	144. 00
				1.00	2. 00	
145.00 f costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility incomperiod? Enter "Y" for yes or "N"	' for yes or "N" for no clude Medicare utilizat	o in column 1. If	column 1 is			145. 00
146.00 Has the cost allocation methodolog Enter "V" for yes or "N" for no in yes, enter the approval date (mm/o	gy changed from the pre n column 1. (See CMS Po			f N		146. 00
					1.00	
147.00 Was there a change in the statisti					N	147. 00
148.00Was there a change in the order of 149.00Was there a change to the simplifi				r no	N N	148. 00 149. 00
177. 00 IIds there a change to the shiptiff	ed cost irriaring method	Part A	Part B	Title V	Title XIX	117.00
Does this facility contain a provi						
or charges? Enter "Y" for yes or '	'N" for no for each con	mponent for Part A N	and Part B.	(See 42 CFR §	413. 13) N	155. 00
156. 00 Subprovi der – TPF		N N	N	N	N N	156. 00
157. 00 Subprovi der – I RF		N	N	N	N	157. 00
158. 00 SUBPROVI DER		N.	N.	, ,		158. 00
159.00 SNF 160.00 HOME_HEALTH_AGENCY		N N	N N	N N	N N	159. 00 160. 00
161. 00 CMHC		14	N	N	N	161.00
Multicampus					1.00	
165.00 s this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	s one or more camp	uses in diff	erent CBSAs?	N	165. 00
	Name 0	County 1.00		p Code CBSA 3.00 4.00	FTE/Campus 5.00	
166.00 f line 165 is yes, for each	U	1.00	2.00	3.00 4.00		00 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						
column 5 (see instructions)						
Health Information Technology (HI	T) incentive in the Amo	erican Recovery an	d Reinvestme	ent Act	1. 00	
167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10	under §1886(n)? Ente O5 is "Y") and is a mea	er "Y" for yes or aningful user (line	"N" for no.		Y	167. 00 168. 00
reasonable cost incurred for the H 168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?	not a meaningful user,	does this provide			N	168. 01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y")				ne 0.	00169.00

Health Financial Systems	IU HEALTH JAY H	IOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA		Peri od:	Worksheet S-2	2
			From 01/01/2020		
			To 12/31/2020		
				7/15/2021 1:0	03 pm
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending da	te for the reporting			170. 00
			1. 00	2.00	
171.00 If line 167 is "Y", does this provider have	any days for indiv	viduals enrolled in	Y	20	7171.00
section 1876 Medicare cost plans reported o	on Wkst. S-3, Pt. I,	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If	column 1 is ves. er	nter the number of section	on		
1876 Medicare days in column 2. (see instru					
11070 medi edi e days 111 eoi amii 2. (See 1115ti e	10 (1 0113)		l .	1	1

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1320 Peri od: Worksheet S-2 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/15/2021 1:03 pm Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1 00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Y/N Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν yes, enter in column 2 the date of termination and in column $\check{\mathbf{3}}$, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 3.00 2.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Υ Α 02/25/2021 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from Ν 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1. 00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing school and/or allied health programs approved and/or renewed during the 8.00 N 8.00 cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education Ν 9.00 program in the current cost report? If yes, see instructions. . Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions γ 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part A Part B Y/N Y/N Date Date 3.00 1.00 2.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? Ν Ν 16.00 If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 04/02/2021 17 00 Was the cost report prepared using the PS&R Report for 04/02/2021 17.00 totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.
19.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν N 19.00 Report data for corrections of other PS&R Report

information? If yes, see instructions.

	ancial Systems IU HEALTH JA				u of Form CM	
HOSPITAL A	ND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-1320	Peri od: From 01/01/2020 To 12/31/2020		repared:
			i pti on	Y/N	Y/N	
			0	1. 00	3. 00	
	line 16 or 17 is yes, were adjustments made to PS&R ort data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
04 00 1111		1.00	2. 00	3. 00	4. 00	
	the cost report prepared only using the provider's ords? If yes, see instructions.	N		N		21.00
					1. 00	
COMF	PLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)		1.00	
	tal Related Cost		,			
22. 00 Have	e assets been relifed for Medicare purposes? If yes, see e changes occurred in the Medicare depreciation expense			ing the cost	N Y	22. 00 23. 00
24.00 Were	orting period? If yes, see instructions. e new leases and/or amendments to existing leases entere	ed into during	this cost re	eporting period?	N	24.00
25. 00 Have	yes, see instructions e there been new capitalized leases entered into during	the cost repo	rting period?	olf yes, see	N	25.00
26.00 Were	tructions. e assets subject to Sec.2314 of DEFRA acquired during the trustions.	he cost report	ing period? I	f yes, see	N	26. 00
	tructions. the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit	N	27. 00
Inte	y. erest Expense e new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cost	reporting	N	28.00
peri	iod? If yes, see instructions. the provider have a funded depreciation account and/or		3	, 3	N	29.00
	ated as a funded depreciation account? If yes, see instr existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30.00
31.00 Has	tructions. debt. been recalled before scheduled maturity without is	ssuance of new	debt? If yes	s, see	N	31.00
	tructions. chased Services					
	e changes or new agreements occurred in patient care ser	rvices furnish	ed through co	ntractual	N	32.00
arra	angements with suppliers of services? If yes, see instru line 32 is yes, were the requirements of Sec. 2135.2 app	ucti ons.	Ü			33.00
Prov	see instructions. vider-Based Physicians					
	services furnished at the provider facility under an ar	rrangement wit	h provi der-ba	ised physicians?	Υ	34.00
35.00 I f Ĭ	yes, see instructions. Line 34 is yes, were there new agreements or amended exi sicians during the cost reporting period? If yes, see ir		ents with the	provi der-based	N	35.00
priy:	sicialis during the cost reporting period? If yes, see if	IISTI UCTI OIIS.		Y/N	Date	
				1, 00	2. 00	
Home	e Office Costs				2. 30	
	e home office costs claimed on the cost report?			Υ		36.00
	line 36 is yes, has a home office cost statement been pr	repared by the	home office?			37.00
1f y 38.00 1f	yes, see instructions. Line 36 is yes , was the fiscal year end of the home off	fice different	from that of	- N		38.00
the 39.00 If I	provider? If yes, enter in column 2 the fiscal year end line 36 is yes, did the provider render services to othe	d of the home	offi ce.			39.00
40.00 If I	instructions. line 36 is yes, did the provider render services to the	home office?	If yes, see	N		40.00
I IIS	tructi ons.	1	00	2	00	
Cost	Report Preparer Contact Information	1.	00	Ζ.	00	
41.00 Ente	er the first name, last name and the title/position d by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41.00
	pecti vel y.					
resp 42.00 Ente	er the employer/company name of the cost report parer.	INDIANA UNIVEF	RSITY HEALTH			42.00

Heal th	Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lieu	of Form CMS-2	2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	QUESTI ONNAI RE	Provi der	CCN: 15-1320		Worksheet S-2 Part II Date/Time Pre 7/15/2021 1:0	pared:
			·				
				3. 00			
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the ti	tle/position	OI RECTOR				41.00
	held by the cost report preparer in column	is 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respec	ti vel y.					

| Period: | Worksheet S-3 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Health Financial SystemsIU HEAHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1320

						To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
							1/P Days /	J piii
							0/P Visits /	
							Tri ps	
	Component	Worksheet A	No	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		28	10, 24	8 28, 008. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovi der							3.00
4. 00	HMO I RF Subprovi der							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF			20	10.24	20,000,00	0	
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			28	10, 24	8 28, 008. 00	0	7. 00
8. 00	INTENSIVE CARE UNIT							8.00
9. 00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12.00
13. 00	NURSERY	43.00					0	13.00
14. 00	Total (see instructions)			28	10, 24	8 28, 008. 00	Ō	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - IPF	40.00		1	30	0	0	16.00
17.00	SUBPROVIDER - IRF							17.00
18.00	SUBPROVI DER							18.00
19.00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC						_	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	
27. 00	Total (sum of lines 14-26)			29				27.00
28. 00	Observation Bed Days						0	
29. 00	Ambulance Trips							29.00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF							30. 00 31. 00
32.00	Labor & delivery days (see instructions)			0		0		32.00
32. 00	Total ancillary labor & delivery room			U				32.00
32. UI	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33.00
	LTCH site neutral days and discharges							33. 01
00.01	12.1. 2.12 hours at days and at sonar gos	l	1		ı	Ţ	ı	, 50.0.

Provider CCN: 15-1320

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2020	Part	
To 12/31/2020	Date/Time Prepared:	7/15/2021 1:03 pm

						7/15/2021 1:0	3 pm
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
				•		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7.00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	549	9	1, 167	'		1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	224	181				2.00
3. 00	HMO IPF Subprovider	0	4				3.00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	448	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	260			6.00
7.00	Total Adults and Peds. (exclude observation	997	9	1, 875			7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNI T						8.00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		_				12.00
13. 00	NURSERY		2	48			13.00
14.00	Total (see instructions)	997	11	1, 923		209. 73	
15.00	CAH visits	0	0	·	1		15.00
16.00	SUBPROVIDER - I PF	44	0	48	0.00	2. 60	
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 22. 00	OTHER LONG TERM CARE						21.00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						23.00
	1						24.00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)			29			24.00
25. 00	CMHC - CMHC			25			25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	(0.00	0.00	
27. 00	Total (sum of lines 14-26)	٩	U		0.00		
28. 00	Observation Bed Days		Q	467		212. 33	28.00
29. 00	Ambulance Trips	0	9	407			29.00
30.00	Employee discount days (see instruction)	٥		(,		30.00
31.00	Employee discount days (see Histruction)						31.00
31.00	Labor & delivery days (see instructions)	0	0				32.00
32. 00	Total ancillary labor & delivery room	١	U				32.00
32.01	outpatient days (see instructions)						32.01
33. 00	LTCH non-covered days	o					33.00
	LTCH site neutral days and discharges	l o					33.00
55. 01	12.5 5. to hour at days and discharges	ı Yı		I	T .	I	1 00.01

Health Financial SystemsIU HEAHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1320

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | | To | 12/31/2020 | Date/Time Prepared: | Prep

				10) 12/31/2020	7/15/2021 1:0	
		Full Time		Di sch	arges	,, 10, 2021 110	, jui
		Equi val ents			,		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	186	4	426	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			76	59		2.00
3. 00	HMO IPF Subprovider				1		3.00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	186	4	426	•
15. 00	CAH visits		_	_	_		15.00
16. 00	SUBPROVIDER - I PF	0. 00	0	5	0	6	16.00
17. 00	SUBPROVI DER - I RF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25.00
26. 00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27.00
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
33. 00	outpatient days (see instructions) LTCH non-covered days			o			33.00
	LTCH non-covered days LTCH site neutral days and discharges						33.00
33. UI	LIGHT SITE HEUTER LAYS AND UTSCHALGES			ı			JJ. UI

SPI TA	AL UNCOMPENSATED AND INDIGENT CARE DATA F	Provi der CCN	N: 15-1320	Peri od:	Worksheet S-	-10
				From 01/01/2020		
				To 12/31/2020	Date/Time Pr 7/15/2021 1:	
					1.00	
Į	Uncompensated and indigent care cost computation					
	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	<u>ided by lir</u>	ne 202 colum	n 8)	0. 49492	1 2
	Medicaid (see instructions for each line)				2 000 /1	4 .
	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				3, 988, 61 Y	4 2
	If line 3 is yes, does line 2 include all DSH and/or supplement	al payments	s from Medic	ai d?	Ϋ́	4
	If line 4 is no, then enter DSH and/or supplemental payments fr			our u .	l .	0 5
	Medicaid charges				12, 901, 80	
	Medicaid cost (line 1 times line 6)				6, 385, 39	9 7
	Difference between net revenue and costs for Medicaid program ((line 7 minu	us sum of li	nes 2 and 5; if	2, 396, 78	5 8
	< zero then enter zero) Children's Health Insurance Program (CHIP) (see instructions fo	or each line	2)			
	Net revenue from stand-alone CHIP	n cach iinc	·)			0 9
00	Stand-alone CHIP charges					0 10
	Stand-alone CHIP cost (line 1 times line 10)				l	0 11
	Difference between net revenue and costs for stand-alone CHIP ((line 11 mir	nus line 9;	if < zero then		0 12
	enter zero) Other state or local government indigent care program (see inst	ructions fo	or each line	<i></i>		
	Net revenue from state or local indigent care program (Not incl				4, 61	1 13
	Charges for patients covered under state or local indigent care				67, 98	
	10)					
	State or local indigent care program cost (line 1 times line 14				33, 64	
	Difference between net revenue and costs for state or local inc	ligent care	program (li	ne 15 minus line	29, 03	15 16
(13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/Local indi	gent care progra	ms (see	
į	nstructions for each line)					
	Private grants, donations, or endowment income restricted to fu				l .	0 17
	Government grants, appropriations or transfers for support of h Total unreimbursed cost for Medicaid , CHIP and state and Local			ns (sum of lines	2, 425, 82	0 18
	8, 12 and 16)	margent (care program	is (suiii or Titles	2, 425, 62	.0 13
	,		Uni nsured	Insured	Total (col.	1
		-	patients 1.00	patients 2.00	+ col . 2) 3.00	+
l	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
00	Charity care charges and uninsured discounts for the entire fac	cility	1, 695, 3	59, 891	1, 755, 27	1 20
00	(see instructions)		000 0	50 004	000 0-	
	Cost of patients approved for charity care and uninsured discou instructions)	ints (see	839, 0	83 59, 891	898, 97	'4 21
	Payments received from patients for amounts previously written	off as		0 0		0 22
	charity care	011 43				
00	Cost of charity care (line 21 minus line 22)		839, 0	83 59, 891	898, 97	4 23
					1.00	+
00	Does the amount on line 20 column 2, include charges for patier	nt days beyo	ond a Length	n of stay limit	N N	24
	imposed on patients covered by Medicaid or other indigent care	program?	_	·		
	If line 24 is yes, enter the charges for patient days beyond th	ne indigent	care progra	am's length of		0 25
	stay limit Total bad debt expense for the entire hospital complex (see ins	structions)			2, 712, 89	8 26
1	Medicare reimbursable bad debts for the entire hospital complex		ructions)		2, 712, 69	
	Medicare allowable bad debts for the entire hospital complex (s				339, 52	
	Non-Medicare bad debt expense (see instructions)	. 23.30	,		2, 373, 37	
	. ,	onco (coo i	nstructions	(;)	1, 293, 47	
	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	Jense (see i	noti do ti one	- /	, , , , , ,	
. 00	Cost of hon-weardare and hon-rembursable weardare bad debt exp Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus li		noti doti one	-,	2, 192, 44 4, 618, 26	

Health Financial Systems	IU HEALIH JAY	_	N 45 4000 B		u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO	JN: 15-1320 P	eriod: rom 01/01/2020	Worksheet A	
				o 12/31/2020	Date/Time Pre	pared:
				1	7/15/2021 1:0	3 pm
Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified	
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +- col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT		0	0	1, 179, 228	1, 179, 228	1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB		0	d		75, 227	1.01
1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB		0	C	35, 030	35, 030	1.02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ		0	O	14, 339	14, 339	1.03
1.04 O0104 CAP REL COSTS-BLDG & FIXT-INTEREST		0	C	0	0	1.04
2.00 O0200 CAP REL COSTS-MVBLE EQUIP		261, 330	261, 330		1, 701, 795	2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB		0	0	39, 881	39, 881	2. 01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB		0	0	0	0	2.02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ	4// 740	07.700	104 445	0 570 470	0 7/4 504	2.03
4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT	166, 712	27, 703			2, 764, 594	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	570, 589 303, 745	9, 305, 265 3, 431, 119	9, 875, 854 3, 734, 864		9, 671, 882 2, 406, 652	5. 00 7. 00
7. 01 00701 OPERATION OF PLANT - MOB	303, 745	181, 111	181, 111		99, 585	7.00
7. 02 00702 OPERATION OF PLANT - POB	o	75, 509				7.02
7. 03 00703 OPERATION OF PLANT - WJ	0	16, 908	16, 908		12, 001	7.02
8. 00 00800 LAUNDRY & LI NEN SERVI CE	35, 680	104, 982	140, 662		129, 081	8.00
9. 00 00900 HOUSEKEEPI NG	381, 538	243, 796	625, 334		506, 802	9.00
10. 00 01000 DI ETARY	360, 524	476, 059	836, 583		197, 857	10.00
11. 00 01100 CAFETERI A	0	0	O	462, 163	462, 163	11.00
13.00 01300 NURSING ADMINISTRATION	1, 173, 606	346, 448	1, 520, 054	-206, 666	1, 313, 388	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	2, 727	2, 727		263, 231	14.00
15. 00 01500 PHARMACY	501, 218	1, 366, 125	1, 867, 343	-1, 180, 983	686, 360	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	1, 746, 296	1, 549, 338				
40. 00 04000 SUBPROVI DER - PF	207, 970	158, 715	366, 685		323, 532	1
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	25, 325	25, 325	43.00
50. 00 05000 OPERATING ROOM	929, 473	2, 034, 856	2, 964, 329	-651, 427	2, 312, 902	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	727, 479	2, 034, 030	2, 704, 327		7, 281	
53. 00 05300 ANESTHESI OLOGY	0	0	Ö	0, 201	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	798, 673	1, 161, 462	1, 960, 135	-809, 294	1, 150, 841	
60. 00 06000 LABORATORY	0	2, 056, 386			2, 024, 748	
65. 00 06500 RESPIRATORY THERAPY	383, 754	181, 145	564, 899	-148, 293	416, 606	65.00
66. 00 06600 PHYSI CAL THERAPY	468, 575	7, 536	476, 111	-3, 257	472, 854	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	85, 715	239			85, 903	67.00
68. 00 06800 SPEECH PATHOLOGY	17, 143	0	17, 143		17, 143	
69. 00 06900 ELECTROCARDI OLOGY	0	3, 570	3, 570		2, 295	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	,	87, 965	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	,		
73. 00 07300 DRUGS CHARGED TO PATIENTS	114 255	124 202	_	., ,	1, 511, 327	
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	116, 255	134, 392	250, 647	-67, 669	182, 978	76.00
90. 00 09000 CLINIC	ol	0	0	٥	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	609, 812	876, 406	1, 486, 218	-482, 675	1, 003, 543	
90. 02 09002 JAY FAMILY MEDICINE	626, 450	1, 080, 702	1, 707, 152		1, 342, 323	
90. 03 09003 WOUND CLINIC	0	19, 802	19, 802		18, 523	1
90. 04 09004 OP ORTHO CLINIC	Ö	0	0		0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	260, 265	302, 209	562, 474	-116, 946	445, 528	
90.06 09006 INFUSION CLINIC	111, 570	44, 349	155, 919		120, 893	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	0	O	165, 976	165, 976	90.07
91. 00 09100 EMERGENCY	1, 121, 629	2, 011, 300	3, 132, 929	-359, 897	2, 773, 032	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00 O4950 OUTPATIENT PSYCH	31, 716	31, 201	62, 917	-30, 778	32, 139	93.00
SPECIAL PURPOSE COST CENTERS						ļ
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	11, 008, 908	27, 492, 690	38, 501, 598	144, 234	38, 645, 832	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	00.054	010 110	-		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	119, 761	92, 351	212, 112		146, 267	
193. 00 19300 NONPALD WORKERS	0	0	0			193. 00 194. 00
194. 00 07950 VACANT 194. 02 07952 WEST JAY CLINIC	127 241	96, 849	224, 090	40 503	174, 497	
194. 02 07952 WEST JAY CLINIC 194. 03 07953 JAY MERI DI AN URGENT CARE	127, 241 93, 511	46, 558			111, 273	
200.00 TOTAL (SUM OF LINES 118 through 199)	11, 349, 421	27, 728, 448				
	, 517, 121	2., .20, 140	0.,0,,,007	١	0.,0,7,007	,_55. 50

Provider CCN: 15-1320

Period: Worksheet A From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm

				7/15/2021 1: 0)3 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For		
			Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FLXT	-547, 155			1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB	-75, 227	0		1. 01
1. 02	00102 CAP REL COSTS-BLDG & FLXT-POB	-35, 030	0		1. 02
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ	-14, 339	0		1.03
1.04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0	0		1.04
2.00	00200 CAP REL COSTS-MVBLE EQUIP	194, 930	1, 896, 725		2.00
2. 01	00201 CAP REL COSTS-MVBLE EQUIP - MOB	-1, 413	38, 468		2. 01
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB	0	0		2. 02
2.03	00203 CAP REL COSTS-MVBLE EQUIP - WJ	0	0		2.03
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-333, 744	2, 430, 850		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 233, 742	8, 438, 140		5.00
7.00	00700 OPERATION OF PLANT	261, 098	2, 667, 750		7.00
7. 01	00701 OPERATION OF PLANT - MOB	0	99, 585		7. 01
7.02	00702 OPERATION OF PLANT - POB	-35, 460	5, 019		7. 02
7.03	00703 OPERATION OF PLANT - WJ	-12, 001	o		7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	0	129, 081		8.00
9.00	00900 HOUSEKEEPI NG	0	506, 802		9.00
10.00	01000 DI ETARY	9, 548			10.00
11. 00	01100 CAFETERI A	-122, 026			11.00
13. 00	01300 NURSING ADMINISTRATION	348, 141	1, 661, 529		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-28			14.00
15. 00	01500 PHARMACY	216, 547	902, 907		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1		16.00
17. 00	01700 SOCIAL SERVICE	0	l ol		17.00
.,, 00	INPATIENT ROUTINE SERVICE COST CENTERS		91		1
30. 00	03000 ADULTS & PEDIATRICS	-780, 548	1, 721, 967		30.00
40. 00	04000 SUBPROVI DER - I PF	-104, 848			40.00
43. 00	04300 NURSERY	0	1		43.00
10.00	ANCILLARY SERVICE COST CENTERS	J	20,020		10.00
50. 00	05000 OPERATING ROOM	-1, 194, 749	1, 118, 153		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			52.00
53. 00	05300 ANESTHESI OLOGY	0	7,201		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	141, 261	1, 292, 102		54.00
60.00	06000 LABORATORY	-5, 141	2, 019, 607		60.00
65. 00	06500 RESPI RATORY THERAPY	29, 237			65.00
66. 00	06600 PHYSI CAL THERAPY	69, 436			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	07, 430	85, 903		67.00
68. 00	06800 SPEECH PATHOLOGY	0	17, 143		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	2, 295		69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	87, 965		71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	20, 085		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	1, 511, 327		73.00
		62, 045			76.00
76. 00	03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	62, 045	245, 023		76.00
00 00	09000 CLINIC	0	0		90.00
	09000 CETNIC	-			90.00
	1	-326, 852			1
90. 02	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	-597, 603 -18, 523	1 1		90.02
90. 03	1	- 18, 523	0		90.03
90. 04	09004 OP ORTHO CLINIC	1/2 7/0	1		90.04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	-163, 760			90.05
90.06	09006 I NFUSI ON CLI NI C	0	120, 893		90.06
90.07	09007 HEALTH BEGINNINGS PROGRAM	1 1/2 057	165, 976		90.07
91.00	09100 EMERGENCY	-1, 162, 057	1, 610, 975		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		00.400		92.00
93. 00	04950 OUTPATIENT PSYCH	0	32, 139		93.00
440.04	SPECIAL PURPOSE COST CENTERS	F 400 000	00 040 000		110 00
118. 00		-5, 432, 003	33, 213, 829		118. 00
400 -	NONREI MBURSABLE COST CENTERS	_			100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	146, 267		192.00
	19300 NONPALD WORKERS	0	0		193.00
	07950 VACANT	0	0		194. 00
	2 07952 WEST JAY CLINIC	0	1		194. 02
	3 07953 JAY MERIDIAN URGENT CARE	0	, =		194. 03
200.00	TOTAL (SUM OF LINES 118 through 199)	-5, 432, 003	33, 645, 866		200.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-1320

					7/15/2021	
	Cook Cooker	Increases	C-1	0+1		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	A - CAFETERIA	3.00	4.00	3.00		
1.00	CAFETERI A	1100	252, 448	209, 715		1.00
	0		252, 448	209, 715		
1. 00	B - DRUGS RECLASS PHARMACY	15. 00	O	35, 894		1.00
2. 00	DRUGS CHARGED TO PATIENTS	73. 00	o	1, 511, 327		2.00
3. 00		0.00	Ö	0		3.00
4.00		0. 00	0	0		4.00
5.00		0.00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8.00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	o	0		13.00
14. 00		0.00	Ö	Ö		14.00
	0		0	1, 547, 221		
1 00	C - SUPPLIES/IMPLANTS	14 00	ما	2/0 504		1 00
1. 00 2. 00	CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED TO	14. 00 71. 00	0	260, 504 87, 965		1. 00 2. 00
2.00	PATI ENTS	71.00	ď	67, 703		2.00
3.00	IMPL. DEV. CHARGED TO	72. 00	0	20, 085		3. 00
4 00	PATIENTS	7 01		2.4		4 00
4. 00 5. 00	OPERATION OF PLANT - MOB SUBPROVIDER - IPF	7. 01 40. 00	0	34 100		4. 00 5. 00
6. 00	OPERATING ROOM	50.00	Ö	1, 714		6. 00
7. 00	WOUND CLINIC	90. 03	0	43		7. 00
8.00	JAY MERIDIAN URGENT CARE	194. 03	0	42		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0.00	o	o		11.00
12. 00		0.00	Ō	0		12.00
13.00		0.00	0	0		13.00
14. 00 15. 00		0. 00 0. 00	0	0		14. 00 15. 00
16. 00		0.00	o	0		16.00
17. 00		0.00	Ö	Ö		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
22. 00		0.00	o	o		22. 00
23.00		0.00	0_	0		23. 00
	0		0	370, 487		
1. 00	D - LAUNDRY LAUNDRY & LINEN SERVICE	8. 00	0	3, 281		1.00
2. 00	ENONDRY & ETHEN SERVI SE	0.00	Ö	0		2.00
3.00		0.00	0_	0		3. 00
	O		0	3, 281		
1. 00	E - DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	0	1, 154, 746		1.00
2.00	CAP REL COSTS-BLDG &	1. 01	0	75, 227		2.00
	FI XT-MOB					
3. 00	CAP REL COSTS-BLDG & FIXT-POB	1. 02	0	35, 030		3.00
4. 00	CAP REL COSTS-BLDG & FIXT-WJ	1. 03	o	14, 339		4.00
5.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 436, 522		5. 00
6.00	CAP REL COSTS-MVBLE EQUIP -	2. 01	0	39, 881		6. 00
7. 00	MOB	0. 00	0	0		7. 00
8. 00		0.00	0	0		8.00
9. 00		0.00	Ö	0		9. 00
10.00		0. 00	О	0		10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0		14.00
15. 00		0. 00	Ö	0		15. 00
16. 00		0. 00	0	0		16.00
17.00		0. 00 0. 00	0	0		17. 00 18. 00
18. 00 19. 00		0.00	0	0		19.00
	1	3. 30	<u> </u>	٩١		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 IU HEALTH JAY HOSPITAL Provider CCN: 15-1320 Peri od: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Increases

	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
20.00		0.00	0			20.00
21. 00			— — — ⁰	2, 755, 745	21.	21. 00
	G - PROPERTY INSURANCE			2,733,743		
1.00	CAP REL COSTS-BLDG & FLXT	1. 00	0	24, 482	1.	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 943	2.	2.00
	0		0	28, 425		
	H - HOUSEKEEPING SUPPLIES			I		
1.00	HOUSEKEEPI NG	9.00	0		· · · · · · · · · · · · · · · · · · ·	1.00
2. 00 3. 00		0. 00 0. 00	0			2.00
4. 00		0.00	0			4. 00
5. 00		0.00	0			5. 00
6.00		0.00	0	1	· · · · · · · · · · · · · · · · · · ·	6.00
7.00		0.00	0	0	7.	7.00
8. 00		0. 00	0	_	·	8.00
9.00		0.00	0			9.00
10. 00 11. 00		0. 00 0. 00	0			0. 00 1. 00
12.00		0.00	0			2. 00
13. 00		0.00	0			3. 00
14. 00		0. 00	0		·	4. 00
15.00		0.00	0		·	5.00
16.00		0. 00	0	0	16.	6.00
17.00		0.00	0	_	·	7.00
18. 00		0. 00	0			8.00
19. 00			0	0 22, 453	19.	9. 00
	J - EMPLOYEE BENEFITS			22, 453		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	2, 578, 266	1.	1.00
2. 00		0.00	0		I	2.00
3.00		0. 00	0	0	3.	3.00
4.00		0.00	0			4.00
5.00		0.00	0		· · · · · · · · · · · · · · · · · · ·	5.00
6. 00		0.00	0			6.00
7. 00 8. 00		0. 00 0. 00	0			7. 00 8. 00
9. 00		0. 00	0		· · · · · · · · · · · · · · · · · · ·	9. 00
10.00		0. 00	0			0.00
11.00		0.00	0	0	11.	1.00
12.00		0.00	0			2.00
13.00		0.00	0			3.00
14.00		0.00	0			4.00
15. 00 16. 00		0. 00 0. 00	0			5. 00 6. 00
17. 00		0. 00	0		I	7. 00
18. 00		0. 00	0		·	8. 00
19.00		0.00	0	0		9.00
20.00		0.00	0	_		20.00
21.00		0. 00	0	0		21.00
22. 00			0		22.	22.00
	K - NURSERY AND LABOR AND DEL	IVEDV	0	2, 578, 266		
1. 00	NURSERY AND LABOR AND DEL	43.00	23, 362	1, 963	1	1. 00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00	6, 717			2. 00
	0		30, 079			50
	M - MOTHER BABY					
1.00	HEALTH BEGINNINGS PROGRAM	90. 07	15 <u>7, 3</u> 68			1.00
505 5	TOTALS		157, 368			
500.00	Grand Total: Increases		439, 895	7, 526, 728	500.	U. 00

RECLASSI FI CATI ONS

Provider CCN: 15-1320

Peri od: Worksheet A-6 From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/15/2021 1:03 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - CAFETERIA 1.00 DI ETARY 10.00 252, 448 209, 715 0 1.00 252, 448 209, 715 B - DRUGS RECLASS 1.00 PHARMACY 15.00 1,057,073 0 1.00 EMPLOYEE BENEFITS DEPARTMENT 0 0 2.00 4.00 7,568 2.00 3.00 ADMINISTRATIVE & GENERAL 5.00 ol 173 0 3.00 0 0 4.00 DI ETARY 10.00 79 4.00 5.00 ADULTS & PEDIATRICS 30.00 0 5, 521 0 5.00 0 6.00 OPERATING ROOM 50.00 0 4,724 6.00 7 00 RADI OLOGY-DI AGNOSTI C 54 00 0 27, 109 0 7 00 RESPIRATORY THERAPY 0 8.00 65.00 0 412 8.00 9.00 CARDI OPULMONARY 76.00 o 7,876 0 9.00 10.00 FAMILY PRACTICE OF JAY 90.01 0 240, 257 0 10.00 COUNTY JAY FAMILY MEDICINE 11.00 0 0 90.02 141,025 11.00 12.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 23, 451 0 12.00 INFUSION CLINIC o 13.00 90.06 23, 321 0 13.00 14.00 EMERGENCY 0 <u>8, 6</u>32 0 91.00 14.00 1, 547, 221 - SUPPLIES/IMPLANTS 0 1.00 EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 499 1.00 0 ADMINISTRATIVE & GENERAL 12, 955 0 2.00 5.00 2.00 3.00 OPERATION OF PLANT 7.00 0 21, 563 3.00 4.00 HOUSEKEEPI NG 9.00 0 14, 942 0 4.00 0 0 DI ETARY 10.00 1, 169 5.00 5.00 6.00 NURSING ADMINISTRATION 13.00 0 175 6.00 7.00 PHARMACY 15.00 0 16, 546 0 7.00 0 0 8.00 ADULTS & PEDIATRICS 30.00 79, 445 8.00 0 İRADI OLOGY-DI AGNOSTI C 0 9.00 54.00 34, 475 9.00 10.00 LABORATORY 60.00 0 10 10.00 0 11.00 RESPIRATORY THERAPY 65.00 0 21,643 11.00 0 PHYSICAL THERAPY 66.00 2,091 12.00 12.00 OCCUPATIONAL THERAPY 0 0 13.00 67.00 51 13.00 0 14.00 ELECTROCARDI OLOGY 69.00 0 1, 275 14.00 CARDI OPULMONARY o 0 15.00 76.00 1, 204 15.00 o 0 FAMILY PRACTICE OF JAY 31, 788 16.00 90.01 16.00 COUNTY 17.00 JAY FAMILY MEDICINE 90.02 0 16, 923 0 17.00 JAY FAMILY FIRST HEALTH CARE 90.05 0 3, 970 0 18.00 18.00 19.00 INFUSION CLINIC 90.06 0 7,015 0 19.00 0 91.00 20 00 EMERGENCY 0 100,810 20.00 21.00 OUTPATIENT PSYCH 93.00 0 176 0 21.00 22.00 PHYSICIANS' PRIVATE OFFICES 192.00 o 947 0 22.00 WEST JAY CLINIC 0 23.00 1<u>94.</u> 02 815 23.00 370, 487 LAUNDRY 1.00 HOUSEKEEPI NG 9. 00 0 1, 815 0 1.00 0 2.00 ADULTS & PEDIATRICS 30.00 0 2.00 17 3.00 OPERATING ROOM 50.00 0 1,449 0 3.00 3, 281 DEPRECIATION ADMINISTRATIVE & GENERAL 1.00 1.00 5.00 68.344 9 2.00 OPERATION OF PLANT 7.00 0 1, 215, 007 2.00 3.00 OPERATION OF PLANT - MOB 7. 01 0 81, 560 9 3.00 OPERATION OF PLANT - POB 0 35,030 4.00 7.024.00 9 OPERATION OF PLANT - WJ 5.00 7.03 0 4, 907 5.00 6.00 DI ETARY 10.00 0 16, 100 9 6.00 0 0 7.00 PHARMACY 15.00 47, 217 7.00 0 0 8.00 ADULTS & PEDIATRICS 30.00 132, 381 8.00 9.00 SUBPROVIDER - IPF 40.00 0 4, 411 9.00 OPERATING ROOM 0 10.00 50.00 0 360, 105 10.00 0 RADI OLOGY-DI AGNOSTI C 54.00 608, 165 11.00 11.00 0 0 12.00 LABORATORY 60.00 31,628 12.00 0 13.00 RESPIRATORY THERAPY 65.00 0 26, 566 13.00 PHYSI CAL THERAPY 0 0 14.00 66.00 1,061 14.00 0 15.00 CARDI OPULMONARY 76.00 ol 28.841 15.00 0 FAMILY PRACTICE OF JAY 0 16.00 90.01 4, 706 16.00 COUNTY 17.00 WOUND CLINIC 90.03 0 1, 322 17.00 18.00 INFUSION CLINIC 90.06 0 445 0 18.00 0 91.00 68.800 0 19.00 19 00 **IEMERGENCY** 20.00 OUTPATIENT PSYCH 93.00 0 9,716 0 20.00 21.00 PHYSICIANS' PRIVATE OFFICES 192.00 9, 433 21.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-1320

					'	7/15/2021 1:	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	0		0	2, 755, 745			_
1 00	G - PROPERTY INSURANCE	F 00	ما	20. 425	- 10		1 00
1.00	ADMINISTRATIVE & GENERAL	5.00	0	28, 425			1.00
2. 00		0.00	0		12		2. 00
	H - HOUSEKEEPING SUPPLIES		U _I	28, 425			_
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	20	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	0	455			2.00
3. 00	OPERATION OF PLANT	7.00	o	16, 082			3.00
4. 00	DI ETARY	10.00	0	10,002			4.00
5. 00	NURSING ADMINISTRATION	13. 00	o	24	-1		5. 00
6. 00	PHARMACY	15. 00	O	112	1		6.00
7.00	ADULTS & PEDIATRICS	30.00	О	940	ol		7.00
8.00	OPERATING ROOM	50.00	О	758	o o		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	О	930	o		9. 00
10.00	RESPI RATORY THERAPY	65. 00	0	117	0		10.00
11.00	PHYSI CAL THERAPY	66. 00	0	105	0		11.00
12.00	CARDI OPULMONARY	76. 00	0	136	0		12.00
13.00	FAMILY PRACTICE OF JAY	90. 01	0	97	0		13.00
	COUNTY						
14. 00	JAY FAMILY MEDICINE	90. 02	0	671	1		14.00
15. 00	JAY FAMILY FIRST HEALTH CARE	90. 05	0	183			15. 00
16. 00	INFUSION CLINIC	90. 06	0	97	1		16.00
17. 00	EMERGENCY	91.00	0	1, 321	1		17.00
18.00	OUTPATIENT PSYCH	93.00	0	60	1		18.00
19. 00	PHYSICIANS' PRIVATE OFFICES	192.00	9	343			19. 00
	0		0	22, 453	3		_
1. 00	J - EMPLOYEE BENEFITS ADMINISTRATIVE & GENERAL	5. 00	0	93, 620	0		1 100
2. 00	OPERATION OF PLANT	7. 00	0	75, 560			1. 00 2. 00
3. 00	LAUNDRY & LINEN SERVICE	8. 00	0	14, 862			3.00
4. 00	HOUSEKEEPI NG	9.00	o	124, 228	1		4.00
5. 00	DI ETARY	10.00	0	159, 213			5. 00
6. 00	NURSING ADMINISTRATION	13. 00	o	206, 467			6.00
7. 00	PHARMACY	15. 00	0	95, 929			7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	376, 233			8. 00
9.00	SUBPROVIDER - IPF	40.00	o	38, 842			9. 00
10.00	OPERATING ROOM	50.00	o	286, 105	0		10.00
11.00	RADI OLOGY-DI AGNOSTI C	54.00	0	138, 615	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	99, 555	0		12.00
13.00	CARDI OPULMONARY	76. 00	0	29, 612			13.00
14.00	FAMILY PRACTICE OF JAY	90. 01	0	205, 827	0		14. 00
	COUNTY						
15. 00	JAY FAMILY MEDICINE	90. 02	0	206, 210			15.00
16.00	JAY FAMILY FIRST HEALTH CARE	90. 05	0	89, 342			16.00
17. 00	I NFUSION CLINIC	90.06	0	4, 148			17. 00
18.00	EMERGENCY	91.00	0	180, 334			18.00
19.00	OUTPATIENT PSYCH	93. 00	-1	20, 826	1		19. 00 20. 00
20. 00 21. 00	PHYSICIANS' PRIVATE OFFICES WEST JAY CLINIC	192. 00 194. 02	0	55, 122 48, 778			21.00
22. 00	JAY MERIDIAN URGENT CARE	194. 02	0	28, 838			22.00
22.00	O WERT DIAN ORGENI CARE	174.03	— — — #	2, 578, 266			22.00
	K - NURSERY AND LABOR AND DEI	LI VERY	<u> </u>	2, 370, 200	-1		
1. 00	ADULTS & PEDIATRICS	30.00	30, 079	2, 527	7 0		1.00
2. 00		0.00	0	2, 32,			2.00
	0 — — — — —	— — -:. °4	30, 079	— — 2, 52 7			
	M - MOTHER BABY			, ,=.			
1.00	ADULTS & PEDIATRICS	30.00	157, 368	<u>8, 6</u> 08	0		1.00
	TOTALS		157, 368	8, 608			
500.00	Grand Total: Decreases		439, 895	7, 526, 728	3		500.00

Provider CCN: 15-1320

| Peri od: | Worksheet A-7 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared:

				Ic	12/31/2020	Date/lime Pre 7/15/2021 1:0	
				Acqui si ti ons		77 107 2021 110	<u> </u>
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	1, 006, 948	0	0	0	17, 800	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3. 00	Buildings and Fixtures	19, 125, 052	0	0	0	147, 200	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	8, 662, 182	724, 381	0	724, 381	16, 448	1
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	28, 794, 182	724, 381	0	724, 381	181, 448	1
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	28, 794, 182	724, 381	0	724, 381	181, 448	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
		/ 00	Assets				
	DART I ANALYCIC OF CHANGES IN CARLTAL ACCE	6.00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						1 00
1.00	Land	989, 148	0				1.00
2.00	Land Improvements	10 077 050	0				2.00
3.00	Buildings and Fixtures	18, 977, 852	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0 270 115	142 124				5.00
6.00	Movable Equipment	9, 370, 115	142, 136				6.00
7.00	HIT designated Assets	20 227 115	142 124				7. 00 8. 00
8.00	Subtotal (sum of lines 1-7)	29, 337, 115	142, 136				9.00
9. 00 10. 00	Reconciling Items Total (line 8 minus line 9)	29, 337, 115	142 124				10.00
10.00	Tiotal (Title o IIII lius Title 9)	29, 337, 115	142, 136				10.00

IU HEALTH JAY HOSPITAL

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

				Ť	o 12/31/2020	Date/Time Pre 7/15/2021 1:0	
			SU	IMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
		0.00	10.00	11 00	instructions)	40.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	9.00	10.00	11.00	12.00	13. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	NSHEET A, CULUWII	N Z, LINES I a	0	0	0	1.00
1. 00	CAP REL COSTS-BLDG & FIXT-MOB	0	0	0	0	0	1.00
1. 02	CAP REL COSTS-BLDG & FIXT-POB		0	0	0	0	1. 02
1. 03	CAP REL COSTS-BLDG & FIXT-WJ	o o	0	0	0	0	1. 03
1. 04	CAP REL COSTS-BLDG & FIXT-INTEREST	o	0	Ö	0	Ö	1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	261, 330	O	O	0	0	2.00
2.01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0	0	0	0	2. 01
2.02	CAP REL COSTS-MVBLE EQUIP - POB	0	0	0	0	0	2. 02
2.03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0	0	0	0	2. 03
3.00	Total (sum of lines 1-2)	261, 330	0	0	0	0	3. 00
		SUMMARY OF	CAPI TAL				
	Cook Combon Documents on	0+1	T-+-1 (1)				
	Cost Center Description	Other Capital-Relat	Total (1)				
		ed Costs (see					
		instructions)	7 tili ougii 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00
1.01	CAP REL COSTS-BLDG & FIXT-MOB	0	0				1. 01
1.02	CAP REL COSTS-BLDG & FIXT-POB	0	0				1. 02
1.03	CAP REL COSTS-BLDG & FIXT-WJ	0	0				1. 03
1.04	CAP REL COSTS-BLDG & FIXT-INTEREST	0	0				1. 04
2.00	CAP REL COSTS-MVBLE EQUIP	0	261, 330				2.00
2. 01	CAP REL COSTS-MVBLE EQUIP - MOB	0	0				2. 01
2. 02	CAP REL COSTS-MVBLE EQUIP - POB	0	0				2. 02
2. 03	CAP REL COSTS-MVBLE EQUIP - WJ	0	0				2. 03
3. 00	Total (sum of lines 1-2)	0	261, 330				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1320 Peri od: Worksheet A-7 From 01/01/2020 Part III Date/Time Prepared: 12/31/2020 7/15/2021 1:03 pm COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITAL Cost Center Description Gross Assets Capi tal i zed Gross Assets Ratio (see Insurance for Ratio Leases instructions) (col. 1 col. 2) 3.00 1.00 2.00 4.00 5.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 29 1.00 29, 337, 115 1.000000 1.00 29, 337, 115 1.01 CAP REL COSTS-BLDG & FIXT-MOB 0.000000 0 1.01 CAP REL COSTS-BLDG & FIXT-POB 0 0 0.000000 1.02 0 1.02 CAP REL COSTS-BLDG & FIXT-WJ 0 0 0.000000 0 1.03 1.03 0 0 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0.000000 0 1.04 2.00 CAP REL COSTS-MVBLE EQUIP 0 0 0.000000 0 2.00 2.01 CAP REL COSTS-MVBLE EQUIP - MOB 0 0.000000 2.01 CAP REL COSTS-MVBLE EQUIP - POB 2.02 0 0 0.000000 0 2.02 C 2.03 CAP REL COSTS-MVBLE EQUIP - WJ 0 0 0.000000 0 2.03 3.00 Total (sum of lines 1-2) 29, 337, 115 29, 337, 115 1.000000 3.00 ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL Cost Center Description Taxes 0ther Total (sum of Depreciation Lease Capi tal -Rel at cols. 5 through 7) ed Costs 6. 00 9. 00 10.00 7.00 8.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 607, 591 0 1.00 1.01 CAP REL COSTS-BLDG & FIXT-MOB 0 1.01 0 0 0 CAP REL COSTS-BLDG & FIXT-POB 0 1.02 0 1.02 CAP REL COSTS-BLDG & FIXT-WJ 0 1.03 0 0 1.03 0 1.04 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 1.04 CAP REL COSTS-MVBLE EQUIP 0 2.00 0 0 1, 892, 782 0 2.00 0 2.01 CAP REL COSTS-MVBLE EQUIP - MOB 0 38, 468 0 2.01 CAP REL COSTS-MVBLE EQUIP - POB 0 2.02 C 0 0 2.02 CAP REL COSTS-MVBLE EQUIP - WJ 2.03 0 0 2.03 3.00 Total (sum of lines 1-2) 2, 538, 841 3.00 SUMMARY OF CAPITAL Cost Center Description Interest Insurance Taxes (see 0ther Total (2) instructions) Capital-Relat (sum of cols. (see instructions) ed Costs (see 9 through 14) instructions) 11. 00 12.00 15.00 13.00 14.00 PART III - RECONCILIATION OF CAPITAL COSTS CENTERS CAP REL COSTS-BLDG & FIXT 1.00 24, 482 632, 073 1.00 0 0 1.01 CAP REL COSTS-BLDG & FLXT-MOB 0 0 1.01 1.02 CAP REL COSTS-BLDG & FIXT-POB 0 C 0 0 0 1.02 CAP REL COSTS-BLDG & FIXT-WJ 0 0 1.03 000000 0 1.03 0 CAP REL COSTS-BLDG & FIXT-INTEREST 0 0 1.04 1.04 0 CAP REL COSTS-MVBLE EQUIP 2.00 3, 943 0 1, 896, 725 2.00 CAP REL COSTS-MVBLE EQUIP - MOB 0 2.01 38, 468 2.01 CAP REL COSTS-MVBLE EQUIP - POB 2.02 C 0 0 0 0 2.02

0

28, 425

2 03

3.00

0

2, 567, 266

2 03

3.00

CAP REL COSTS-MVBLE EQUIP - WJ

Total (sum of lines 1-2)

From 01/01/2020 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL -91,526 CAP REL COSTS-BLDG & FIXT 1.00 1.00 COSTS-BLDG & FIXT (chapter 2) 1.01 Investment income - CAP REL OCAP REL COSTS-BLDG & 1.01 1.01 COSTS-BLDG & FIXT-MOB (chapter FIXT-MOB OCAP REL COSTS-BLDG & 1.02 Investment income - CAP REL 1.02 1.02 COSTS-BLDG & FLXT-POB (chapter FI XT-POB 1.03 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT-WJ 1.03 1.03 COSTS-BLDG & FIXT-WJ (chapter OCAP REL COSTS-BLDG & 1.04 Investment income - CAP REL 1.04 1.04 COSTS-BLDG & FIXT-INTEREST FLXT-LNTEREST (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 2.01 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP -2. 01 2.01 COSTS-MVBLE EQUIP - MOB MOB (chapter 2) Investment income - CAP REL 2.02 OCAP REL COSTS-MVBLE EQUIP -2.02 0 2.02 COSTS-MVBLE EQUIP - POB P0B (chapter 2) OCAP REL COSTS-MVBLE EQUIP -2.03 Investment income - CAP REL 2.03 2.03 COSTS-MVBLE EQUIP - WJ W. J (chapter 2) 3.00 Investment income - other 0 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0 4.00 0.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 -68, 094 CAP REL COSTS-BLDG & FIXT 1.00 6.00 suppliers (chapter 8) Tel ephone services (pay 7 00 7 00 0 00 stations excluded) (chapter 21) 8.00 Television and radio service 0.00 8.00 (chapter 21) 9.00 9.00 Parking Lot (chapter 21) 0.00 |Provider-based physician -2, 887, 307 10.00 A-8-2 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 4.504.515 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -122, 026 CAFETERI A 14.00 В 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20 00 Vending machines 20.00 0.00O Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) 22 00 Interest expense on Medicare 22.00 0 00 O overpayments and borrowings to repay Medicare overpayments

ADJUSTMENTS TO EXPENSES Provider CCN: 15-1320 Peri od: Worksheet A-8 From 01/01/2020 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1.00 2.00 3.00 4.00 5. 00 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00 therapy costs in excess of limitation (chapter 14) OPHYSICAL THERAPY 24.00 24.00 Adjustment for physical A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -0 *** Cost Center Deleted *** 114.00 25.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 26.00 COSTS-BLDG & FIXT OCAP REL COSTS-BLDG & 26.01 Depreciation - CAP REL 1.01 26.01 COSTS-BLDG & FIXT-MOB FLXT-MOB Depreciation - CAP REL OCAP REL COSTS-BLDG & 26.02 26.02 1.02 COSTS-BLDG & FIXT-POB FI XT-POB Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT-WJ 26.03 26.03 1.03 COSTS-BLDG & FIXT-WJ Depreciation - CAP REL OCAP REL COSTS-BLDG & 26.04 1.04 26.04 COSTS-BLDG & FIXT-INTEREST FLXT-INTEREST OCAP REL COSTS-MVBLE EQUIP 27.00 Depreciation - CAP REL 2.00 27.00 COSTS-MVBLE EQUIP Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP -27.01 2.01 27.01 COSTS-MVBLE EQUIP - MOB MOB Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP -27.02 2.02 27.02 COSTS-MVBLE EQUIP - POB P0B Depreciation - CAP REL 27.03 OCAP REL COSTS-MVBLE EQUIP -2.03 27.03 COSTS-MVBLE EQUIP - WJ WJ 28.00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29 00 Physicians' assistant 29 00 0.00 30.00 Adjustment for occupational A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions) O SPEECH PATHOLOGY 31.00 Adjustment for speech A-8-3 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 0.00 0 32.00 Depreciation and Interest -2, 579, 709 EMPLOYEE BENEFITS DEPARTMENT 33.00 EMPLOYEE BENEFITS 4.00 Α 0 33.00 33.01 HOSPITAL ASSESSMENT FEES -1, 894, 583 ADMINISTRATIVE & GENERAL 5.00 33.01 33. 02 MISCELLANEOUS INCOME В -162, 216 ADMINISTRATIVE & GENERAL 5.00 33.02 MISCELLANEOUS INCOME -35, 460 OPERATION OF PLANT - POB 7.02 33.03 R 33.03 33.04 MISCELLANEOUS INCOME В -12,001 OPERATION OF PLANT - WJ 7.03 33.04 MISCELLANEOUS INCOME 33.05 В -1, 696 DI ETARY 10.00 33.05 MISCELLANEOUS INCOME -55 NURSING ADMINISTRATION В 33.06 33.06 13.00 MISCELLANEOUS INCOME 33.07 В -28 CENTRAL SERVICES & SUPPLY 14.00 33.07 33.08 MISCELLANEOUS INCOME В -3, 142 PHARMACY 15.00 33.08 MARKETING EXPENSES -11, 455 ADMINI STRATI VE & GENERAL 33.09 Α 5.00 33.09 33 10 CONTRACTED HOSPITALIST -780, 388 ADULTS & PEDIATRICS 30 00 ol 33 10 Α CONTRACTED CRNA -711, 225 OPERATING ROOM 33.11 Α 50.00 33.11 MEDICARE DEPRECIATION EXPENSE -405, 327 CAP REL COSTS-BLDG & FIXT 33.12 33.12 Α 1.00 -75, 227 CAP REL COSTS-BLDG & FIXT-MOB MEDICARE DEPRECIATION EXPENSE 1.01 33.13 33.13 Α MEDICARE DEPRECIATION EXPENSE -35, 030 CAP REL COSTS-BLDG & 33.14 33.14 Α 1.02 FI XT-POB MEDICARE DEPRECIATION EXPENSE -14, 339 CAP REL COSTS-BLDG & FIXT-WJ 1.03 33.15 MEDICARE DEPRECIATION EXPENSE 33.16 -14, 667 CAP REL COSTS-MVBLE EQUIP 2.00 33. 16 Α -1, 413 CAP REL COSTS-MVBLE EQUIP -MEDICARE DEPRECIATION EXPENSE 33.17 Α 2.01 33.17 MOB 33. 18 MARKETING EXPENSES -160 ADULTS & PEDIATRICS 30.00 0 33.18 Α 33. 19 MARKETING EXPENSES -60 OPERATING ROOM 50.00 33.19 Α MARKETING EXPENSES 33 20 -171 EMERGENCY 91.00 33 20 Α 33. 21 MISCELLANEOUS INCOME В -836 OPERATION OF PLANT 7.00 0 33.21 33. 22 MISCELLANEOUS INCOME В -23, 236 RADI OLOGY-DI AGNOSTI C 54.00 9 33. 22 33. 23 MISCELLANEOUS INCOME -5, 141 LABORATORY 60.00 ol 33. 23

Health Financial Systems		IU HEALTH JA	Y HOSPI TAL	In Lie	u of Form CMS-	2552-10
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1320	Period: From 01/01/2020	Worksheet A-8	
					Date/Time Pre 7/15/2021 1:0	
			Expense Classification o	n Worksheet A		
			To/From Which the Amount is	s to be Adjusted		
Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	(2)				Ref.	
	1. 00	2. 00	3.00	4. 00	5. 00	
50.00 TOTAL (sum of lines 1 thru 4	9)	-5, 432, 003				50.00
(Transfer to Worksheet A,						
column 6, line 200.)						

⁽¹⁾ Description - all chapter references in this column pertain to CMS Pub. 15-1.

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

⁽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.

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

Provider CCN: 15-1320 Period: From 01/01/2020 To 12/31/2020 Date/Time Silva 2532 To 12/31/2020 Date/Time Silva

				To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	75 PIII
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	ORGANIZATIONS OF	R CLAIMED HOME	
4 00	OFFICE COSTS:	04B BEL 000TO BLBO 6 FLVT	luous ossuos	17.700		
1.00	II	CAP REL COSTS-BLDG & FIXT	HOME OFFICE	17, 792	0	1.00
2.00	l e	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE	209, 597	0	2.00
3.00	II	EMPLOYEE BENEFITS DEPARTMENT	l e e e e e e e e e e e e e e e e e e e	2, 247, 931	1, 966	3.00
3. 01	1	ADMINISTRATIVE & GENERAL	HOME OFFICE	6, 461, 183	6, 302, 296	3. 01
3. 02		ADMINISTRATIVE & GENERAL	RELATED PARTY	761, 743	86, 118	3. 02
3. 03 3. 04		OPERATION OF PLANT DIETARY	RELATED PARTY	261, 934	0	3. 03 3. 04
3. 04		NURSING ADMINISTRATION	RELATED PARTY RELATED PARTY	11, 244 348, 196	0	3.04
3. 06			RELATED PARTY	219, 689	0	3.05
3. 00		RADI OLOGY-DI AGNOSTI C	RELATED PARTY	164, 497	0	3.00
3. 07		RESPI RATORY THERAPY	RELATED PARTY	29, 237	0	3. 08
3. 09		PHYSI CAL THERAPY	RELATED PARTY	69, 436	0	3. 09
3. 10	II	CARDI OPULMONARY	RELATED PARTY	92, 416	0	3. 10
3. 11	II	EMPLOYEE BENEFITS DEPARTMENT	INCERTIES TAIRT	11, 902	11, 902	3. 11
3. 12		ADMINISTRATIVE & GENERAL		75, 618	75, 618	3. 12
3. 13	II.	OPERATION OF PLANT		231, 598	231, 598	3. 13
3. 14	II	DI ETARY		55, 294	55, 294	3. 14
3. 15	II.	PHARMACY		88, 767	88, 767	3. 15
3. 16	30.00	ADULTS & PEDIATRICS		805, 870	805, 870	3. 16
3. 17		SUBPROVIDER - IPF		100, 260	100, 260	3. 17
3. 18	50.00	OPERATING ROOM		521, 997	521, 997	3. 18
3. 19	54.00	RADI OLOGY-DI AGNOSTI C		341	341	3. 19
3. 20	60.00	LABORATORY		1, 939, 030	1, 939, 030	3. 20
3. 21	65.00	RESPI RATORY THERAPY		1, 338	1, 338	3. 21
3. 22	66.00	PHYSI CAL THERAPY		470, 237	470, 237	3. 22
3. 23	II	OCCUPATI ONAL THERAPY		85, 903	85, 903	3. 23
3. 24	II	SPEECH PATHOLOGY		17, 143	17, 143	3. 24
3. 25	1	ELECTROCARDI OLOGY		1, 060	1, 060	3. 25
3. 26	II	CARDI OPULMONARY		56, 944	56, 944	3. 26
3. 27		FAMILY PRACTICE OF JAY COUNT		326, 852	326, 852	3. 27
3. 28		JAY FAMILY MEDICINE		663, 500	663, 500	3. 28
3. 29		WOUND CLINIC		18, 523	18, 523	3. 29
3. 30		JAY FAMILY FIRST HEALTH CARE		164, 335	164, 335	3. 30
3. 31		INFUSION CLINIC		55	55	3. 31
3. 32		EMERGENCY		1, 551, 509	1, 551, 509	3. 32
3. 33		OUTPATIENT PSYCH		380	380	3. 33
3. 34 3. 35		PHYSICIANS' PRIVATE OFFICES WEST JAY CLINIC		1, 101 35, 577	1, 101 35, 577	3. 34 3. 35
3. 35 4. 00		JAY MERIDIAN URGENT CARE		9, 353		3. 35 4. 00
4. 00 5. 00	TOTALS (sum of lines 1-4).	DAT WENT DIAN UNGENT CARE		18, 129, 382	9, 353 13, 624, 867	5.00
5.00	Transfer column 6, line 5 to			10, 127, 302	13, 024, 007	5.00
	Worksheet A-8, column 2,					
	line 12.					

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

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

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

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

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	8. 00
9.00		0.00	9.00
10.00		0.00	10.00
	G. Other (financial or		100.00
	non-financial) specify:		

Heal th	Financial Systems	IU HEALTH J	AY HOSPITAL		In Lie	u of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider (CCN: 15-1320	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS				From 01/01/2020 To 12/31/2020		
				Related Organ	nization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	N	lame	Percentage of	
			Ownershi p			Ownershi p	
	1. 00	2. 00	3. 00	4	1. 00	5. 00	

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

0 3.14 3.14 3.15 0 3.15 3.16 0 3.16 3.17 3.17 3.18 3.18 3. 19 0 3.19 0 3.20 3.20 3.21 3.21 0 3. 22 3.22 0 3.23 3. 23 0 3. 24 3. 24 3. 25 3.25 0 3. 26 3.26 3.27 00000 3.27 3.28 3.28 3. 29 3.29 3.30 3.30 3.31 3.31 3.32 3.32 0 3.33 3.33 0 3.34 0 3.34 0 0 3.35 3.35 O 4 00 Λ 4.00

* 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.

5.00

	t boon pooted to not honout in	our amile i and or 2, the amount arronable chould be that eated in corami i or this part	•
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
-	B. INTERRELATIONSHIP TO RELA	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.

reriiibur	Sement under title XVIII.		
	HOSPI TAL	6.	00
7.00	HOME OFFICE	7.	00
8.00		8.	00
9.00		9.	00
10.00		10.	00
100.00		100.	00

5.00

4, 504, 515

Health Financial Systems	HOSPI TAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provi der CCN: 15-1320	Peri od:	Worksheet A-8-1
OFFICE COSTS			From 01/01/2020 To 12/31/2020	Date/Time Prepared: 7/15/2021 1:03 pm
Related Organization(s) and/or Home Office				
Type of Business				
6, 00				

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.B. Corporation, partnership, or other organization has financial interest in provider.C. Provider has financial interest in corporation, partnership, or other organization.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1320

					1	To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	уд ріп
		I denti fi er	Remuneration	Component	Component		ider Component	
				'	'		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	40. 00	SUBPROVI DER - I PF	104, 848	104, 848	0	0	0	1.00
2.00	50.00	OPERATING ROOM	483, 464	483, 464	0	0	0	2.00
3.00	76. 00	CARDI OPULMONARY	30, 371	30, 371	0	0	0	3.00
4.00	90. 01	FAMILY PRACTICE OF JAY	326, 852	326, 852	0	0	0	4.00
		COUNTY						
5. 00		JAY FAMILY MEDICINE	597, 603			0	0	5.00
6. 00		WOUND CLINIC	18, 523	•		0	0	6.00
7.00		JAY FAMILY FIRST HEALTH CARE	163, 760			0	0	7.00
8. 00		EMERGENCY	1, 434, 073	1, 161, 886	272, 187	0	0	8.00
9. 00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			3, 159, 494				0	200.00
	Wkst. A Line #		Unadj usted RCE		Cost of		Physician Cost	
		I denti fi er	Li mi t		Memberships &	Component	of Malpractice	
				Limit	Continuing	Share of col.	Insurance	
	4 00	0.00	0.00	0.00	Educati on	12	44.00	
1 00	1.00	2. 00 SUBPROVI DER – I PF	8. 00	9.00	12.00	13. 00	14.00	1. 00
1. 00 2. 00		OPERATING ROOM	0	0			0	2. 00
3. 00		CARDI OPULMONARY	0	0		_	0	3. 00
4. 00		FAMILY PRACTICE OF JAY	0	0	_	0	0	4. 00
4.00	70.01	COUNTY	0	0	0	0	U	4.00
5. 00	90.02	JAY FAMILY MEDICINE	0	0	0	n	0	5. 00
6. 00		WOUND CLINIC	0	0	0	0	0	6. 00
7. 00		JAY FAMILY FIRST HEALTH CARE	0	0	0	0	0	7. 00
8. 00		EMERGENCY	0	0	0	0	Ö	8. 00
9. 00	0.00		0	0	0	0	o o	9. 00
10.00	0.00		0	0	0	0	o o	10.00
200.00			Ö	Ō	0	0	o	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	_	
		I denti fi er	Component	Limit	Di sal I owance	.,		
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1.00		SUBPROVI DER - I PF	0	0	_	104, 848		1.00
2.00	50. 00	OPERATING ROOM	0	0		,		2.00
3.00		CARDI OPULMONARY	0	0		30, 371		3.00
4. 00	90. 01	FAMILY PRACTICE OF JAY	0	0	0	326, 852		4.00
		COUNTY	_		_			
5.00		JAY FAMILY MEDICINE	0	0		597, 603		5.00
6. 00		WOUND CLINIC	0	0		18, 523		6. 00
7.00	90. 05	JAY FAMILY FIRST HEALTH CARE	0	0		163, 760		7.00
8.00		EMERGENCY	0	0	0	1, 161, 886		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0. 00		0	0		0		10.00
200.00			0	0	0	2, 887, 307		200.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Period: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Provider CCN: 15-1320

					7/15/2021 1:0	
		CAPITAL RELATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	BLDG & FIXT-MOB	BLDG & FIXT-POB	BLDG & FIXT-WJ	
	0	1.00	1. 01	1. 02	1. 03	
GENERAL SERVICE COST CENTERS	(00.070	(22.072				1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 CAP REL COSTS-BLDG & FIXT-MOB	632, 073	632, 073	0			1.00
1. 02 00102 CAP REL COSTS-BLDG & FLXT-POB	0	l o	0	0		1.02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ	0	O	0	0	0	1
1. 04 00104 CAP REL COSTS-BLDG & FLXT-INTEREST		0	0	0	0	
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB	1, 896, 725 38, 468					2.00
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB	38, 408					2.02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ	0					2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 430, 850	l I	0	0	0	1
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT	8, 438, 140		0	0	0	
7. 01 00700 OPERATION OF PLANT - MOB	2, 667, 750 99, 585		0	0	0	
7. 02 OO702 OPERATION OF PLANT - POB	5, 019	Ö	Ö	o	0	
7.03 OO703 OPERATION OF PLANT - WJ	0	0	0	0	0	
8. 00 00800 LAUNDRY & LI NEN SERVI CE	129, 081	4, 670	0	0	0	1
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	506, 802 207, 405	4, 717 10, 070	0	0	0	
11. 00 01100 CAFETERI A	340, 137	23, 513	0	0	0	
13. 00 01300 NURSING ADMINISTRATION	1, 661, 529		0	Ö	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	263, 203	1	0	0	0	
15. 00 01500 PHARMACY	902, 907	7, 861	0	0	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0		0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>			1
30. 00 03000 ADULTS & PEDI ATRI CS	1, 721, 967	97, 454	0	0	0	
40. 00 04000 SUBPROVI DER - I PF 43. 00 04300 NURSERY	218, 684 25, 325		0	0	0	
ANCI LLARY SERVI CE COST CENTERS	25, 325	2, 123	U _I	U _I	0	43.00
50. 00 05000 OPERATING ROOM	1, 118, 153	31, 382	0	0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 281	873	0	0	0	
53. 00 05300 ANESTHESI OLOGY	1 202 102	0	0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	1, 292, 102 2, 019, 607	39, 258 20, 557	0	0	0	
65. 00 06500 RESPIRATORY THERAPY	445, 843		0	o	0	
66. 00 06600 PHYSI CAL THERAPY	542, 290		0	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	85, 903		0	0	0	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	17, 143 2, 295	189	0	0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		0	0	o	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 085	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 511, 327	0	0	0	0	
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	245, 023	0	0	0	0	76.00
90. 00 09000 CLINIC	0	o	0	ol	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	676, 691	o	0	Ö	0	
90.02 O9002 JAY FAMILY MEDICINE	744, 720	1	0	0	0	
90. 03 09003 WOUND CLINIC 90. 04 09004 OP ORTHO CLINIC	0	2, 681	0	0	0	
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	281, 768	30, 407	0	0	0	
90. 06 09006 I NFUSI ON CLI NI C	120, 893		0	Ö	0	
90. 07 09007 HEALTH BEGINNINGS PROGRAM	165, 976		0	0	0	
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	1, 610, 975	37, 498	0	0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR 93.00 04950 OUTPATIENT PSYCH	32, 139	12, 350	0	0	0	92. 00 93. 00
SPECIAL PURPOSE COST CENTERS	02,107	12,000	<u> </u>	<u> </u>		70.00
118.00 SUBTOTALS (SUM OF LINES 1 through	117) 33, 213, 829	605, 534	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS	-N 0		0	ما		100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	146, 267	6, 061	0	0		190. 00 192. 00
193. 00 19300 NONPALD WORKERS	0	l o	0	Ö		193.00
194. 00 07950 VACANT	0	20, 478	0	О		194. 00
194. 02 07952 WEST JAY CLINIC	174, 497	0	0	0		194. 02
194.03 07953 JAY MERIDIAN URGENT CARE 200.00 Cross Foot Adjustments	111, 273	0	0	O	0	194. 03 200. 00
201.00 Negative Cost Centers		o	0	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	33, 645, 866	632, 073	0	o		202.00
		•				

Provider CCN: 15-1320

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm

			СФР	ITAL RELATED C	nsts	7/15/2021 1:0	3 pm
	Cost Center Description	BLDG & FIXT-INTEREST	MVBLE EQUIP	MVBLE EQUIP - MOB	MVBLE EQUIP - POB	MVBLE EQUIP - WJ	
		1. 04	2. 00	2. 01	2. 02	2. 03	
4 00	GENERAL SERVI CE COST CENTERS			I	T	I	4 00
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 CAP REL COSTS-BLDG & FIXT-MOB						1. 00 1. 01
1. 02	00102 CAP REL COSTS-BLDG & FLXT-POB						1.01
1. 03	00103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1. 04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST	0					1.04
2.00	00200 CAP REL COSTS-MVBLE EQUIP		1, 896, 725				2.00
2. 01 2. 02	00201 CAP REL COSTS-MVBLE EQUIP - MOB 00202 CAP REL COSTS-MVBLE EQUIP - POB		0	38, 468	0		2. 01 2. 02
2. 02	00203 CAP REL COSTS-MVBLE EQUIP - WJ			0	0	0	2.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 666	0	0	0	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	0	253, 659	1		0	5.00
7.00	00700 OPERATION OF PLANT	0	366, 819	0 877	_	0	7. 00 7. 01
7. 01 7. 02	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0		8//		0	7.01
7. 03	00703 OPERATION OF PLANT - WJ	i o	Ö	Ö	-	Ö	7.03
8.00	00800 LAUNDRY & LINEN SERVICE	0	14, 012	0	0	0	8. 00
9.00	00900 HOUSEKEEPI NG	0	14, 154	l .	-	0	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	30, 218 70, 557	l .	-	0	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	0	26, 161	1	-	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	Ō		0	14.00
15. 00	01500 PHARMACY	0	23, 590	l .	0	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	0			16.00
17. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	17.00
30.00		0	292, 441	0	0	0	30.00
40.00	04000 SUBPROVI DER - I PF	0	7, 053	0	0	0	40.00
43.00	04300 NURSERY	0	6, 369	0	0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	0	04 170	1, 618	0	0	E0 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	94, 170 2, 618	1			50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0	2,010	Ö			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	117, 807	0	0	0	54.00
60.00	06000 LABORATORY	0	61, 687	1	0	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	17, 244 75, 864	1	0	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	14, 177	1		0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	566	l .	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71.00 72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0		73.00
	03160 CARDI OPULMONARY	0	0	2, 681			ł
	OUTPATIENT SERVICE COST CENTERS	1 -		1	T		
	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY	0	0				
	09002 JAY FAMILY MEDICINE	0					1
90. 03	09003 WOUND CLINIC	0	8, 044		0	•	90.03
	09004 OP ORTHO CLINIC	0	0	0		0	90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	91, 245	l .		0	
90.06	09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM	0	14, 578 61, 805	l .	_	0 0	
91. 00		0	112, 523	l .	0		1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 00		0	37, 059	0	0	0	93.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 817, 086	38, 468	0	1 0	118. 00
110.00	NONREI MBURSABLE COST CENTERS	<u> </u>	1,017,000	30, 400			1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 188	1			190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0			192.00
	19300 NONPAID WORKERS 07950 VACANT	0	0 61, 451	0	0		193. 00 194. 00
	207952 WEST JAY CLINIC	0	01,431	0	0	l .	194.00
	07953 JAY MERIDIAN URGENT CARE	O	0	Ö	Ö		194. 03
200.00	, ,						200.00
201.00		0	1 904 735	20 440	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	1, 896, 725	38, 468	0	1 0	202. 00

Provider CCN: 15-1320

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			11	0 12/31/2020	Date/IIme Pre 7/15/2021 1:0	
Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	OPERATION OF PLANT - MOB	<u>σ</u>
	DEPARTMENT 4.00	4A	5. 00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FLXT-MOB						1. 01
1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB 1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ						1. 02 1. 03
1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.03
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 434, 404					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	124, 214	8, 903, 053		4 000 (40		5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - MOB	66, 123	3, 222, 930			1/1 107	7.00
7. 01 00701 OPERATION OF PLANT - MOB 7. 02 00702 OPERATION OF PLANT - POB	0	100, 462 5, 019		24, 516 30, 398	161, 127 0	7. 01 7. 02
7. 03 00703 OPERATION OF PLANT - FOB	0	5, 01 9	1,800	30, 370	0	7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE	7, 767	155, 530	ľ	29, 360	0	8. 00
9. 00 00900 HOUSEKEEPI NG	83, 059	608, 732	219, 036	29, 657	0	9.00
10. 00 01000 DI ETARY	23, 527	271, 220	97, 591	63, 318	0	10.00
11. 00 01100 CAFETERI A	54, 956	489, 163	176, 013	147, 840	0	11.00
13.00 O1300 NURSING ADMINISTRATION	255, 487	1, 951, 895		54, 816	0	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	263, 203		0	0	14.00
15. 00 01500 PHARMACY	109, 112	1, 043, 470		49, 428	0	15.00
16. 00 01600 MEDI CAL RECORDS & LIBRARY 17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	16. 00 17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	o _l		0	<u> </u>	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	339, 349	2, 451, 211	882, 005	612, 765	0	30. 00
40. 00 04000 SUBPROVI DER - I PF	45, 274	273, 361	98, 362	14, 779	0	40.00
43. 00 04300 NURSERY	5, 086	38, 903	13, 998	13, 346	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 0PERATI NG ROOM	202, 341	1, 447, 664	520, 904	558, 985	7, 431	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY	1, 462 0	12, 234	4, 402 0	5, 487	0	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	173, 866	1, 623, 033	_	246, 845	0	54.00
60. 00 06000 LABORATORY	173,000	2, 101, 851	756, 296	129, 255	0	60.00
65. 00 06500 RESPI RATORY THERAPY	83, 541	552, 374		36, 132	0	65.00
66. 00 06600 PHYSI CAL THERAPY	102, 006	745, 441	268, 228	158, 962	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	18, 660	123, 465	44, 426	29, 706	0	67.00
68. 00 06800 SPEECH PATHOLOGY	3, 732	21, 630		1, 186	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	2, 295		0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	87, 965		0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	20, 085 1, 511, 327		0	0	72. 00 73. 00
76. 00 03160 CARDI OPULMONARY	25, 308	273, 012	· ·	74, 933	12, 312	76.00
OUTPATIENT SERVICE COST CENTERS	20,000	2707012	70,200	7 17 700	12, 012	70.00
90. 00 09000 CLI NI C	0	0			0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	132, 752	824, 884				
90. 02 09002 JAY FAMILY MEDICINE	136, 374	896, 188			69, 324	
90. 03 09003 WOUND CLINIC	0	10, 725		16, 855	0	90. 03 90. 04
90. 04 09004 0P ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE	56, 658	460, 326	0 165, 636	198, 109	1, 137	90.04
90. 06 09006 INFUSION CLINIC	24, 288	164, 617	59, 233	30, 547	1, 137	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	34, 258	282, 635		129, 502	0	90. 07
91. 00 09100 EMERGENCY	244, 172	2, 005, 168			0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
93. 00 04950 OUTPATI ENT PSYCH	6, 904	88, 452	31, 827	77, 652	0	93.00
SPECIAL PURPOSE COST CENTERS	2 2/0 27/	22 022 522	0 (00 710	2 052 720	1/1 107	110 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 360, 276	33, 033, 523	8, 682, 718	3, 853, 730	161, 127	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	24, 249	8, 725	38, 109	n	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	26, 071	172, 338		308, 878		192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 VACANT	0	81, 929				194. 00
194. 02 07952 WEST JAY CLINIC	27, 700	202, 197				194. 02
194. 03 07953 JAY MERI DI AN URGENT CARE	20, 357	131, 630	47, 364	0	0	194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	0		0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 434, 404	33, 645, 866	_	4, 382, 613		
(38m 11.135 1.10 till 34gir 201)	= 101 101	, 5.5, 550	, 2,,20,000	., 552, 575	.51, 127	,

	Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	o 12/31/2020 HOUSEKEEPI NG	Date/Ti me Pre 7/15/2021 1:0 DI ETARY	
	cost center bescription	PLANT - POB	PLANT - WJ	LINEN SERVICE			
	GENERAL SERVICE COST CENTERS	7. 02	7. 03	8. 00	9. 00	10.00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB						1. 01
1. 02	00102 CAP REL COSTS-BLDG & FLXT-POB						1.02
1. 03 1. 04	00103 CAP REL COSTS-BLDG & FIXT-WJ 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. 01
2. 02	00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2. 03	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
7. 01	00701 OPERATION OF PLANT - MOB						7. 01
7. 02	00702 OPERATION OF PLANT - POB	37, 223					7. 02
7. 03	00703 OPERATION OF PLANT - WJ	0	0	240 052			7.03
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	0	240, 853 0	857, 425		8. 00 9. 00
10.00	01000 DI ETARY	Ö	0	7, 348	l ' l	452, 216	10.00
11.00	01100 CAFETERI A	0	0	0	29, 744	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	0	11, 028	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	0	0	9, 944	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	9, 944	0	16.00
17. 00	01700 SOCI AL SERVI CE	Ö	0	Ö	Ö	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	0	75, 488		443, 134	30.00
40. 00 43. 00	04000 SUBPROVI DER - I PF 04300 NURSERY	0	0	0	2, 973 2, 685	9, 082 0	40. 00 43. 00
10.00	ANCILLARY SERVICE COST CENTERS		<u> </u>		2,000		10.00
50.00	05000 OPERATING ROOM	26, 706	0	60, 957	112, 461	0	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	1, 104	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	33, 098	49, 662	0	54.00
60.00	06000 LABORATORY	0	0	0	26, 005	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	7, 269	0	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0	160 0	l ' '	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	239	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	O	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
76. 00		0	0	0	15, 076	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	0 7, 003	· ·	0	90. 00 90. 01
	09002 JAY FAMILY MEDICINE	0	0	551	84, 885	0	
	09003 WOUND CLINIC	O	0	0		0	90. 03
90. 04		0	0	0	0	0	90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	0	459		0	90.05
90. 06 90. 07	09006 INFUSION CLINIC 09007 HEALTH BEGINNINGS PROGRAM	0	0) 	6, 146 26, 054	0	90. 06 90. 07
91.00	09100 EMERGENCY	Ö	0	55, 570		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00		0	0	0	15, 623	0	93. 00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	26, 706	0	240, 634	752, 403	452, 216	118. 00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0 10, 517	0	0 72	,		190. 00 192. 00
	19300 NONPALD WORKERS	0,317	0	0	02, 142		193.00
194.00	07950 VACANT	o	0	Ō	25, 905	0	194. 00
	2 07952 WEST JAY CLINIC	0	0	0	0		194.02
200.00	307953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	0	0	147	9, 308		194. 03 200. 00
201.00	, ,	o	0	0	О	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	37, 223	0	240, 853	857, 425	452, 216	202. 00

Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

			10) 12/31/2020	7/15/2021 1:0	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
	11. 00	N 13. 00	SUPPLY 14.00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	10.00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01 O0101 CAP REL COSTS-BLDG & FLXT-MOB					l	1.01
1.02 O0102 CAP REL COSTS-BLDG & FIXT-POB					l	1.02
1.03 O0103 CAP REL COSTS-BLDG & FIXT-WJ					ļ	1.03
1.04 O0104 CAP REL COSTS-BLDG & FIXT-INTEREST					ļ	1.04
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					ļ	2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB					ļ	2. 02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
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 OO700 OPERATION OF PLANT 7. 01 OO701 OPERATION OF PLANT - MOB					l	7.00
7. 02 00707 OPERATION OF PLANT - MOB						7.01
7. 03 00703 OPERATION OF PLANT - WJ						7.02
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY					ļ	10.00
11. 00 01100 CAFETERI A	842, 760				l	11.00
13.00 01300 NURSING ADMINISTRATION	71, 142	2, 791, 220			ļ	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	357, 910			14.00
15. 00 01500 PHARMACY	30, 744	0	5, 889	1, 514, 941		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	128, 469	673, 523	59, 537	5. 293	0	30.00
40. 00 04000 SUBPROVI DER - I PF	12, 872	72, 752	111	0, 243	0	40.00
43. 00 04300 NURSERY	2, 723	14, 625		0	0	43.00
ANCILLARY SERVICE COST CENTERS	=, :==,	, ====	-			
50. 00 05000 OPERATING ROOM	77, 875	409, 889	0	2, 313	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	446	2, 625	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	57, 626	0	31, 143	2, 124	0	54.00
60. 00 06000 LABORATORY	56, 240	0	12	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	29, 061 22, 328	0	19, 514 1, 957	236	0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	5, 594	0	45	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	842	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0 12	0	521	0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	77, 836	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	17, 772	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	1, 479, 960	0	73.00
76. 00 03160 CARDI OPULMONARY	8, 565	1, 500	1, 078	0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	.1					
90. 00 09000 CLINI C	00 774	200 274	0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE	82, 776 83, 915	398, 264		14, 663	0	
90.02 09002 JAY FAMILY MEDICINE 90.03 09003 WOUND CLINIC	03, 913	450, 765	15, 652 0	0	0	90. 02 90. 03
90. 04 09004 OP ORTHO CLINIC	0	0	0	0	0	90.03
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	33, 665	146, 630	3, 737	353	0	90.05
90. 06 09006 NFUSI ON CLINI C	7, 377	55, 502	6, 310	1, 969	0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	10, 941	75, 003		0	0	90.07
91. 00 09100 EMERGENCY	83, 221	490, 142	85, 344	8, 030	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					ļ	92.00
93. 00 O4950 OUTPATIENT PSYCH	7, 822	0	231	0	0	93.00
SPECIAL PURPOSE COST CENTERS		0 704 000	05/ 000			
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	814, 244	2, 791, 220	356, 292	1, 514, 941	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	O	ol	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	15, 545	0	897	0		192.00
193. 00 19300 NONPALD WORKERS	.5, 5 (5)	o O	0	ol O		193.00
194. 00 07950 VACANT	ol	Ö	o	ol		194. 00
194. 02 07952 WEST JAY CLINIC	o	o	721	0		194. 02
194.03 07953 JAY MERIDIAN URGENT CARE	12, 971	o	0	0		194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	842, 760	2, 791, 220	357, 910	1, 514, 941	01	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1320 Peri od: Worksheet B From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 1:03 pm Cost Center Description SOCI AL Intern & Total Subtotal SERVI CE Resi dents Cost & Post Stepdown Adjustments 17. 00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 CAP REL COSTS-BLDG & FIXT-MOB 1.01 1 01 1.02 00102 CAP REL COSTS-BLDG & FIXT-POB 1.02 00103 CAP REL COSTS-BLDG & FIXT-WJ 1.03 1.03 00104 CAP REL COSTS-BLDG & FIXT-INTEREST 1.04 1.04 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 2.01 00201 CAP REL COSTS-MVBLE EQUIP - MOB 2.01 2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB 2.02 00203 CAP REL COSTS-MVBLE EQUIP - WJ 2 03 2 03 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 00701 OPERATION OF PLANT - MOB 7.01 7.01 7.02 00702 OPERATION OF PLANT - POB 7.02 7.03 00703 OPERATION OF PLANT - WJ 7.03 00800 LAUNDRY & LINEN SERVICE 8 00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16 00 01600 MEDICAL RECORDS & LIBRARY 16 00 01700 SOCIAL SERVICE 17.00 17.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 5, 454, 706 0 5, 454, 706 30.00 04000 SUBPROVI DER - I PF 40 00 0 484. 292 0 484, 292 40 00 04300 NURSERY 0 43.00 0 86, 280 86, 280 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 225, 185 3, 225, 185 50.00 05200 DELIVERY ROOM & LABOR ROOM 000000000 0 52 00 52 00 26, 298 26, 298 0 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 627, 537 2, 627, 537 54.00 54.00 60.00 06000 LABORATORY 3, 069, 659 0 3,069,659 60.00 0 06500 RESPIRATORY THERAPY 843.343 65.00 65.00 843, 343 0 66.00 06600 PHYSI CAL THERAPY 1, 229, 057 1, 229, 057 66.00 67.00 06700 OCCUPATI ONAL THERAPY 209, 213 0 209, 213 67.00 06800 SPEECH PATHOLOGY 0 68.00 31,680 31, 680 68.00 06900 ELECTROCARDI OLOGY 0 69.00 3, 642 3, 642 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 197, 453 0 197, 453 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 45, 084 72.00 72.00 45.084 07300 DRUGS CHARGED TO PATIENTS 0 73.00 3, 535, 099 3, 535, 099 73 00 76.00 03160 CARDI OPULMONARY 484, 712 484, 712 76.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLINIC 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 0 2, 241, 787 2, 241, 787 90.01 90.01 09002 JAY FAMILY MEDICINE 0 0 0 2, 345, 670 2, 345, 670 90.02 90.02 09003 WOUND CLINIC 0 90. 03 34, 830 34, 830 90.03 0 09004 OP ORTHO CLINIC 90.04 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 1, 049, 909 1, 049, 909 90.05 0 90.06 09006 INFUSION CLINIC 331, 701 0 331, 701 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 627, 478 0 627, 478 90.07 0 09100 EMERGENCY 0 91 00 3, 732, 191 3, 732, 191 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 04950 OUTPATIENT PSYCH 93.00 0 221,607 0 221, 607 93.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 32, 138, 413 32, 138, 413 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 78, 750 0 78, 750 190.00 0 632, 400 0 632, 400 192 00 0 193. 00 19300 NONPALD WORKERS 193.00 194. 00 07950 VACANT 0 266, 075 0 266, 075 194.00 0 194.02 07952 WEST JAY CLINIC 328, 808 0 328, 808 194.02 0 194. 03 07953 JAY MERIDIAN URGENT CARE 0 201, 420 194. 03 201, 420 200.00 Cross Foot Adjustments 0 200.00 0 201.00 Negative Cost Centers 0 201.00

33, 645, 866

33, 645, 866

202 00

TOTAL (sum lines 118 through 201)

202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320

					CADITAL DEL	ATED COSTS	7/15/2021 1:0	
					CAPITAL REL	ATED COSTS		
		Cost Center Description	Directly	BLDG & FIXT	BLDG &	BLDG &	BLDG &	
			Assi gned New Capi tal		FIXT-MOB	FIXT-POB	FIXT-WJ	
			Related Costs 0	1.00	1 01	1 00	1 02	
	GENER	AL SERVICE COST CENTERS	0	1. 00	1. 01	1. 02	1. 03	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02		CAP REL COSTS-BLDG & FIXT-MOB CAP REL COSTS-BLDG & FIXT-POB						1. 01 1. 02
1. 03	00103	CAP REL COSTS-BLDG & FIXT-WJ						1.03
1. 04 2. 00	1	CAP REL COSTS-BLDG & FIXT-INTEREST CAP REL COSTS-MVBLE EQUIP						1. 04 2. 00
2. 00	1	CAP REL COSTS-MVBLE EQUIP - MOB						2.00
2. 02		CAP REL COSTS-MVBLE EQUIP - POB						2.02
2. 03 4. 00		CAP REL COSTS-MVBLE EQUIP - WJ EMPLOYEE BENEFITS DEPARTMENT	0	888	o	o	0	2. 03 4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	0	84, 531	0	0	0	5.00
7. 00 7. 01		OPERATION OF PLANT OPERATION OF PLANT - MOB	0	122, 238 0	0	0	0	7. 00 7. 01
7. 02	1	OPERATION OF PLANT - POB	o o	0	Ö	o	0	7. 02
7. 03	1	OPERATION OF PLANT - WJ	0	0	0	0	0	7.03
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING	0	4, 670 4, 717	0	0	0	8. 00 9. 00
10.00		DIETARY	0	10, 070		0	0	10.00
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0	23, 513 8, 718		0	0	11. 00 13. 00
14.00	01400	CENTRAL SERVICES & SUPPLY	O	0	0	Ö	0	14. 00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	7, 861 0	0	0	0	15. 00 16. 00
17. 00	1	SOCIAL SERVICE	0	0		0	0	17.00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	O	97, 454	0	٥	0	20.00
40. 00		SUBPROVIDER - IPF	0	2, 350		0	0	30. 00 40. 00
43. 00		NURSERY	0	2, 123	0	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	O	31, 382	O	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	873	0	o	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0 39, 258		0	0	53. 00 54. 00
60.00	06000	LABORATORY	0	20, 557	0	0	0	60.00
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	0	5, 746 25, 281	0	0	0	65. 00 66. 00
67. 00	06700	OCCUPATI ONAL THERAPY	O	4, 725	0	Ö	0	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	189 0	0	0	0	68. 00 69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	o o	0	Ö	o	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
76. 00		CARDI OPULMONARY	0	0	0	0	0	
90. 00		TIENT SERVICE COST CENTERS CLINIC		0	0	٥	0	90.00
90.00		FAMILY PRACTICE OF JAY COUNTY	0	0	o o	0	0	90.00
90. 02	1	JAY FAMILY MEDICINE	0	0	0	0	0	90.02
90. 03 90. 04		WOUND CLINIC OP ORTHO CLINIC	0	2, 681 0	0	0	0	90. 03 90. 04
90.05		JAY FAMILY FIRST HEALTH CARE	0	30, 407		0	0	90.05
90. 06 90. 07		INFUSION CLINIC HEALTH BEGINNINGS PROGRAM	0	4, 858 20, 596		0	0	90. 06 90. 07
91. 00	09100	EMERGENCY	0	37, 498		0	0	91.00
92. 00 93. 00	1	OBSERVATION BEDS (NON-DISTINCT PART OUTPATIENT PSYCH	0	12, 350	0	0	0	92.00 93.00
	SPECI	AL PURPOSE COST CENTERS						
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	0	605, 534	0	0	0	118. 00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 061		0		190. 00
		PHYSICIANS' PRIVATE OFFICES NONPAID WORKERS	0	0	0	0		192. 00 193. 00
194.00	07950	VACANT		20, 478		0	0	194. 00
		WEST JAY CLINIC	0	0	0	0		194. 02 194. 03
200. 0		JAY MERIDIAN URGENT CARE Cross Foot Adjustments		0		٥	Ü	200.00
201. 00	1	Negative Cost Centers	0	622.072	0	0		201. 00 202. 00
202. 00	7	TOTAL (sum lines 118 through 201)	١	632, 073	ı o	ΟĮ	U	1202.00

| Peri od: | Worksheet B | From 01/01/2020 | Part II | Date/Time Prepared: 7/15/2021 1:03 pm

			040	LTAL DELATED O	0070	7/15/2021 1:0	3 pm
			CAP	ITAL RELATED C	0515		
	Cost Center Description	BLDG &	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	
	·	FIXT-INTEREST		MOB	POB	WJ	
	CENEDAL CEDIUCE COCT CENTERS	1. 04	2. 00	2. 01	2. 02	2. 03	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1		I	1.00
1. 01	00101 CAP REL COSTS-BLDG & FIXT-MOB						1.01
1. 02	00102 CAP REL COSTS-BLDG & FIXT-POB						1. 02
1.03	00103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1. 04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 2. 02	OO201 CAP REL COSTS-MVBLE EQUIP - MOB OO202 CAP REL COSTS-MVBLE EQUIP - POB						2. 01 2. 02
2. 02	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 666	0	0	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	253, 659	1	0	0	5. 00
7.00	00700 OPERATION OF PLANT	0	366, 819	l .	0	0	7.00
7. 01 7. 02	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0	0	877 0		0	7. 01 7. 02
7. 02	00703 OPERATION OF PLANT - POB	0	0			0	7.02
8. 00	00800 LAUNDRY & LINEN SERVICE	Ö	14, 012			Ö	8.00
9. 00	00900 HOUSEKEEPI NG	0	14, 154	0	0	0	9. 00
10.00	01000 DI ETARY	0	30, 218	l .	_	0	10.00
11.00	01100 CAFETERI A	0	70, 557	l .		0	11.00
14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	26, 161	0		0	13. 00 14. 00
	01500 PHARMACY	0	23, 590	1	0	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	Ö	Ö	_	16.00
17.00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_			_	_	
30.00		0	292, 441	0			
40. 00 43. 00	O4000 SUBPROVI DER - I PF O4300 NURSERY	0	7, 053 6, 369				40. 00 43. 00
43.00	ANCILLARY SERVICE COST CENTERS		0, 307				75.00
50.00	05000 OPERATING ROOM	0	94, 170	1, 618	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 618				
53.00	05300 ANESTHESI OLOGY	0	0	1	0		
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	117, 807 61, 687	1	0	0	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	0	17, 244	1		0	65.00
66.00	06600 PHYSI CAL THERAPY	Ö	75, 864	1	Ö	Ö	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	14, 177	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	566	i	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	69.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	Ö	Ö	Ö	l .	73.00
76.00	03160 CARDI OPULMONARY	0	0	2, 681	0	0	ı
	OUTPATIENT SERVICE COST CENTERS			1	1	T .	
	09000 CLINIC	0	0			l	
	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0	0	15, 441 15, 094			ı
90. 03	09003 WOUND CLINIC	0	8, 044			Ö	
90.04	09004 OP ORTHO CLINIC	0	0	0	0	0	90.04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	91, 245	l .			
90.06	09006 I NFUSI ON CLI NI C	0	14, 578	1	-	0	90.06
90. 07 91. 00	09007 HEALTH BEGINNINGS PROGRAM 09100 EMERGENCY	0	61, 805	1	0	0	90. 07 91. 00
91.00		0	112, 523		U	0	91.00
	04950 OUTPATIENT PSYCH	0	37, 059	o	0	0	93.00
	SPECIAL PURPOSE COST CENTERS						
118.00	5 /	0	1, 817, 086	38, 468	0	0	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 188	0	0	_	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10, 100				190.00
	19300 NONPALD WORKERS	0	0	0	0	l .	193.00
	07950 VACANT	0	61, 451	0	0	0	194. 00
	07952 WEST JAY CLINIC	0	0	0	0		194. 02
	307953 JAY MERI DI AN URGENT CARE	0	0	0	0	0	194. 03
200. 00 201. 00	, ,	0	0	_	0	_	200. 00 201. 00
201.00		0	1, 896, 725	38, 468			202.00
50		'	, , . 20		'	,	

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2020 | Part II |
| To | 12/31/2020 | Date/Time | Prepared: | 7/15/2021 | 1:03 pm |

					7/15/2021 1:0	
Cost Center Description	Subtotal	EMPLOYEE	ADMI NI STRATI V	OPERATION OF	OPERATION OF	
		BENEFITS DEPARTMENT	E & GENERAL	PLANT	PLANT - MOB	
	2A	4. 00	5. 00	7. 00	7. 01	
GENERAL SERVICE COST CENTERS			2.22			
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FIXT-MOB						1. 01
1. 02 00102 CAP REL COSTS-BLDG & FLXT-POB						1.02
1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ 1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1. 03 1. 04
2. 00 00200 CAP REL COSTS-BEDG & TTXT-TNTEREST						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2. 02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2. 03 00203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	3, 554	3, 554				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	340, 699	181	340, 880			5.00
7.00 00700 OPERATION OF PLANT 7.01 00701 OPERATION OF PLANT - MOB	489, 057 877	97 0			5, 246	7. 00 7. 01
7. 02 00707 OPERATION OF PLANT - MOB	0	0	69		0	7. 01
7. 03 00703 OPERATION OF PLANT - WJ	0	0	0	3, 701	Ö	7. 02
8. 00 00800 LAUNDRY & LINEN SERVICE	18, 682	11	2, 143	3, 574	0	8. 00
9. 00 00900 HOUSEKEEPI NG	18, 871	121	8, 387	3, 611	0	9. 00
10. 00 01000 DI ETARY	40, 288	34	3, 737		0	10.00
11. 00 01100 CAFETERI A	94, 070	80		l '	0	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	34, 879	373		6, 673	0	13.00
14.00 01400 CENTRAL SERVI CES & SUPPLY 15.00 01500 PHARMACY	0 31, 451	0 159	3, 626 14, 376		0	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	14, 370	0,018	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	Ö	ő	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDIATRICS	389, 895	497	33, 770		0	30.00
40. 00 04000 SUBPROVI DER - PF	9, 403	66			0	40.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS	8, 492	7	536	1, 625	0	43. 00
50. 00 05000 OPERATING ROOM	127, 170	296	19, 944	68, 053	242	50. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 491	2	169		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	157, 065	254	22, 361	30, 052	0	54.00
60. 00 06000 LABORATORY	82, 244	0			0	60.00
65. 00 06500 RESPI RATORY THERAPY	22, 990	122	7, 610		0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	101, 145 18, 902	149 27	10, 270 1, 701	19, 352 3, 617	0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	755	5	298		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	32	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1, 212	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	277	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	20, 822	0	0	73.00
76. 00 03160 CARDI OPULMONARY OUTPATI ENT SERVI CE COST CENTERS	2, 681	37	3, 761	9, 123	401	76. 00
90. 00 09000 CLINIC	0	0	0	ol	0	90. 00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	15, 441	194				90. 01
90.02 09002 JAY FAMILY MEDICINE	15, 094	199			2, 257	90.02
90. 03 09003 WOUND CLINIC	10, 725	0	148	2, 052	0	90. 03
90. 04 09004 OP ORTHO CLINIC	0	0		0	0	90.04
90. 05 09005 JAY FAMILY FIRST HEALTH CARE	121, 900	83			37	90.05
90. 06 09006 NFUSION CLINIC 90. 07 09007 HEALTH BEGINNINGS PROGRAM	19, 436 82, 401	35 50			0	90. 06 90. 07
91. 00 09100 EMERGENCY	150, 021	357			0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	007	27,020	20, 701		92.00
93. 00 04950 OUTPATIENT PSYCH	49, 409	10	1, 219	9, 454	0	93.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 461, 088	3, 446	332, 444	469, 164	5, 246	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	24, 249	0	334	4, 640	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	24, 247	38				190.00
193. 00 19300 NONPALD WORKERS	O	0				193. 00
194. 00 07950 VACANT	81, 929	0				194. 00
194. 02 07952 WEST JAY CLINIC	0	40				194. 02
194. 03 07953 JAY MERI DI AN URGENT CARE	0	30	1, 813	이		194. 03
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	_			200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 567, 266	3, 554	340, 880	533, 553		201.00
	_, 557, 250	0,004	, 5.0,000	, 555, 555	5, 2 10	, 30

					7/15/2021 1:0	3 pm
Cost Center Description	OPERATION OF	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	PLANT - POB	PLANT - WJ	LINEN SERVICE			
OFNEDAL OFDINOS COOT OFNEDO	7. 02	7. 03	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
1. 01 00101 CAP REL COSTS-BLDG & FLXT-MOB						1.01
1. 02 00102 CAP REL COSTS-BLDG & FIXT-POB						1. 02
1. 03 00103 CAP REL COSTS-BLDG & FIXT-WJ						1.03
1. 04 00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1. 04
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2.02 O0202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2.03 O0203 CAP REL COSTS-MVBLE EQUIP - WJ						2.03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 OO701 OPERATION OF PLANT - MOB						7. 01
7.02 00702 OPERATION OF PLANT - POB	3, 770					7. 02
7.03 00703 OPERATION OF PLANT - WJ	0	0				7. 03
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	24, 410			8.00
9. 00 00900 HOUSEKEEPI NG	0	0	0	30, 990		9. 00
10. 00 01000 DI ETARY	0	0	745	460	52, 972	10.00
11. 00 01100 CAFETERI A	0	0	0	1, 075	0	11.00
13.00 01300 NURSING ADMINISTRATION	0	0	0	399	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY	0	0	0	359	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS				٥		17.00
30. 00 03000 ADULTS & PEDIATRICS	0	0	7, 651	4, 455	51, 908	30. 00
40. 00 04000 SUBPROVI DER - PF	0	Ö	0	107	1, 064	40.00
43. 00 04300 NURSERY	0	0	0	97	0	43. 00
ANCI LLARY SERVI CE COST CENTERS			<u>_</u>	,,,		10.00
50. 00 05000 OPERATING ROOM	2, 705	0	6, 178	4, 065	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0,	40	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	n	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	n	3, 354	1, 795	0	54.00
60. 00 06000 LABORATORY	0	n	0,001	940	0	60.00
65. 00 06500 RESPIRATORY THERAPY	0	o n	0	263	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	16	1, 156	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	216	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	210	0	68.00
69. 00 06900 SELECT FATHOLOGY	0	0	0	7	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
i i	0	0	0	0	0	
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
	0	0	0	U E4E	0	
76. 00 03160 CARDI OPULMONARY	0	0	0	545	0	76. 00
90. 00 OUTPATIENT SERVICE COST CENTERS 90. 00 O9000 CLINIC	0	0	0	O	0	90.00
90. 01 09000 CETNIC 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0	710	٥	0	90.00
	0				0	
90. 02 09002 JAY FAMILY MEDICINE		_				90. 02
90. 03 09003 WOUND CLINIC	0	0	0	123	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	46	1, 441	0	90.05
90. 06 09006 NFUSI ON CLINIC	0	0	0	222	0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	0	0	942	0	90.07
91. 00 09100 EMERGENCY	0	0	5, 632	1, 714	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	_	_	_		_	92.00
93. 00 04950 0UTPATI ENT PSYCH	0	0	0	565	0	93. 00
SPECIAL PURPOSE COST CENTERS	0.705			07.405	50.070	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 705	0	24, 388	27, 195	52, 972	118.00
NONREI MBURSABLE COST CENTERS	_	_	_	01		100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	277		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 065	0	1 7	2, 246		192.00
193. 00 19300 NONPAI D WORKERS	0	0	0	_ 0		193.00
194. 00 07950 VACANT	0	0	0	936		194.00
194. 02 07952 WEST JAY CLINIC	0	0	0	0		194. 02
194. 03 07953 JAY MERIDIAN URGENT CARE	0	0	15	336	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	3, 770	0	24, 410	30, 990	52, 972	202. 00

				1270172020	7/15/2021 1:0	3 pm
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	
		N	SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1. 01 00101 CAP REL COSTS-BLDG & FLXT-MOB						1. 01
1. 02 00102 CAP REL COSTS-BLDG & FLXT-POB						1. 02
1.03 O0103 CAP REL COSTS-BLDG & FLXT-WJ						1.03
1.04 OO104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 00201 CAP REL COSTS-MVBLE EQUIP - MOB						2. 01
2.02 00202 CAP REL COSTS-MVBLE EQUIP - POB						2. 02
2.03 OO203 CAP REL COSTS-MVBLE EQUIP - WJ						2. 03
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
7.01 OO701 OPERATION OF PLANT - MOB						7. 01
7. 02 00702 OPERATION OF PLANT - POB						7. 02
7. 03 00703 OPERATION OF PLANT - WJ						7. 03
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A	119, 963					11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	10, 127	79, 342				13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY	10, 127	79, 342	2 424			14.00
	_	0	3, 626	56, 799		
15. 00 01500 PHARMACY	4, 376	U	60	50, 799		15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	U	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	U	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	40.000	40.444	(00	400		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	18, 288	19, 144	603	198	0	30.00
40. 00 04000 SUBPROVI DER - I PF	1, 832	2, 068	1	0	0	40.00
43. 00 04300 NURSERY	388	416	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS					_	
50. 00 05000 OPERATING ROOM	11, 085	11, 651	0	87	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	63	75	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	8, 203	0	315	80	0	54.00
60. 00 06000 LABORATORY	8, 006	0	0	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	4, 137	0	198	9	0	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 178	0	20	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	796	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	120	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	5	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	789	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	180	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	55, 487	0	73.00
76. 00 03160 CARDI OPULMONARY	1, 219	43	11	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	11, 783	11, 321	283	550	0	90. 01
90. 02 09002 JAY FAMILY MEDICINE	11, 945	12, 813	159	o	0	90. 02
90. 03 09003 WOUND CLINIC	. 0	0	0	ol	0	90. 03
90. 04 09004 OP ORTHO CLINIC	0	0	0	o	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE	4, 792	4, 168	38	13	0	90.05
90. 06 09006 I NFUSI ON CLINI C	1, 050	1, 578	64	74	0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM	1, 557	2, 132	17	0	0	90.07
91. 00 09100 EMERGENCY	11, 846	13, 933	865	301	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	11,010	10, 700	000	001	١	92.00
93. 00 04950 OUTPATIENT PSYCH	1, 113	0	2	0	0	93.00
SPECIAL PURPOSE COST CENTERS	1, 113	<u> </u>		<u> </u>		73.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	115, 904	79, 342	3, 610	56, 799	0	118. 00
NONREI MBURSABLE COST CENTERS	113, 704	17, 342	3,010	30, 177	0	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	٥		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	2, 213	0	9	0		190.00
	2, 213	0	7	0		193. 00
193.00 19300 NONPALD WORKERS	0		0			193.00 194.00
194. 00 07950 VACANT	_	U A	U	ol o		
194. 02 07952 WEST JAY CLINIC	1 044	٥	/	o		194. 02
194. 03 07953 JAY MERI DI AN URGENT CARE	1, 846	이	Ü	이		194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	70 0.0	0	5, 700		201.00
202.00 TOTAL (sum lines 118 through 201)	119, 963	79, 342	3, 626	56, 799	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1320 Cost Center Description

	Cost Center Description	SOCI AL	Subtotal	Intern &	Total		
		SERVI CE		Resi dents			
				Cost & Post			
				Stepdown Adjustments			
		17. 00	24. 00	25. 00	26. 00		
GENE	ERAL SERVICE COST CENTERS	17.00	21.00	20.00	20.00		
	DO CAP REL COSTS-BLDG & FIXT						1.00
1. 01 0010	D1 CAP REL COSTS-BLDG & FIXT-MOB						1.01
1	D2 CAP REL COSTS-BLDG & FLXT-POB						1. 02
	O3 CAP REL COSTS-BLDG & FIXT-WJ						1. 03
	D4 CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
•	DO CAP REL COSTS-MVBLE EQUIP D1 CAP REL COSTS-MVBLE EQUIP - MOB						2. 00 2. 01
	D2 CAP REL COSTS-MVBLE EQUIP - MOB						2.01
	O3 CAP REL COSTS-MVBLE EQUIP - WJ						2. 02
	DO EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO ADMINISTRATIVE & GENERAL						5. 00
7.00 0070	OO OPERATION OF PLANT						7. 00
	O1 OPERATION OF PLANT - MOB						7. 01
	O2 OPERATION OF PLANT - POB						7. 02
	O3 OPERATION OF PLANT - WJ						7. 03
	DO LAUNDRY & LI NEN SERVI CE DO HOUSEKEEPI NG						8. 00 9. 00
	DO DI ETARY						10.00
	DO CAFETERI A						11.00
	DO NURSI NG ADMI NI STRATI ON						13.00
	DO CENTRAL SERVICES & SUPPLY						14.00
15. 00 0150	DO PHARMACY						15.00
	DO MEDICAL RECORDS & LIBRARY						16. 00
	00 SOCI AL SERVI CE	0				<u> </u>	17. 00
	ATIENT ROUTINE SERVICE COST CENTERS	0	(01.00/		(01,00/		20.00
	DO ADULTS & PEDIATRICS DO SUBPROVIDER - IPF	0	601, 006		601, 006	ł	30. 00 40. 00
1	DO NURSERY	0	20, 106 11, 561	0			43. 00
	LLARY SERVICE COST CENTERS	0	11, 301	0	11, 301		43.00
	DO OPERATING ROOM	0	251, 476	0	251, 476		50.00
	DO DELIVERY ROOM & LABOR ROOM	0	4, 508			1	52.00
53.00 0530	DO ANESTHESI OLOGY	0	0	0	0		53.00
	DO RADI OLOGY-DI AGNOSTI C	0	223, 479		223, 479	1	54.00
	DO LABORATORY	0	135, 883		135, 883	1	60.00
	OO RESPIRATORY THERAPY	0	39, 728		39, 728	1	65. 00
	DO PHYSI CAL THERAPY DO OCCUPATI ONAL THERAPY	0	135, 286 25, 259		135, 286 25, 259	1	66. 00 67. 00
	DO SPEECH PATHOLOGY	0	1, 331	0	1, 331		68.00
	DO ELECTROCARDI OLOGY	0	37	0	37		69.00
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 001	0			71.00
	DO IMPL. DEV. CHARGED TO PATIENTS	0	457		457		72.00
	DO DRUGS CHARGED TO PATIENTS	0	76, 309	0	76, 309		73.00
	60 CARDI OPULMONARY	0	17, 821	0	17, 821		76. 00
	PATIENT SERVICE COST CENTERS	_	_		_		4
1	OO CLINIC	0				ł	90.00
•	D1 FAMILY PRACTICE OF JAY COUNTY D2 JAY FAMILY MEDICINE	0	109, 645 109, 304		109, 645 109, 304		90. 01 90. 02
•	D3 WOUND CLINIC	0	13, 048		13, 048		90.02
	04 OP ORTHO CLINIC	0	13, 040		13, 040		90.03
•	D5 JAY FAMILY FIRST HEALTH CARE	0	162, 978		162, 978		90.05
	D6 INFUSION CLINIC	0	28, 446		28, 446	ł	90.06
90. 07 0900	D7 HEALTH BEGINNINGS PROGRAM	0	106, 759	0	106, 759		90. 07
	DO EMERGENCY	0	240, 998	0	240, 998		91.00
	OO OBSERVATION BEDS (NON-DISTINCT PART			0			92.00
	50 OUTPATIENT PSYCH	0	61, 772	0	61, 772		93. 00
	CLAL PURPOSE COST CENTERS	0	2 270 100	0	2 270 100		110 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	U	2, 379, 198	0	2, 379, 198		118. 00
	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	29, 500	0	29, 500		190. 00
	DO PHYSICIANS' PRIVATE OFFICES	0	45, 556		45, 556		192.00
	DO NONPAI D WORKERS	0	0	Ö	0	1	193. 00
194. 00 0795	50 VACANT	0	99, 670	0	99, 670		194. 00
	52 WEST JAY CLINIC	0	9, 302		9, 302		194. 02
	JAY MERIDIAN URGENT CARE	0	4, 040	1	4, 040	1	194. 03
200.00	Cross Foot Adjustments	_	0		0		200.00
201.00	Negative Cost Centers	0	2 567 266		2 547 377		201.00
202. 00	TOTAL (sum lines 118 through 201)	O	2, 567, 266	1 0	2, 567, 266	l .	202. 00

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

Period: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm

COST CONTON PROSCRIPTON SELECT & FIXTY WITE COSTS SELECT & FIXTY WIND (SQUARE) COUNTRY (SQUARE) CO				CARI	ITAL DELATED CO	CTC	7/15/2021 1:0	
COURT STATE COURT COUR				CAPI	ITAL RELATED CO	515		
CHERCAL SERVICE COST CENTERS		Cost Center Description		FIXT-MOB (SQUARE	FIXT-POB (SQUARE	FIXT-WJ (SQUARE	FIXT-INTEREST	
1.00			1. 00				1. 04	
1.01 1.02 00102 CAP REL COSTS-BLOG & FIXT-NOB	4 00		00.405				T	
1.02 OTTOX CAP REL COSTS-BLICK & FIRT-POIS 0			· · ·	21 755				1
1.03 0.0102 CAP REL COSTS-BLOG & FIXT-HUTCHEST				21, 733	9, 538			
2 00			0	O		4, 803		1
2.01 0.0201 CAP REL COSTS-WILE EQUIP - MOB 2.02 2.03 0.0020 CAP REL COSTS-WILE EQUIP - W.J. 1.13 2.03 2.00			0	0	0	0	80, 405	1
2.02 2.02 0.0202 CAP REL COSTS-WRILE EQUIP - POB 2.03 0.0203 CAP REL COSTS-WRILE EQUIP - VIJ 1.13 0 0 0 1.73 1.00 1.73 1.00 1.73 1.00 1.75 1.00 1.00 1.75 1.00								1
2.03 00203 CAP REL COSTS-MULE EQUIP - WJ 4.00 00400 (PIMOVFF BINNETS DEPARTENTY) 1.13 0 0 0 0 11.733 4.00 1.5.00 00500 (AMINISTRATIVE & CEMERAL 10,753 1,417 0 0 0 15.507 7.00 1.7.00 00700 (PERATION OF PLANT - POB 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1						
0.000 DIPLOYER BENEFITS DEPARTMENT								
7.00 07000 OPERATION OF PLANT 15,550 0 0 15,550 7.00 7.01 07010 OPERATION OF PLANT - 100B 0 0 0 0 0 0 0 0 7.02 7.02 07020 OPERATION OF PLANT - 100B 0 0 0 0 0 0 0 7.02 8.03 07030 OPERATION OF PLANT - 100B 0 0 0 0 0 0 0 7.03 8.04 050800 LANDROY & LINEN SERVICE 594 0 0 0 0 556 8.00 8.05 050800 LANDROY & LINEN SERVICE 594 0 0 0 0 556 8.00 9.06 050800 LANDROY & LINEN SERVICE 594 0 0 0 0 0 1.281 10.00 9.07 11.00 01000 DETARY 1.00 0 0 0 0 0 0 1.281 10.00 9.08 11.00 01000 DETARY 1.00 0 0 0 0 0 0 0 1.00 9.09 11.00 01000 DETARY 1.00 0 0 0 0 0 0 0 0 0			113	О	0	0	113	
1,000 0.0701 OPERATION OF PLANT - MOB 0 496 615 0 0 7,01			1	1, 419	_	0		
1.02 00702 OPERATION OF PLANT - P08 1.03 00703 OPERATION OF PLANT - NJ 1.03 00703 OPERATION OF PLANT - NJ 1.03 00703 OPERATION OF PLANT - NJ 1.04 0.00 0.00 0.00 0.00 0.00 0.00 0.00			15, 550	0	_	0		
7. 03 00703 DERBATION OF PLANT - WJ		1		496		0		1
0,000 00000 00000 00000 0000 0			1	ő	0	0		1
10.00 01000 DIETARY 1.281 0	8.00		594	О	0	0	594	8. 00
11.00 01100 CAFETERI A 2, 991 10 0 0 0, 1109 13.00 13.00 1300 NURSI MG ABMIN ISTRATION 1.109 0 0 0 0 1.109 13.00 13.00 1300 NURSI MG ABMIN ISTRATION 1.109 0 0 0 0 0 1.109 13.00			1	0	0	0		1
13.00 01300 NURSING ADMINISTRATION 1,109 0 0 0 1,109 13.00 15.00 15.00 05.00 1		1	1	0	_	0		1
14 00 01400 CENTRAL SERVICES & SUPPLY 0 0 0 0 0 0 0 0 0 1.000 15.00 15.00 15.00 15.00 01500 PHARMACY 1.000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	0	0	0		1
16. 00 01600 MEDICAL RECORDS & LIBRARY 0 0 0 0 0 0 17.00 170.0		1	1	o	Ö	0		
17. 00 01700 SOCIAL SERVICE 0 0 0 0 0 17. 00	15. 00	01500 PHARMACY	1,000	O	0	0	1, 000	15.00
INPATIENT ROUTINE SERVICE COST CENTERS 12,397 0 0 0 12,397 30,00			1	-	-	0	l .	1
30.00 03000 03000 03000 03000 03	17. 00		0	0	0	0	0	17.00
A0. 00 OGOOOD OGOOD OG	30. 00		12, 397	ol	0	0	12, 397	30.00
ANCILLARY SERVICE COST CENTERS				0				1
50.00 0500	43.00		270	0	0	0	270	43.00
11	50.00		2 002	015	6 402	0	2 002	50.00
S3. 00 05300 AMESTHESI OLOGY 0 0 0 0 0 4.994 54. 00 65. 00 64.00 65.		1						1
60.0 06000 LABORATORY C. 615 0.0 0 0 0 2,615 60.0 65.0 0 06500 RESPLATORY HERAPY 731 0 0 0 0 731 65.00 66.00 06000 PHYSICAL THERAPY 3.216 0 0 0 0 3.216 66.00 67.00 06700 06700 06700 06700 0 0 0 0 0 0 0 67.00 06700 06700 06700 06700 0 0 0 0 0 0 0 68.00 06800 SPECEN PATHOLOGY 24 0 0 0 0 0 0 0 69.00 06900 0 0 0 0 0 0 0 0 0			1	-	-	0		1
65.00 06500 RESPI RATORY THERAPY 3,216 0 0 0 3,216 66.00 06.		1	l	0	0	0		
66.00 06600 PHYSI CAL THERAPY 3, 216 0 0 0 3, 216 66.00 67. 00 0670 0CCUPATIONAL THERAPY 601 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 24 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 24 0 0 0 0 0 69.00 06900 0 0 0 0 0 0 69.00 071.00 07100 07100 0 0 0 0 71.00 07100 07100 07100 071.00 0 0 0 0 72.00 07200 MPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 07030			1	0	0	0		
67.00 06700 05CUIPATI ONAL THERAPY 601 0 0 0 601 67, 00 88.00 06800 SPEECH PATHOLOGY 24 0 0 0 0 0 99.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 072.00 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 ORUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 76.00 30160 CARDIO POLLMOMARY 0 0 0 0 0 0 0 76.00 30160 CARDIO POLLMOMARY 0 0 0 0 0 0 0 00000 00000 CLI NI C 0 0 0 0 0 0 0 90.01 09000 FAMI LY PRACTICE OF JAY COUNTY 0 8,733 0 0 0 0 0 0 90.02 09002 JAY FAMI LY MEDI CI NE 0 8,536 0 0 0 0 0 0 90.03 09003 WOUND CLI NI C 341 0 0 0 0 3,486 90.04 09004 OP ORTHO CLI NI C 341 0 0 0 0 3,886 90.05 09005 JAY FAMI LY FIRST HEALTH CARE 3,868 140 0 0 3,886 90.06 09006 INFUSI ON CLI NI C 618 0 0 0 0 618 90.06 09006 INFUSI ON CLI NI C 618 0 0 0 0 2,620 90.07 09007 HEALTH BEGI NIN NSS PROGRAM 2,620 0 0 0 2,620 90.07 09008 OUTPATI ENT PSYCH 1,571 0 0 0 1,571 91.00 09008 OUTPATI ENT PSYCH 1,571 0 0 0 0 91.00 09009 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 OUTPATI ENT SCH 1,571 0 0 0 0 91.00 09000 0000 0000 0000 0000 0000 0000 0000 0000 91.00 0193.00 0193.00 0000			1	0	0	0		1
69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0		1	1	Ö	Ö	0		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 75. 00 03160 CARDI OPULMONARY 0 0 1.516 0 0 0 0 76. 00 0010 0010 0010 00 0 0			24	o	0	0	24	1
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 76. 00 03160 CARDI OPULMONARY 0 0 1,516 0 0 0 0 0 73. 00 0000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0	0	0		1
73.00 07300 07300 0RUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73.00		1		0	0	0		
76. 00 03160 CARDI OPULMONARY 0 1,516 0 0 0 76. 00		1	١	ő	0	0		
90. 00 09000 CLINIC	76. 00		0	1, 516	0	0	0	76.00
90. 01 09001 FAMILLY PRACTICE OF JAY COUNTY 0 8, 733 0 0 0 90. 01 90. 02 09002 JAY FAMILLY MEDICINE 0 8,536 0 0 0 90. 02 90. 03 09003 WOUND CLINIC 341 0 0 0 0 341 90. 03 90. 04 09004 0P ORTHO CLINIC 0 0 0 0 0 0 0 90. 05 09005 JAY FAMILLY FIRST HEALTH CARE 3,868 140 0 0 0 3,868 90. 05 90. 06 09005 JAY FAMILLY FIRST HEALTH CARE 3,868 140 0 0 0 618 90. 06 90. 07 09007	00.00			ما				00.00
90. 02 09002 JAY FAMILLY MEDICINE			-1	8 733		0	l .	1
90. 04		1			_	0		
90. 05			341	o	0	0	341	1
90. 06			0	- 1	0	0		1
90. 07 09007 HEALTH BEGINNINGS PROGRAM 2,620 0 0 0 2,620 90. 07 91. 00 09100 EMERGENCY 4,770 0 0 0 0 4,770 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 04950 OUTPATIENT PSYCH 1,571 0 0 0 1,571 93. 00 04950 OUTPATIENT PSYCH 1,571 0 0 0 0 1,571 0 0 0 0 1,571 0 0 0 0 0 0 0 0 0			l	140	0	0		1
91. 00 09100 EMERGENCY 4,770 0 0 0 4,770 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1,571 0 0 0 0 1,571 93. 00 04950 OUTPATIENT PSYCH 1,571 0 0 0 0 1,571 93. 00 04950 OUTPATIENT PSYCH 1,571 0 0 0 0 1,571 93. 00 05 05 05 05 0 0 0 0			1	ő	0	0		
93. 00		09100 EMERGENCY	l	0	0	0		
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 77,029 21,755 7,017 0 77,029 118.00		,						
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 029 21, 755 7, 017 0 77, 029 118. 00	93. 00		1, 571	0	0	0	1, 5/1	93.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 771 0 0 0 771 190. 00 192. 00 19200 19200 19200 19300	118. 0		77. 029	21, 755	7. 017	0	77. 029	118.00
192. 00 19200 19200 19200 19200 193000 193			,		.,		,	
193. 00 19300 NONPAI D WORKERS 194. 00 07950 VACANT 194. 02 07952 WEST JAY CLINIC 194. 03 07953 JAY MERI DI AN URGENT CARE 200. 00 201. 00 Negati ve Cost Centers 202. 00 Part I) 193. 00 0 0 0 0 0 193. 00 0 0 0 0 194. 00 0 0 0 194. 00 0 0 0 194. 03 0 0 0 0 0 194. 03 0 0 0 0 0 0 194. 03 0 0 0 0 0 0 194. 03 0 0 0 0 0 0 0 194. 03 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		-	-		
194. 00 07950 VACANT			1	0	2, 521	3, 728		
194. 02 07952 WEST JAY CLINIC 0 0 1,075 0 194. 02 194. 03 07953 JAY MERIDIAN URGENT CARE 0 0 0 0 194. 03 200. 00 Cross Foot Adjustments 200. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, Part I) 0 0 0 0 0 0 0 0 0 0 202. 00			1 -1	0	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 632,073 0 0 0 0 202.00			0	ő	Ö	1, 075		
201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, Part I) 0 0 0 0 0 0 0 0 0				o	0	0	0	
202.00 Cost to be allocated (per Wkst. B, 632,073 0 0 0 202.00								
Part I)			632 073	Λ	n	0	0	
203.00 Unit cost multiplier (Wkst. B, Part I) 7.861116 0.000000 0.000000 0.000000 0.000000 0.000000	_02.0	71		Ĭ		O		
	203. 0	O Unit cost multiplier (Wkst. B, Part I)	7. 861116	0. 000000	0. 000000	0. 000000	0.000000	203.00

Health Financial Systems	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-1320	Peri od: Worksheet B-1 From 01/01/2020 To 12/31/2020 Date/Time Prepared:		
		7/15/2020 Date/Trille Prepared:		

						7/15/2021 1:0	3 pm
			CAP	ITAL RELATED CO	0STS		
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	BLDG & FIXT-MOB (SQUARE	BLDG & FIXT-POB (SQUARE	BLDG & FIXT-WJ (SQUARE	BLDG & FIXT-INTEREST (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,						204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part						205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1320

				Ť	o 12/31/2020	Date/Time Pre 7/15/2021 1:0	
			CAPI TAL REI	LATED COSTS		77 107 202 1 11 0	5 p
	Cost Center Description	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	EMPLOYEE	
	'	(SQUARE FEET)	MOB	POB	WJ	BENEFITS	
			(SQUARE FEET-MOB)	(SQUARE FEET-POB)	(SQUARE FEET-WJ)	DEPARTMENT (GROSS	
				ŕ	ŕ	SALARI ES)	
G	GENERAL SERVICE COST CENTERS	2. 00	2. 01	2.02	2. 03	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
	00101 CAP REL COSTS-BLDG & FIXT-MOB 00102 CAP REL COSTS-BLDG & FIXT-POB						1. 01 1. 02
	00103 CAP REL COSTS-BLDG & FIXT-POB						1. 02
1.04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1.04
	00200 CAP REL COSTS-MVBLE EQUIP 00201 CAP REL COSTS-MVBLE EQUIP - MOB	80, 405 0	21, 755				2. 00 2. 01
2.02	00202 CAP REL COSTS-MVBLE EQUIP - POB	o	0				2. 02
	DO203 CAP REL COSTS-MVBLE EQUIP - WJ DO400 EMPLOYEE BENEFITS DEPARTMENT	0 113	0	1	4, 803 0	11, 182, 709	2. 03 4. 00
	00500 ADMINISTRATIVE & GENERAL	10, 753	1, 419		o	570, 589	5. 00
	00700 OPERATION OF PLANT	15, 550	0		0	303, 745	7.00
	00701 OPERATION OF PLANT - MOB 00702 OPERATION OF PLANT - POB	0	496 0		0	0	7. 01 7. 02
7.03	00703 OPERATION OF PLANT - WJ	Ö	0		o	0	7. 03
	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	594 600	0	_	0	35, 680	8. 00 9. 00
	01000 DI ETARY	1, 281	0		0	381, 538 108, 076	10.00
	01100 CAFETERI A	2, 991	0		0	252, 448	11.00
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	1, 109 0	0	0	0	1, 173, 606 0	13. 00 14. 00
	01500 PHARMACY	1, 000	0	Ö	ő	501, 218	15. 00
1	01600 MEDICAL RECORDS & LIBRARY	0	0		0	0	16.00
	D1700 SOCIAL SERVICE NPATIENT ROUTINE SERVICE COST CENTERS	U	0	0	<u> </u>	0	17. 00
30.00	03000 ADULTS & PEDIATRICS	12, 397	0	•	l	1, 558, 849	30.00
	04000 SUBPROVI DER – I PF 04300 NURSERY	299 270	0	•	0	207, 970 23, 362	40. 00 43. 00
A	NCILLARY SERVICE COST CENTERS			-	-		
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	3, 992 111	915 0		0	929, 473 6, 717	50. 00 52. 00
	05300 ANESTHESI OLOGY	0	0	•	o	0, 717	53.00
	05400 RADI OLOGY-DI AGNOSTI C	4, 994	0	1	0	798, 673	
	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 615 731	0	1	0	0 383, 754	60. 00 65. 00
66.00	06600 PHYSI CAL THERAPY	3, 216	0	0	0	468, 575	66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	601 24	0	0	0	85, 715 17, 143	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	O	0	Ö	o	0	69. 00
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENTS D7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	o	0	ő	o	-	73. 00
	03160 CARDI OPULMONARY	0	1, 516	0	0	116, 255	76. 00
	OUTPATIENT SERVICE COST CENTERS	0	0	0	O	0	90. 00
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0	8, 733		O	609, 812	90. 01
	09002 JAY FAMILY MEDICINE 09003 WOUND CLINIC	0 341	8, 536 0	1	0	626, 450 0	90. 02 90. 03
90.04	09004 OP ORTHO CLINIC	0	0		o	0	90. 04
	09005 JAY FAMILY FIRST HEALTH CARE	3, 868	140 0		0	260, 265 111, 570	
	09007 HEALTH BEGINNINGS PROGRAM	618 2, 620	0		o	157, 368	
	09100 EMERGENCY	4, 770	0	0	0	1, 121, 629	
	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	1, 571	0	0	o	31, 716	92. 00 93. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) IONREI MBURSABLE COST CENTERS	77, 029	21, 755	7, 017	0	10, 842, 196	118. 00
190.001	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	771	0		0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	2, 521	3, 728	119, 761	192. 00 193. 00
194.000	07950 VACANT	2, 605	0	0		0	194. 00
	07952 WEST JAY CLINIC	o	0	0	1, 075	127, 241	
200.00	07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	O	0	"		93, 511	194. 03 200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 896, 725	38, 468	0	0	2, 434, 404	202. 00
	1 - 1 - 1 - 1	ı		1	ı <u>I</u>	l l	

Health Finan	cial Systems	IU HEALTH JA	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	FION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020		
			CAPITAL REI	LATED COSTS			
	Cost Center Description	MVBLE EQUIP	MVBLE EQUIP -	MVBLE EQUIP -	MVBLE EQUIP -	EMPLOYEE	
		(SQUARE FEET)	MOB	POB	WJ	BENEFITS	
			(SQUARE	(SQUARE	(SQUARE	DEPARTMENT	
			FEET-MOB)	FEET-POB)	FEET-WJ)	(GROSS	
						SALARI ES)	
		2. 00	2. 01	2. 02	2. 03	4. 00	
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 589640	1. 768237	0.00000	0.000000	0. 217694	203.00
204.00	Cost to be allocated (per Wkst. B,					3, 554	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part					0. 000318	205.00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
203. 00 204. 00 205. 00 206. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,	2. 00 23. 589640	MOB (SQUARE FEET-MOB)	POB (SQUARE FEET-POB)	WJ (SQUARE FEET-WJ)	BENEFITS DEPARTMENT (GROSS SALARIES) 4.00 0.217694 3,554	204. 205. 206.

| Period: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-1320

				T	o 12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	3 piii
		n	E & GENERAL	PLANT	PLANT - MOB	PLANT - POB	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET-MOB)	(SQUARE FEET-POB)	
		5A	5. 00	7. 00	7. 01	7. 02	
4 00	GENERAL SERVICE COST CENTERS	T	ı	T			
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FLXT OO101 CAP REL COSTS-BLDG & FLXT-MOB						1. 00 1. 01
1. 01	00102 CAP REL COSTS-BLDG & FLXT-MOB						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						2.00
2. 01 2. 02	OO201 CAP REL COSTS-MVBLE EQUIP - MOB OO202 CAP REL COSTS-MVBLE EQUIP - POB						2. 01 2. 02
2. 02	00203 CAP REL COSTS-MVBLE EQUIP - WJ						2.02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	-8, 903, 053	1				5.00
7. 00 7. 01	OO7OO OPERATION OF PLANT OO7O1 OPERATION OF PLANT - MOB	0	3, 222, 930 100, 462	88, 666 496	19, 840		7. 00 7. 01
7. 01	00702 OPERATION OF PLANT - WOB	0	5, 019	•	19, 840	8, 923	7.01
7. 03	00703 OPERATION OF PLANT - WJ	0	0	0	0	0	7. 03
8.00	00800 LAUNDRY & LINEN SERVICE	0	155, 530	1	0	0	8. 00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	608, 732		0	0	9.00
10. 00 11. 00	01100 CAFETERI A	0	271, 220 489, 163		0	0	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	Ö	1, 951, 895		0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	263, 203		0	0	14.00
15.00	01500 PHARMACY	0	1, 043, 470		0	0	15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	0	0	0	0	16. 00 17. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS				U		17.00
30.00	03000 ADULTS & PEDIATRICS	0	2, 451, 211		0	0	30. 00
40.00	04000 SUBPROVI DER - I PF	0	1	299	0		40.00
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	38, 903	270	0	0	43. 00
50. 00	05000 OPERATING ROOM	0	1, 447, 664	11, 309	915	6, 402	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	12, 234	111	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	1, 623, 033 2, 101, 851		0	0	54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY		552, 374	2, 615 731	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	Ö	745, 441	3, 216	0	Ö	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	123, 465		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	21, 630		0	0 0	68.00
69. 00 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 295 87, 965		0	0	69. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	20, 085		0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	, , , , , ,	0	0	0	73.00
76. 00	03160 CARDI OPULMONARY	0	273, 012	1, 516	1, 516	0	76. 00
90 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	0	0	0	0	90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	Ö	824, 884		8, 733	Ö	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	896, 188		8, 536	0	90. 02
	09003 WOUND CLINIC	0	10, 725	341	0	0	90.03
	O9004 OP ORTHO CLINIC O9005 JAY FAMILY FIRST HEALTH CARE	0	460, 326	·	140	0	90. 04 90. 05
	09006 INFUSION CLINIC	Ö	1			Ö	90.06
	09007 HEALTH BEGINNINGS PROGRAM	0	282, 635		0	0	90. 07
	09100 EMERGENCY	0	2, 005, 168	4, 770	0	0	91.00
92. 00 93. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	0	88, 452	1, 571	0	0	92. 00 93. 00
70.00	SPECIAL PURPOSE COST CENTERS		00, 102	1,071	<u> </u>		70.00
118. 00	, ,	-8, 903, 053	24, 130, 470	77, 966	19, 840	6, 402	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		24 240	771	0	0	100 00
	19200 PHYSICIANS' PRIVATE OFFICES	0			0		190. 00 192. 00
	19300 NONPAI D WORKERS	0	1	0,217	0		193.00
	07950 VACANT	0	81, 929		0		194. 00
	07952 WEST JAY CLINIC	0	202, 197		0		194. 02
194. 03 200. 00	07953 JAY MERIDIAN URGENT CARE Cross Foot Adjustments	0	131, 630	0	0	0	194. 03 200. 00
201.00							200.00
202.00	Cost to be allocated (per Wkst. B,		8, 903, 053	4, 382, 613	161, 127	37, 223	
202 27	Part I)		0.05005	40 40005	0.40405		202 62
203. 00 204. 00			0. 359824 340, 880	1		4. 171579 3. 770	203. 00 204. 00
204.00	Part II)		340, 000	333, 333	5, 240	3,770	207.00
-	· · · · · · · · · · · · · · · · · · ·					-	

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
Cost Center Description	Reconciliatio	ADMI NI STRATI V	OPERATION OF	OPERATION OF	OPERATION OF	
	n	E & GENERAL	PLANT	PLANT - MOB	PLANT - POB	
		(ACCUM. COST)	(SQUARE FEET)	(SQUARE	(SQUARE	
				FEET-MOB)	FEET-POB)	
	5A	5. 00	7. 00	7. 01	7. 02	
205.00 Unit cost multiplier (Wkst. B, Part		0. 013777	6. 01756	0. 264415	0. 422504	205.00
1)						
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems	IU HEALTH JA				u of Form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provider C	Fr	eriod: rom 01/01/2020	Worksheet B-1	
				To	12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT - WJ (SQUARE	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(MAN HOURS)	
		FEET-WJ)	LAUNDRY)	0.00	ŕ	11.00	
	GENERAL SERVICE COST CENTERS	7. 03	8.00	9. 00	10.00	11. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
1.01	00101 CAP REL COSTS-BLDG & FLXT-MOB						1.01
1. 02 1. 03	00102 CAP REL COSTS-BLDG & FIXT-POB 00103 CAP REL COSTS-BLDG & FIXT-WJ						1.02
1. 04	00104 CAP REL COSTS-BLDG & FIXT-INTEREST						1. 04
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01 2. 02	OO201 CAP REL COSTS-MVBLE EQUIP - MOB OO202 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						4.00
5. 00 7. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT						5. 00 7. 00
7. 01	00701 OPERATION OF PLANT - MOB						7. 01
7. 02	00702 OPERATION OF PLANT - POB	4 000					7. 02
7. 03 8. 00	OO7O3 OPERATION OF PLANT - WJ OO8OO LAUNDRY & LINEN SERVICE	4, 803 0	57, 233				7. 03 8. 00
9. 00	00900 HOUSEKEEPI NG	0	07,233	86, 222			9. 00
10.00	01000 DI ETARY	0	1, 746		7, 170	17 000	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0		2, 991 1, 109	0 0	17, 023 1, 437	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	Ö	0	Ö	0	1
15.00	01500 PHARMACY	0	1	1, 000	0	621	•
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0		0 0	0	0	16. 00 17. 00
.,, 00	INPATIENT ROUTINE SERVICE COST CENTERS			,	<u> </u>		1
30.00	03000 ADULTS & PEDIATRICS	0			7, 026	2, 595	1
40. 00 43. 00	04000 SUBPROVI DER - PF 04300 NURSERY	0			144 O	260 55	1
.0.00	ANCILLARY SERVICE COST CENTERS				٥		10.00
50.00	05000 OPERATING ROOM	0	1		0	1, 573	1
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY		0	111	0 0	9	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	-	4, 994	ō	1, 164	1
60.00	06000 LABORATORY	0	0	2, 615	0	1, 136	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	-		0 0	587 451	1
67. 00	06700 OCCUPATI ONAL THERAPY	0		601	o	113	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY	0	0	24	0	17	1
71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0			0 0	0	69. 00 71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		o	o	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS 03160 CARDI OPULMONARY	0		-	0	0 173	73. 00 76. 00
76.00	OUTPATIENT SERVICE COST CENTERS	0		1,510	U	1/3	76.00
90.00	09000 CLI NI C	0	-	-	0	0	
90. 01 90. 02	09001 FAMILY PRACTICE OF JAY COUNTY 09002 JAY FAMILY MEDICINE	0			0	1, 672 1, 695	1
	09003 WOUND CLINIC	0	0		Ö	0	
90. 04	09004 OP ORTHO CLINIC	0	1	-	o	0	
90. 05 90. 06	09005 JAY FAMILY FIRST HEALTH CARE 09006 INFUSION CLINIC	0	109	4, 008	0	680 149	1
	09007 HEALTH BEGINNINGS PROGRAM	0		2, 620	ő	221	1
91.00	09100 EMERGENCY	0	13, 205	4, 770	o	1, 681	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART 04950 OUTPATIENT PSYCH	0		1, 571	o	150	92. 00 93. 00
73.00	SPECIAL PURPOSE COST CENTERS	0		1, 371	<u> </u>	130	73.00
118.00		0	57, 181	75, 661	7, 170	16, 447	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		771	ol	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 728	-		Ö		192.00
193.00	19300 NONPALD WORKERS	0	1	0	0		193.00
	07950 VACANT 07952 WEST JAY CLINIC	1, 075	0	2, 605	0		194. 00 194. 02
	07953 JAY MERI DI AN URGENT CARE	0	35	936	Ö		194. 03
200.00	, ,						200.00
201. 00 202. 00	1 9	0	240, 853	857, 425	452, 21 6	842, 760	201.00
	Part I)	_		037, 425	752, 210		
203.00		0. 000000			63. 070572	49. 507137	
204.00	Cost to be allocated (per Wkst. B, Part II)	0	24, 410	30, 990	52, 972	119, 963	204.00
	1 - 1 - 2	•			I		•

Health Fina	ncial Systems	IU HEALTH JA	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der Co		Peri od: From 01/01/2020	Worksheet B-1	
					To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
		PLANT - WJ	LINEN SERVICE	(SQUARE FEET) (MEALS	(MAN HOURS)	
		(SQUARE	(POUNDS OF		SERVED)		
		FEET-WJ)	LAUNDRY)				
		7. 03	8. 00	9. 00	10.00	11. 00	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 426502	0. 35942	7. 388006	7. 047113	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

GENERAL SE 1. 00 00100 CAP 1. 01 00101 CAP 1. 02 00102 CAP 1. 04 00104 CAP 2. 00 00200 CAP 2. 01 00201 CAP 2. 02 00202 CAP 2. 03 00203 CAP 4. 00 00400 EMPL 5. 00 00500 ADMI 7. 00 00700 OPER 7. 01 00701 OPER 7. 02 00702 OPER 7. 03 00703 OPER 7. 03 00703 OPER 9. 00 00900 HOUS 10. 00 01000 DI ET 11. 00 01100 CAFE	- STATISTICAL BASIS t Center Description ERVICE COST CENTERS REL COSTS-BLDG & FIXT	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY		MEDI CAL	Worksheet B-1 Date/Time Pre 7/15/2021 1:0 SOCIAL	pared:
GENERAL SE 1. 00 00100 CAP 1. 01 00101 CAP 1. 02 00102 CAP 1. 04 00104 CAP 2. 00 00200 CAP 2. 01 00201 CAP 2. 02 00202 CAP 2. 03 00203 CAP 4. 00 00400 EMPL 5. 00 00500 ADMI 7. 00 00700 OPER 7. 01 00701 OPER 7. 02 00702 OPER 7. 03 00703 OPER 7. 03 00703 OPER 9. 00 00900 HOUS 10. 00 01000 DI ET 11. 00 01100 CAFE	SERVICE COST CENTERS REL COSTS-BLDG & FIXT	ADMI NI STRATI O N (DI RECT	SERVICES &				3 pm
1. 00	REL COSTS-BLDG & FIXT		(COSTED REQUIS.)	REQUI S.)	RECORDS & LI BRARY (GROSS CHARGES)	SERVICE (TIME SPENT)	
1. 00	REL COSTS-BLDG & FIXT	13. 00	14. 00	15. 00	16.00	17. 00	
1. 01 00101 CAP 1. 02 00102 CAP 1. 03 00103 CAP 1. 04 00104 CAP 2. 00 00200 CAP 2. 01 00201 CAP 2. 02 00202 CAP 2. 03 00203 CAP 4. 00 00400 EMPL 5. 00 00500 ADMI 7. 00 00700 OPER 7. 01 00701 OPER 7. 02 00702 7. 03 00703 OPER 8. 00 00800 LAUN 9. 00 00900 HOUS 10. 00 01000 DI ET 11. 00 01100 CAFE		<u> </u>					
15. 00 01500 PHAR 16. 00 01600 MEDI 17. 00 01700 SOCI	TARY ETERIA SING ADMINISTRATION TRAL SERVICES & SUPPLY	7, 443 0 0 0	404, 488 6, 655 0	1, 547, 048 0 0	64, 936, 178 0	0	1. 00 1. 01 1. 02 1. 03 1. 04 2. 00 2. 01 2. 02 2. 03 4. 00 5. 00 7. 01 7. 02 7. 03 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00
	LTS & PEDIATRICS	1, 796	67, 285	5, 405	5, 729, 911	0	30.00
1 1	PROVI DER - I PF	194	126	0	84, 316	0	1
43. 00 04300 NURS	SERY SERVICE COST CENTERS	39	0	0	62, 174	0	43.00
	RATING ROOM	1, 093	0	2, 362	7, 458, 543	0	50.00
1 1	IVERY ROOM & LABOR ROOM	7	O	0	409, 615	0	
1 1	STHESI OLOGY	0	0	0	0 105 070	0	
54. 00 05400 RADI 60. 00 06000 LAB0	I OLOGY-DI AGNOSTI C		35, 196 13	2, 169 0	9, 185, 078 6, 327, 341	0	
	PI RATORY THERAPY		22, 054	241	1, 033, 757	0	65.00
	SI CAL THERAPY		2, 212	0	1, 133, 177	0	66.00
	UPATI ONAL THERAPY	o	51	0	300, 700	0	67.00
68. 00 06800 SPEE	ECH PATHOLOGY	0	0	0	31, 750	0	68.00
	CTROCARDI OLOGY	0	589	0	934, 484	0	69.00
1 1	ICAL SUPPLIES CHARGED TO PATIENTS	0	87, 965	0	423, 231	0	
	L. DEV. CHARGED TO PATIENTS	0	20, 085	1 511 327	221, 726		72.00
	GS CHARGED TO PATIENTS DIOPULMONARY	0	0 1, 218	1, 511, 326 0	9, 444, 428 1, 648, 097	0	
	IT SERVICE COST CENTERS	41	1,210	0	1, 040, 077		70.00
90. 00 09000 CLI N		0	0	0	0	0	90.00
	ILY PRACTICE OF JAY COUNTY	1, 062	31, 598	14, 974	1, 108, 454	0	
90. 02 09002 JAY		1, 202	17, 689	0	908, 443	0	90.02
90. 03 09003 WOUN 90. 04 09004 OP 0	ORTHO CLINIC	0	0	0	0	0	90.03
	FAMILY FIRST HEALTH CARE	391	4, 223	360	107, 798	Ö	1
1 1	USION CLINIC	148	7, 131	2, 011	2, 031, 982	0	90.06
	LTH BEGINNINGS PROGRAM	200	1, 858	0	24, 186	0	
91. 00 09100 EMER		1, 307	96, 450	8, 200	16, 165, 070	0	91.00
	ERVATION BEDS (NON-DISTINCT PART PATIENT PSYCH	o	261	0	161, 917	0	92. 00 93. 00
	PURPOSE COST CENTERS	O ₁	201	J.	101, 717		75.00
118. 00 SUBT	TOTALS (SUM OF LINES 1 through 117)	7, 443	402, 659	1, 547, 048	64, 936, 178	0	118.00
NONREI MBUF	RSABLE COST CENTERS						
	T, FLOWER, COFFEE SHOP & CANTEEN SICIANS' PRIVATE OFFICES	0	1, 014	0	0		190. 00 192. 00
193. 00 19300 NONP			1,014	0	Ö		193. 00
194. 00 07950 VACA		o	ō	0	Ö		194.00
194. 02 07952 WEST		0	815	0	0		194. 02
	MERI DI AN URGENT CARE		0	0	0	0	194. 03
1 1	ss Foot Adjustments ative Cost Centers					ı	200. 00 201. 00
	t to be allocated (per Wkst. B,	2, 791, 220	357, 910	1, 514, 941	n		201.00
Part		_,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	55.,,10	., , , , ,	Ĭ		
203. 00 Uni t	t cost multiplier (Wkst. B, Part I)	375. 012764	0. 884847	0. 979246	0. 000000	0. 000000	203.00

Heal th Fi	nancial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT	(COSTED		(GROSS		
		NRSING HRS)	REQUIS.)		CHARGES)		
		13. 00	14. 00	15.00	16.00	17. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)	79, 342	3, 626	56, 79	9 0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	10. 659949	0. 008964	0. 03671	0. 000000	0. 000000	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

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

From 01/01/2020 | Part I To 12/31/2020 | Date/Time Prepared: 7/15/2021 1:03 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 454, 706 5, 454, 706 5, 454, 706 30.00 484, 292 04000 SUBPROVI DER - I PF 484, 292 0 40.00 40.00 484, 292 43.00 04300 NURSERY 86, 280 86, 280 0 86, 280 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 225, 185 3, 225, 185 3, 225, 185 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 26, 298 26, 298 0 26, 298 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 0 |05400| RADI OLOGY-DI AGNOSTI C 2, 627, 537 2, 627, 537 2, 627, 537 54.00 54 00 60.00 06000 LABORATORY 3,069,659 3,069,659 0 3,069,659 60.00 65.00 06500 RESPIRATORY THERAPY 843, 343 843, 343 0 0 843, 343 65.00 1, 229, 057 66.00 06600 PHYSI CAL THERAPY 66.00 1, 229, 057 0 1, 229, 057 67.00 06700 OCCUPATI ONAL THERAPY 209, 213 C 209, 213 209, 213 67.00 68.00 06800 SPEECH PATHOLOGY 31,680 31,680 0 68.00 31,680 69.00 06900 ELECTROCARDI OLOGY 3,642 3, 642 0 0 3,642 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 197.453 197.453 197, 453 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 45, 084 45,084 45,084 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 535, 099 3, 535, 099 0 3, 535, 099 73.00 73.00 03160 CARDI OPULMONARY 484, 712 484, 712 484, 712 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 2, 241, 787 2, 241, 787 o 2, 241, 787 90. 01 90.01 0 2, 345, 670 90 02 09002 JAY FAMILY MEDICINE 2.345.670 2, 345, 670 90 02 90.03 09003 WOUND CLINIC 34,830 34,830 34,830 90.03 90.04 09004 OP ORTHO CLINIC 0 90.04 0 90.05 09005 JAY FAMILY FIRST HEALTH CARE 1,049,909 1, 049, 909 1, 049, 909 90.05 09006 INFUSION CLINIC 90.06 331, 701 331, 701 331, 701 90.06 0 90.07 09007 HEALTH BEGINNINGS PROGRAM 627, 478 627, 478 627, 478 90.07 09100 EMERGENCY 0 91.00 3, 732, 191 3, 732, 191 3, 732, 191 91.00 1, 210, 856 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 210, 856 1, 210, 856 92 00 93. 00 | 04950 | OUTPATI ENT PSYCH 221, 607 221, 607 221, 607 93.00 200.00 Subtotal (see instructions) 33, 349, 269 33, 349, 269 33, 349, 269 200. 00 201.00 Less Observation Beds 1, 210, 856 1, 210, 856 1, 210, 856 201. 00 202.00 32, 138, 413 202. 00 Total (see instructions) 32, 138, 413 32, 138, 413

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

To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 247, 104 30.00 03000 ADULTS & PEDIATRICS 3, 247, 104 30.00 40.00 04000 SUBPROVI DER - I PF 84, 316 84, 316 40.00 04300 NURSERY 43.00 43.00 62, 174 62, 174 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 1, 244, 886 6, 213, 657 7, 458, 543 0.432415 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 274, 814 134, 801 409, 615 0.064202 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 452, 983 8, 732, 095 9.185.078 0.286066 0.000000 54.00 54.00 0.485142 0.000000 60.00 06000 LABORATORY 712,007 5, 615, 334 6, 327, 341 60 00 65.00 06500 RESPIRATORY THERAPY 589, 338 444, 419 1,033,757 0.815804 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 307, 090 826, 087 1, 133, 177 1.084612 0.000000 66.00 67.00 67.00 06700 OCCUPATIONAL THERAPY 204, 165 96, 535 300, 700 0.695753 0.000000 68.00 06800 SPEECH PATHOLOGY 22, 562 9, 188 31, 750 0.997795 0.000000 68.00 06900 ELECTROCARDI OLOGY 888, 080 934, 484 0.003897 0.000000 69 00 46, 404 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 145, 897 71.00 277, 334 423, 231 0.466537 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 9,626 212, 100 221, 726 0.203332 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 2,005,785 7, 438, 643 9, 444, 428 0.374305 0.000000 73.00 73.00 03160 CARDI OPULMONARY 76.00 224, 110 1, 423, 987 1, 648, 097 0.294104 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 108, 454 1, 108, 454 2.022445 0.000000 90.01 0 09002 JAY FAMILY MEDICINE 908, 443 908, 443 2.582077 0.000000 90.02 90.02 90 03 09003 WOUND CLINIC C Ω 0.000000 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0 0 0.000000 0.000000 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 107, 798 107, 798 9. 739596 90.05 0.000000 90.05 0 09006 INFUSION CLINIC 2.031.982 0.000000 90.06 2.031.982 0.163240 90.06 09007 HEALTH BEGINNINGS PROGRAM 90.07 0 24, 186 24, 186 25.943852 0.000000 90.07 91.00 09100 EMERGENCY 420, 597 15, 744, 473 16, 165, 070 0.230880 0.000000 91.00 2, 471, 909 0. 487696 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 898 2, 482, 807 0.000000 92.00 93. 00 | 04950 | OUTPATIENT PSYCH 161, 917 161 917 1 368646 0.000000 93.00 200.00 Subtotal (see instructions) 10, 064, 756 54, 871, 422 64, 936, 178 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 10,064,756 54, 871, 422 64, 936, 178 202.00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1320	Peri od: Worksheet C From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared:

				To 12/31/2020	7/15/2021 1:0	
			Title XVIII	Hospi tal	Cost	50 piii
C	Cost Center Description	PPS Inpatient		<u> </u>		
		Ratio				
		11. 00				
	ENT ROUTINE SERVICE COST CENTERS					
	ADULTS & PEDIATRICS					30.00
	SUBPROVIDER - IPF					40.00
43. 00 04300 N						43.00
	ARY SERVICE COST CENTERS					4
	PERATING ROOM	0. 432415				50.00
1 1	DELIVERY ROOM & LABOR ROOM	0. 064202				52.00
	ANESTHESI OLOGY	0. 000000				53.00
	RADI OLOGY-DI AGNOSTI C	0. 286066				54.00
	ABORATORY	0. 485142				60.00
	RESPI RATORY THERAPY	0. 815804				65.00
	PHYSI CAL THERAPY	1. 084612				66.00
	OCCUPATI ONAL THERAPY	0. 695753				67. 00
	SPEECH PATHOLOGY	0. 997795				68. 00
	LECTROCARDI OLOGY	0. 003897				69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 466537				71.00
	MPL. DEV. CHARGED TO PATIENTS	0. 203332				72.00
	DRUGS CHARGED TO PATIENTS	0. 374305				73.00
	CARDI OPULMONARY	0. 294104				76. 00
	ENT SERVICE COST CENTERS					
90.00 09000 0		0. 000000				90.00
	FAMILY PRACTICE OF JAY COUNTY	2. 022445				90. 01
	JAY FAMILY MEDICINE	2. 582077				90. 02
90. 03 09003 W		0. 000000				90. 03
	OP ORTHO CLINIC	0. 000000				90.04
	JAY FAMILY FIRST HEALTH CARE	9. 739596				90.05
	NFUSION CLINIC	0. 163240				90.06
	HEALTH BEGINNINGS PROGRAM	25. 943852				90.07
	MERGENCY	0. 230880				91.00
	DBSERVATION BEDS (NON-DISTINCT PART	0. 487696				92.00
	OUTPATIENT PSYCH	1. 368646				93.00
	Subtotal (see instructions)					200.00
	Less Observation Beds					201.00
202. 00 T	otal (see instructions)					202.00

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

From 01/01/2020 | Part I To 12/31/2020 | Date/Time Prepared: 7/15/2021 1:03 pm Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs (from Wkst. Adj Di sal I owance B, Part I, col. 26) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 454, 706 5, 454, 706 5, 454, 706 30.00 484, 292 04000 SUBPROVI DER - I PF 484, 292 0 40.00 40.00 484, 292 43.00 04300 NURSERY 86, 280 86, 280 0 86, 280 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 225, 185 3, 225, 185 3, 225, 185 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 26, 298 26, 298 0 26, 298 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 |05400| RADI OLOGY-DI AGNOSTI C 2, 627, 537 2, 627, 537 2, 627, 537 54.00 54 00 60.00 06000 LABORATORY 3,069,659 3,069,659 0 3,069,659 60.00 65.00 06500 RESPIRATORY THERAPY 843, 343 843, 343 0 0 843, 343 65.00 1, 229, 057 66.00 06600 PHYSI CAL THERAPY 66.00 1, 229, 057 0 1, 229, 057 67.00 06700 OCCUPATI ONAL THERAPY 209, 213 C 209, 213 209, 213 67.00 68.00 06800 SPEECH PATHOLOGY 31,680 31,680 0 68.00 31,680 69.00 06900 ELECTROCARDI OLOGY 3,642 3, 642 0 0 3,642 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 197.453 197.453 197, 453 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 45, 084 45,084 45,084 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 535, 099 3, 535, 099 0 3, 535, 099 73.00 73.00 03160 CARDI OPULMONARY 484, 712 484, 712 484, 712 76.00 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 2, 241, 787 2, 241, 787 o 2, 241, 787 90. 01 90.01 0 2, 345, 670 90 02 09002 JAY FAMILY MEDICINE 2.345.670 2, 345, 670 90 02 90.03 09003 WOUND CLINIC 34,830 34,830 34,830 90.03 90.04 09004 OP ORTHO CLINIC 0 90.04 0 90.05 09005 JAY FAMILY FIRST HEALTH CARE 1,049,909 1, 049, 909 1, 049, 909 90.05 09006 INFUSION CLINIC 90.06 331, 701 331, 701 331, 701 90.06 0 90.07 09007 HEALTH BEGINNINGS PROGRAM 627, 478 627, 478 627, 478 90.07 09100 EMERGENCY 0 91.00 3, 732, 191 3, 732, 191 3, 732, 191 91.00 1, 210, 856 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 210, 856 1, 210, 856 92 00 93. 00 | 04950 | OUTPATI ENT PSYCH 221, 607 221, 607 221, 607 93.00 200.00 Subtotal (see instructions) 33, 349, 269 33, 349, 269 33, 349, 269 200. 00 201.00 Less Observation Beds 1, 210, 856 1, 210, 856 1, 210, 856 201. 00 202.00 32, 138, 413 32, 138, 413 202. 00 Total (see instructions) 32, 138, 413

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1320	Peri od: From 01/01/2020	Worksheet C

12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Title XIX Hospi tal PPS Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 247, 104 30.00 03000 ADULTS & PEDIATRICS 3, 247, 104 30.00 40.00 04000 SUBPROVI DER - I PF 84, 316 84, 316 40.00 04300 NURSERY 43.00 43.00 62, 174 62, 174 ANCILLARY SERVICE COST CENTERS 0.000000 50.00 1, 244, 886 6, 213, 657 7, 458, 543 0.432415 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 274, 814 134, 801 409, 615 0.064202 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 452, 983 8, 732, 095 9.185.078 0.286066 0.000000 54.00 54.00 60.00 06000 LABORATORY 712,007 5, 615, 334 6, 327, 341 0.485142 0.000000 60 00 65.00 06500 RESPIRATORY THERAPY 589, 338 444, 419 1,033,757 0.815804 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 307, 090 826, 087 1, 133, 177 1.084612 0.000000 66.00 67.00 204, 165 06700 OCCUPATIONAL THERAPY 96, 535 300, 700 0.695753 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 22, 562 9, 188 31, 750 0.997795 0.000000 68.00 06900 ELECTROCARDI OLOGY 888, 080 934, 484 0.003897 0.000000 69 00 46, 404 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 145, 897 71.00 277, 334 423, 231 0.466537 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 9,626 212, 100 221, 726 0.203332 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 2,005,785 7, 438, 643 9, 444, 428 0.374305 0.000000 73.00 73.00 03160 CARDI OPULMONARY 76.00 224, 110 1, 423, 987 1, 648, 097 0.294104 0.000000 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 1, 108, 454 1, 108, 454 2.022445 0.000000 90.01 0 09002 JAY FAMILY MEDICINE 908, 443 908, 443 2.582077 0.000000 90.02 90.02 90 03 09003 WOUND CLINIC C Ω 0.000000 0.000000 90.03 90.04 09004 OP ORTHO CLINIC 0 0 0.000000 0.000000 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 107, 798 107, 798 9. 739596 90.05 0.000000 90.05 0 09006 INFUSION CLINIC 2.031.982 0.000000 90.06 2.031.982 0.163240 90.06 09007 HEALTH BEGINNINGS PROGRAM 90.07 0 24, 186 24, 186 25.943852 0.000000 90.07 91.00 09100 EMERGENCY 420, 597 15, 744, 473 16, 165, 070 0.230880 0.000000 91.00 2, 471, 909 0. 487696 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 10, 898 2, 482, 807 0.000000 92.00 93. 00 | 04950 | OUTPATIENT PSYCH 161, 917 161 917 1 368646 0.000000 93.00 200.00 Subtotal (see instructions) 10, 064, 756 54, 871, 422 64, 936, 178 200.00 201.00 Less Observation Beds 201.00 202.00 Total (see instructions) 10,064,756 54, 871, 422 64, 936, 178 202.00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1320	From 01/01/2020	Worksheet C Part I Date/Time Prepared: 7/15/2021 1:03 pm

					7/15/2021 1:03 pm
			Title XIX	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	NPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDIATRICS				30.00
	4000 SUBPROVI DER - I PF				40.00
	4300 NURSERY				43.00
	NCILLARY SERVICE COST CENTERS	0.422415			
	5000 OPERATING ROOM 5200 DELIVERY ROOM & LABOR ROOM	0. 432415 0. 064202			50. 00 52. 00
	5300 ANESTHESI OLOGY	0.000000			53.00
	5300 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
1	6000 LABORATORY	0. 485142			60.00
	6500 RESPI RATORY THERAPY	0. 465142			65.00
	6600 PHYSI CAL THERAPY	1. 084612			66.00
	6700 OCCUPATIONAL THERAPY	0. 695753			67.00
	6800 SPEECH PATHOLOGY	0. 997795			68.00
	6900 ELECTROCARDI OLOGY	0. 003897			69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 466537			71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 203332			72. 00
	7300 DRUGS CHARGED TO PATIENTS	0. 374305			73.00
- 1	3160 CARDI OPULMONARY	0. 294104			76.00
OI	UTPATIENT SERVICE COST CENTERS				
90.00	9000 CLI NI C	0. 000000			90.00
90. 01 0	9001 FAMILY PRACTICE OF JAY COUNTY	2. 022445			90. 01
90. 02 0	9002 JAY FAMILY MEDICINE	2. 582077			90. 02
90. 03 09	9003 WOUND CLINIC	0. 000000			90. 03
90. 04 09	9004 OP ORTHO CLINIC	0. 000000			90. 04
	9005 JAY FAMILY FIRST HEALTH CARE	9. 739596			90. 05
	9006 INFUSION CLINIC	0. 163240			90.06
	9007 HEALTH BEGINNINGS PROGRAM	25. 943852			90. 07
	9100 EMERGENCY	0. 230880			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 487696			92.00
	4950 OUTPATIENT PSYCH	1. 368646			93.00
200.00	Subtotal (see instructions)				200.00
201.00	Less Observation Beds				201.00
202.00	Total (see instructions)				202. 00

Health Financial Systems IU HEALTH CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2020 | Part II | To 12/31/2020 | Date/Time Prepared:

					10 12/31/2020	7/15/2021 1:0	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating	Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reducti on	
		26)	26)	(col. 1 -		Amount	
				col. 2)			
		1. 00	2.00	3.00	4. 00	5. 00	
	CILLARY SERVICE COST CENTERS						
	OOO OPERATING ROOM	3, 225, 185	251, 476	2, 973, 70	9 0	0	50.00
	200 DELIVERY ROOM & LABOR ROOM	26, 298	4, 508	21, 79	0	0	52.00
	300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00 054	400 RADI OLOGY-DI AGNOSTI C	2, 627, 537	223, 479	2, 404, 05	0 8	0	54.00
	000 LABORATORY	3, 069, 659	135, 883	2, 933, 77	6 0	0	60.00
	500 RESPI RATORY THERAPY	843, 343	39, 728	803, 61	5 0	0	65.00
	600 PHYSI CAL THERAPY	1, 229, 057	135, 286	1, 093, 77	1 0	0	66. 00
	700 OCCUPATI ONAL THERAPY	209, 213	25, 259		4 0	0	67.00
	800 SPEECH PATHOLOGY	31, 680	1, 331			0	68. 00
69.00 069	900 ELECTROCARDI OLOGY	3, 642	37	3, 60	5 0	0	69. 00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	197, 453	2, 001	195, 45	2 0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	45, 084	457	44, 62	7 0	0	72.00
73.00 073	300 DRUGS CHARGED TO PATIENTS	3, 535, 099	76, 309	3, 458, 79	0	0	73.00
76. 00 <u>03</u>	160 CARDI OPULMONARY	484, 712	17, 821	466, 89	1 0	0	76. 00
	TPATIENT SERVICE COST CENTERS						
90.00 090	000 CLI NI C	0	0		0 0	0	90.00
90. 01 090	001 FAMILY PRACTICE OF JAY COUNTY	2, 241, 787	109, 645	2, 132, 14	2 0	0	90. 01
90. 02 090	002 JAY FAMILY MEDICINE	2, 345, 670	109, 304	2, 236, 36	6 0	0	90. 02
90. 03 090	OO3 WOUND CLINIC	34, 830	13, 048	21, 78	2 0	0	90. 03
90. 04 090	004 OP ORTHO CLINIC	0	0		0 0	0	90. 04
90.05 090	005 JAY FAMILY FIRST HEALTH CARE	1, 049, 909	162, 978	886, 93	1 0	0	90. 05
90.06 090	006 INFUSION CLINIC	331, 701	28, 446	303, 25	5 0	0	90.06
90. 07 090	007 HEALTH BEGINNINGS PROGRAM	627, 478	106, 759	520, 71	9 0	0	90. 07
91.00 091	100 EMERGENCY	3, 732, 191	240, 998	3, 491, 19	3 0	0	91.00
92.00 092	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 210, 856	133, 413	1, 077, 44	3 0	0	92.00
93.00 049	950 OUTPATIENT PSYCH	221, 607	61, 772	159, 83	5 0	0	93.00
200.00	Subtotal (sum of lines 50 thru 199)	27, 323, 991	1, 879, 938	25, 444, 05	3 0		200. 00
201.00							
201.00	Less Observation Beds Total (line 200 minus line 201)	1, 210, 856 26, 113, 135	133, 413 1, 746, 525				201. 00 202. 00

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

Provider CCN: 15-1320
From 01/01/2020
To 12/31/2020
To 12/31/2020
To Date/Time Prepared:

					0 12/31/2020	7/15/2021 1:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and	(Worksheet C,	Cost to			
		Operati ng	Part I,	Charge Ratio			
		Cost	column 8)	(col. 6 /			
		Reducti on		col. 7)			
	ANOLILA ADV. OF DIVINOS ANOT AFITEDO	6. 00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS	2 225 105	7 450 540	0.42041	-1		
	05000 OPERATING ROOM	3, 225, 185					50.00
	05200 DELIVERY ROOM & LABOR ROOM	26, 298					52.00
	05300 ANESTHESI OLOGY	0	0 105 070	0.00000			53.00
	05400 RADI OLOGY-DI AGNOSTI C	2, 627, 537					54.00
	06000 LABORATORY	3, 069, 659					60.00
	06500 RESPI RATORY THERAPY	843, 343					65.00
	06600 PHYSI CAL THERAPY	1, 229, 057					66.00
	06700 OCCUPATI ONAL THERAPY	209, 213					67.00
	06800 SPEECH PATHOLOGY	31, 680					68.00
	06900 ELECTROCARDI OLOGY	3, 642					69. 00 71. 00
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	197, 453					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	45, 084					73.00
		3, 535, 099					
76. 00	03160 CARDI OPULMONARY OUTPATIENT SERVICE COST CENTERS	484, 712	1, 648, 097	0. 294104	ł		76. 00
90. 00	09000 CLINIC	0	0	0. 000000	1		90.00
	09001 FAMILY PRACTICE OF JAY COUNTY	2, 241, 787					90.00
	09002 JAY FAMILY MEDICINE	2, 345, 670					90.01
	09003 WOUND CLINIC	34, 830					90.02
	09004 OP ORTHO CLINIC	0.00	0	0. 000000			90.03
	09005 JAY FAMILY FIRST HEALTH CARE	1, 049, 909	107, 798				90. 05
	09006 INFUSION CLINIC	331, 701					90.06
	09007 HEALTH BEGINNINGS PROGRAM	627, 478					90. 07
	09100 EMERGENCY	3, 732, 191					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 210, 856					92.00
	04950 OUTPATIENT PSYCH	221, 607					93.00
200.00		27, 323, 991					200.00
201.00		1, 210, 856		i			201.00
202. 00	l l	26, 113, 135	l e				202. 00

Heal th F	inancial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI C	DNMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
			Title	XVIII	Hospi tal	Cost	<u> </u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col . 2)			
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	251, 476				7, 040	
	5200 DELIVERY ROOM & LABOR ROOM	4, 508				0	
	5300 ANESTHESI OLOGY	0	0	1 0.0000		0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	223, 479					54.00
	6000 LABORATORY	135, 883				5, 597	60.00
	6500 RESPI RATORY THERAPY	39, 728					65.00
	6600 PHYSI CAL THERAPY	135, 286	1, 133, 177				
67.00 0	6700 OCCUPATI ONAL THERAPY	25, 259	300, 700	0. 08400	1 27, 028	2, 270	67.00
68.00 0	6800 SPEECH PATHOLOGY	1, 331	31, 750		1 8, 356	350	68. 00
69.00 0	6900 ELECTROCARDI OLOGY	37	934, 484	0. 00004	0 15, 556	1	69. 00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 001	423, 231	0. 00472	8 43, 110	204	71.00
72. 00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	457	221, 726	0. 00206	1 0	0	72.00
73. 00 0	7300 DRUGS CHARGED TO PATIENTS	76, 309	9, 444, 428	0. 00808	0 808, 809	6, 535	73.00
76. 00 03	3160 CARDI OPULMONARY	17, 821	1, 648, 097	0. 01081	3 111, 694	1, 208	76.00
Ol	UTPATIENT SERVICE COST CENTERS						
90.00	9000 CLI NI C	0	0	0. 00000	0 0	0	90.00
90. 01 09	9001 FAMILY PRACTICE OF JAY COUNTY	109, 645	1, 108, 454	0. 09891	7 0	0	90. 01
90. 02 0	9002 JAY FAMILY MEDICINE	109, 304	908, 443	0. 12032	o o	0	90. 02
90. 03 0	9003 WOUND CLINIC	13, 048	0	0. 00000	o o	0	90.03
90. 04 09	9004 OP ORTHO CLINIC	0	0	0. 00000	o o	0	90.04
90.05 0	9005 JAY FAMILY FIRST HEALTH CARE	162, 978	107, 798	1. 51188	3 0	0	90.05
90.06 0	9006 INFUSION CLINIC	28, 446	2, 031, 982	0. 01399	9 0	0	90.06
90. 07 09	9007 HEALTH BEGINNINGS PROGRAM	106, 759	24, 186	4. 41408	3 0	0	90. 07
	9100 EMERGENCY	240, 998				387	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	133, 413				496	
	4950 OUTPATIENT PSYCH	61, 772				0	93.00
200.00	Total (lines 50 through 199)	1, 879, 938	61, 542, 584		1, 955, 067	43, 677	200.00

In Lieu of Form CMS-2552-10

 Heal th Financial
 Systems
 IU HEALTH JAY HOSPITAL

 APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 Provider CCN: 15-1320
 Period: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/Time Prepared: THROUGH COSTS

				10 12/31/2020	7/15/2021 1:0	
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS				.		
50. 00 05000 OPERATI NG ROOM	0	0		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73.00
76. 00 03160 CARDI OPULMONARY	0	0) (0	0	76.00
OUTPATIENT SERVICE COST CENTERS	1		.1			
90. 00 09000 CLINIC	0	0		0	0	
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0	90. 01
90. 02 09002 JAY FAMILY MEDICINE	0	0		0	0	90.02
90. 03 09003 WOUND CLINIC	0	0		0	0	90.03
90. 04 09004 OP ORTHO CLINIC	0	0			0	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
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	0			0	90.07
91. 00 09100 EMERGENCY	0	0	'	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_)	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0	0		0	0	
200.00 Total (lines 50 through 199)	0	0	y (0	0	200. 00

Health Financial Systems	IU HEALTH JAY H	IOSPI TAL	In Lie	eu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCLLLADY SERVICE OTHER DASS	Provider CCN: 15-1320	Pari od:	Workshoot D

From 01/01/2020 | Part IV To 12/31/2020 | Date/Tim THROUGH COSTS Date/Time Prepared: 7/15/2021 1:03 pm Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal Outpati ent (sum of cols. (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 7, 458, 543 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 409, 615 0.000000 52.00 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 9, 185, 078 54.00 0.000000 54.00 60.00 06000 LABORATORY 0 0 6, 327, 341 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 1, 033, 757 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 1, 133, 177 0.000000 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 300, 700 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 31, 750 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 0 934, 484 0.000000 69.00 69.00 |07100|MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 C 423, 231 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 221, 726 0.000000 72.00

07300 DRUGS CHARGED TO PATIENTS 0 0 0 9, 444, 428 0.000000 73.00 73.00 03160 CARDI OPULMONARY 0 76.00 0 0 1, 648, 097 0.000000 76 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0.000000 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 1, 108, 454 90.01 0000000000 0 0 0.000000 90.01 0 908, 443 09002 JAY FAMILY MEDICINE 0 0.000000 90 02 90 02 0 90.03 09003 WOUND CLINIC 0 0 0.000000 90.03 09004 OP ORTHO CLINIC 0.000000 90.04 90.04 90.05 09005 JAY FAMILY FIRST HEALTH CARE 0 0 107, 798 0.000000 90.05 2, 031, 982 90.06 09006 INFUSION CLINIC 0 0 0.000000 90.06 90. 07 | 09007 | HEALTH BEGINNINGS PROGRAM 0 0 24, 186 0.000000 90.07 91.00 09100 EMERGENCY 0 0 16, 165, 070 0.000000 91.00 2, 482, 807 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 0 0.000000 0 93. 00 | 04950 | OUTPATIENT PSYCH 0 161, 917 0.000000 93.00 200.00 Total (lines 50 through 199) 61, 542, 584 200.00

Health Financial Systems	IU HEALTH JAY HOSPI	TAL	In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT/OUTDATIENT	ANCILLADY SERVICE OTHER DASS Dro	vidor CCN: 15 1220 Pori	od: Workshoot D

Peri od: From 01/01/2020 To 12/31/2020 Part IV THROUGH COSTS Date/Time Prepared: 7/15/2021 1:03 pm Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Charges Pass-Through Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11.00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 208, 793 50 00 05000 OPERATING ROOM 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 128, 582 0.000000 0 54.00 0 54.00 06000 LABORATORY 60.00 0.000000 260, 631 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 249, 902 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 57, 423 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0.000000 27, 028 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 8, 356 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 15, 556 0 0 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 43, 110 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0.000000 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 808, 809 0 73.00 03160 CARDI OPULMONARY 0 0 0 76.00 0.000000 111, 694 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 0 0 90.01 0 0 0 0 0 0 0 0 90.02 09002 JAY FAMILY MEDICINE 0.000000 90.02 0 0 0 09003 WOUND CLINIC 90.03 0.000000 0 0 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0 90.05 90.05 0.000000 0 0 90 06 09006 INFUSION CLINIC 0.000000 0 Ω 90.06 09007 HEALTH BEGINNINGS PROGRAM 0.000000 0 90.07 90.07 C 0

0.000000

0.000000

0.000000

25, 958

1, 955, 067

9, 225

0 91.00

0

Ω

92.00

93.00

0 200.00

0

0

0

91. 00 09100 EMERGENCY

93. 00 |04950 | OUTPATI ENT PSYCH

92.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1320 Peri od: Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0. 432415 1, 529, 890 05200 DELIVERY ROOM & LABOR ROOM 0.064202 0 52.00 52.00 0 0 0 05300 ANESTHESI OLOGY 0.000000 53.00 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 286066 0 2,006,990 0 0 0 0 54.00 60.00 06000 LABORATORY 0.485142 1, 336, 970 0 60.00 06500 RESPIRATORY THERAPY 65.00 0.815804 120, 746 0 65.00 66.00 06600 PHYSI CAL THERAPY 1.084612 265, 725 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 695753 19, 216 0 0 67.00 4, 390 o 68.00 06800 SPEECH PATHOLOGY 0. 997795 0 68.00 06900 ELECTROCARDI OLOGY 0.003897 221, 237 0 69.00 69.00 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.466537 0 64, 965 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 45, 727 72.00 0.203332 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0.374305 1 912 028 167, 841 0 73 00 03160 CARDI OPULMONARY 76.00 0. 294104 0 436, 450 0 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 09001 FAMILY PRACTICE OF JAY COUNTY 267, 935 90 01 2.022445 0 29, 247 Ω 90 01 09002 JAY FAMILY MEDICINE 90.02 2.582077 0 384, 881 38,005 0 90.02 90.03 09003 WOUND CLINIC 0.000000 0 90.03 09004 OP ORTHO CLINIC 90.04 0.000000 0 0 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 90.05 9.739596 0 48, 061 90.05 3,868 0 90.06 09006 INFUSION CLINIC 0. 163240 0 1, 196, 570 0 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 25. 943852 0 90.07 09100 EMERGENCY 0. 230880 2, 962, 630 91.00 91.00 3.453 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 839, 516 0.487696 0 92.00 1, 467 0 93.00 04950 OUTPATIENT PSYCH 1.368646 0 22, 427 0 93.00 200.00 Subtotal (see instructions) 13, 686, 354 243, 881 0 200.00

O

13, 686, 354

243, 881

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

Health Financial Systems	IU HEALTH JAY H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1320	Peri od:	Worksheet D

From 01/01/2020 Part V To 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 661, 547 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 574, 132 0 54.00 60.00 06000 LABORATORY 648, 620 60.00 06500 RESPIRATORY THERAPY 98, 505 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 288, 209 66.00 67.00 06700 OCCUPATI ONAL THERAPY 13, 370 67.00 4, 380 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 862 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 30, 309 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 9, 298 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 715, 682 73.00 73 00 62,824 03160 CARDI OPULMONARY 76.00 128, 362 76.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 59, 150 09001 FAMILY PRACTICE OF JAY COUNTY 541, 884 90 01 90 01 09002 JAY FAMILY MEDICINE 90.02 993, 792 98, 132 90.02 90.03 09003 WOUND CLINIC 90.03 09004 OP ORTHO CLINIC 90.04 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 90.05 468, 095 37,673 90.05 90.06 09006 INFUSION CLINIC 195, 328 90.06 90.07 09007 HEALTH BEGINNINGS PROGRAM 0 90.07 91.00 09100 EMERGENCY 684, 012 797 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 409, 429 715 93.00 04950 OUTPATIENT PSYCH 30, 695 93.00 200.00 Subtotal (see instructions) 6, 496, 511 259, 291 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

6, 496, 511

259, 291

202.00

202.00

Net Charges (line 200 - line 201)

			V HOCDITAL		1 . 12 .	. C. F OHC . (2550 40
	inancial Systems NMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IU HEALTH JA AL COSTS	Provi der C	CN: 15-1320 CCN: 15-M320	Peri od: From 01/01/2020 To 12/31/2020		pared:
			Title	: XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
		(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
		B, Part II,	col. 8)	col. 2)			
		col. 26)					
		1. 00	2. 00	3.00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	251, 476				0	50.00
	5200 DELIVERY ROOM & LABOR ROOM	4, 508	409, 615			0	52.00
	5300 ANESTHESI OLOGY	0		0.0000		0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	223, 479	9, 185, 078				54.00
	6000 LABORATORY	135, 883				157	60.00
	5500 RESPIRATORY THERAPY	39, 728				0	65.00
	6600 PHYSI CAL THERAPY	135, 286				0	66.00
	5700 OCCUPATI ONAL THERAPY	25, 259				0	67.00
	SPEECH PATHOLOGY	1, 331				0	68. 00
	5900 ELECTROCARDI OLOGY	37				l e	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 001				0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	457				0	72.00
	7300 DRUGS CHARGED TO PATIENTS	76, 309					73.00
	3160 CARDI OPULMONARY	17, 821	1, 648, 097	0. 0108	13 0	0	76. 00
	JTPATIENT SERVICE COST CENTERS						
	9000 CLINIC	0					90.00
	9001 FAMILY PRACTICE OF JAY COUNTY	109, 645					90. 01
	9002 JAY FAMILY MEDICINE	109, 304				0	90. 02
	9003 WOUND CLINIC	13, 048	l e	0.0000		0	90.03
	9004 OP ORTHO CLINIC	0		0. 00000		0	90.04
	9005 JAY FAMILY FIRST HEALTH CARE	162, 978				0	90. 05
	9006 INFUSION CLINIC	28, 446				0	90.06
	9007 HEALTH BEGINNINGS PROGRAM	106, 759				0	90.07
	9100 EMERGENCY	240, 998				85	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	_,,			1	92.00
	4950 OUTPATIENT PSYCH	61, 772		l .		0	93.00
200. 00	Total (lines 50 through 199)	1, 746, 525	61, 542, 584	l	27, 979	392	200. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	IU HEALTH JA RVICE OTHER PAS	S Provider C	CN: 15-1320 CCN: 15-M320	Peri od: From 01/01/2020 To 12/31/2020		pared:
		Title	· XVIII	Subprovi der -	PPS	
Cost Center Description	Non Physician Anesthetist Cost	School Post-Stepdown Adjustments	Nursi ng School	Allied Health Post-Stepdown Adjustments		
ANCILLARY SERVICE COST CENTERS	1. 00	2A	2. 00	3A	3. 00	
50. 00 05000 OPERATI NG ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 00 03160 CARDI OPULMONARY 00TPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	52. 00 53. 00 54. 00 60. 00 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00
90. 00 09000 CLINIC 90. 01 09001 FAMILY PRACTICE OF JAY COUNTY 90. 02 09002 JAY FAMILY MEDICINE 90. 03 09003 WOUND CLINIC 90. 04 09004 0P ORTHO CLINIC 90. 05 09005 JAY FAMILY FIRST HEALTH CARE 90. 06 09006 INFUSION CLINIC 90. 07 09007 HEALTH BEGINNINGS PROGRAM 91. 00 09100 EMERGENCY 92. 00 09200 09SERVATION BEDS (NON-DISTINCT PART 93. 00 04950 OUTPATIENT PSYCH Total (Lines 50 through 199)	0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	90. 01 90. 02 90. 03 90. 04 90. 05 90. 06 90. 07 91. 00 92. 00

Health Financial Systems I U HEALTH JAY HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1320			ON 45 4000	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		SS Provider C		Peri od: From 01/01/2020	Worksheet D Part IV	
Inkough Costs			CCN: 15-M320	To 12/31/2020		pared:
					7/15/2021 1:0	
			Title XVIII		Subprovi der - PPS	
	111 011			I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medical	(sum of cols.	Outpatient	(from Wkst.	to Charges (col. 5 ÷	
	Education Cost	1, 2, 3, and	Cost (sum of			
	COST	4)	cols. 2, 3, and 4)	col. 8)	col. 7) (see	
			and 4)		instructions)	
	4. 00	5. 00	6, 00	7. 00	8.00	
ANCILLARY SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM) C	1	0 7, 458, 543	0.000000	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1	l .	0 409, 615	l	1
53. 00 05300 ANESTHESI OLOGY				0 407,019	0. 000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0 9, 185, 078		
60. 00 06000 LABORATORY				0 6, 327, 341	l .	
65. 00 06500 RESPIRATORY THERAPY				0 1, 033, 757	l .	1
66. 00 06600 PHYSI CAL THERAPY				0 1, 133, 177		
67. 00 06700 OCCUPATI ONAL THERAPY				0 300, 700		1
68. 00 06800 SPEECH PATHOLOGY				0 31, 750		
69. 00 06900 ELECTROCARDI OLOGY				0 934, 484		1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C			0 423, 231		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C) c		0 221, 726	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C) c		0 9, 444, 428	0.000000	73.00
76. 00 03160 CARDI OPULMONARY	C) c		0 1, 648, 097	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	C) c)	0		
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	C) C)	0 1, 108, 454		
90.02 09002 JAY FAMILY MEDICINE	C) C)	0 908, 443		
90. 03 09003 WOUND CLINIC	C) C)	0	0. 000000	
90. 04 09004 OP ORTHO CLINIC	C) C		0	0.000000	
90.05 09005 JAY FAMILY FIRST HEALTH CARE	C) C		0 107, 798		
90. 06 09006 I NFUSI ON CLI NI C	C) C		0 2, 031, 982		
90. 07 09007 HEALTH BEGINNINGS PROGRAM	C	0		0 24, 186		
91. 00 09100 EMERGENCY	C	C		0 16, 165, 070		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C	1		0 2, 482, 807		
93. 00 04950 OUTPATIENT PSYCH		C	1	0 161, 917	l	1
200.00 Total (lines 50 through 199)	C) C	ή	0 61, 542, 584	I	200. 00

Heal th	Financial Systems	IU HEALTH JAY	HOSPI TAI		Inlie	u of Form CMS-2	2552-10
APPOR1	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS		Provi der CO	CN: 15-1320 CCN: 15-M320	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D Part IV	pared:
			Title	XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Throug Costs (col. x col. 10)		Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 124		0	0	54.00
60.00	06000 LABORATORY	0. 000000	7, 333		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	0		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	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	666		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	12, 145		0 0	0	73.00
76.00	03160 CARDI OPULMONARY	0. 000000	0		0 0	0	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0.000000	0				00.00
90.00	09000 CLINIC	0.000000	0		0 0	0	
90. 01	09001 FAMILY PRACTICE OF JAY COUNTY	0.000000	0		0 0	1	90. 01 90. 02
90. 02 90. 03	09003 WOUND CLINIC	0. 000000	0		0	0	90.02
90.03	109004 OP ORTHO CLINIC	0. 000000	0		0	0	90.03
90.04	09005 JAY FAMILY FIRST HEALTH CARE	0. 000000	0			0	90.04
90.06	09006 INFUSION CLINIC	0. 000000	0			0	90.06
90.07	09007 HEALTH BEGINNINGS PROGRAM	0. 000000	0			0	90.07
91.00	09100 EMERGENCY	0. 000000	5, 711			0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	3, 711		0 0	0	
93. 00	04950 OUTPATIENT PSYCH	0. 000000	0		0 0	0	1
200.00		0.000000	27, 979		0 0		200.00
	, , , , , , , , , , , , , , , , , , , ,	1		ı	1	1	

Health Financial Systems	IU HEALTH JA	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Peri od:	Worksheet D	
				From 01/01/2020 To 12/31/2020		narod:
				10 12/31/2020	7/15/2021 1:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	601, 006					
40. 00 SUBPROVI DER - I PF	20, 106	0	20, 10	5 48	418. 88	
43. 00 NURSERY	11, 561		11, 56		240. 85	
200.00 Total (lines 30 through 199)	632, 673		498, 47	1, 730		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days					
		Capital Cost				
		(col. 5 x				
		col . 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	9	2, 571			l	30.00
40. 00 SUBPROVI DER - I PF	0	0			l	40.00
43. 00 NURSERY	2	482			ļ	43.00
200.00 Total (lines 30 through 199)	11	3, 053			ļ	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH JAY HOSPITAL APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-1320 Peri od: Worksheet D From 01/01/2020 Part II 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Title XIX Hospi tal PPS Total Charges Ratio of Cost Capital Costs Cost Center Description Capi tal Inpati ent to Charges Related Cost (column 3 x (from Wkst. Program (from Wkst. C, Part I, (col. 1 ÷ Charges column 4) B, Part II, col. 8) col. 2) col. 26) 1. 00 2.00 4. 00 5. 00 3.00 ANCILLARY SERVICE COST CENTERS 50 00 251, 476 7, 458, 543 50 00 05000 OPERATING ROOM 0.033717 52.00 05200 DELIVERY ROOM & LABOR ROOM 4,508 409, 615 0.011005 25, 287 278 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 223, 479 9, 185, 078 494 54.00 0.024331 12 54.00 60.00 06000 LABORATORY 135, 883 6, 327, 341 0.021476 5,654 121 60.00 65.00 06500 RESPIRATORY THERAPY 39, 728 1,033,757 0.038431 0 65.00 66.00 06600 PHYSI CAL THERAPY 135, 286 1, 133, 177 0.119386 302 36 66.00 25, 259 06700 OCCUPATI ONAL THERAPY 300, 700 67.00 0.084001 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 1, 331 31, 750 0.041921 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 37 934, 484 0.000040 222 0 69.00 1, 197 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2,001 423, 231 0.004728 71.00 6 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 457 221, 726 0.002061 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 76, 309 9, 444, 428 0.008080 2, 984 24 73.00 03160 CARDI OPULMONARY 0 76.00 17, 821 1, 648, 097 0.010813 76.00 0 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.000000 0 09001 FAMILY PRACTICE OF JAY COUNTY 109, 645 1, 108, 454 0.098917 0 0 90.01 90.01 0 09002 JAY FAMILY MEDICINE 109, 304 908, 443 0.120320 90.02 90.02 0 09003 WOUND CLINIC 90.03 13, 048 C 0.000000 0 90.03 90.04 09004 OP ORTHO CLINIC 0.000000 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 162, 978 0 90.05 107, 798 1.511883 0 90.05 90. 06 09006 INFUSION CLINIC 28. 446 2,031,982 0.013999 0 Ω 90.06 09007 HEALTH BEGINNINGS PROGRAM 90.07 106, 759 24, 186 4.414083 0 0 90.07 91. 00 09100 EMERGENCY 240, 998 16, 165, 070 0.014909 7, 016 105 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 133, 413 2, 482, 807 0.053735 0 92.00 0 93. 00 04950 OUTPATIENT PSYCH 61, 772 161, 917 0.381504 Ω 93.00 0 200.00 Total (lines 50 through 199) 1, 879, 938 61, 542, 584 43, 156 582 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1320 Period: From 01/01/2020 Trom 01/01/2020 Provider CCN: 15-1320 Provider C	Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
Nursing School Post-Stepdown Adjustments	APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	THER PASS THROUGH COS	TS Provider C		From 01/01/2020 Fo 12/31/2020	Part III Date/Time Pre 7/15/2021 1:0	epared: 03 pm
Nursing School Post-Stepdown Adjustments Nursing School Post-Stepdown Adjustments All Other Medical Education Cost			Ti tl	e XIX	Hospi tal	PPS	
School Post-Stepdown Adjustments Adjustment Adjustment	Cost Center Description	Nursi ng	Nursi ng	Allied Health		All Other	
INPATI ENT ROUTINE SERVICE COST CENTERS		School	School	Post-Stepdown	Cost	Medi cal	
INPATIENT ROUTINE SERVICE COST CENTERS 1		Post-Stepdown		Adjustments		Educati on	
INPATIENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		Adjustments				Cost	
NPATIENT ROUTINE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		1A	1. 00	2A	2.00	3. 00	
A0. 00 040	INPATIENT ROUTINE SERVICE COST CENTERS						
A3.00 04300 NURSERY 0 0 0 0 0 0 0 0 0	30. 00 03000 ADULTS & PEDIATRICS	0	0)	0	0	30.00
Total (lines 30 through 199)	40. 00 04000 SUBPROVI DER - 1 PF	o	0)	0	0	40.00
Cost Center Description	43. 00 04300 NURSERY	l ol	0)	o	0	43.00
Adjustment Amount (see 1 through 3, instructions) minus col 4)	200.00 Total (lines 30 through 199)	l ol	0)	o	0	200.00
Amount (see instructions) 1 through 3, minus col. 4)	Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem	Inpatient	
INPATIENT ROUTINE SERVICE COST CENTERS		Adjustment	(sum of cols.	Days	(col. 5 ÷	Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS		Amount (see	1 through 3,		col . 6)		
INPATI ENT ROUTI NE SERVI CE COST CENTERS		instructions)	minus col. 4)		·		
30. 00		4. 00	5. 00	6.00	7. 00	8. 00	
40. 00	INPATIENT ROUTINE SERVICE COST CENTERS						
43. 00	30. 00 03000 ADULTS & PEDIATRICS	0	0	1, 63	0.00	9	30.00
Total (lines 30 through 199) 0 1,730 11 200.00	40. 00 04000 SUBPROVI DER - 1 PF	o	0	48	0.00	0	40.00
Inpatient	43. 00 04300 NURSERY		0	48	0.00	2	43.00
Program Pass-Through Cost (col. 7 x col. 8) 9.00	200.00 Total (lines 30 through 199)		0	1, 730		11	200.00
Pass-Through Cost (col . 7 x col . 8) 9.00	Cost Center Description	Inpatient					
Cost (col. 7 x col. 8) 9.00		Program					
X COİ . 8) 9.00		Pass-Through					
9.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 40.00 43.00 04300 NURSERY 0 43.00		Cost (col. 7					
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 3000 ADULTS & PEDI ATRI CS 0 40.00 4000 SUBPROVI DER - I PF 0 40.00 43.00 04300 NURSERY 0 43.00		x col. 8)					
30. 00		9. 00					
40. 00							
43. 00 04300 NURSERY 0 43. 00		0					
		0					
200.00 Total (lines 30 through 199) 0 200.00		0					
	200.00 Total (lines 30 through 199)	0					200.00

 Heal th Financial
 Systems
 IU HEALTH JAY HOSPITAL

 APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS
 Provider CCN: 15-1320
 THROUGH COSTS

				0 12/31/2020	7/15/2021 1:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	0		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 00 03160 CARDI OPULMONARY	0	0	(0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	T .	1	T		T	
90. 00 09000 CLI NI C	0	0	(0	•	
90.01 09001 FAMILY PRACTICE OF JAY COUNTY	0	0		0	0	90. 01
90. 02 09002 JAY FAMILY MEDICINE	0	0		0	0	90. 02
90. 03 09003 WOUND CLI NI C	0	0		0	0	90. 03
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
90. 07 09007 HEALTH BEGINNINGS PROGRAM	0	0		0	0	90. 07
91. 00 09100 EMERGENCY	0	0		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92.00
93. 00 04950 OUTPATIENT PSYCH	0	0	(0	0	
200.00 Total (lines 50 through 199)	0	0	(0	0	200. 00

Health Financial Systems	IU HEALTH JAY H	IOSPI TAL	In Lie	eu of Form CMS-2552-10
ADDODTIONMENT OF INDATIENT/OUTDATIENT	ANCLLLADY SERVICE OTHER DASS	Provider CCN: 15-1320	Pari od:	Workshoot D

Period: Worksheet D From 01/01/2020 Part IV To 12/31/2020 Date/ime Prepared: THROUGH COSTS 7/15/2021 1:03 pm Title XIX Hospi tal PPS Cost Center Description All Other Total Cost Total Total Charges Ratio of Cost to Charges Medi cal (sum of cols. Outpati ent (from Wkst. 1, 2, 3, and 4) (col. 5 ÷ col. 7) Educati on Cost (sum of C, Part I, col s. 2, 3, col. 8) Cost and 4) (see instructions) 6.00 4. 00 5.00 7. 00 8. 00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 7, 458, 543 0.000000 50.00 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 409, 615 0.000000 52.00 0 53. 00 05300 ANESTHESI OLOGY 0 0.000000 53.00 9, 185, 078 0.000000 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 6, 327, 341 1, 033, 757 0 60. 00 | 06000 | LABORATORY 0 0.000000 60.00 0 65. 00 06500 RESPIRATORY THERAPY 0 0.000000 65.00 0 66. 00 06600 PHYSI CAL THERAPY 0.000000 66.00 1, 133, 177 00 00 00

67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	300, 700	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	31, 750	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	934, 484	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	423, 231	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	221, 726	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	9, 444, 428	0.000000	73.00
76.00	03160 CARDI OPULMONARY	0	0	0	1, 648, 097	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, 108, 454	0.000000	90. 01
90. 02	09002 JAY FAMILY MEDICINE	0	0	0	908, 443	0.000000	90. 02
90. 03	09003 WOUND CLINIC	0	0	0	0	0.000000	90. 03
90.04	09004 OP ORTHO CLINIC	0	0	0	0	0.000000	90. 04
90.05	09005 JAY FAMILY FIRST HEALTH CARE	0	0	0	107, 798	0.000000	90. 05
90.06	09006 INFUSION CLINIC	0	0	0	2, 031, 982	0.000000	90.06
90. 07	09007 HEALTH BEGINNINGS PROGRAM	0	0	0	24, 186	0.000000	90. 07
91.00	09100 EMERGENCY	0	0	0	16, 165, 070	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2, 482, 807	0.000000	92.00
93.00	04950 OUTPATIENT PSYCH	0	0	0	161, 917	0.000000	93.00
200.00	Total (lines 50 through 199)	0	0	0	61, 542, 584		200. 00

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

Part IV From 01/01/2020 THROUGH COSTS 12/31/2020 Date/Time Prepared: 7/15/2021 1:03 pm Title XIX Hospi tal PPS Cost Center Description I npati ent Outpati ent Outpati ent I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col . 12) x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 0.000000 50 00 05000 OPERATING ROOM 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 25, 287 0 0 52.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 05400 RADI OLOGY-DI AGNOSTI C 0 0.000000 54.00 494 0 54.00 06000 LABORATORY 0.000000 60.00 5, 654 0 60.00 65.00 06500 RESPIRATORY THERAPY 0.000000 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 302 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0.000000 0 67.00 C 68.00 06800 SPEECH PATHOLOGY 0.000000 C 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 222 0 0 69.00 1, 197 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 2, 984 0 73.00 03160 CARDI OPULMONARY 0 0 0 76.00 76.00 0.000000 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 90.01 09001 FAMILY PRACTICE OF JAY COUNTY 0.000000 0 0 90.01 0 0 0 0 0 0 0 0 0 0 90.02 09002 JAY FAMILY MEDICINE 0.000000 0 90.02 0 0 09003 WOUND CLINIC 90.03 90.03 0.000000 0 0 90.04 09004 OP ORTHO CLINIC 0.000000 0 0 90.04 09005 JAY FAMILY FIRST HEALTH CARE 0.000000 0 90.05 90.05 0 0 90 06 09006 INFUSION CLINIC 0.000000 0 Ω 90.06 09007 HEALTH BEGINNINGS PROGRAM 0.000000 0 90.07 90.07 C 0 91. 00 09100 EMERGENCY 0.000000 7,016 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 0.000000 0 0

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Total (lines 50 through 199)

200.00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 01/01/2020	
		10 12/31/2020	Date/Time Prepared: 7/15/2021 1:03 pm
	Title XVIII	Hospi tal	Cost

DATE OF CONTRIBUTION 1.00 1.			T' II - MIII	Here the Land	7/15/2021 1:0	3 pm
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2.00 2.00						
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	Financial Systems	IU HEALTH JAY				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	CCN: 15-1320	Peri od: From 01/01/2020		
				2011	To 12/31/2020	7/15/2021 1:0	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5.00	42.00
43. 00 44. 00 45. 00 46. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						43. 00 44. 00 45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
	<u> </u>					1. 00	
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		913, 063 2, 336, 532	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpulli	atient routine s	services (fro	om Wkst. D, su	m of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillary	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines total Program inpatient operating cost exclumedical education costs (line 49 minus line to the cost of the	ding capital rel	ated, non-ph	nysician anest	hetist, and	0	
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Target amount (line 54 x line 55)					0.00	55.00
57. 00 58. 00 59. 00	57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 58.00 Bonus payment (see instructions)					0.00	58.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see	s 55, 59 or 60 e n expected costs	enter the les	ser of 50% of	the amount by	0.00	1
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	·	ctions)			0	1
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	mber 31 of th	ne cost report	ing period (See	1, 161, 592	64.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decembe	er 31 of the	cost reportin	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 6	64 plus line	65)(title XVI	II only). For	1, 161, 592	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)			•	orting period		68.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY,	AND ICF/IID	ONLY		0	
70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of Program routine service cost (line 9 x line) Medically necessary private room cost application of Program general inpatient routine service capital related cost allocated to inpatient	ost per diem (li 71) able to Program ice costs (line	ne 70 ÷ line (line 14 x l 72 + line 73	e 2) ine 35) 3)			70.00 71.00 72.00 73.00 74.00 75.00
76. 00 77. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	76)					76. 00 77. 00
78. 00 79. 00 80. 00 81. 00 82. 00 83. 00 84. 00 85. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess Total Program routine service costs for comp. Inpatient routine service cost per diem limi. Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (Seprogram inpatient ancillary services (see insultization review - physician compensation.)	s costs (from prarison to the contact that is seen instructions)	ost limitatio) s)	,	nus line 79)		78.00 79.00 80.00 81.00 82.00 83.00 84.00 85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 thr					86.00
87. 00 88. 00 89. 00	Total observation bed days (see instructions) diem (line 27 ÷	line 2)			467 2, 592. 84 1, 210, 856	1

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	601, 006	5, 454, 706	0. 11018	1 1, 210, 856	133, 413	90.00
91.00 Nursing School cost	0	5, 454, 706	0.00000	0 1, 210, 856	0	91.00
92.00 Allied health cost	0	5, 454, 706	0.00000	0 1, 210, 856	0	92.00
93.00 All other Medical Education	o	5, 454, 706	0.00000	0 1, 210, 856	0	93.00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-M320		
	Title XVIII	Subprovi der -	PPS
		IPF	

		I PF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		48	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		48	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only	private room days,	0	3.00
	do not complete this line.			
4. 00	Semi-private room days (excluding swing-bed and observation bed days)		48	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through Decem	ber 31 of the cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after Decembe	r 21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	i si di the cost	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through Decemb	er 31 of the cost	0	7.00
	reporting period			
8.00	Total swing-bed NF type inpatient days (including private room days) after December	31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)			
9. 00	Total inpatient days including private room days applicable to the Program (excluding private room days)	ng swing-bed and	44	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	1 Oolii days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	,		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including priva	ate room days)	0	12.00
	through December 31 of the cost reporting period		_	
13. 00			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this I Medically necessary private room days applicable to the Program (excluding swing-be-		0	14.00
15. 00		u uays)	0	15.00
	Nursery days (title V or XIX only)		0	
10.00	SWING BED ADJUSTMENT			
17.00		of the cost		17. 00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 o	f the cost		18. 00
10.00	reporting period	of the cost	216. 95	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 reporting period	or the cost	210. 93	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of	the cost	0. 00	20.00
	reporting period			
21.00	Total general inpatient routine service cost (see instructions)		484, 292	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost repo	rting period (line	0	22. 00
22.00	5 x line 17)		0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost report x line 18)	ing period (line o	0	23. 00
24. 00		ting period (line	0	24.00
21.00	7 x line 19)	tring porroa (irino	ŭ	2 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporti	ng period (line 8	0	25. 00
	x line 20)			
26. 00	,		0	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26))	484, 292	27. 00
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed	charace)	0	28. 00
	Private room charges (excluding swing-bed charges)	charges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)		0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instru	uctions)	0. 00	1
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)	differential (!:-	494 202	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost 27 minus line 36)	urrierentiai (IINe	484, 292	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)		10, 089. 42	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)		443, 934	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)		443, 934	41.00

	Financial Systems	IU HEALTH JAY			In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-1320	Peri od: From 01/01/2020	Worksheet D-1	
			· ·	CCN: 15-M320	To 12/31/2020	7/15/2021 1:0	
			li tl e	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+i +i - V 0 VIV and)	1. 00	2. 00	3. 00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
49.00	Drogram i posti ent ancillary carvi co cost (Wk	c+ D 2 col 2	lino 200)			1. 00 10, 034	49.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		453, 968	
50.00	Pass through costs applicable to Program inp	atient routine	servi ces (fro	m Wkst. D, sı	um of Parts I and	0	50.00
51. 00	<pre> </pre>	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	392	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				392	52.00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-ph	ysician anest	thetist, and	453, 576	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION					0	F4 00
55. 00	Program di scharges Target amount per di scharge						54. 00 55. 00
56.00				it Ez ete		0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (Time so minus	s iiile 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996,	updated and o	compounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0. 00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
(0.00	amount (line 56), otherwise enter zero (see					0	
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ting period (See	0	64.00
65. 00	instructions)(title XVIII only)					0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing				-		67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	_					68. 00
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient				er mild bernen		69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY		<u> </u>	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of				7)		70.00 71.00
72. 00	Program routine service cost (line 9 x line	71)		•			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient 26, line 45)			•	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p					79. 00
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		ost IImitatio	n (line 78 mi	nus line 79)		80. 00 81. 00
82.00	Inpatient routine service cost limitation (ine 9 x line 81	* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		s)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions))				0	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)				88. 00 89. 00
37.00	(30)				ı	· ·	, 57. 00

Health Financial Systems	IU HEALTH JA	AY HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
		Component		From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
		Title	XVIII	Subprovi der -	PPS	<u> </u>
				. I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	C	484, 292	0. 00000	0 0	0	90.00
91.00 Nursing School cost	C	484, 292	0. 00000	0 0	0	91.00
92.00 Allied health cost	C	484, 292	0. 00000	0 0	0	92.00
93.00 All other Medical Education	c	484, 292	0. 00000	0	0	93. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	From 01/01/2020	Worksheet D-1 Date/Time Prepared: 7/15/2021 1:03 pm
	Title XIX	Hospi tal	PPS

		Title XIX	Hospi tal	7/15/2021 1: 0 PPS	3 pm
	Cost Center Description	II LIE XIX	поѕрі таі	PP3	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	excluding newhorn)		2, 342	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			1, 634	
3.00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3.00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	1, 167 448	4. 00 5. 00
5.00	reporting period	on days) through becember	er 31 or the cost	440	5.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	260	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	R1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	augs) area becomber a	or the cost	· ·	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	9	9. 00
40.00	newborn days) (see instructions)				10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e	enter O on this line)			
12.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te 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 XI	V only (including privat	to room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar y			U	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15. 00	Total nursery days (title V or XIX only)			48	
16. 00	Nursery days (title V or XIX only)			2	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
17.00	reporting period	les thi ough beceiliber 31 to	i the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
40.00	reporting period			04/ 05	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	216. 95	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instruction			5, 454, 706	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1 = 17$	er 31 of the cost report	ting period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)]	_	
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	56, 407	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	noried (line 9	0	25. 00
23.00	x line 20)	31 of the cost reporting	j periou (iiile o	U	23.00
26.00	Total swing-bed cost (see instructions)			1, 217, 999	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 236, 707	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and absorbert on had al	norman)	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	iai ges)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nuc line 22) (see instru	stions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li		Lti olis)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	LICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			2, 592. 84	38. 00
39. 00	Program general inpatient routine service cost per diem (see			23, 336	
40.00	Medically necessary private room cost applicable to the Progr	am (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		23, 336	41.00

	Financial Systems	IU HEALTH JAY				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2020	Worksheet D-1	
					To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
			_	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 4)	
40.00	NUDGEDY (1) II - V o VIV - I - V	1.00	2. 00	3.00	4. 00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	86, 280	48	1, 797. 5	0 2	3, 595	42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
45. 00 46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			8, 131	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		35, 062	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst D sur	n of Parts I and	3, 053	50.00
			•				
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	582	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				3, 635	52.00
53. 00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anesth	netist, and	31, 427	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
	Program di scharges					0	54.00
	Target amount per discharge					1	55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)	· ·			,	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00
60.00		cost report, up	dated by the	market basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	•				0	1
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	<u>ent (see instru</u>	ctions)			0	63.00
64. 00		ts through Dece	mber 31 of th	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to after Decemb	or 21 of the	cost roporting	a pariod (Saa	0	65.00
03.00	instructions)(title XVIII only)	ts arter beceilib	el 31 01 the	cost reporting	g perrou (see		05.00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
67. 00	,	e costs through	December 31	of the cost re	eporting period	0	67.00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NI Skilled nursing facility/other nursing facil)		70.00
71. 00	Adjusted general inpatient routine service c	,		, ,			71.00
72.00	Program routine service cost (line 9 x line	,	(line 14 v l	ino 2E)			72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi dor rocor	de)			78. 00 79. 00
80. 00	Total Program routine service costs for comp	, ,		,	nus line 79)		80.00
81.00	Inpatient routine service cost per diem limi		`		-		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00	Program inpatient ancillary services (see in		/				84.00
85.00	Utilization review - physician compensation	•					85.00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		i ougii 85)			<u> </u>	86.00
87. 00	Total observation bed days (see instructions)				467	87.00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	,			2, 592. 84 1, 210, 856	1
57.00	(3e)					1,210,000	, 57.50

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	601, 006	5, 454, 706	0. 11018	1 1, 210, 856	133, 413	90.00
91.00 Nursing School cost	0	5, 454, 706	0.00000	0 1, 210, 856	0	91.00
92.00 Allied health cost	0	5, 454, 706	0.00000	0 1, 210, 856	0	92.00
93.00 All other Medical Education	0	5, 454, 706	0. 00000	0 1, 210, 856	0	93. 00

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1320	Peri od: From 01/01/2020	Worksheet D-1
	Component CCN: 15-M320		
	Title XIX	Subprovi der -	Cost
		IPF	

			I PF		
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			48 48	1. 00 2. 00
2. 00 3. 00	Private room days (excluding swing-bed and observation bed da		ivate room days	48	3.00
0.00	do not complete this line.	усу уса наче с.н.у р.	. varo . com dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation b			48	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roreporting period	om days) through Decembe	r 31 of the cost	0	5.00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 ,			
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Teporting period Total_swing-bed_NF_type_inpatient_days (including private roo	m davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	0	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, e		o room dove)	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including private	e room days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progr Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0 48	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			2	16.00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost		17.00
18 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
10.00	reporting period	as arter becomber or or	the cost		10.00
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0. 00	19. 00
20.00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 21 of t	ho cost	0.00	20.00
20.00	reporting period	s arter becember 31 or th	ne cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instruction			484, 292	1
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22.00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	n period (line A	0	23. 00
20.00	x line 18)	or or the dost reporting	g perrou (rriie d	Ü	20.00
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	21 of the cost reporting	poriod (line 9	0	25. 00
25.00	x line 20)	of the cost reporting	perrou (Trile 8	O	25.00
	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		484, 292	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation hed ch	arges)	0	28. 00
	Private room charges (excluding swing-bed charges)	a and observation bed on	ai ges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	32. 00 33. 00
34. 00	Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x li			0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room asst di	fforontial (1)	494 202	36.00
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrentral (IINe	484, 292	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38.00	Adjusted general inpatient routine service cost per diem (see	,		10, 089. 42	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			0	•

Heal th	Financial Systems	IU HEALTH JAY	/ HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2020		
			· ·	CCN: 15-M320	To 12/31/2020	7/15/2021 1:0	
			Ti tl	e XIX	Subprovi der - I PF	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00	NUDGEDY (1) 11 - V o VIV - 1	1. 00	2.00	3. 00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. (00 0	0	42.00
43.00	INTENSIVE CARE UNIT						43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
40.00	Program inpatient ancillary service cost (Wk	a+ D 2 aal 2	Line 200)			1.00	40,00
48. 00 49. 00	Total Program inpatient costs (sum of lines			ons)		0	
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	atient routine	servi ces (fro	m Wkst. D, su	ım of Parts I and	0	50. 00
51. 00		atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	0	51.00
	and IV)		<i>y</i> (1.				
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		elated, non-ph	ysician anest	hetist, and	0	
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00						0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	1
58.00	' ' '		1004			0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	ending 1996, 1	updated and c	compounaea by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines					0.00	1
01.00	which operating costs (line 53) are less than	n expected cost				٥	01.00
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payments	ent (see instru	ıcti ons)			0	1
64. 00		ts through Dece	ember 31 of the	e cost report	ing period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	er 31 of the o	cost reportin	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66. 00
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	·	•	, ,	3,	0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	-				0	
	(line 13 x line 20)				of tring perrou		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil	•		•	")		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		THE 70 - TIME	2)			71. 00 72. 00
73.00	Medically necessary private room cost application		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	76)					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for excess		rovi der recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for compa	arison to the c		•	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instruction	* .				83.00
84.00	Program inpatient ancillary services (see in		une)				84. 00 85. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum					<u> </u>	85.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					
87. 00 88. 00		diem (line 27 ÷				l	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems	IU HEALTH JA	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2020 To 12/31/2020		
		Ti tl	e XIX	Subprovi der - I PF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	20, 106	484, 292	0. 04151	6 0	0	90.00
91.00 Nursing School cost	0	484, 292	0.00000	0 0	0	91.00
92.00 Allied health cost	0	484, 292	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	484, 292	0.00000	0 0	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1320	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Pre 7/15/2021 1:0	epare
	Ti tl e	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					-
. 00			1, 171, 634 0		30. 40. 43.
ANCILLARY SERVICE COST CENTERS				00.005	١
. 00 05000 OPERATING ROOM		0. 4324	·	90, 285	1
. 00 05200 DELIVERY ROOM & LABOR ROOM . 00 05300 ANESTHESI OLOGY		0. 06420 0. 00000		0	
. 00 05300 ANESTHEST OLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2860		36, 783	1
. 00 06000 LABORATORY		0. 4851		126, 443	
. 00 06500 RESPI RATORY THERAPY		0. 81580		203, 871	
. 00 06600 PHYSI CAL THERAPY		1. 0846		62, 282	
. 00 06700 OCCUPATI ONAL THERAPY		0. 6957!		18, 805	
. 00 06800 SPEECH PATHOLOGY		0. 9977	95 8, 356	8, 338	68.
. 00 06900 ELECTROCARDI OLOGY		0. 00389	97 15, 556	61	69.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4665		20, 112	71.
.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2033		0	
.00 07300 DRUGS CHARGED TO PATIENTS		0. 37430		302, 741	
. 00 O3160 CARDI OPULMONARY		0. 29410	04 111, 694	32, 850	76
OUTPATIENT SERVICE COST CENTERS		0.0000	20	0	1
.00 09000 CLINIC .01 09001 FAMILY PRACTICE OF JAY COUNTY		0. 00000 2. 0224		0	
. 02 09000 FAMILY PRACTICE OF JAY COUNTY		2. 5820		0	
. 03 09002 SAT FAMILET MEDICINE		0. 00000		0	
04 09004 OP ORTHO CLINIC		0.0000		0	
05 09005 JAY FAMILY FIRST HEALTH CARE		9. 73959		0	
06 09006 INFUSION CLINIC		0. 1632		0	1
07 09007 HEALTH BEGINNINGS PROGRAM		25. 9438!		0	
. 00 09100 EMERGENCY		0. 2308		5, 993	
. OO O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4876		4, 499	
. 00 04950 OUTPATIENT PSYCH		1. 3686	·	0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)			1, 955, 067	913, 063	
1.00 Less PBP Clinic Laboratory Services-Program only char	ges (line 61)		0		201
2.00 Net charges (line 200 minus line 201)	- ,		1, 955, 067		202

INDATIE	Financial Systems IU HEALTH JAY H NT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1320	Peri od:	u of Form CMS-2 Worksheet D-3	
INFAILE	INI ANGLELAKI JEKVICE COJI AFFOKITUNMENI	i i ovi dei C	ON. 13-132U	From 01/01/2020		
		Component	CCN: 15-M320	To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
		Titl∈	e XVIII	Subprovi der -	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
	·		To Charges	Program Charges	Program Costs (col. 1 x	
			1.00		col . 2)	
li li	NPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	03000 ADULTS & PEDIATRICS			0		30.00
	04000 SUBPROVI DER – I PF			55, 388		40.00
43.00	04300 NURSERY			·		43.00
	NCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 4324			
	DELIVERY ROOM & LABOR ROOM		0. 0642			
	D5300 ANESTHESI OLOGY		0.0000		0	1
	05400 RADI OLOGY-DI AGNOSTI C		0. 2860			
	06000 LABORATORY 06500 RESPI RATORY THERAPY		0. 4851	·		
	06600 PHYSI CAL THERAPY		0. 8158 1. 0846		0	
4	06700 OCCUPATI ONAL THERAPY		0. 6957		0	1
	06800 SPEECH PATHOLOGY		0. 9977			1
	06900 ELECTROCARDI OLOGY		0.0038		3	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4665		Ö	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2033		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 3743		4, 546	73.0
76.00	03160 CARDI OPULMONARY		0. 2941	04 0	0	76.0
	DUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0.0000		-	1
	99001 FAMILY PRACTICE OF JAY COUNTY		2. 0224		_	
	09002 JAY FAMILY MEDICINE		2. 5820		0	1
	09003 WOUND CLINIC		0.0000		0	
	09004 OP ORTHO CLINIC 09005 JAY FAMILY FIRST HEALTH CARE		0. 0000 9. 7395		0	
	19005 JAY FAMILY FIRST HEALTH CARE		0. 1632		0	
	09007 HEALTH BEGINNINGS PROGRAM		25. 9438		0	1
	09100 EMERGENCY		0. 2308		1, 319	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4876		0	1
	04950 OUTPATIENT PSYCH		1. 3686		ő	
200.00	Total (sum of lines 50 through 94 and 96 through 98)			27, 979	_	
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	,,,,,,	201. 0
202.00	Net charges (line 200 minus line 201)	•	1	27, 979		202. 0

PATIENT A			CN: 15-1320 CCN: 15-Z320	Peri od: From 01/01/2020 To 12/31/2020	Worksheet D-3 Date/Time Pre 7/15/2021 1:0	epared
		Ti tl e	XVIII	Swing Beds - SNF		is pili
	Cost Center Description	11 (1)	Ratio of Cos To Charges		Inpati ent Program Costs (col. 1 x col. 2) 3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS					
03000 04000 04300	O ADULTS & PEDIATRICS O SUBPROVIDER - IPF O NURSERY			0		30. (40. (43. (
	LLARY SERVICE COST CENTERS					4
	O OPERATING ROOM		0. 4324		2, 130	1
	O DELIVERY ROOM & LABOR ROOM O ANESTHESIOLOGY		0. 06420 0. 00000		0	
	O RADI OLOGY-DI AGNOSTI C		0. 00000		6, 620	
	O LABORATORY		0. 4851		28, 664	
	O RESPIRATORY THERAPY		0. 81580		97, 821	
	O PHYSI CAL THERAPY		1. 0846		149, 749	
	O OCCUPATI ONAL THERAPY		0. 6957!			
	O SPEECH PATHOLOGY		0. 9977		8, 251	
	O ELECTROCARDI OLOGY		0. 00389		15	69
. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 4665	37 73	34	71
00 0720	O IMPL. DEV. CHARGED TO PATIENTS		0. 2033	32 0	0	72
00 0730	O DRUGS CHARGED TO PATIENTS		0. 37430	05 217, 965	81, 585	73
	O CARDI OPULMONARY		0. 29410	3, 287	967	76
	ATIENT SERVICE COST CENTERS		1 0 0000	20		٠.
	O CLINIC		0.00000		0	
	1 FAMILY PRACTICE OF JAY COUNTY 2 JAY FAMILY MEDICINE		2. 0224 2. 5820		0	1
	3 WOUND CLINIC		0. 00000		0	1
	4 OP ORTHO CLINIC		0.0000		0	
	5 JAY FAMILY FIRST HEALTH CARE		9. 7395		0	
	6 I NFUSION CLINIC		0. 1632		0	
	7 HEALTH BEGINNINGS PROGRAM		25. 9438!		0	
	O EMERGENCY		0. 2308		0	
	O OBSERVATION BEDS (NON-DISTINCT PART		0. 4876		Ö	
	O OUTPATIENT PSYCH		1. 3686		Ö	
0. 00	Total (sum of lines 50 through 94 and 96 through 98)			673, 016	441, 515	200
1. 00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201
2.00	Net charges (line 200 minus line 201)	ŕ		673, 016		202

Health Financial Systems IU I	HEALTH JAY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Period: From 01/01/2020 To 12/31/2020	Worksheet D-3	pared:
	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			18, 300		30.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
43. 00 04300 NURSERY			2, 868		43.00
ANCILLARY SERVICE COST CENTERS			-		
50. 00 05000 OPERATING ROOM		0. 43241		0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.06420		1, 623	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 28606		141	54.00
65. 00 06500 RESPI RATORY THERAPY		0. 48514 0. 81580		2, 743 0	60. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		1. 08461		328	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 69575		320	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 99779		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 00389		1	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 46653		558	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20333		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 37430		1, 117	73.00
76. 00 03160 CARDI OPULMONARY		0. 29410		0	76.00
OUTPATIENT SERVICE COST CENTERS		0.27	<u> </u>		70.00
90. 00 09000 CLINIC		0. 00000	00 0	0	90.00
90. 01 09001 FAMILY PRACTICE OF JAY COUNTY		2. 02244		0	90. 01
90. 02 09002 JAY FAMILY MEDICINE		2. 58207	7 0	0	90. 02
90. 03 09003 WOUND CLINIC		0. 00000	00	0	90. 03
90. 04 09004 OP ORTHO CLINIC		0. 00000	00	0	90.04
90.05 09005 JAY FAMILY FIRST HEALTH CARE		9. 73959	0	0	90. 05
90.06 09006 INFUSION CLINIC		0. 16324	0 0	0	90.06
90. 07 09007 HEALTH BEGINNINGS PROGRAM		25. 94385	52 0	0	90. 07
91 00 09100 EMERCENCY		0 22000	7 016	1 620	01 00

0 92.00 0 93.00 8, 131 200.00

1, 620

91.00

201.00

0. 230880

0. 487696

1. 368646

43, 156

91. 00 09100 EMERGENCY

201.00

202.00

92.00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART 93.00 | 04950 | 0UTPATIENT PSYCH | 200.00 | Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	From 01/01/2020	Worksheet E Part B Date/Time Prepared: 7/15/2021 1:03 pm

	T' II - MILL	7/15/2021 1:0	3 pm
	Title XVIII Hospital	Cost	
		1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	6, 755, 802	1.0
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.0
3. 00 4. 00	OPPS payments Outlier payment (see instructions)	0	
4. 00	Outlier reconciliation amount (see instructions)	0	4.0
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6.00	Line 2 times line 5	0	6.0
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.0
8.00	Transitional corridor payment (see instructions)	0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	
10.00	Organ acqui si ti ons	0	10.0
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	6, 755, 802	111.0
	Reasonable charges		1
12.00	Anci II ary servi ce charges	0	12.0
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.0
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.0
	Customary charges		
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.0
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	l 17. 0
	Total customary charges (see instructions)	0.00000	18.0
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	1
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.0
	instructions)		
	Lesser of cost or charges (see instructions)	6, 823, 360	
	Interns and residents (see instructions)	0	
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		24.0
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)	120, 178	25.0
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	2, 373, 977	1
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	4, 329, 205	
	instructions)		
	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 0
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	
	Subtotal (sum of lines 27 through 29)	4, 329, 205	1
	Primary payer payments Subtotal (line 30 minus line 31)	1, 520 4, 327, 685	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	4, 327, 003	32.0
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.0
	Allowable bad debts (see instructions)	322, 544	
35.00	Adjusted reimbursable bad debts (see instructions)	209, 654	35.0
	Allowable bad debts for dual eligible beneficiaries (see instructions)	301, 765	36.0
	Subtotal (see instructions)	4, 537, 339	1
	MSP-LCC reconciliation amount from PS&R	0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Diagnost ACO demonstration payment adjustment (see instructions)	0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration	0	39. 5 39. 9
39. 9 <i>1</i> 39. 98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	1
	RECOVERY OF ACCELERATED DEPRECIATION	0	39.9
	Subtotal (see instructions)	4, 537, 339	
	Sequestration adjustment (see instructions)	29, 946	
	Demonstration payment adjustment amount after sequestration	0	1
40. 03	Sequestration adjustment-PARHM pass-throughs		40.0
	Interim payments	2, 595, 393	41.0
	Interim payments-PARHM		41.0
	Tentative settlement (for contractors use only)	0	42.0
42. 01	Tentative settlement-PARHM (for contractor use only)	1 010 000	42.0
43. 00 43. 01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)	1, 912, 000	43. 0 43. 0
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	500, 226	1
74. UU	§115. 2	300, 220	0
	TO BE COMPLETED BY CONTRACTOR		1
90.00	Original outlier amount (see instructions)	0	90. C
	Outlier reconciliation adjustment amount (see instructions)	0	1
91.00	The section of the section of the Theory and the Company	0.00	92.0
	The rate used to calculate the Time Value of Money	0.00	
92. 00 93. 00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0.00	93.0

Health Financial Systems IU

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-1320

			1	0 12/31/2020	7/15/2021 1:0	
		Title	: XVIII	Hospi tal	Cost	•
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2, 00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 300, 830		2, 595, 393	1. 00
2. 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,		0		0	2. 00
3. 00	write "NONE" or enter a zero 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					3. 00
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			
3. 01 3. 02 3. 03 3. 04 3. 05	ADJUSTMENTS TO PROVIDER		0 0 0 0		0 0 0 0	3. 01 3. 02 3. 03 3. 04 3. 05
	Provider to Program					
3. 50 3. 51	ADJUSTMENTS TO PROGRAM		0		0	3. 50 3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		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) TO BE COMPLETED BY CONTRACTOR		1, 300, 830		2, 595, 393	4.00
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
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		865, 315		1, 912, 000	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		2, 166, 145		4, 507, 393	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8.00

Health Financial Systems	IU HEALTH JAY I	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR S	SERVI CES RENDERED	Provider CCN: 15-1320	Period: From 01/01/2020	Worksheet E-1 Part I
		Component CCN: 15-M32	0 To 12/31/2020	Date/Time Prepared: 7/15/2021 1:03 pm
		T' 11 . \0.00 11	C 1 1 1	DDC

		Title	xVIII	Subprovi der -	7/15/2021 1: 0 PPS	з рт
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		33, 054		0	
2. 00	Interim payments payable on individual bills, either		C)	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					-
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER				0	3.01
3. 02	ADJUSTIMENTS TO TROVIDER					
3. 03					Ö	
3.04			(0	
3. 05			C)	0	3.05
	Provi der to Program					
3.50	ADJUSTMENTS TO PROGRAM		C		0	
3. 51 3. 52					0	
3. 52						
3. 54					ĺ	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines	•	ď		0	
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		33, 054	ļ.	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)				<u> </u>	
	Program to Provider		1			
5. 01 5. 02	TENTATI VE TO PROVI DER				0	
5. 02						
0.00	Provider to Program			′ 1		0.00
5. 50	TENTATI VE TO PROGRAM		C)	0	5.50
5. 51			C		0	
5. 52			(0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C)	0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6.00
0.00	the cost report. (1)] 0.00
6. 01	SETTLEMENT TO PROVIDER		3, 606		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		C		0	
7. 00	Total Medicare program liability (see instructions)		36, 660		0	7. 00
				Contractor	NPR Date	
		,	<u> </u>	Number 1.00	(Mo/Day/Yr) 2.00	
				1.00	2.00	1

Health Financial Systems IU

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 15-1320 | Peri od: From 01/01/2020 | Part | From 01/01/2020 | Date/Time Prepared: 7/15/2021 1:03 pm

					7/15/2021 1:0)3 pm
				ving Beds - SNF		
		Inpati en	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00	Total interim payments paid to provider		1, 027, 616		C	1.00
2.00	Interim payments payable on individual bills, either		0			2.00
	submitted or to be submitted to the contractor for		_			
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	<u>'</u>	•		•	
3. 01	ADJUSTMENTS TO PROVIDER		0		C	3. 01
3. 02			0		l c	3.02
3. 03			0		l c	3.03
3. 04			0			3.04
3. 05			0		1	
0.00	Provider to Program					1 0.00
3. 50	ADJUSTMENTS TO PROGRAM		0		C	3.50
3. 51	The section of the se		0			
3. 52			0		ĺ	
3. 53			0			
3. 54			0			
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			
3. 77	3. 50-3. 98)] 3. //
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 027, 616			4.00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		1,027,010			1.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	l.				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider		•			
5. 01	TENTATI VE TO PROVI DER		0		C	5. 01
5. 02			0			
5. 03			0			
	Provider to Program			l		
5.50	TENTATI VE TO PROGRAM		0		C	5.50
5. 51			0			
5. 52			0		l d	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		l d	
0. , ,	5. 50-5. 98)		ľ			0. , ,
6. 00	Determined net settlement amount (balance due) based on					6.00
00	the cost report. (1)					5.00
6. 01	SETTLEMENT TO PROVIDER		577, 863		l c	6.01
6. 02	SETTLEMENT TO PROGRAM		0,7,000			
7. 00	Total Medicare program liability (see instructions)		1, 605, 479			
	The second of th		., 555, 177	Contractor	NPR Date	100
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		I .		ı	I .	

Heal th	Health Financial Systems IU HEALTH JAY HOSPITAL In Lieu				2552-10
CALCUL				Worksheet E-	1
To 12/31/2020 Date/Tin 7/15/202					
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				1.00
	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					2. 00 3. 00
	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		İ	4. 00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			ı	5. 00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3			ı	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of	certified HIT technology	Wkst. S-2, Pt. I	ı	7. 00
	line 168			ı	
	Calculation of the HIT incentive payment (see instructions)			ı	8. 00
9. 00	Sequestration adjustment amount (see instructions)			ı	9. 00
	Calculation of the HIT incentive payment after sequestration	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)			ı	30.00
	Other Adjustment (specify)			ı	31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

Health Financial Systems	IU HEALTH JAY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	- SWING BEDS	Provider CCN: 15-1320	Peri od: From 01/01/2020	Worksheet E-2
		Component CCN: 15-7320	To 12/31/2020	Date/Time Prepared

		Component CCN: 15-Z320	To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
		Title XVIII	Swing Beds - SNF		<u> </u>
			Part A	Part B	
	PONUTATION OF MET COOT OF COMPRED OFFINIONS		1.00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)		1, 173, 208	0	1.00
1. 00 2. 00	Inpatient routine services - swing bed-NF (see instructions)		1, 173, 206	U	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	445, 930	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi		110,700	ŭ	0.00
	instructions)				
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4. 00
5. 00	instructions) Program days		448	0	5.00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)	440	0	6.00
7. 00	Utilization review - physician compensation - SNF optional me		o	Ü	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	,	1, 619, 138	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		1, 619, 138	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	11.00
12. 00	professional services) Subtotal (line 10 minus line 11)		1, 619, 138	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	2, 992	0	13.00
10.00	for physician professional services)) (exertade corrisar ance	2, ,,2	Ü	10.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (see instructions)		1, 616, 146	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction				16.50
16. 55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16. 55
16. 99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		O	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)	0	0	18. 00
19.00	Total (see instructions)		1, 616, 146	0	19. 00
19. 01	Sequestration adjustment (see instructions)		10, 667	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19.02
19. 03 20. 00	Sequestration adjustment-PARHM pass-throughs Interim payments		1, 027, 616	0	19. 03 20. 00
	Interim payments Interim payments-PARHM		1,027,010	U	20.00
21. 00	Tentative settlement (for contractor use only)		o	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	577, 863	0	22. 00
22. 01	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	119, 532	0	23. 00
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstr	ration) Adjustment			
200 00	Is this the first year of the current 5-year demonstration pe				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	. Fou andor the 21st			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
202.00	66 (title XVIII hospital))	Wi+ D 21 2 1:	_		202 00
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro 200 (title XVIII swing-bed SNF))	m wkst. D-3, col. 3, lin	9		202. 00
203 00	Total (sum of lines 201 and 202)				203. 00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
207 00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	•	1		208.00
200.00	and 3)	2, 30 1, 34 31 1133			200.00
209.00	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210. 00
015 00	Comparision of PPS versus Cost Reimbursement	200 -1 11 212			015 00
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line instructions)	209 plus line 210) (see			215. 00
	[Thisti dott ons]		1		l

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prep 7/15/2021 1:03	pared:
	Title XVIII	Hospi tal	Cost	

Primary payer payments					7/15/2021 1:0	3 pm
PART V - CALCULATION OF BELINDURSCHEMT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSCHEMT			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF BELINDURSCHEMT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSCHEMT						
Inpatient services					1. 00	
2.00 Nursing and Allied Health Menaged Care payment (see instructions) 0 2.00 3.00 0.00 0.00 0.00 0.00 0.0000 0.0000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000			PART A SERVICES - COST	REIMBURSEMENT		
Organ acquisition Capture Capt						
4.00 Subtotal (sum of lines 1 through 3) 2,336,532 4.00			ons)			
Primary payer payments 0 0 5.00		9				
Total Cost (Line 4 less line 5). For CAH (see instructions) 2,359,897 6.00		,				4.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Routine service charges Routine service charges Routine service charges Routine service charges Routine service charges Routine service charges Routine service charges Routine service charges Routine service charges Routine service charges Routine services Routine					-	
Reasonable charges 0	6. 00				2, 359, 897	6.00
Routine service charges						
Ancillary service charges 0 8.00 10.00						
0.00						
10. 00 Total reasonable charges 0 10. 00 Customary charges 11. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 11. 00 Anounts that would have been realized from patients liable for payment for services on a charge basis 12. 00 Anounts that would have been realized from patients liable for payment for services on a charge basis 12. 00 Anounts that would have been realized from patients liable for payment for services on a charge basis 12. 00 Anounts that would have been realized from patients liable for payment for services on a charge basis 12. 00 12. 00 13. 00 14. 00						
Customarry charges						9.00
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00	10. 00				0	10.00
12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 0.000000 13.00 13.00 14.00 101al customary charges (see instructions) 0.000000 14.00 101al customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 15.00		, ,				
had such payment been made in accordance with 42 CFR 413.13(e) 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 14.00 Total customary charges (see instructions) 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see						11.00
13.00	12. 00			on a charge basis	0	12.00
14.00 Total customary charges (see instructions) 14.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 15.00 Excess of customary charges over reasonable cost (complete only if line 6 exceeds line 14) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 0 17.00 Cost of covered services (sum of lines 6, 17 and 18) 0 18.00 0 18.70 0 18.00 0 18.70		, ,)			
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 19.00 Cost of covered services (sum of lines 24 and 25, or line 26) 21.00 Cost of covered services (sum of lines 24 and 25, or line 26) 22.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 23.00 Cost of covered services (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Demonstration payment adjustment amount before sequestration 29.00 Cost of covered services (see instructions) 20.00 Cost of covered services (see instruc						13.00
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 16.00 16.00 17.						
16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 1nstructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 18.00 Interior graduate medical education payments (from Worksheet E-4, line 49) 0 18.00 19.00 Cost of covered services (sum of lines 6, 17 and 18) 2, 359,897 19.00 187,220 20.00 Cost of covered services (sum of lines 6, 17 and 18) 2, 359,897 19.00 21.00 Excess reasonable cost (from line 16) 22.10 22.10 23.00 Coinsurance 2, 172,677 24.00 22.00 Coinsurance 2, 172,677 24.00 23.00 24.00 Subtotal (line 19 minus line 23) 2, 172,677 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 12, 093 25.00 25.00 Allowable bad debts (see instructions) 7, 860 26.00 27.00 28.00 28.00 27.00 28	15. 00		ly if line 14 exceeds li	ne 6) (see	0	15. 00
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17. 00	16. 00		ly if line 6 exceeds lir	ne 14) (see	0	16. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0.18.00 0.20.00						
18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18.00 19.00 Cost of covered services (sum of lines 6, 17 and 18) 2,359,897 19.00 20.00 Deductibles (exclude professional component) 187,220 20.00 21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 2,172,677 22.00 23.00 Coinsurance 0 23.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 12,093 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 7,860 26.00 Adjusted reimbursable bad debts (see instructions) 7,860 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 7,860 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 7,860 26.00 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 27.00 29.00 27.00	17. 00		ructions)		0	17.00
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23. 00 Coinsurance		· · · · · · · · · · · · · · · · · · ·				
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30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	30.00	Subtotal (see instructions)			2, 180, 537	30.00
30.03 Sequestration adjustment-PARHM 30.03 31.00 Interim payments Interim payments-PARHM 1,300,830 31.00 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 865, 315 33.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 33.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	30. 01	Sequestration adjustment (see instructions)			14, 392	
31.00 Interim payments 31.01 Interim payments	30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	30. 03	Sequestration adjustment-PARHM				30.03
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	31.00	Interim payments			1, 300, 830	31.00
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00						31.01
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33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	33.00				865, 315	
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 174,006 34.00	33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	inus lines 30.03, 31.01,	and 32.01)		33. 01
§115. 2	34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	174, 006	34.00
		§115. 2				

Health Financial Systems	IU HEALTH JAY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1320	Peri od: From 01/01/2020	Worksheet E-3
	Component CCN: 15-M320	To 12/31/2020	Date/Time Prepared: 7/15/2021 1:03 pm
	Title XVIII	Subprovi der -	PPS
		IPF	

	. I PF		
		1. 00	
	PART II - MEDI CARE PART A SERVI CES - I PF PPS	22.274	
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	30, 874	1.00
2.00	Net IPF PPS Outlier Payments	5, 671	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4. 00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4. 01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "ne	w 0.00	6. 00
7. 00	teaching program" (see instuctions) Current year's unweighted L&R FTE count for residents within the new program growth period of a "ne teaching program" (see instuctions)	w 0.00	7. 00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9. 00	Average Daily Census (see instructions)	0. 131148	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	36, 545	•
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	
14.00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16. 00 17. 00	Subtotal (see instructions) Primary payer payments	36, 545 0	
18.00	Subtotal (line 16 less line 17).	36, 545	
19. 00	Deductibles	2, 816	
20.00	Subtotal (line 18 minus line 19)	33, 729	
21. 00	Coi nsurance	0	21.00
22. 00	Subtotal (line 20 minus line 21)	33, 729	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	4, 884	
24. 00	Adjusted reimbursable bad debts (see instructions)	3, 175	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2, 204	
26. 00	Subtotal (sum of lines 22 and 24)	36, 904	
27. 00	Direct graduate medical education payments (see instructions)	0	27.00
28. 00	Other pass through costs (see instructions)		28.00
29. 00	Outlier payments reconciliation		
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		30. 50
30. 99	Demonstration payment adjustment amount before sequestration	0	30. 99
31. 00	Total amount payable to the provider (see instructions)	36, 904	
31. 01	Sequestration adjustment (see instructions)	244	
31. 02	Demonstration payment adjustment amount after sequestration	0	
32. 00	Interim payments	33, 054	
33. 00	Tentative settlement (for contractor use only)	0	
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	3, 606	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0,000	35.00
	§115. 2	١	
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	5, 671	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

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

Provider CCN: 15-1320 Pr

Peri od: Worksheet G From 01/01/2020 To 12/31/2020 Date/Time Prepared:

7/15/2021 1:03 pm General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 5, 167, 550 0 0 0 1.00 0 2.00 Temporary investments 0 0 0 2.00 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 3, 830, 256 0 4.00 5.00 -1, 839, 569 0 0 0 5.00 Other receivable o 6.00 Allowances for uncollectible notes and accounts receivable 0 0 6.00 o 674 891 0 7 00 7 00 0 Inventory 0 0 8.00 Prepaid expenses 166, 217 0 8.00 0 9.00 Other current assets 0 9.00 10.00 Due from other funds 0 ol 0 10.00 7, 999, 345 Total current assets (sum of lines 1-10) 11.00 0 0 0 11.00 FIXED ASSETS 12.00 Land 989, 148 0 0 0 12.00 Land improvements 0 0 13.00 0 13.00 0 14.00 Accumulated depreciation 0 14.00 Bui I di ngs o 15.00 18, 977, 852 0 0 15.00 Accumulated depreciation -3, 608, 716 16.00 0 0 0 0 0 16.00 0 17.00 Leasehold improvements 17.00 0 0 18 00 Accumulated depreciation r 0 18 00 Fixed equipment 19.00 19.00 0 0 20.00 Accumulated depreciation 0 0 0 20.00 0 21.00 Automobiles and trucks 42, 146 0 21.00 22.00 Accumulated depreciation -7, 902 0 22.00 23.00 Major movable equipment 9, 330, 969 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -4, 426, 346 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 0 0 26.00 26.00 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 21, 297, 151 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 0 0 0 0 32.00 Deposits on Leases C 0 0 32.00 0 0 33.00 Due from owners/officers 0 0 33.00 o 34.00 Other assets 0 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 0 35.00 36.00 Total assets (sum of lines 11, 30, and 35) 29, 296, 498 0 0 0 36.00 CURRENT LIABILITIES 37 00 12 520 605 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 1, 292, 499 0 38.00 Payroll taxes payable 62, 980 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 0 0 0 40.00 C o 0 Deferred income 41 00 41 00 0 42.00 Accelerated payments 3, 381, 198 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities ol 44.00 661.344 0 0 44.00 17, 918, 626 0 Total current liabilities (sum of lines 37 thru 44) 45.00 0 0 45.00 ONG TERM LIABILITIES 46.00 Mortgage payable 0 0 0 46.00 0 0 47.00 Notes payable C 0 47.00 48.00 Unsecured Loans C 0 0 0 48.00 Other long term liabilities 0 0 49.00 49.00 0 Total long term liabilities (sum of lines 46 thru 49) 0 ol 0 50.00 50.00 17, 918, 626 51.00 Total liabilities (sum of lines 45 and 50) 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 11, 377, 872 52.00 0 53.00 Specific purpose fund 53.00 54 00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 11, 377, 872 0 0 0 59.00

29, 296, 498

0

0

0 60.00

Total liabilities and fund balances (sum of lines 51 and

60.00

IU HEALTH JAY HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 Peri od: From 01/01/2020 Provi der CCN: 15-1320

					To 12/31/2020	Date/Time Pre 7/15/2021 1:0	pared: 3 pm
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2.00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 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) Total additions (sum of line 4-9)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15, 342, 155 -3, 964, 283 11, 377, 872		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	6. 00 7. 00 8. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) 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	11, 377, 872 0 11, 377, 872		0 0 0 0 0 0 0 0	0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 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		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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		18. 00 19. 00

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

			To 12/31/2020	Date/Time Pre 7/15/2021 1:0	
	Cost Center Description	Inpatient	Outpati ent	Total	<u> </u>
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	2, 702, 79	5	2, 702, 795	1.00
2.00	SUBPROVI DER - I PF	84, 31	6	84, 316	2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF	606, 48	3	606, 483	5.00
6.00	Swing bed - NF		o	0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	3, 393, 59	4	3, 393, 594	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines		0	0	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	3, 393, 59		3, 393, 594	17.00
18. 00	Ancillary services	6, 239, 66	7 32, 312, 260	38, 551, 927	18.00
19. 00	Outpatient services	431, 49	5 22, 559, 162	22, 990, 657	19.00
20.00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE				26.00
27. 00	OTHER (SPECI FY)		0	0	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	it. 10, 064, 75	6 54, 871, 422	64, 936, 178	28.00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		39, 077, 869		29.00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35. 00	T		0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38.00
39. 00			0		39.00
40.00			0		40.00
41.00	Table 1.1 at 1.2		0		41.00
42.00	Total deductions (sum of lines 37-41)		0 077 0/0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tran	srer	39, 077, 869		43.00
	to Wkst. G-3, line 4)		1	l	

		IEALTH JAY HOSPI TAL		u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-13	20 Period: From 01/01/2020	Worksheet G-3	
			To 12/31/2020		nared.
			12, 01, 2020	7/15/2021 1:0	
	<u> </u>				
				1. 00	
. 00	Total patient revenues (from Wkst. G-2, Part I, col			64, 936, 178	1.00
2. 00	Less contractual allowances and discounts on patien	nts' accounts		35, 296, 908	
3. 00	Net patient revenues (line 1 minus line 2)			29, 639, 270	3.00
1.00	Less total operating expenses (from Wkst. G-2, Par			39, 077, 869	
5. 00	Net income from service to patients (line 3 minus	line 4)		-9, 438, 599	5.00
	OTHER I NCOME				
b. 00	Contributions, donations, bequests, etc			0	
7. 00	Income from investments			0	
3. 00	Revenues from telephone and other miscellaneous con	mmunication services		0	8.00
9. 00	Revenue from television and radio service			0	9.00
0.00	Purchase di scounts			0	10.00
1.00	Rebates and refunds of expenses			0	
	Parking Lot receipts			0	
3.00	Revenue from Laundry and Linen service			0	13.00
4.00	Revenue from meals sold to employees and guests			0	14.00
	Revenue from rental of living quarters			0	15.00
6.00	Revenue from sale of medical and surgical supplies	to other than patients		0	16.00
7.00	Revenue from sale of drugs to other than patients			0	17.00
8.00	Revenue from sale of medical records and abstracts			0	18.00
9.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and can	teen		0	20.00
21. 00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			1, 071, 493	24.00
24. 50	COVI D-19 PHE Fundi ng			4, 402, 823	24.50
25.00	Total other income (sum of lines 6-24)			5, 474, 316	25.00
26. 00	Total (line 5 plus line 25)			-3, 964, 283	26.00
	OTHER EXPENSES (SPECIFY)			0	
	Total other expenses (sum of line 27 and subscripts	s)		0	28.00
9.00	Net income (or loss) for the period (line 26 minus	line 28)		-3, 964, 283	29.00